Executive Summary

The Colorado Department of Health Care Policy & Financing (Department) created the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for State Fiscal Year 2021 – 2022 in accordance with Colorado Revised Statutes (C.R.S.) 25.5-5-421. The MHPAEA is designed to ensure Medicaid Managed Care Organizations (MCOs) and Medicaid alternative benefit plans providing mental health or substance use disorder (MH/SUD) benefits apply limitations on those benefits that are comparable to and no more stringent than those limitations imposed upon medical and surgical (M/S) benefits in the same classifications. The following comparative analysis was performed across Colorado Medicaid's statewide managed care system, consisting of seven Regional Accountable Entities (RAEs) and two MCOs, and the Department's fee-for-service (FFS) system to determine the status of parity compliance within the Colorado Medicaid delivery system.

The State of Colorado's Medicaid capitated behavioral health benefit is administered through the Accountable Care Collaborative (ACC). The state is divided into seven regions with a single Managed Care Entity (MCE), the RAE, operating the ACC in each region. The ACC is a hybrid managed care program authorized through a Section 1915(b) waiver approved by the Centers for Medicare & Medicaid Services (CMS). The RAEs function as a prepaid inpatient health plan (PIHP) for the administration of all ACC members' capitated MH/SUD services, as well as a Primary Care Case Management (PCCM) entity accountable for the effective and coordinated utilization of FFS M/S Medicaid benefits. The RAEs are responsible for administering Colorado Medicaid's capitated MH/SUD benefit, which includes paying claims and authorizing MH/SUD services. Physical health services are paid FFS by the Department's fiscal agent. In addition, two regions allow members in specific counties to participate in capitated M/S MCOs, Rocky Mountain Health Plan (RMHP) Prime and Denver Health Medicaid Choice (DHMC).

The Department follows a process to determine parity compliance that is based on the federal parity guidance outlined in the CMS parity toolkit, "Parity Compliance in Mental Health and Substance Use Disorder Parity Requirements for Medicaid and Children's Health Insurance Programs," and in accordance with the requirements in C.R.S. § 25.5-5-421. The Department collects public input throughout the year to help assess how processes, strategies, evidentiary standards, and other factors operate in practice. This public input helps inform the comparative analysis. Department research on best practices has also led to improvements for data gathering, reporting, and transparency. The process involves a full analysis of a detailed data request submitted by each RAE, MCO, and the Department's FFS system, along with supporting policy and procedural documentation. The analysis also includes direct interviews with each entity in order to verify, elaborate on, or correct any details.

The Colorado Medicaid service delivery system has multiple components that add complexity to assessing parity. The analysis requires the comparison of a capitated MH/SUD payment structure to a FFS M/S payment structure. The Department chose to design its coverage in this manner to maximize the breadth of MH/SUD services available to its members. The

comparison between MH/SUD and M/S benefits seeks to assess whether the written policies and procedures, in design and applied in practice, affect the ability of Medicaid members to access MH/SUD services.

Summary of Findings

An assessment and comparative analysis of MH/SUD benefit limitations compared to M/S benefit limitations found the written policies and procedures to be parity compliant in all Non-Quantitative Treatment Limitations (NQTLs) except in two situations: the fee-for-service inpatient hospital review program's compliance within one NQTL and Denver Health Medicaid Choice's compliance within three NQTLs. Details are provided in *Non-Quantitative Treatment Limitations* below. Limited situations were also found where MCEs were determined not to have followed their written policies, impacting compliance with Availability of Information parity requirements.

The Department's determination was based on the analysis of the following limitations:

Aggregate Lifetime and Annual Dollar Limits

Based on the information collected during the analysis, none of the Managed Care or FFS structures utilize aggregate lifetime or annual dollar limits for MH/SUD benefits and are, therefore, compliant with parity requirements for these limits.

Financial Requirements and Quantitative Treatment Limitations

Based on the information collected during the analysis, none of the RAEs, MCOs, or the Department utilize financial requirements (FRs) or quantitative treatment limitations (QTLs) for MH/SUD benefits and are, therefore, compliant with the parity requirements of these limitations.

Non-Quantitative Treatment Limitations

The Department completed an analysis of the non-quantitative treatment limitations (NQTLs) being used by each of the benefit packages. NQTLs are non-numerical limits on the scope or duration of benefits for treatment, such as preauthorization requirements. In accordance with CMS regulations and guidance, the Department conducted an analysis of how each NQTL is used within the broad benefit classifications of inpatient, outpatient, prescription drugs, and emergency care. While there may be differences between individual NQTL policies and procedures and their application to MH/SUD and M/S services within the benefit classifications, the federal requirement is to analyze whether the NQTLs used for MH/SUD within a benefit classification are comparable to, and applied no more stringently than, those used in the same M/S benefit classification.

Written policies and procedures were determined to be parity-compliant in all benefit categories for all NQTLs except for the following two instances:

- The Department continues to be out of parity compliance with Concurrent Review NQTL for inpatient hospitalizations as a result of the temporary suspension of the M/S Inpatient Hospital Review Program (IHRP). The Department is still in compliance for the Prior Authorization and Retrospective Review NQTLs. The ongoing public health

emergency placed a great stress upon hospitals and hospital systems, and the Department has responded by taking actions to reduce burden on those hospitals and providers and ensure members have appropriate and timely access to care. This compliance issue was first identified in the 2021 MHPAEA Parity Report.[1] The Department did not pursue a similar suspension to the MH/SUD inpatient authorization review process because it was not at risk of system capacity breach in the same way the hospitals were. The Department also required real-time SUD review insights from tracking the use of the newly effective (January 1, 2021) SUD inpatient and residential benefit. These insights needed to be incorporated into the July 1, 2021 inpatient and residential SUD rate adjustments and were important to the Department's efforts to analyze network access, pinpoint areas needing technical assistance, monitor utilization against projections, identify variations in utilizations by RAE region, and confirm that members were being connected to the most effective treatment options. The Department determined that continuing the MH/SUD inpatient authorization review process was the best course of action to ensure the health and effectiveness of the new SUD residential benefit and the MH/SUD system, as a whole.

The Department is currently working to finalize improvements to the program prior to IHRP reinstitution, with redesign efforts underway. As part of the redesign, the Department will ensure the new IHRP concurrent review process is compliant with parity. To ensure parity compliance, the Department is also taking this opportunity to assess the MCEs' concurrent review policies and procedures for MH/SUD inpatient hospitalizations. Reinstituting the IHRP with the program improvements will not start before January 1, 2023. This date has been delayed from initial estimates due to the ongoing COVID-19 public health emergency to help with hospital overwhelm, and to ensure the full system redesign is completed with extensive planning and receives stakeholder input prior to implementation. The Department is working diligently to complete the work earlier if possible.

- This year's analysis identified a parity compliance issue in the policies used by Denver Health Medicaid Choice (DHMC). DMHC is a staff-model MCO, meaning its medical/health providers are employees rather than independent providers who contract with the health plan. Through their efforts to reduce administrative hurdles for providers in their preferred provider network, they inadvertently created a situation where their M/S services authorization policies were less stringent than comparable MH/SUD policies specific to the Denver Health hospital system. These authorization policies impacted the parity compliance for M/S inpatient and outpatient services regarding Prior Authorization, Concurrent Review, and Retrospective Review. DHMC engages in a risk-based sub-capitation arrangement with Denver Health Hospital Authority. As part of the risk-based arrangement, Denver Health Hospital Authority M/S providers do not need to submit any services for authorization. In contrast, nearly all inpatient MH/SUD services and a select set of

[1] 2021 MHPAEA Parity Report: https://hcpf.colorado.gov/sites/hcpf/files/2021%20MHPAEA%20Parity%20Report.pdf.

outpatient MH/SUD services require authorization. While all out-of-network M/S care requires authorization, a significant majority of M/S and MH/SUD services are provided in the Denver Health hospital system. Upon discovery of this finding, the Department immediately began work with DHMC to address the issues and bring their policies back into compliance. DHMC is currently finalizing the policy changes which should be implemented by July 1, 2022. These changes will be evaluated by the Department to ensure the policies meet parity compliance prior to implementation.

The Department remains compliant with all other aspects of mental health parity.

Availability of Information

Based on the information collected, the Department verified that the written polices of the RAEs and MCOs are compliant with both requirements for availability of information:

- Criteria for medical necessity determinations regarding MH/SUD benefits are made available to enrollees, potential enrollees, and contracting providers upon request.
- The reasons for any denial of reimbursement or payment for MH/SUD benefits are made available to the beneficiary.

Health Services Advisory Group (HSAG) performed the external quality review audit of the RAEs' and MCOs' policies and procedures in operation. In this year's audit, they determined the MCEs combined to successfully meet 1,221 applicable elements out of a total of 1,316, for a 93 percent compliance score.

Their audit found a few limited situations where confusing member notices were sent out, and inappropriate denials were made to out-of-network providers. In one situation, an MCE was identified to have not sent any members letters with appeals information, rather, they copied the members on letters sent to the providers. The Department determined these instances were not compliant with the Availability of Information parity requirements. The Department notified the specific MCEs of the issues, which then established plans to address these issues. Additionally, HSAG identified situations where service decisions were not well-documented internally. While they are not parity concerns, HSAG notified the specific MCE about the issue for process improvement.