Introduction

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 C.R.S. § 25.5-5-421. The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and related regulations require state Medicaid agencies that have implemented an Alternative Benefit Plan and/or that deliver services through Managed Care Organization (MCO)s to ensure mental health and substance use disorder (MH/SUD) benefits are not managed more stringently than medical/surgical (M/S) benefits.

The Department follows a process to determine parity compliance that is based on the federal parity guidance outlined in the Centers for Medicare and Medicaid Services (CMS) parity toolkit, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs,"[2] and in following with the requirements in C.R.S. § 25.5-5-421.

The final Medicaid/Children's Health Insurance Program parity rule requires analysis of:

- Aggregate lifetime and annual dollar limits (AL/ADLs); and
- Financial requirements and treatment limitations, which include:
  - ✓ Financial requirements (FRs), such as copayments, coinsurance, deductibles, and out-of-pocket maximums.
  - ✓ Quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits.
  - ✓ Non-quantitative treatment limitations (NQTLs), such as medical management standards, provider network admission standards and reimbursement rates, fail-first policies, and other limits on the scope or duration of benefits; and
- Availability of information.

Definition of M/S and MH/SUD Services

The federal statute and regulations do not identify specific conditions or services as MH/SUD or M/S; instead, states must look to "generally recognized independent standards of current medical practice" to define benefits.

[2] CMS Parity Toolkit: https://www.medicaid.gov/sites/default/files/2019-12/parity-toolkit.pdf.

For the purposes of the parity analysis, the Department has adopted the current version (10) of the International Classification of Diseases, Clinical Modification (ICD-10-CM) as the standard for defining MH/SUD services and M/S services. The Department defines MH/SUD benefits as benefits specifically designed to treat a MH/SUD condition.

- Mental health conditions are those conditions listed in ICD-10 Chapter 5(F), except for subchapter 1 (mental disorders due to known physiological conditions), subchapter 8 (intellectual disabilities), and subchapter 9 (pervasive and specific developmental disorders). The etiology of these conditions is a medical condition—physiological or neurodevelopmental—and treatment would address medical concerns first.
- Substance use disorder benefits are defined as benefits used in the treatment of SUD conditions listed in ICD-10 Chapter 5 (F), subchapter 2 (mental and behavioral disorders due to psychoactive substance use).
- Benefits used to treat all other ICD-10 diagnoses are considered M/S.

Benefit Classifications

The final federal regulations specify requirements for FRs and treatment limitations apply to each benefit classification individually. Colorado Medicaid benefits were classified and mapped into four categories, as directed by the CMS Parity Toolkit. The following definitions were used to differentiate benefit classifications:

Inpatient

Treatment as a registered bed patient in a hospital or facility and for whom room and board charges are made, excluding nursing facilities.

Outpatient

All covered services or supplies not included in inpatient, emergency care, or prescription drug categories.

Prescription Drugs

Medications that have been approved or regulated by the Food and Drug Administration that can, under federal and state law, be dispensed only pursuant to a prescription drug order from a licensed, certified, or otherwise legally authorized prescriber.

Emergency Care

All covered emergency services or items (including medications) provided in an emergency department setting or to stabilize an emergency/crisis, other than in an inpatient setting.

Colorado Medicaid Accountable Care Collaborative

The State of Colorado administers Colorado Medicaid through its Accountable Care Collaborative (ACC). The state is divided into seven geographic regions with a single Managed Care Entity, the Regional Accountable Entity (RAE), operating the ACC in each region. The ACC is a hybrid managed care program authorized through a Section 1915(b) waiver with 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 fee-for-service (FFS) M/S Medicaid benefits. The RAEs are responsible for administering Colorado Medicaid's capitated MH/SUD benefit, which includes paying claims under the capitated MH/SUD benefit and authorizing MH/SUD services. M/S services are paid FFS by the Department's fiscal agent. The Department contracts with a third-party vendor to administer Colorado Medicaid's Utilization Management Program for FFS, referred to as the Colorado Prior Authorization Review.

In two regions covering specific counties, members participate in capitated M/S MCOs. In Region 1, the MCO is operated by the RAE, Rocky Mountain Health Plans (RMHP). In Region 5, the Department contracts directly with the MCO operated by Denver Health Medicaid Choice (DHMC), which is also contracted to function as the MH/SUD PIHP for all members enrolled in the MCO. DHMC subcontracts administration of their MH/SUD PIHP to Colorado Access (COA), including utilization management and network and provider interactions. As of March 2022, there were 156,797 members in MCOs whose M/S and MH/SUD services are covered through capitation payments.

As authorized by the Affordable Care Act of 2010, Colorado expanded Medicaid benefits to individuals ages 19 through 64 at or below 133 percent federal poverty level through an Alternative Benefit Plan that closely aligns, but does not exactly match, the Medicaid state plan adult benefit package. Approximately 513,944 members in the Alternative Benefit Plan receive capitated MH/SUD services, but their M/S services are provided FFS.

MHPAEA and related regulations require state Medicaid agencies that have implemented an Alternative Benefit Plan and/or that deliver services through MCOs to ensure MH/SUD benefits are not managed more stringently than M/S benefits. This analysis complies with 42 Code of Federal Regulations (CFR) § 438.910 and 42 CFR § 440.395.

As MHPAEA is focused on ensuring members' MH/SUD benefits are not managed more stringently than M/S benefits, the Department's unique structure for the Alternative Benefit Plan creates complexity for the parity determination. Instead of comparing managed care policies and procedures against each other, for the Alternative Benefit Plan, the Department compares managed care policies and procedures for a MH/SUD program against an M/S FFS program.

The Department has chosen to provide behavioral health benefits through a managed care program in order to offer members a full continuum of behavioral health services that are not available under federal FFS guidelines, allowing for more flexible service provision. It is only under the federal managed care authority that the Department can offer reimbursement for short-term inpatient stays in Institutions for Mental Diseases, peer recovery services, clubhouse and drop-in centers, vocational services, intensive case management, and other alternative services.

The Department goes beyond federal requirements by conducting the MHPAEA comparative analyses across all members enrolled with the seven RAEs and the two MCOs. The Department does not restrict its MHPAEA comparative analyses only to members eligible for the Medicaid Alternative Benefit Plan or in an MCO.

Methodology

Defining Member Scenarios for Analysis

Colorado Medicaid's unique structure for MH/SUD and M/S benefits creates a need to define the various potential member scenarios available. These scenarios are documented in *Table 1*. Furthermore, *Table 2* defines the mechanism for payment of covered benefits by each of the benefit classifications. These steps define the scope of questions and data needed from each respective payer in order to complete a parity analysis.

The potential member scenarios are listed in *Table 1*. The colors used for the scenarios in the table are applied to the corresponding scenarios in the appendices.

Table 1. Potential Member Scenarios

Scenario 1	Scenario 2	Scenario 3	Scenario 4
Member gets their inpatient and outpatient MH/SUD services, emergency MH services, and M/S benefits through FFS (this is a service-by-service situation). <1% of all Medicaid members are in this scenario.	Member gets their inpatient and outpatient MH/SUD services, emergency MH services through a RAE (RMHP RAE) under a capitated rate and M/S benefits through an MCO (RMHP Prime MCO). 3% of all Medicaid members are in this scenario.	Member gets their inpatient and outpatient MH/SUD services, emergency MH services through a RAE under a capitated rate and M/S benefits through FFS. 89% of all Medicaid members are in this scenario.	Member gets their inpatient and outpatient MH/SUD services, emergency MH services through Denver Health PIHP under a capitated rate and M/S benefits through an MCO (DHMC). 7% of all Medicaid members are in this scenario.

Benefit Map – By Classification

Table 2. Covered Benefits

	Inpatient	Outpatient	Emergency Care	Prescription Drugs
Scenario 1	Med/Surg = FFS MH/SUD = FFS	Med/Surg = FFS MH/SUD = FFS	Med/Surg = FFS MH/SUD = FFS	Pharmacy Benefit Manager (PBM)
Scenario 2	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	MCO Managed PBM
Scenario 3	Med/Surg = FFS MH/SUD = RAE	Med/Surg = FFS MH/SUD = RAE	Med/Surg = FFS MH/SUD = RAE	PBM
Scenario 4	Med/Surg = MCO MH/SUD =PIHP	Med/Surg = MCO MH/SUD = PIHP	Med/Surg = MCO MH/SUD = PIHP	MCO Managed PBM

Tools and Resources to Collect and Analyze Required Data

The Department determined the scope of the parity analysis by researching each benefit plan for the presence of any FRs or QTLs that would require analysis. Colorado Medicaid benefit packages do not currently have any FRs, QTLs, or AL/ADLs for MH/SUD services.

Additionally, a set of NQTLs were identified by comparing each benefit plan, along with stakeholder feedback, to a list of NQTLs outlined in the final Medicaid/parity rule, the parity toolkit, written guidance from CMS, and the Department of Labor regarding the commercial parity rule (including frequently asked questions and related guidance). The Department utilizes tools and resources based on federal guidance to collect and analyze the required NQTL data. The tools and resources have been improved from input from stakeholders, industry best practices, and contractor guidance to better capture the policies and procedures that are key to a robust analysis.

A data request was sent to the RAEs, MCOs, and the Department's Utilization Management (UM) team to collect policy and procedural detail for key areas, including:

1. Medical Management Standards.
    a. Prior Authorization – Identify services by name and service code.
    b. Concurrent Review.
    c. Retrospective Review.
    d. Medical Necessity Criteria.
    e. Medical Appropriateness Review.
    f. Fail First/Step Therapy Protocols.
    g. Conditioning Benefits on Completion of a Course of Treatment.
    h. Outlier Management.
    i. Coding Limitations.
2. Provider Admission Standards.
    a. Network Provider Admission.
    b. Establishing Charges/Reimbursement Rates.
    c. Restrictions Based on Geographic Location, Facility Type, or Provider Specialty.
3. Provider Access.
    a. Network Adequacy Determination.
    b. Out-of-Network Provider Access Standards.

For the 2022 report, the Department significantly updated the data request to provide for an improved communication of policy and procedures. This improved format increased the ability for the MCEs to provide greater clarity, while allowing the Department a more straightforward method to collect detail on policies of particular interest to the parity analysis. Stakeholder feedback was instrumental to identifying additional policies of interest.

Completed data requests were required by March 1. The MHPAEA report is accurate and complete through March 1, 2022. Any policy or procedural changes made after that date will be reviewed on an ongoing basis and noted in the following year's MHPAEA Report. There are a few exceptions to the inclusion of policies updated after the March 1 timeframe, which have been noted in the appropriate section. These specific policies were not found to have negatively impacted parity compliance and are being included for informational purposes.

Responses to the data requests were followed with a virtual interview with a team from each RAE and MCO. The interviews provide an opportunity for the Department to ask questions stemming from the review of the data request responses and gain additional insight into the implementation of the policies and procedures.

Review Process for Medical Necessity Criteria

The Department reviewed the medical necessity criteria collected from the RAEs and MCOs for both EPSDT and the general population, both through the written data requests and follow-up interviews, to verify the criteria utilized to determine medical necessity for MH/SUD and M/S services. The Department analyzed differences in MH/SUD and M/S medical necessity determinations within the care delivery system.

Review Process for NQTLs

The Department prepared a list of common NQTLs that may be in use by the RAEs and the Department for MH/SUD services from the illustrative list of NQTLs in the final Medicaid/parity rule, the parity toolkit, and written guidance from CMS and the Department of Labor regarding the commercial parity rule (including FAQs and related guidance). The Department also gathered feedback through stakeholder written comments, which the Department used to inform the analysis by either affirming previously identified NQTLs or highlighting other areas that may require analysis. The final list included NQTLs applicable to categories such as medical management standards, network admission standards, and provider access. As mentioned previously, the list of NQTLs was reordered for the 2022 report to more logically group them and increase the readability of the appendixes. The appendix for the NQTL Penalties for Noncompliance was removed from this year's report as no health plan applies penalties for non-compliance in any benefit categories. Failure of a provider or participant to follow required procedures may result in an administrative denial, but no additional penalties are levied. The Department will continue to monitor the health plans for this and any other NQTL not listed in the report and will address them specifically when found to be utilized.

The data request for the RAEs, MCOs, and Department's UM included the list of NQTLs identified and asked them to identify any additional NQTLs they apply to MH/SUD services. The request addressed processes, strategies, evidentiary standards, and other factors for

each of the NQTLs that apply to MH/SUD and M/S services, broken down by benefit classification. The request included prompts to help identify the type of information relevant to the parity analysis.

Review Process for Availability of Information

The requirements for availability of information are as follows:

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

These requirements apply to all Colorado Medicaid members receiving MH/SUD benefits, whether through FFS, RAEs, or MCOs. The MCEs were required to provide evidence that they are compliant with this parity requirement, as part of the Health Services Advisory Group (HSAG) audit.

Determining if an FR, QTL, or AL/ADL Will Apply

Based on the information collected during the analysis, the Colorado Medicaid benefit packages impose no FRs, QTLs, or AL/ADLs on MH/SUD benefits. Should future financial, unit, or dollar limits be imposed, these limitations would be reviewed to ensure parity compliance.

Factors Used to Determine if an NQTL Will Apply

Parity requires NQTLs not be applied to MH/SUD benefits in any classification unless their application to MH/SUD benefits are comparable to and no more stringent than the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification. The application standards for any NQTL must be clearly delineated under the policies and procedures of the State, MCO, or PIHP, as written and in operation.

The CMS Parity Toolkit divides this analysis into two parts:

1. Evaluate the comparability of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying the NQTL to MH/SUD benefits and M/S benefits.
2. Evaluate the stringency with which the processes, strategies, evidentiary standards, and other factors (in writing and operation) are applied to MH/SUD benefits and M/S benefits.

Following the process outlined in the CMS Parity Toolkit, the Department used the information provided in the data request and interviews with the RAEs, MCOs, and the Department's FFS UM to determine if an NQTL applies and requires analysis. Any identified NQTL is tested for comparability and stringency to ensure it meets parity guidelines. During this analysis, multiple reference points are explored to determine compliance with parity guidelines including: policy follows standard industry practice, is little to no exception or

variation when operationalizing procedures, policy and practice follows established state definitions and guidelines, the staff operationalizing the policy are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policy is operationalized as documented.

Evaluation of Parity Compliance in Operation

Colorado House Bill 19-1269, updated the C.R.S. § 25.5-5-421(4), which requires the Department to contract with an external quality review organization to perform an annual review of the RAEs' and MCOs' policies and procedures in operation:

- "25.5-5-421 (4). The State Department shall contract with an external quality review organization at least annually to monitor MCEs' utilization management programs and policies, including those that govern adverse determinations, to ensure compliance with the MHPAEA. The quality review report must be readily available to the public."

Health Services Advisory Group (HSAG) was the contractor selected to perform this year's annual review of the RAEs' and MCOs' policies and procedures in operation. A summary of HSAG's review can be found below in *Findings, External Quality Review Analysis*. The full report can be found on the Department's parity webpage.[3]

Updates to the MHPAEA Report

The Department has made many improvements to the MHPAEA Report for SFY 2021 - 2022 to improve the readability and clarity of the document, but more importantly, to increase the accuracy and thoroughness of the analysis.

- The Department significantly updated the data request to provide for an improved communication of policy and procedures. This improved format increased the ability for the MCEs to provide greater clarity, while allowing the Department a more straightforward method to collect detail on policies of particular interest to the parity analysis. Stakeholder feedback was instrumental to identifying additional policies of interest.
- The appendices have been updated to provide a side-by-side comparison of MH/SUD and M/S policies and procedures to improve readability. The change also reflects the update to the data request and the additional information acquired. The appendix for the NQTL Penalties for Noncompliance was removed from this year's report as no health plan applies penalties for non-compliance in any benefit categories. Failure of a provider or participant to follow required procedures may result in an administrative denial, but no additional penalties are levied. The Department will continue to monitor the health plans for this and any other NQTL not listed in the report and will address them specifically when found to be utilized.

[3] The Department of Health Care Policy & Financing Mental Health Parity webpage: https://hcpf.colorado.gov/parity.

Stakeholder Engagement and Feedback

The Department considers stakeholder feedback vital to the monitoring of MH/SUD parity. Department staff engage and seek out input in multiple opportunities and formats throughout the year to ensure ongoing compliance with federal and state parity laws, but also to inform the NQTL analyses. Opportunities for engagement and reporting issues include:

- A quarterly hospital forum attended by the Colorado Hospital Association, urban and rural hospitals, and the RAEs.
- Communications and complaints received by the Office of Behavioral Health Ombudsman of Colorado.
- Provider and stakeholder outreach to Department staff directly.
- Grievances filed by members that have been escalated to the Department.
- An electronic form to provide written comments.

The Department received a total of 16 written comments submitted through the electronic form created specifically for this report. The majority of submissions were received from providers, with some feedback also received from advocates, community members, a Community Centered Board, and a Medicaid member.

Stakeholders shared concerns about prior authorization, reimbursement rates, network adequacy, administrative burden, access to behavioral health services, and the Department writing its own parity report. Concerns that touched on parity-related topics were analyzed for compliance. In regard to the comment about the Department writing its own parity report, CMS holds the Department accountable for parity compliance, the Colorado state statute[4] requires the Department to submit a yearly report, and the Department contracts with Myers and Stauffer to perform an independent review of these reports and the analysis process followed by the Department (see the Mental Health Parity Report External Assessment report.[5])

Provider reimbursement rate concerns are commonly raised by stakeholders, including specific concerns about reimbursement based on clinical licensure, and lower provider reimbursement rates for MH/SUD services in comparison to other states or M/S services. First, it was determined that the processes used by the RAEs to establish charges/reimbursement rates for MH/SUD benefits is comparable and no more stringent than that used for M/S benefits in the same classification in writing and in operation. Further, reimbursement was analyzed for its impact on network adequacy, and it was determined that the processes used

[4] Colorado Revised Statutes 25.5-5-421 (4).
[5] Mental Health Parity External Assessment Report: https://hcpf.colorado.gov/sites/hcpf/files/Mental%20Health%20Parity%20Report%20External%20Assessment%202021.pdf.

to maintain network adequacy by the RAEs for MH/SUD benefits was also comparable and no more stringent than the process used for M/S benefits. Details can be found in *Appendix K: Establishing Charges/Reimbursement Rates*. The Department continually monitors the provider networks and requires the RAEs and MCOs to submit network adequacy plans annually and network adequacy reports quarterly.

Parity Monitoring During Reporting Year

In addition to the review and analysis of policies and procedures performed for the comprehensive annual MHPAEA Report, the Department continually monitors the parity compliance of the RAEs and MCOs throughout the year. Monitoring activities include regular communication with the RAEs and MCOs, meetings and events with stakeholder groups, or direct contact with the Behavioral Health Ombudsman office, practitioners, or members. Any concerns that are raised are analyzed and addressed as they are identified.

The following are some of the changes to policies and procedures made by the RAEs, MCOs, or the Department's FFS UM over the reporting year that warranted a review for parity compliance.

- As of April 1, 2022, Northeast Health Partners and Health Colorado, Inc. eliminated their policy that applied a prior authorization requirement after 25 sessions to the following services: 90832 (30-minute psychotherapy), 90834 (45-minute psychotherapy), 90837 (60-minute psychotherapy), 90846 (family psychotherapy without patient), and 90847 (family psychotherapy with patient).
  - ✓ This change is compliant with parity requirements as it reduces the limitations applied to MH/SUD services.
- As of September 1, 2021, the Colorado Community Health Alliance (CCHA) eliminated their policy that applied a prior authorization requirement after 20 sessions to the following services: 90832 (30-minute psychotherapy), 90834 (45-minute psychotherapy), 90837 (60-minute psychotherapy), 90846 (family psychotherapy without patient), and 90847 family psychotherapy with patient).
  - ✓ This change is compliant with parity requirements as it reduces the limitations applied to MH/SUD services.
- As of January 1, 2022, RMHP eliminated their policy that applied a prior authorization requirement after 12 sessions to 60-minute psychotherapy (90837).
  - ✓ This change is compliant with parity requirements as it reduces the limitations applied to a MH/SUD service.
- In January 2022, the Department temporarily paused prior authorizations requests for Pediatric long-term home health Certified Nursing Assistant services, and home health therapies: occupational therapy, physical therapy, and speech-language pathology therapy services. The pause was extended through at least March 2024 and now

includes pediatric long-term home health intermittent skilled nursing. The two-year pause allows the Department and partners time to robustly engage with stakeholders, train providers on operational changes, evaluate benefit policy, and notify Health First Colorado members before the pause is lifted. This also gives the Department time to ensure full compliance with federal and state policy while keeping Health First Colorado members and their needs front and center.

- ✓ There were no prior authorization requirements on these services during the 2021 MHPAEA Parity Report comparative analysis where compliance with parity was determined. The removal of the prior authorization of the services returns us to that level, and, therefore, continues to be in parity compliance on this aspect.

During the 2022 Legislative Session, the Department supported SB22-156 Medicaid Prior Authorization & Recovery of Payment[6], which removes prior authorizations for Medicaid outpatient psychotherapy and limits when a PIHP (RAE) can retroactively recover provider payments.

Findings

The Department completed an analysis of the NQTLs being used in each of the member scenarios, and an analysis of whether, for each NQTL, there are differences in policies and procedures, or the application of the policies and procedures for MH/SUD benefits and M/S benefits.

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.[7] 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 that 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

[6] Colorado State Senate Bill 22-156: https://leg.colorado.gov/bills/sb22-156
[7] 2021 MHPAEA Parity Report: https://hcpf.colorado.gov/sites/hcpf/files/2021%20MHPAEA%20Parity%20Report.pdf.

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. It was 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 that 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 outpatient MH/SUD services require authorization, and 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. 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.

External Quality Review Analysis

Health Services Advisory Group (HSAG) completed their annual review of the RAEs and MCOs' policies and procedures in operation on April 2022. In their review, they perform a detailed record review of a random sample of denial letters in order to provide a score for each MCE that indicates the level at which each one followed their internal policies related to prior authorization and the reason for denial, notification of determination, timeframes for the sending of notices, notice of adverse benefit determinations including required content, use

of qualified clinicians when making denial decisions, peer-to-peer review, and use of established authorization criteria. **For the 2022 report, HSAG determined the MCEs combined for a 93 percent compliance score.** This is a three percent decrease from last year's 96 percent compliance score, but still indicates a strong adherence to policies: out of 1,316 combined applicable elements, they satisfied 1,221 elements.

All MCEs use nationally-recognized utilization review criteria, and all followed their policies and procedures regarding consistency and quality of UM decisions. Three of nine MCEs were in full compliance with the timeframes for sending Notice of Adverse Benefit Determinations (NABDs). The Department launched new benefits for inpatient and residential SUD services on January 1, 2021, and all MCEs met the 72-hour timeliness requirement for these determinations in the first quarter, as inpatient and residential SUD benefits were initiated, and each MCE implemented the new programs. All MCEs used a Department-approved NABD template letter that included the required information and notified members of their right to an appeal.

However, in a few limited situations, confusing member notices were sent out, and inappropriate denials were made due 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. HSAG also found variability in prior authorization requirements for alternative services (i.e., vocational services, intensive case management, residential, respite care, and recovery services). The Department notified the specific MCEs of the issues, who then established plans to address their issues. Additionally, HSAG found that all health plans' policies and procedures described an appropriate level of expertise required for UM staff members making denial determinations; however, record reviews demonstrated that only seven of nine health plans had consistent documentation in the files regarding the individual who made the determination. These situations are not parity concerns, but HSAG notified the specific MCEs about the issues for process improvement.

The full HSAG annual review can be found on the Department's Parity webpage.[8]

[8] The Department of Health Care Policy & Financing Mental Health Parity webpage: https://hcpf.colorado.gov/parity