Executive Summary

The goal of parity is to make it no more difficult for people to access behavioral health benefits than to access physical health benefits. Behavioral health includes mental health and substance use disorder care (MH/SUD) and physical health includes medical and surgical care (M/S). Specifically, parity laws require that limitations applied to behavioral health within a benefit classification, such as inpatient, outpatient, emergency care, and pharmacy, should be comparable to and applied no more stringently than those used in the same physical health benefit classification. Differences are allowed at the individual service level if they are not more burdensome overall. The following report describes the annual analysis performed by the Colorado Department of Health Care Policy & Financing (HCPF) to ensure that parity standards are maintained statewide for all Health First Colorado (Colorado's Medicaid program) members.

HCPF created the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for State Fiscal Year 2023 – 2024 in accordance with Colorado Revised Statutes (C.R.S.) 25.5-5-421. MHPAEA is designed to ensure Medicaid Managed Care Organizations (MCOs) and Medicaid alternative benefit plans providing MH/SUD benefits apply limitations on those benefits that are comparable to and no more stringent than those limitations imposed upon 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 HCPF'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 when applicable. M/S services are paid FFS by HCPF'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).

HCPF follows a process to determine parity compliance that is based on the federal parity guidance outlined in the CMS parity toolkit, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs," and in accordance with the requirements in C.R.S. § 25.5-5-421. HCPF 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. HCPF research on best practices has also led to improvements in data

gathering, reporting, and transparency. The process involves a full analysis of a detailed data request submitted by each RAE, MCO, and HCPF'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 an FFS M/S payment structure. HCPF 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 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. This includes a review of all changes to RAE, MCO, and FFS UM policies over the past year, which were all found to be in compliance.

HCPF'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 HCPF 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

HCPF 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, HCPF 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.

In April 2023, HCPF resumed aspects of the Inpatient Hospital Review Program (IHRP) focusing on facilitating hospital notification of RAEs to facilitate complex discharges for procedures codes where HCPF has specific coverage criteria. HCPF continued its management of utilization and cost control through an inpatient All-Patient Refined Diagnosis Related Group (APR-DRG) based reimbursement system combined with a Recovery Audit Contractor (RAC) retrospective claims audit system. The change has reestablished the compliance of the Medicaid benefit with parity requirements.

While the APR-DRG + RAC system utilized for M/S services and the per diem + authorization system utilized for MH/SUD services are not the same, they both accomplish the same goals of ensuring member access to medically necessary treatment, utilizing the least restrictive setting possible for care and avoiding unnecessary institutionalization, and maintaining cost control savings for Colorado. Both approaches are nationally recognized industry standards of practice. The requirements, processes, and rationale are comparable and applied no more stringently. Therefore, it is determined that while these policies and procedures are not the same, they are compliant with parity regulations. Additional details of this analysis can be found in the Parity Monitoring During Reporting Year section and Appendix P below.

Availability of Information

Based on the information collected, **HCPF verified that the written policies 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.

External Quality Review Audit

Health Services Advisory Group (HSAG) performed the external quality review audit of the seven RAEs' and two MCOs' (MCEs) policies and procedures in operation, through a review of inpatient and outpatient adverse benefit determination records. Overall, the MCE average score for the mental health parity (MHP) audit decreased slightly from 96 percent in the calendar year (CY) 2022 record reviews to 95 percent compliance score in CY 2023 record reviews. Out of 1,380 applicable elements, the MCEs combined to successfully meet 1,315. In both CY 2022 and 2023, scores for the MCEs ranged from 91 percent to 100 percent, which demonstrated strong adherence to their prior authorization policies and procedures.

The primary reasons for the RAEs missing elements included:

- Denial determinations not sent within the required timeframes.
- Inconsistent inclusion of American Society of Addiction Medicine (ASAM) level of care criteria dimensions within the notice letters.
- Not offering peer-to-peer review to the requesting provider before issuing a medical necessity denial determination.

HCPF has shared the findings with the MCEs. HCPF is delivering a required training in June for all MCEs, who will then develop implementation plans for revising their level of care authorization process as well as any issues identified in the report.

The full External Quality Review Audit can be found on HCPF's Parity webpage.