Introduction

The Colorado Department of Health Care Policy & Financing (HCPF) created the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for state fiscal year 2023 – 2024 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 Organizations (MCOs) to ensure mental health and substance use disorder (MH/SUD or behavioral health) benefits are not managed more stringently than medical/surgical (M/S or physical health) benefits.

HCPF 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,"[1] 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.

[1] CMS Parity Toolkit.

For the purposes of the parity analysis, HCPF 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. HCPF 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 is a registered bed patient in a hospital or facility and for whom the service duration is 24 hours or greater, 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 when applicable. M/S services are paid FFS by HCPF's fiscal agent. HCPF 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, HCPF 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 2024, there were 112,820 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 341,145 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, HCPF'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, HCPF compares managed care policies and procedures for a MH/SUD program against an M/S FFS program.

HCPF 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 of the 1915(b) waiver that HCPF can offer reimbursement for short-term inpatient mental health stays in Institutions for Mental Diseases, peer recovery services, clubhouse and drop-in centers, vocational services, and other alternative services. Substance use disorder stays in Institutions for Mental Diseases, authorized under an 1115 SUD Demonstration Waiver, are provided through the managed care program.

HCPF goes beyond federal requirements by conducting the MHPAEA comparative analyses across all members enrolled with the seven RAEs and the two MCOs. HCPF 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/SUD 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/SUD 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/SUD services through a RAE under a capitated rate and M/S benefits through FFS. 90% of all Medicaid members are in this scenario.	Member gets their inpatient and outpatient MH/SUD services, emergency MH/SUD services through Denver Health PIHP under a capitated rate and M/S benefits through an MCO (DHMC). 6% 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 = RAE	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	MCO Managed PBM

Tools and Resources to Collect and Analyze Required Data

HCPF 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). HCPF 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 HCPF'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.

The MHPAEA report is accurate and complete through March 1, 2024, and the policies and procedures detailed in the data requests received by HCPF were required to be accurate as of that date. 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.

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 HCPF 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

HCPF 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. HCPF analyzed differences in MH/SUD and M/S medical necessity determinations within the care delivery system. The full analysis can be found in the Medical Necessity Criteria Appendix below.

Review Process for NQTLs

HCPF prepared a list of common NQTLs that may be in use by the RAEs and HCPF 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). HCPF also gathered feedback through stakeholder written comments, which HCPF 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. The list of NQTLs is unchanged from the previous year. HCPF will continue to monitor the health plans for any NQTLs, including those not listed in the report, and will address them specifically when found to be utilized.

The data request for the RAEs, MCOs, and HCPF'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, HCPF used the information provided in the data request and interviews with the RAEs, MCOs, and HCPF'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 C.R.S. § 25.5-5-421(4) by requiring HCPF 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 HCPF's Parity webpage.

Stakeholder Engagement and Feedback

HCPF considers stakeholder feedback vital to the monitoring of MH/SUD parity. HCPF 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.

Ongoing Opportunities for Engagement and Reporting Issues

HCPF provides various opportunities for the public to share information including the following:

- A quarterly behavioral health policy hospital forum attended by the Colorado Hospital Association, urban and rural hospitals, and the RAEs.
- A monthly Institutes for Mental Disease (IMD) forum attended by free-standing psychiatric hospitals, facilities offering crisis stabilization, and the RAEs.
- An annual SUD stakeholder forum, a part of Colorado's Expanding the Substance Use Disorder Continuum of Care Section 1115 Demonstration Waiver requirements.
- Ongoing provider focused forums: quarterly SUD Provider Forum, monthly Safety Net Provider Forum, bi-monthly Crisis Services Forum, and quarterly IPN Collaboration Webinar.
- Communications and complaints received by the Office of Behavioral Health Ombudsman of Colorado.
- Provider and stakeholder outreach to HCPF staff directly.
- Grievances filed by members that have been escalated to HCPF.
- Managed care grievances filed by providers that have been escalated to HCPF.
- An electronic form to provide written comments.

HCPF hosts a quarterly behavioral health policy forum for the hospitals and the RAEs to discuss behavioral health issues in hospital settings. Topics discussed in the last year have included a discussion on Mobile Crisis Response billing, sharing behavioral health emergency department data, care coordination of members discharging from emergency departments for SUD treatment, and integrating unlicensed providers into a hospital setting. HCPF also hosts two SUD stakeholder forums. The annual SUD stakeholder forum is part of a federal requirement to present the progress of the SUD benefit. The last stakeholder forum was held

on October 10, 2023, and had an attendance of 20.[2] The SUD forum for providers, also open to stakeholders, is held quarterly to discuss policies, changes and expectations of service delivery and billing in the SUD continuum of care, to ask questions and to raise concerns. A monthly IMD Forum hosted by HCPF is used to discuss access and reimbursement challenges providers face when providing care to members in need of intensive mental health support and psychiatric care while also meeting the requirements of the federal IMD exclusion. Topics discussed over the last year include discharge planning, care transition improvement, IMD patient length of stay and readmit data, claims denial data, and increasing opportunities to provide step-down levels of care to increase mental health support in Colorado. Lastly, in February of 2022, HCPF created a communication form for the independent provider network. This form allows the opportunity for providers to report to HCPF any outstanding issues or concerns they have with the MCEs. More information can be found in the HCPF behavioral health legislative request for information.[3]

Annual Request for Written Public Comment

In addition to the ongoing communication routes to provide information, HCPF makes an electronic form available annually for stakeholders to share their concerns. HCPF received a total of ten written comments submitted through the electronic form created specifically for this report. A majority of the responses received were from those representing providers and the other responses were from those representing stakeholders and advocates. Of the ten submissions received, five were relevant to Medicaid parity compliance.

Comments were shared about reimbursement rates, contracting and credentialing, network adequacy, attribution, coverage of a mental health service, availability of information, SUD treatment in comparison to MH treatment, HCPF's stakeholder engagement process, and HCPF's analysis of parity between the MCEs' process and standards in operation. Concerns that touched on parity-related topics were analyzed for compliance.

A comment on Medicaid covering "transcranial magnetic stimulation" did not raise to the level of a parity concern as it's not a reimbursable service at this time.

Comments were also received regarding a difference in the process and standards for prior authorization requests (PAR), and medical necessity criteria in operation between the MCEs. The comment on the PAR referred to some RAEs having a "streamlined" process to request authorization for placement at a facility while they have not experienced the same with other RAEs and suggested the difference in timeframes impacting access to care. The response times mentioned were all within the timeframes required by regulation. Additionally, denials are audited by our External Quality Review Organization to ensure compliance with stated standards for timeliness; HCPF is collaborating with the RAEs to identify opportunities to improve the timely execution of their processes and learn from others' best practices. The comment about medical necessity criteria shared an experience of "each RAE having different

[2] Colorado Third Annual Substance Use Disorder Stakeholder Forum
[3] 2023 Response to a Request from the Colorado General Assembly

requirements and expectations that affect determinations of medical necessity". Blood alcohol level (BAL) was provided as an example as "each RAE has a requirement for what an individual's BAL can be at the time of a mental health evaluation." HCPF has established that the RAEs are all using the state established medical necessity criteria, however, BAL isn't defined in the medical necessity criteria and is a level of detail that could differ across the RAEs. HCPF is exploring the possibility of creating a statewide standard across all RAEs. A comment was also received which questioned the veracity of the MCEs' PAR procedures and requirements in practice, using the example of inpatient withdrawal management (3.7WM) which doesn't require PAR. Concurrent authorization (concurrent review) and initial authorization (prior authorization review) are distinct processes under ASAM. HCPF sees no inconsistency in UM processes to allow immediate initiation of treatment (treated as an urgent/emergency/crisis level of care service) versus concurrent review at five days when a patient is no longer in an emergent crisis situation. And per ASAM guidelines, determining whether an individual can more appropriately be treated at a different level of care is reasonable.

Two comments were received about a difference between SUD treatment in comparison to MH treatment regarding coding and Pre-Admission Screening and Resident Review (PASRR) screening. The comment on coding shared that "SUD primary codes should be the same as MH primary [codes]" with an IOP example provided. This concern does not impact parity as codes cannot be modified because they are established by a federal agency and a national organization. However, HCPF is looking into the example provided to determine if there are any issues with the established rates. The comment about PASRR shared that it "does not screen for addiction treatment needs, only mental health". It is not a parity concern that addiction treatment needs are not assessed as part of this specific screening method. The Screening, Brief Intervention & Referral to Treatment (SBIRT) SUD screening tool accomplishes this task. PASRR is a federally mandated program which screens for mental illness, or intellectual or developmental disability and related conditions, but if a PASRR Level II evaluation is triggered then SUD is part of this more in-depth assessment. The ASAM Level of Care Assessment tool is used for systematic determination of initial levels of care placement and the Continuing Care Level of Care version is used for ongoing level of care determinations. These are equivalent tools used in the SUD space and required by HCPF.

Comments received about attribution, contracting, and credentialing were related to administrative burden. The comment about attribution shared that "because members are allocated to the RAEs by the physical address of their [primary care provider], mental health care gets interrupted" referring to when a member receives behavioral health treatment in one county and then receives physical health treatment in another county under a different RAE that may cause the member to then be attributed to this county. The design for the next iteration of the ACC, referred to as Phase III, includes a change in attribution intended to simplify the process for providers. Additionally, current functionality exists to allow for attribution to a RAE where the member receives the majority of their behavioral health services regardless of physical health utilization. Lastly, HCPF intends to transition to a single contractor to credential all behavioral health providers who serve Health First Colorado members after the first year of ACC Phase III. Each MCE will conduct their own credentialing for at least the first year of Phase III. The comment received regarding availability of information shared a concern on the "lack of information" on the Notice of Adverse Benefit

Determination (NABD) letters sent to members. In accordance with C.R.S. 25.5-5-421, HCPF contracts with an external quality review organization to monitor the MCEs UM programs and policies, including those that govern adverse determinations, to ensure compliance with parity. See the External Quality Review Analysis section of this report for more information. Regarding the availability of information in an NABD, all MCEs use a HCPF-approved NABD letter template in compliance with federal requirements which includes the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the MCE in filing, access to pertinent records, and the reason for the denial.

Three comments were shared on reimbursement rates for MH/SUD providers regarding different reimbursements received by the RAEs for a mental health service and the "rate-setting processes". In sharing the information from last year's report regarding reimbursement rates, each RAE establishes its own contracts with its providers with its own requirements and reimbursement rates, within the parameters of the RAE's contract with HCPF. After review, 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. Parity does not require the rate setting processes to be identical. The rate setting processes for MH/SUD benefits are comparable to those for M/S benefits when both include input from the providers (either via negotiations with the RAEs or by proxy through the MPRRAC advisory committee). Details can be found in Appendix K: Establishing Charges/Reimbursement Rates.

Parity Monitoring During Reporting Year

In addition to the review and analysis of policies and procedures performed for the comprehensive annual MHPAEA Report, HCPF 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.

This report reviewed all changes to RAE, MCO, and FFS UM policies and procedures over the past year and found them all to be in compliance.

The following are some of the changes made over the reporting year that warranted a review for parity compliance.

- HCPF's Inpatient Hospital Review Program (IHRP) was suspended at the beginning of 2020 due to the COVID-19 Public Health Emergency. IHRP included elements of prior authorization review (PAR) for all inpatient admissions as well as concurrent review (CCR). In April 2023, HCPF resumed the IHRP attempting to conduct prior authorizations for inpatient admission on a limited number of procedure types and focusing on facilitating hospital notification of RAEs to facilitate complex discharges. The procedures codes selected were related to codes HCPF has specific coverage criteria for and this program continues. The focused PAR aspect of the IHRP program was suspended in July 2023 due to challenges with hospitals being able to select the correct International Classification of Diseases Procedure Coding System (ICD-10-PCS) codes accurately at the time of admission, which is necessary to link these PARs to our claims system. HCPF does not intend to resume the program based on the challenges faced by performing PARs for admissions within the framework of an inpatient All-Patient Refined Diagnosis Related Group (APR-DRG) based reimbursement system. Diagnosis Related Groups (DRGs) are not known until final coding of claims and submission to HCPF. In addition, as each APR-DRG has a specific Average Length of Stay there is no specific day HCPF can identify to conduct such a review of a given admission. Finally, conducting PARs and CCRs interferes with the existing Recovery Audit Contractor (RAC) system that systematically audits claims. The RAC system retrospectively identifies potential payment errors in areas such as duplicate payments, fiscal intermediaries' mistakes, medical necessity, and coding and determines if documentation supports the inpatient versus observation status. The whole concept of DRGs reimbursement is incompatible with concurrent reviews as the system is based on Trim Points, levels of deviation from the Average Length of Stay for a service, that drive the same reimbursement level when the Length of Stay is within those Trim Points, and a reduced rate outlier payment is applied when it goes beyond it. For mental health and substance use disorder services, an authorization process is in place that occurs prior to admission to an inpatient setting, and on a concurrent

basis to determine the need for continued length of stay. Claims are generally paid on a per diem basis. Additional details can be found in Appendix P.

  - ✓ 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.

- Rocky Mountain Health Plans created an internally developed guideline for Eating Disorder Treatment in collaboration with HCPF and in response to Colorado Senate Bill 23-176.
  - ✓ This change is compliant with parity requirements as it reduces the limitations applied to MH/SUD services.
- As of September 1, Rocky Mountain Health Plans no longer requires PAR for Qualified Residential Treatment Programs (QRTPs), Psychiatric Residential Treatment Facilities (PRTFs), and Acute Treatment Units (ATUs).
  - ✓ This change is compliant with parity requirements as it reduces the limitations applied to MH/SUD services.
- Colorado Community Health Alliance no longer requires PAR for psychotherapy services for out-of-network providers, in response to 25.5-5-406.1, C.R.S..
  - ✓ This change is compliant with parity requirements as it reduces the limitations applied to MH/SUD services.

During the 2024 Legislative Session, HCPF supported behavioral health bills in an effort to increase access to services and treatment. HCPF worked in collaboration with Mental Health Colorado to draft and support House Bill 24-1045 Treatment for Substance Use Disorders to create and expand programs and services for substance use disorder treatments including expanding access to medically assisted treatment (MAT). HCPF supported: House Bill 24-1384 Certified Community Behavioral Health Clinics that requires HCPF to seek a federal certified community behavioral health clinics planning grant; House Bill 24-1038 High-Acuity Crisis for Children & Youth to expand programs for youths who are in, or are at risk of being placed in, out-of-home care; Senate Bill 24-047 Prevention Of Substance Use Disorders which creates several measures regarding the prevention of substance use disorders; Senate Bill 24-059 Children's Behavioral Health Statewide System of Care that requires the development of a comprehensive children’s behavioral health system of care by the Behavioral Health Administration.

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 determined 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 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.

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.

External Quality Review Analysis

HCPF contracts with Health Services Advisory Group, Inc. (HSAG) to annually review the utilization management (UM) program and related policies and procedures of each RAE and MCO, as well as a sample of prior authorization denials to determine whether the MCEs followed federal and state regulations and internal policies and procedures that impact mental health parity. HSAG's FY 2023-2024 report contains findings from their audit of calendar year (CY) 2023 denial letter records for each MCE. The findings include 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.

Overall, the MCE average score for the mental health parity 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.**

All MCEs used nationally-recognized utilization review criteria and followed their policies and procedures regarding consistency and quality of UM decisions. All MCEs' policies and procedures described an appropriate level of expertise for determining medical necessity determinations. All record reviews demonstrated that all MCEs consistently documented the individual who made the adverse benefit determination. The documentation within the files demonstrated that in all cases, the individual who made the determination possessed the required credentials and expertise to do so. Five of the nine MCEs were fully compliant in notifying the provider of the determination within the required time frame. Six of the nine MCEs demonstrated consistency between the reason for the denial determination stated in the NABDs sent to members and the reason for the determination that was documented in the UM system. All MCEs used a HCPF-approved NABD letter template, which included the required information and notified members of their right to an appeal.

However, eight of the nine MCEs were out of compliance for not sending the NABD to the member within the required time frame, despite having accurate policies and procedures. Four of the nine MCEs did not consistently include all required ASAM dimensions in the NABD to demonstrate to the member how each of the dimensions were used when making the denial determination. Six of the nine MCEs did not follow outlined policies and procedures for offering a peer-to-peer review to the requesting provider before issuing a medical necessity denial determination. Six of the nine MCEs did not consistently demonstrate outreach to the requesting provider to request additional information before issuing a denial related to a lack of adequate documentation to determine medical necessity. HCPF notified the specific MCEs of the issues, who then established plans to address their issues. HCPF will be monitoring progress on these plans and report on them in the next report.

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