BEHAVIORAL HEALTH PARITY AND COLORADO MEDICAID

MAY 25, 2021

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MEET THE MYERS AND STAUFFER TEAM

ASHLEIGH PEREZ

CPA, Member

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MYERS AND STAUFFER

- Independent CPA firm
- 19 offices nationwide
- Health care auditing, compliance, and program integrity support
- Health care policy and reimbursement consulting with state and federal agencies
- Engaged with HCPF to provide MHPAEA resources and evaluate parity assessment process

AGENDA

- Behavioral Health Parity
- Colorado Medicaid Delivery System
- Evaluating Medicaid Parity

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BEHAVIORAL HEALTH PARITY

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MHPAEA AUTHORITY

- Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Affordable Care Act expansion of requirements
- CMS parity rule finalized in 2016
- CMS parity toolkit published in 2017
- Colorado Revised Statutes 25.5-5-421

MHPAEA APPLICABILITY

- **Medicaid managed care plans***
- **Medicaid alternative benefit plans***
- Children's Health Insurance Program (CHIP)*
- Large health plans sponsored by an employer (51+ employees)
- Non-federal governmental plans purchased from an insurer

The CMS parity rule applies to plans marked with an asterisk (*).

THE BASICS OF MHPAEA

- Mental health (MH) and substance use disorder (SUD) benefits provided to enrollees must be offered at a level no more restrictive than those provided for medical and surgical care
- Generally recognized independent standards used to classify benefits as MH/SUD
- Annual assessment and report

MHPAEA NUANCES

MHPAEA DOES

Require MH/SUD benefits, if provided, to be provided for every classification in which medical/surgical (M/S) benefits are provided.

Require that processes, evidentiary standards, and policies governing MH/SUD benefits do not result in more stringent management of MH/SUD benefits as compared to M/S benefits.

Require comparability.

MHPAEA DOES NOT

Mandate coverage of MH/SUD benefits.

Require MH/SUD benefits to equal M/S benefits.

Require alignment of benefits with other states' Medicaid programs or with commercial insurance requirements.

Dictate utilization management policy or process requirements.

Require equality.

CLASSIFICATIONS FOR ASSESSMENT

INPATIENT

Benefits furnished to enrollees as a registered bed patient in a facility for whom room and board charges are made.

OUTPATIENT

Benefits furnished to enrollees that are not covered under inpatient, emergency care, or prescription drug categories.

EMERGENCY CARE

Benefits (including medications) furnished to enrollees in an emergency department or to stabilize an emergency or crises outside an inpatient setting.

PRESCRIPTION DRUGS

Benefits furnished to enrollees for medications approved by the FDA that can only be dispensed via an appropriate order by an authorized prescriber.

COMPONENTS OF MHPAEA

AL / ADL	FR	QTL	NQTL
Aggregate Lifetime (AL) and Annual Dollar Limits (ADL)	**Financial Requirements (FR)**	**Quantitative Treatment Limits (QTL)**	**Non-Quantitative Treatment Limits (NQTL)**
Dollar limits on the total amount of specified benefits provided over the lifetime of an enrollee or within a defined 12-month period.	Deductibles, coinsurance, copayments, and out-of-pocket maximums.	Limitations on the scope or duration of benefits for treatments or services that can be defined numerically.	Limitations on the scope or duration of benefits for treatments that cannot be defined numerically.

AGGREGATE LIFETIME / ANNUAL DOLLAR LIMITS COMPONENT

- Dollar limits on the total amount of specified benefits provided over the lifetime of an enrollee or within a defined 12-month period
- May not be applied to MH/SUD benefits unless they are also applied to at least two-thirds of medical/surgical benefits (*Substantially All* test)
- May not be more restrictive than limits applied to at least 2/3 of medical/surgical benefits
- Colorado Medicaid does not impose any aggregate lifetime or annual dollar limits

FINANCIAL REQUIREMENTS COMPONENT

- Deductibles, coinsurance, copayments, and out-of-pocket maximums
- *Substantially All* test applies
- FRs applied to MH/SUD benefits may not be more restrictive than the requirements applied to more than half of the medical/surgical benefits (*Predominance* test)
- Outpatient benefits may be subdivided into office visits and other services to assess compliance
- Colorado Medicaid does not impose any financial requirements

QUANTITATIVE TREATMENT LIMITATIONS COMPONENT

- Limitations on the scope or duration of benefits that can be defined numerically.
- *Substantially All* and *Predominance* tests apply
- Limits must be numerically quantifiable
  - Limits subject to discretion or revision based on medical necessity or other clinical criteria may be considered NQTLs
- Outpatient benefits may be subdivided into office visits and other services to assess compliance
- Colorado Medicaid does not impose any QTLs

NON-QUANTITATIVE TREATMENT LIMITATIONS COMPONENT

- Limits applied to MH/SUD benefits may not be more restrictive than those applied to medical/surgical benefits
- Medical management standards, provider network admission standards, provider access
- Assessment includes evaluation of processes, strategies, evidentiary standards, and other factors used in applying the limitations
- Application of written processes are evaluated to identify departures from established procedures

COLORADO MEDICAID DELIVERY SYSTEM

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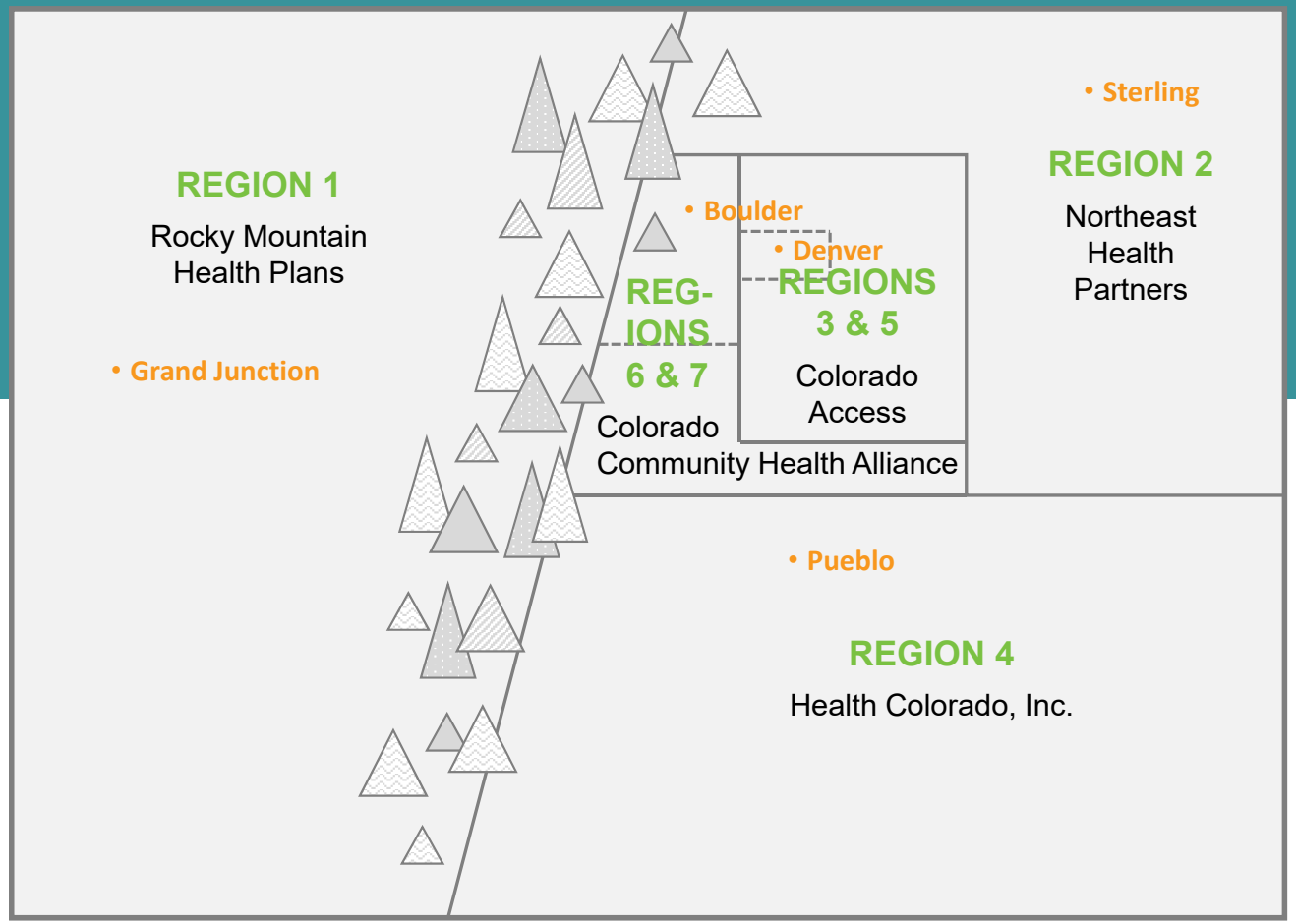
BEHAVIORAL HEALTH CARE COVERAGE

- Primary behavioral health coverage provided by the state's Capitated Behavioral Health Benefit
- Established under a federal 1915b waiver
- Expands covered behavioral health services to include services not available otherwise:
  - Short-term inpatient stays
  - Clubhouse and drop-in centers
  - Vocational services
  - Intensive case management
  - Other alternative services

COLORADO MEDICAID ACC

- Medicaid administered through Accountable Care Collaborative (ACC) hybrid managed care program
- Seven geographic regions
- The state contracts with a Regional Accountable Entity (RAE) in each region to:
  - Administer capitated behavioral health benefit
  - Coordinate case management for fee-for-service medical and surgical benefits with behavioral health and other community resources
- Two regions allow members to participate in capitated medical and surgical benefits

REGIONS AND RAEs



VARYING BENEFIT COMBINATIONS

- Benefits covered via different payment mechanisms
  - Capitated benefits
  - Managed care organizations
  - Fee-for-service (FFS)
  - Denver Health PIHP
- Availability of payment mechanisms is region-specific
- MH/SUD benefits covered through managed care program must be compared to medical/surgical benefits covered FFS

BENEFIT COVERAGE COMBINATIONS*

Four ways members could have their benefits covered:

ONE

All MH/SUD and medical/surgical benefits are provided through fee-for-service (FFS) arrangements.

TWO

MH/SUD benefits are covered under the capitated behavioral health benefit through the RAE; medical/surgical benefits are covered through a managed care organization (MCO).

THREE

MH/SUD benefits are covered under the capitated behavioral health benefit through the RAE; medical/surgical benefits are covered FFS.

FOUR

MH/SUD benefits are covered under Denver Health PIHP; medical/surgical benefits are covered through an MCO.

*Referred to as “Member Benefit Scenarios” in HCPF parity report.

COLORADO MEDICAID PARITY

- MHPAEA and CMS' final parity rule apply to:
  - The Medicaid Alternative Benefit Plan
  - The Medicaid Managed Care Plans
- Colorado's parity evaluation considers benefits cover by:
  - Regional Accountable Entities (RAEs)
  - Managed Care Organizations (MCOs)
  - The Department, Fee-for-Service

EVALUATING MEDICAID PARITY

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ASSESSING COMPLIANCE

- Identify standard to define benefits falling into each of the four classifications
- Define the four classifications and map benefits
- Understand and incorporate nuances for Colorado's unique delivery system landscape
- Collect and evaluate documentation
- Compare actual practices to written procedures
- Solicit stakeholder input

STAGES OF ASSESSMENT

STAGE 1
Research

STAGE 2
Stakeholder Engagement

STAGE 3
Data Request

STAGE 4
Interviews

STAGE 4
Analyze

STAGE 5
Report

NONQUANTITATIVE TREATMENT LIMITATION ASSESSMENT

- Goal to evaluate if MH/SUD benefits are *comparable* to M/S benefits and if MH/SUD benefits are *applied more stringently* than M/S
- Evaluation of written policy documentation combined with actual practices in place
- Stakeholder interviews inform analysis
- General categories to evaluate:
  - Medical management
  - Network management
  - Prescription drugs

MEDICAL MANAGEMENT

- Prior authorization
- **Concurrent review**
- Retrospective review
- Conditioning of benefits
- Medical appropriateness review
- Outliers management
- Penalties for noncompliance
- Coding limitations
- Medical necessity criteria

NETWORK MANAGEMENT

- **Process for establishing charges and reimbursement rates**
- Network provider admission
- Network adequacy determination
- **Restrictions based on geographic location, facility type, or provider specialty**
- Out-of-network provider access standards

PRESCRIPTION DRUGS

- Formulary design
- **Fail first and step therapy protocols**
- Potential for off-label use
- Clinical efficacy

CONTACT US

COParityQuestions@mslc.com

General questions regarding parity requirements should be submitted through June 1, 2021 to inform FAQ.

HCPF_Parity@state.co.us

Specific inquiries and requests.

RECOMMENDED RESOURCES

www.Colorado.gov./HCPF

General parity and Colorado-specific resource materials, contact information for inquiries.

www.CMS.gov

General parity resources, federal register authority, periodically updated Q&A.

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Q&A

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PARITY OVERSIGHT

1. How is parity compliance managed for Medicaid's alternative benefit and managed care plans in Colorado?

2. How does HCPF ensure ongoing parity compliance when there are policy or legislative changes that impact either MH/SUD or medical and surgical services, but not both?

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PLACE OF SERVICE

1. If place of service restrictions exist for a MH/SUD service, is this a violation of parity?

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PROVIDER REIMBURSEMENT

1. Is it a violation of parity if pay rates vary for behavioral health providers that provide the same service, but are licensed differently?

2. Is it a violation of parity if provider reimbursement rates or rate setting processes differ for MH/SUD benefits and medical surgical benefits?

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