COLORADO MENTAL HEALTH PARITY AND ADDICTIONS EQUITY ACT

STAKEHOLDER ENGAGEMENT REPORT

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PRODUCED BY

CEDARBRIDGE GROUP

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Introduction

Signed into law on May 16, 2019, House Bill 19-1269 requires the Colorado Department of Health Care Policy and Financing (Department) to issue an annual report on the state's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). The bill is intended to ensure the state is compliant with federal parity laws and extends into state law the requirements of the federal MHPAEA, along with some additional provisions intended to ensure transparency. The bill added into state law new requirements for the Department to "ensure that benefits under the medical assistance program for behavioral, mental health, and substance use disorder services are not less extensive than benefits for any physical illness and are in compliance with MHPAEA." The bill covers both private insurance and Medicaid.

With respect to Medicaid, the Department is mandated to require each "Managed Care Entity (MCE)" contracted with the State Department to disclose all necessary information in order for the State Department by June 1, 2020 and by each June 1 thereafter to submit a report…regarding behavioral, mental health and substance use disorder parity. Also, by October 1, 2019, for purposes of obtaining meaningful public input during the assessment process…, the State Department shall seek input from stakeholders who may have competency in benefit and delivery systems, utilization management, managed care contracting, data and reporting, or compliance audits."

The Department partnered with CedarBridge Group (CedarBridge) to conduct stakeholder engagement and to design and create an annual Mental Health Parity and Addiction Equity Act (MHPAEA) report in compliance with House Bill 19-1269.

This report reflects the input received by stakeholders and may not accurately reflect Department policies and procedures. It was compiled prior to CedarBridge completing its analysis of Colorado Medicaid's compliance with MHPAEA. The final report is available at: https://www.colorado.gov/pacific/hcpf/regulatory-resource-center

Methodology for Gathering Stakeholder Input

Stakeholder engagement began as the novel coronavirus 2019 (COVID-19) pandemic took hold which limited the options available for conducting stakeholder outreach as well as the bandwidth of some stakeholders to participate in outreach opportunities. CedarBridge collaborated with the Department to design and implement the stakeholder engagement strategy given the limitations presented by COVID-19.

For stakeholder engagement, the Department thought it was important to go beyond the statute requirement of engaging individuals with competency in managed care and benefit management. As parity is confusing for many people, the Department sought to provide an opportunity to hear from members, providers, and other stakeholders to learn about potential parity issues and identify areas of confusion in order to work to provide greater clarity in the future.

The stakeholder engagement plan prioritized collecting meaningful public input for the Department's assessment of the Statewide Managed Care System's compliance with MHPAEA with the goal of assessing how processes, strategies, evidentiary standards, and other factors operate in practice. To accomplish this, CedarBridge, in collaboration with the Department gathered input from state agencies, payors, providers, advocates, and related professional organizations through a multi-pronged outreach approach.

1. CedarBridge interviewed teams from each of the seven Regional Accountable Entities (RAEs) and Managed Care Organizations (MCOs) to ascertain how each entity implements its written policies and to ask clarifying questions based upon our review of the data submitted in response to the data request.
2. Interviews were held with teams of Department staff charged with implementing and monitoring the fee-for-service programs under which medical and surgical services are delivered to Medicaid enrollees (alternative benefit plan, rates, utilization management), as well as the vendors managing the fee-for-service program.
3. CedarBridge facilitated two virtual public listening sessions; the first was held on March 31, 2020 from 11:30 am to 1:30 pm, the second was held on Thursday, April 2, 2020 from 6:00 pm to 8:00 pm.
4. Interviews with the stakeholders listed below:

Organization	Individual(s)
Colorado Office of Behavioral Health	Camille Harding, Division Director
Colorado Center on Law and Policy	Bethany Pray, Christina Yebua
Colorado Behavioral Healthcare Council	Mindy Klowden
Colorado Community Health Network	Stephanie Brooks, Taylor Miranda Thompson
Dimensions Counseling and Consulting	Emily Schrader, MA, LPC, CACIII
Division of Insurance	Cara Cheevers, Behavioral Health Program Manager
Mental Health Colorado	Moe Keller
Colorado Hospital Association	Lila Cummings
Colorado Ombudsman for Behavioral Health	Aubrey Boggs, Ombudsman Rebecca Swanson, Deputy Ombudsman
Creative Treatment Options	Joyce Smith, PsyD, LPC, LAC, MAC, Director and Clinical Supervisor

   Interviews ranged from 60 to 120 minutes. The interview process concluded on May 8, 2020 with 10 organizations interviewed.
5. Stakeholders were also invited to submit written comments through an online platform. Seven written comments were received; Those comments pertaining to the Medicaid program are included as Appendix A.

Stakeholder Feedback

Throughout the stakeholder outreach process common themes emerged. Providers shared frustrations about utilization management, administrative burden, the tiered network design, reimbursement rates, credentialing process, and time to receive payment. Advocates for Medicaid members shared frustrations with network adequacy and understanding how to navigate the managed care system structure. The RAEs and MCOs expressed frustration regarding being held responsible for actions and metrics not currently included in their contracts with the State.

In 2018, the Department made a significant transition in the delivery system by joining physical and behavioral health under one accountable entity in each of seven regions.

The concerns shared most frequently are described in more detail below along with representative quotes from stakeholders.

Utilization Management

Stakeholders reported concerns and frustrations with the utilization management (UM) process across all managed care entities, with some RAEs being cited more often than others.

1. Processes and Practices
    - Differing processes and practices across the RAEs cited as a cause of confusion and additional administrative burden for the providers.
    - Lengthy back and forth process to procure approvals cited as a cause of disruption in treatment for the Medicaid enrollee.
2. Independent Review
    - Stakeholders recommended the Department evaluate utilizing an Independent Reviewer or Review Organization. They suggest an independent review would address many issues, including variability among managed care entities, a lack of expertise in the areas of MH/SUD at the managed care entities, and the perceived motivation of a managed care entity reviewer.
    - Stakeholders shared a desire to see another level in the appeal process after the appeal to the managed care entity and prior to moving to the administrative law judge (ALJ) level. An independent reviewer after the denial at the managed care entity and before the ALJ level would be less expensive and more efficient. Stakeholders acknowledged the details, such as payment for the independent review, would need to be developed.

- *"The UM process is over-used and lacks transparency across all RAEs."*
- *"Providers cannot access UM policies from the RAEs, and this leads to confusion and unnecessary work."*
- *"There are inconsistencies in the application of UM policies both within RAEs (you will get a different response depending on the reviewer assigned to the request) as well as across RAEs."*
- *"MH treatment still being denied based upon a non-MH primary diagnosis."*

- *"There is a lack of expertise in RAE management for MH/SUD."*
- *"Moving patients from the Emergency Department to a behavioral health setting is very difficult. On the M/S side this process is immediate; MH/SUD requires a prior authorization which can sometimes take multiple days to receive."*
- *"Denial rates from RAEs do not match the denial rates providers are calculating."*

Administrative Burden

Administrative burden was consistently raised by providers, their associations, and advocates as a perceived parity issue.

RAEs are required to have a statewide behavioral health network to ensure members can receive services no matter where they may be in the state.

1. Multiple RAEs – Multiple Administrative Requirements

    - Providers report the attribution model leaves little choice but to contract with all managed care entities to ensure payment.
    - RAEs utilize different codes, different payment policies, different requirements for billing, and often, different credentialing requirements.
    - The processes for prior authorization and medical necessity determination vary from RAE to RAE making it very time consuming to ensure the correct paperwork is being completed and submitted in the timeframes required. Each RAE has its own billing and UM portals MH/SUD providers must utilize for these purposes.
    - Stakeholders recommended the Department require standardization of policy and administration across all RAEs and MCOs. It is clear from stakeholder feedback, MH/SUD providers experience great frustration with the variability in policy, procedure, and outcomes across the RAEs and MCOs.

- *"Billing and paperwork keep providers from serving Medicaid. 50% of behavioral health providers will not serve Medicaid because of the administrative burden."*

2. Intake Process
    - The state requires intake forms necessary for compliance with federal law which must be completed manually, with numerous updates. Providers are not compensated for the time required to complete these forms.

- *"The intake process for behavioral health providers is very onerous. It is estimated to take 45 minutes per paid service hour to complete documentation and administrative tasks."*

Timely and Appropriate Payment

Providers report difficulty getting reimbursement from RAEs.

The Department includes contract requirements for the MCEs to pay 90% of clean claims within 30 days of the date of receipt and paying 99% of clean claims within 90 days.

1. Independent MH/SUD providers report difficulty in getting timely, appropriate reimbursement for services delivered.
    - Reports of payments routinely taking longer than 60 days, and sometimes in excess of 120 days, especially for complex patients with cross program needs.
    - *"The shift to the RAE system forced providers to shift from a consistent revenue stream which they had with the BHO structure. This has been difficult for many organizations. Complex patients with cross program needs can take a very long time to be paid for."*
2. Community Mental Health Centers (CMHC) report challenges with incentive payments flowing from the RAE to the CMHC.
    - *"Community Mental Health Centers (CMHC) do not receive payments for community health services under the RAE structure; Office of Behavioral Health can offset some of these costs, but some services have had to be discontinued due to lack of resources."*
    - *"Primary Care Medical Provider (PCMP) can receive care coordination payments that are not available to the CMHC; CMHCs are doing care coordination and not being reimbursed for the service."*
3. FQHCs report concerns about encounter payments from RAEs.
    - *"FQHCs have difficulty getting encounter payments from RAEs; continuous follow-up is necessary resulting in additional administrative burden."*
4. Reimbursement for telehealth is a point of confusion and concern.
    - *"Telehealth reimbursement is not happening as promised; with COVID-19 issues, this is very troubling for behavioral health providers."*
5. Stakeholders recommended the Department seek a more flexible funding approach to address the needs of individuals with Intellectual and Developmental Disabilities (IDD) and Traumatic Brain Injury (TBI) patients who fall under the 1915(b) waiver. They suggested a more flexible funding framework could provide a better approach to managing the needs of patients who are served under the State's 1915(b) waiver.

Network Adequacy

Stakeholders report a critical shortage of mental health and substance use disorder providers serving the Medicaid population; multiple contributing factors were cited:

- Low rates paid to MH/SUD providers;
- Administrative burden; and
- Credentialing process.

Long wait times to get appointments for MH/SUD treatment were reported. Inpatient bed space for MH/SUD treatment was reported to be inadequate to serve the needs of Medicaid enrollees.

- *"I had a patient present with a relapse needing detox. No space was available for the patient in a detox setting - patient was told to continue to drink alcohol until a spot becomes available."*
- *"Patient cannot get an appointment with a provider to get prescriptions continued after discharge from an inpatient facility and must go to the ER to get medication."*
- *"Access for non-English speakers is very limited: intake for Spanish speakers is only on Tuesday afternoon; number of providers who speak Spanish is extremely low".*
- *"There are not adequate pediatric providers."*
- *"RAEs do not engage in contract negotiations with small providers."*
- *"We have received reports of a 16-month waitlist for care."*
- *"There is limited availability of facilities willing to accept Medicaid patients; single case agreements are occasionally used, but patients often do not get timely, appropriate care."*

Credentialing

Providers report concerns with the variability across RAEs with respect to the types of providers being credentialed, the timeframe for the process, the ability to gain understanding of the process, where in the process an application sits, and the differences in the process depending on the type of organization making the application.

Credentialing is federally required of managed care entities to ensure provision of quality services to members.

- *"RAEs owned by provider groups are less open to new providers than those not owned by provider groups. This can lead to less choice of providers in the areas with provider owned RAEs. This is especially troubling because the more rural RAEs are the ones owned by providers and there is already a shortage of providers in these areas."*
- *"Community Mental Health Centers have more flexibility with respect to licensure of providers than individual providers due to difference in how services are permitted to be billed."*

Reimbursement Rates

Provider reimbursement rates for all providers, across all RAEs and MCOs, were reported to be unsustainably low, however, providers experiencing the switch to a tiered-rate structure shared the greatest frustration. Stakeholders recommended the Department review the Tiered Payment Structure. Providers report the tiered payment structure is not aligned with how services are delivered, especially for SUD services.

- *". . . an SUD provider running a relapse prevention support group saw its rates decrease due to not having a psychiatrist leading the group. However, psychiatrists do not lead relapse prevention support groups. Providers believe the tiered structure is not aligned with how services are delivered and results in decreased payment for necessary services."*

Lack of Leadership and Communication

Stakeholders across the spectrum spoke to a perceived lack of leadership and communication from the Department.

1. Expectations and Goals
    - Comments from all sectors indicated a desire to have the Department be clearer about its goals and expectations, to have RAE and MCO contract metrics clearly reflect those goals and expectations, and contractual requirements for policy and administrative standardization.
    - RAEs and MCOs concurred on the lack of contractual specificity.
    - Stakeholders recommended the Department hold RAEs and MCOs accountable for meeting metrics designed to reflect the intent and expectations of the State through contracting provisions.
    - RAEs and MCOs, as well as providers, expressed a desire to see more specificity in the contracts between the State and the managed care entities. RAEs and MCOs expressed frustration about being held to expectations not expressly stated in contract.
2. Stakeholder Engagement
    - Stakeholders recommend the Department design a more robust stakeholder engagement process. They expressed a desire for more opportunities to communicate with the Department about their experiences and concerns.
    - Providers and Medicaid members report difficulty navigating the system, especially when intellectual developmental disabilities and traumatic brain injury is involved.
    - More robust stakeholder engagement would benefit both the Department and the stakeholders by allowing better communication and information sharing as this nascent program evolves.

- "HCPF has given RAEs immense flexibility."
- "HCPF should be monitoring the RAEs more closely and should require RAEs to demonstrate parity as part of their contract."
- "The Department should review the complaint process; it is very complicated which is why so few Medicaid members file complaints."

Methodology for Analyzing Stakeholder Input

MHPAEA compliance requires financial requirements and treatment limitations on Mental Health or Substance Use Disorder (MH/SUD) benefits are no more restrictive or stringent than those on medical or surgical (M/S) benefits. This is commonly referred to as providing MH/SUD benefits in parity with M/S benefits. There are requirements for determining parity with respect to financial requirements (such as copays) and for treatment limitations, which limit the scope or duration of benefits for treatment. Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment (such as preauthorization requirements).

The rules for financial requirements and QTLs are different from the rules for NQTLs. The current structure of Medicaid benefits does not include QTLs. Therefore, the analysis of stakeholder input focuses on NQTLs and whether the issues raised pose parity concerns or require further inquiry in order to determine compliance with mental health parity requirements. Under MHPAEA regulations, Medicaid may not impose an NQTL on MH/SUD benefits unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to M/S benefits in the same classification.

The phrase "applied no more stringently" is intended to ensure any processes, strategies, evidentiary standards, or other factors that are comparable on their face as written are actually applied in the same manner to M/S benefits and to MH/SUD benefits. However, because many processes and strategies for applying NQTLs can only be shown by documenting differences in quantitative measures, outcomes data become very important in conducting comparative analyses.

Stakeholder comments were assessed to determine whether a policy or procedure is a parity issue on its face. For example, if RAEs required MH/SUD facilities be licensed by the State but the same requirement is not imposed on M/S facilities, the policy is likely a parity compliance concern. Stakeholder comments were also assessed to determine if a concern about the way a policy or procedure was being implemented was the source of a parity compliance issue. For example, if a RAE reduces the reimbursement rate for every CPT code whenever healthcare practitioners other than physicians deliver MH/SUD services, but doing the same for nonphysician M/S service providers only when certain factors support the reduction, this could be a parity compliance issue.

Analysis of Stakeholder Input

Colorado's Accountable Care Collaborative (ACC) structure is complex and adaptation to Phase II has been challenging for providers and Medicaid members to master.

CedarBridge will review all stakeholder input against the policies and procedures of the seven RAEs, two MCOs, and the fee-for-service program to identify any parity compliance concerns in the written policies and procedures governing the MH/SUD benefits and M/S benefits. CedarBridge will also assess stakeholder input to determine whether NQTLs are applied more stringently in operation by analyzing the data supplied from the RAEs, MCOs, and fee-for-service program. Data, such as rates of denials for MH/SUD as compared to M/S benefits, may provide a warning sign, or indicator of potential operational parity noncompliance.

If an NQTLs is determined to result in disparate outcomes, it will be carefully analyzed to ensure the NQTL is not being applied more stringently to MH/SUD benefits than to M/S benefits in operation.

CedarBridge will conduct this analysis on an entity by entity basis to ensure each MCE is in compliance with MHPAEA, as well as the program as a whole.

CedarBridge's preliminary analysis of stakeholder feedback is as follows:

- Stakeholder feedback on administrative burden and timely and appropriate payment are unlikely to be documentable parity issues. The feedback in these areas raises operational concerns which could be addressed through negotiation and contracting between the Department, the MCEs, and the providers. Data will be assessed to determine if an identifiable impact in other areas, such as network adequacy, exists as a result of administrative burden or lack of timely and appropriate payment.
- The structure of the managed care program does not raise a parity compliance issue. The manner in which the individual managed care entities administer the program may create a parity concern, however, administrative burden on its face is not a parity issue. Rather, feedback helps identify data sources to be assessed to test if administrative burden has risen to a parity concern.
- Lack of timely and appropriate payment is unlikely to rise to the level of a parity concern, however, over time may become a parity concern by impacting network adequacy. Payment issues could be addressed directly through contract provisions requiring timely payment.
- Perceptions regarding the Department's leadership and communications is not a NQTL. Feedback in this topic area has been shared with the Department.
- Feedback on utilization management, network adequacy, credentialing, and reimbursement rates has been helpful in identifying specific written policies as well as types of outcomes data to evaluate to test for parity compliance issues.

Conclusion

CedarBridge would like to acknowledge and thank all the stakeholders who took the time to provide input and comments during the stakeholder engagement process, especially in light of the burdens on stakeholders during the COVID-19 pandemic.

The MHPAEA compliance analysis will be enriched by the input and feedback provided by stakeholders. Stakeholder experiences and input will allow CedarBridge to undertake a more robust analysis of MHPAEA compliance and potential parity concerns.

Our final analysis will also highlight for the Department suggested data and trends to track year over year in order to determine whether parity concerns are developing.

The final comparative analysis will be submitted to the Department and the Legislature, pursuant to HB 19-1269.

All issues and concerns shared during the stakeholder engagement process have been shared with the Department, including specific issues pertaining to particular RAEs and individual concerns.

APPENDIX A

An opportunity to submit written comments was provided as part of the stakeholder engagement process. The comments directed to the Medicaid program are included in their entirety below.

It has recently been brought to the attention of the Colorado Coalition for Parity that there is a fundamental flaw in the payment structure for services delivered through the state's Medicaid program which places the state out of compliance with the parity requirements of the Affordable Care Act. This flaw makes it impossible for the state to conduct an adequate parity analysis between behavioral health services provided and medical/surgical services provided. This issue urgently needs to be addressed.

Thank you for your work on parity and mental health access.
"Anthem" when mentioned here refers to CCHA/Anthem that administers RAE 6 and RAE 7.

Concern: Pay cuts:
Anthem cut contracted Medicaid mental health provider rates 20% January 1, 2020 after notifying us in October 2019. This was an illegal violation of parity laws. No medical side billing procedures changed.

Anthem and apparently HCPF still view reimbursement as something Anthem can simply change at will without reason. This is false. Dropping our rate was illegal. The fact that mental health rates can be changed in ways that phys/med/surg can't is a parity violation. Note that the money saved did not return to Colorado but rather to Anthem shareholders.

Concern: Inexplicable payment scheme:
Additionally, Anthem is paying "Centers" a vastly higher rate for the exact same service, in fact over $300 when contractors receive around $85. This payment scheme is miles outside of parity compliance. The intention of parity is to create more access to mental health. HCPF's current payment scheme actually reduces the number of therapists that will participate because for-profit MCOs are given free rein to manipulate our payment rates.

Concern: The ACC Phase II was a boondoggle that violates parity in its structure:
The promise of "coordination of care" in ACC Phase II which made this RAE system has never been supported by HCPF or Anthem, other RAEs. There has been ZERO change on the ground. The contracts between HCPF-RAE mention an "app" that would be HIPAA compliant and allow for info exchange between mental health and physical. That never happened. Capitated mental health payment structures are themselves violation of parity, which insists that treatment
limitations must be administered similarly for phys/med/surg as for mental health. Provider reimbursement is clearly a treatment limitation as low reimbursements limit participation and therefor limit access. Anecdotally members in Boulder County are simply unable to access care because the provider network is so small. Anthem, Beacon, Colorado Access, and RMHP must all lose these contracts. HCPF should use the same mechanisms to pay for and administrate mental health that they do for physical health. There is no need for "geographic regions", there is no argument made for it that has been satisfactory or has come true to my knowledge. The RAEs claim there are 'geographic

differences' but the pay scales do not reflect that. HCPF has the capacity to manage mental health claims the same way they handle physical.

Parity concern: "Slamming" children into different RAEs by doctor visits:
It has been a real parity violation for mental health providers to HAVE TO HAVE 4 contracts in order to cover our clients, when medical only needs one. To illustrate: I serve in Region 6. I provide high conflict divorce services for children. The children may see doctors across the county line to the East (Region 2), or Fort Collins (RAE 1), or Denver (RAE 3/5), which means I had to contract with RMHP (Ft Collins), Beacon (RAE 2), and Colorado Access (RAE 3/5).

There needs to be one program, not 7. Then children won't get "slammed" around (assigned into a new RAE without notification). This is a treatment limitation and a parity violation. Children can get medical care, and the claim gets paid, if they seek care outside their RAE. Not so for mental health, our claims are denied and guardian has to work to get child back into coverage. ALL children in medicaid, not just foster kids, are subject to being moved by this RAE system. This is an NQTL parity concern. To illustrate: Two children, living next door to each other in Louisville, are covered by Anthem (RAE 6), and come to our clinic for play therapy. One child has divorced parents and splits time in Denver. Child gets ill in Denver and goes to a clinic. Because of the way enrollment is determined, which is by THE PHYSICAL LOCATION OF THE MEDICAL PROVIDER, the child is 'slammed' (this is a term used in the telecom industry when customers have their carriers changed without asking for it), into RAE 3 or 5 (Denver, Colorado Access). The parent is not notified that this happened. Then the child that went to the Denver clinic comes to play therapy. I file a claim with CCHA, and it gets denied, because the child is now in another RAE. Then, I have to notify the parent that their child is no longer covered. Turns out, I'm the first one to tell them. So who do they get mad at? Then, I have to give them the magic phone number to get their child re-enrolled in Anthem (RAE 6). By the way, that phone number is 303-839-2120. This stresses the treatment, the provider, and the parent, and medical/physical never has to deal with this.

Parity concern: Contracting Time. We do not know the contracting time for medical. The time elapsed to gain a contract from Anthem (RAE 6,7) is extremely, unethically, lengthy, in some cases longer than 6 months. It is absolutely a treatment limitation for Anthem to take so long to simply produce a contract for providers that have ALREADY been vetted by HCPF through 'validation.'

Parity Concern: RAE 4 (Beacon) "Health Colorado" announced that 90837 (outpatient psychotherapy 53+ minutes) will require re-authorization after 8 sessions, 16 sessions, and 26 sessions. This will create a huge paperwork drag. Calling for pre-authorization or using an electronic form is a parity concern. I believe that insurer stated they get 10 days to decide.

Parity Concern extension codes
Family therapy is a difficult and time consuming service. The Colorado Medicaid Fee Schedule allows for the "extension code" which is 99354, which is allowed for Fee For Service and Medical.
This presumes that the medical/physical side is reimbursed for meetings with a doctor that run over an hour longer than their minimum times. Anthem has not paid on any of these claims for mental health provision. We put two therapists into a family session to support the family. Then we run those sessions 90 minutes because that's what works. That equals 3 hours of 'therapist time', which we could bill as individual at over $300. Currently the pay for family therapy is lower than $70.
We need this extension code to make the service worth delivering. If medical gets it, mental health should get it too.

Parity concern: uneven application of rules between RAEs:
Colorado Access (RAE 3,5) denies claims for services provided by interns/pre-licensure therapists, while all other RAEs pay. This is a parity violation as a similar qualification regime does not exist on the phys/med side and this policy also limits access to treatment.

We need a systemic way to enforce parity in addition to a case by case basis. A case by case system is not sufficient to overcome the high denial rates by insurance companies for behavioral health services.

Thank you for the opportunity to submit feedback on the Department's implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA). We hope these comments will help provide a consumer perspective as the Department works on the design of the mental health parity analyses and the Department's annual report due in June. We encourage the contractor responsible for reviewing parity compliance will work with the goal of assessing how the processes, strategies, evidentiary standards and other factors applied to behavioral health versus physical health operate in practice.

Mental Health Colorado's recommendations for the mental health parity analysis and subsequent report are as follows:

• The mental health parity analysis should be done by each distinct regional managed care entity region separately. This is crucial in ensuring the requirements outlined in MHPAEA are being met in every region of the state.

• The review process for nonquantitative treatment limitations (NQTLs) should be extensive and include a definition of possible NQTLS, including but not limited to:

- o Medical management standards limiting or excluding benefits based on:
- o Medical necessity or medical appropriateness; or
- o Whether the treatment is experimental or investigational.
- o Step therapy or fail-first protocols;
- o Exclusions based on failure to complete a course of treatment;
- o Restrictions based on:
    - Geographic location;
    - Facility type;
    - Provider specialty; and
    - Other criteria that limit the scope or duration of benefits.
- o Formulary design for prescription drugs; and
- o Standards for provider admission to a network, including reimbursement rates.

• Create a comparative analysis demonstrating that, for any non-quantitative treatment limitation, including medical necessity criteria, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to benefits for behavioral, mental health, and substance use disorders within each classification of benefits are comparable to, and are applied no more stringently than, the processes,

strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits.

• These comparative analyses at a minimum:

    o Identification of any factors used to determine whether a non-quantitative treatment limitation will apply to a benefit, including any factors considered and rejected;

    o Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each non-quantitative treatment limitation;

    o Provide the comparative analyses, including any results of the analyses, performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, as written, and the written processes and strategies used to apply each non-quantitative treatment limitation for benefits for behavioral, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to design and apply each non-quantitative treatment limitation, as written, and the written processes and strategies used to apply each non-quantitative treatment limitation for medical and surgical benefits;

    o Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each non-quantitative treatment limitation, in operation, for benefits for behavioral, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply each non-quantitative treatment limitation, in operation, for medical and surgical benefits.

We would also like to provide the following comments based on what we have heard from consumers of behavioral health services and supports in Colorado:

Mental Health Colorado believes the Department of Health Care Policy and Financing has a responsibility to apply and enforce federal and state mental health and substance use parity laws. However, systemic flaws in how delivery of care is set up in Colorado makes it possible for parity violations to occur. With two different payment structures for behavioral health care vs. med/surgical care, HCPF can't do an accurate parity comparison.

Of specific concern to us are:

• Stringent utilization management policies and procedures in the mental health/substance use delivery of care compared to the medical/surgical fee for service side of care.

• We also hear from providers that mental health and substance use providers are paid less than medical/surgical providers on the fee for service side.

• Another concern is the provision of non- quantitative limitations on the mental health/substance use care compared to the medical/surgical side of care in determining level of services provided.

• Lack of adequate networks of providers for Medicaid members to access appropriate care and treatment.

• Inappropriate application of medical necessity criteria for mental health/substance use claims versus medical/surgical claims.

We strongly believe it is the Department's responsibility to comply with federal and state parity lays as the Department writes and manages the contracts with the RAEs and thus, holds ultimate responsibility. Perhaps this confusion could be eliminated with an amendment in the current RAE contracts specifying that HCPF will enforce observance of mental health/substance use disorder parity compliance.
We look forward to participating in the two stakeholder meetings that will help inform the parity analysis and the Department's annual report to give further information to the contractor.

Mental Health Colorado is also submitting to you the model parity reporting templates already adopted by the Division of Insurance.
