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 2021 – 2022 in accordance with C.R.S. § 25.5-5-421. The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and related regulations require state Medicaid agencies that have implemented an Alternative Benefit Plan and/or that deliver services through Managed Care Organizations (MCOs) to ensure mental health and substance use disorder (MH/SUD) benefits are not managed more stringently than medical/surgical (M/S) 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,"[2] and in following with the requirements in C.R.S. § 25.5-5-421.

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

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

Definition of M/S and MH/SUD Services

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

[2] CMS Parity Toolkit.

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. 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 2022, there were 167,261 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 560,068 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 that HCPF can offer reimbursement for short-term inpatient stays in Institutions for Mental Diseases, peer recovery services, clubhouse and drop-in centers, vocational services, intensive case management, and other alternative services.

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

Benefit Map – By Classification

Table 2. Covered Benefits

	Inpatient	Outpatient	Emergency Care	Prescription Drugs
Scenario 1	Med/Surg = FFS MH/SUD = FFS	Med/Surg = FFS MH/SUD = FFS	Med/Surg = FFS MH/SUD = FFS	Pharmacy Benefit Manager (PBM)
Scenario 2	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	MCO Managed PBM
Scenario 3	Med/Surg = FFS MH/SUD = RAE	Med/Surg = FFS MH/SUD = RAE	Med/Surg = FFS MH/SUD = RAE	PBM
Scenario 4	Med/Surg = MCO MH/SUD = 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, 2023, 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. HCPF is working on the final steps to implement the improved IHRP and reinstituting IHRP with program improvements is set to occur on June 1, 2023. The new policies and procedures of IHRP have been evaluated for compliance with all parity laws and regulation, however, additional changes may be made during implementation. Therefore, the details and analysis of these policies will be included in next year's 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.

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 the C.R.S. § 25.5-5-421(4), which requires 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.[3]

[3] The Department of Health Care Policy & Financing Mental Health 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. Opportunities for engagement and reporting issues include:

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

HCPF received a total of seven written comments submitted through the electronic form created specifically for this report. There was a relatively even distribution of responses received from those representing providers, consumers and advocates. Of the seven submissions received, three were relevant to Medicaid parity compliance.

Comments were shared about reimbursement rates, contracting and credentialing, network adequacy, and HCPF's analysis of parity including recommended assessments of policies in practice or in operation. Concerns that touched on parity-related topics were analyzed for compliance. The comment on network adequacy did not raise to the level of a parity concern as it noted an "acute need for clinicians that are willing to work with this population", referring to individuals with an Intellectual and Developmental Disability (IDD).

A comment was shared regarding the difference in reimbursement rates between SUD and MH services that a provider receives between different RAEs they are contracted with. 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. Details can be found in *Appendix K: Establishing Charges/Reimbursement Rates*. One submitted comment shared a provider's experience with the process of contracting and credentialing. An analysis of the parity compliance of the contracting and credentialing process and requirements has determined they are industry standard and parity compliant. However, HCPF collaborated with the RAEs

during the past year to streamline credentialing processes. More information about these efforts can be found in the HCPF behavioral health legislative request for information[4].

A comment was received from an advocate that provided recommendations on HCPF's analysis of parity and expressed concerns about the findings within the report. Regarding the concerns shared about the Notice of Adverse Benefit Determinations (NABDs) issues being "minimized or ignored", these notices have been reviewed by HSAG. Additional information about this audit can be found in the *External Quality Review Analysis* section of this report within *Findings*, see below. Other comments provided HCPF with changes that can be made to the report to address concerns with the analysis and findings.

[4] Response to a Request from the Colorado General.

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.

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

- Since last year's report, Northeast Health Partners and Health Colorado, Inc. eliminated their prior authorization, concurrent review, and retrospective review requirements for psychological testing.
    - ✓ This change is compliant with parity requirements as it reduces the limitations applied to MH/SUD services.
- As of July 1, 2022, DHMC eliminated authorization requirements for inpatient services within the DHMP preferred network. Prior to the change, some inpatient MH/SUD services were subject to authorization whereas no inpatient M/S services were subject to authorization and therefore they were out of compliance.
    - ✓ This change has brought DHMC back into compliance with parity requirements as it has created a similar policy of authorizations for MH/SUD and M/S services.

During the 2023 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 Senate Bill 23-174 Access To Certain Behavioral Health Services to cover select mental health services for Medicaid members under 21 and supported House Bill 23-1269 Extended Stay and Boarding Patients to promote clinical stabilization for youth involved in the behavioral health system.

Findings

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 except for the following instance:

> HCPF continues to be out of parity compliance with Concurrent Review NQTL for inpatient hospitalizations, as a result of the temporary suspension of the M/S Inpatient Hospital Review Program (IHRP). HCPF is still in compliance for the Prior Authorization and Retrospective Review NQTLs. The ongoing public health emergency placed a great stress upon hospitals and hospital systems, and HCPF has responded by taking actions to reduce burden on those hospitals and providers and ensure members have appropriate and timely access to care. This compliance issue was first identified in the 2021 MHPAEA Parity Report.[5] HCPF did not pursue a similar suspension to the MH/SUD inpatient authorization review process because it was not at risk of system capacity breach in the same way that the hospitals were. HCPF also required real-time SUD review insights from tracking the use of the newly effective (January 1, 2021) SUD inpatient and residential benefit. These insights needed to be incorporated into the July 1, 2021 inpatient and residential SUD rate adjustments and were important to HCPF's efforts to analyze network access, pinpoint areas needing technical assistance, monitor utilization against projections, identify variations in utilizations by RAE region, and confirm that members were being connected to the most effective treatment options. It was determined that continuing the MH/SUD inpatient authorization review process was the best course of action to ensure the health and effectiveness of the new SUD residential benefit and the MH/SUD system as a whole.
>
> This report is accurate as of March 1, 2023, and as of that date HCPF is working on the final steps to implement the improved IHRP. Reinstituting IHRP with program improvements is set to occur on June 1, 2023. The new policies and procedures of IHRP have been evaluated for compliance with all parity laws and regulation. However, to avoid constraining policy makers from making any necessary programmatic changes prior to implementation, these policies are not included in this year's report. The policies will instead be included in next year's report.

On July 1, 2022, Denver Health Medicaid Choice (DHMC) addressed the parity compliance issue that was identified in the 2022 MHPAEA Report. The issue impacted their authorization policies specific to services provided in the Denver Health hospital system. DHMC eliminated authorization requirements for all inpatient services within the DHMP preferred network. Prior to the change, some inpatient MH/SUD services were subject to authorization whereas

[5] 2021 MHPAEA Parity Report.

no inpatient M/S services were subject to authorization and therefore they were out of compliance. This change has brought DHMC back into compliance with parity requirements as it has created a similar policy of authorizations for MH/SUD and M/S services.

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 2022-2023 report contains findings from their audit of calendar year (CY) 2022 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.

In this year's audit, **HSAG determined the MCEs combined for a 96 percent compliance score**, having successfully met 1,440 applicable elements out of a total of 1,506. This is a three percent increase from last year's 93 percent compliance score; likely attributed to process and internal oversight improvements made since last year's audit.

All MCEs use 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. Eight of the nine MCEs were in full compliance of following outlined policies and procedures in offering peer-to-peer review with the requesting provider before issuing a medical necessity denial determination. Seven of the nine MCEs demonstrated consistency between the reason for the denial determination stated within the Notice of Adverse Benefit Determinations (NABDs) sent to members and the reason for the determination that was documented in the UM system. All MCEs used a Department-approved NABD letter template, which included the required information and notified members of their right to an appeal.

However, seven of the nine MCEs had one or more instances of not meeting timeliness requirements in notifying the provider of the denial determination and/or sending the NABD to the member within the required time frame. Of the 167 total records reviewed, 22 records did not meet timeliness requirements. Additionally, only five of the nine MCEs consistently listed all required ASAM dimensions for SUD inpatient and residential denials and how the dimensions were considered when making the denial determination. Five inpatient SUD NABDs only listed the ASAM dimensions that were not met and two NABDs did not include required ASAM dimensions at all. The Department notified the specific MCEs of the issues, who then established plans to address their issues.

The full HSAG annual review can be found on the Department's Parity webpage.[6]

[6] The Department of Health Care Policy & Financing Mental Health Parity webpage.