



COLORADO

**Department of Health Care
Policy & Financing**

Mental Health Parity and Addiction Equity Act (MHPAEA)

**Analysis and Demonstration of Compliance for Colorado's Medicaid and
Children's Health Insurance Programs**

Updated May 1, 2019

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Introduction

This report summarizes the Colorado Department of Health Care Policy & Financing's (Department's) analysis of Health First Colorado's (Colorado's Medicaid Program) compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA requires that Health First Colorado members are offered behavioral health benefits equal to their Medical/Surgical benefits.

MHPAEA applies to members covered by Medicaid Managed Care Organizations (MCOs), the Alternative Benefit Plan (ABP), and Children's Health Insurance Program (CHIP). While this rule applies to members being served through a Medicaid MCO, approximately 132,000 members in the state of Colorado, the state wants to ensure all Medicaid members have similar access to behavioral health and physical health benefits.

Analytical Components

The final rule requires the state to ensure compliance with three general areas: aggregate lifetime and annual dollar limits (AL/ADLs), financial requirements (FRs) and quantitative treatment limitations (QTLs), and non-quantitative treatment limitations (NQTLs). States were asked to look at their benefit and utilization management practices and policies to ensure compliance with the following general requirements:

- AL/ADLs are not applied to mental health and substance use disorder (MH/SUD) benefits unless a limit is applied to at least one-third of Medical/Surgical benefits.
- FRs and QTLs applied to a classification of MH/SUD benefits, may not be more restrictive than the financial requirements and quantitative treatment limits applied to Medical/Surgical benefits in the same classification.
- Any processes, strategies, evidentiary standards, or other factors used to apply NQTLs to MH/SUD benefits in a classification are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply NQTLs to Medical/Surgical benefits.

Determination

The state of Colorado determined that the robust mental health and substance use disorder benefits offered by the state's Medicaid program and CHIP satisfy the requirements of MHPAEA as detailed in the final rule issued by the Centers for Medicare & Medicaid Services in 42 CFR Parts 438, 440, 456, and 457. The analysis was conducted by gathering benefit information from the state's MCOs, Regional Accountable Entities (RAEs), and CHIP, as well as an analysis of the ABP.

Overview of Colorado's Medicaid System

The Accountable Care Collaborative (ACC) is the Department's primary delivery system for Health First Colorado members. Within each of the state's seven regions, a single Regional Accountable Entity (RAE) is responsible for coordinating both physical and behavioral health (defined as mental health and substance use disorder) for members. These are the duties previously contracted by Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs).

All full-benefit Health First Colorado members (excluding members enrolled in Program for All-Inclusive Care for the Elderly [PACE]) are enrolled in the ACC and assigned to one of the seven RAEs. The RAEs are responsible for administering Health First Colorado's capitated behavioral health benefit, which includes paying claims under the capitated behavioral health benefit and authorizing behavioral health services. Physical health services are paid fee for service by the Department's fiscal agent.

Two of the RAEs also operate physical health Managed Care Organizations (MCOs) for a portion of their members. There are approximately 132,000 members enrolled in these capitated MCOs which provide services in Denver County and six counties in the western part of the state. Members enrolled in these MCOs are also covered by the capitated behavioral health benefit.

The Department uses the State Plan to describe the services available through Medicaid and CHIP, referred to as Child Health Plan *Plus* (CHP+), programs in Colorado. Anytime a change is made to the State Plan, the Department files a State Plan Amendment (SPA) with the Center for Medicaid & Medicare Services (CMS). Any services offered outside of the State Plan must be approved through a federal waiver program, which gives the state the ability to offer additional services through alternative payment methodologies. The ACC and the capitated behavioral health benefit are authorized through a 1915(b) waiver.

Colorado chose to expand Medicaid in 2014 under the Patient Protection and Affordable Care Act through an Alternative Benefit Plan (ABP). The ABP offers the same benefits package as the State Plan. As the Department treats the ABP as an aid category, members receive their services through the ACC.

Medicaid members who require specialized care beyond what is authorized in the State Plan may qualify for a Home and Community Based Services (HCBS) waiver. Each waiver has unique services, guidelines, and payment methodologies. These waivers are designed to help members stay in-home and community-based service settings. Members in a HCBS waiver may also be in a managed care plan.

As none of Colorado's Medicaid MCOs are fully comprehensive (offering both MH/SUD and Medical/Surgical benefits), the Department conducted the analysis using data provided by the MCOs and RAEs.

Defining Mental Health and Substance Use Disorder (MH/SUD) Benefits

The Department uses standard definitions to define the behavioral health and Medical/Surgical benefits, which is reflected in the Colorado rules and regulations:

- Behavioral health benefit: A benefit specifically designed to treat a mental health or substance use disorder condition.
- Medical/Surgical benefit: a benefit specifically designed to treat a medical condition.

Defining Classifications and Mapping Benefits to Classifications

In completing the Medicaid MHPAEA analysis, the Department examined the full array of Medicaid services offered to members and mapped the benefits to each classification in the chart below. Benefits are broken into two categories: MH/SUD and Medical/Surgical.

Benefit Category	MH/SUD	Medical/Surgical
Inpatient	Covered by a RAE (MH only)	Covered by an MCO or through FFS
Outpatient	Covered by a RAE	Covered by an MCO or through FFS
Emergency	Covered by a RAE	Covered by an MCO or through FFS
Pharmacy	Covered by an MCO or through FFS	Covered by an MCO or through FFS

RAEs cover inpatient and outpatient behavioral health services for the State Plan and MCO enrollees. As members are mandatorily assigned to a RAE, they cannot opt out of receiving behavioral health services through their RAE.

Long-Term Services & Supports and HCBS Waivers

Long-term services and supports (LTSS) in Colorado are managed by State Administrators who work with local entities to coordinate services for people with disabilities, older adults, and other Coloradans with complex and acute health care needs through HCBS waiver services. The Department determined all HCBS waiver services fall into the Medical/Surgical category of benefits. The scope and duration of these services are described in service plans developed by Case Managers who are familiar with the individuals receiving services, their families, and care needs.

Analysis of Financial Requirements, Quantitative Treatment Limitations, and Aggregate Lifetime and Annual Dollar Limits

The capitated behavioral health benefit does not utilize any Financial Requirements (FRs), Quantitative Treatment Limitations (QTLs), or Aggregate Lifetime or Annual Dollar Limits (AL/ADLs). Therefore, the Department is compliant with MHPAEA requirements put forth in 42 CFR 438 Subpart K.

Through CMS guidance, ABP benefits must be parity compliant regardless of whether the benefits are administered through FFS or managed care. As the ABP mirrors the State Plan benefit, the Department has determined the ABP compliant with MHPAEA.

Identifying and Analyzing Medicaid Non-Quantitative Treatment Limitations

A requirement of this analysis per 42 CFR 438.910(d) requires a review of Non-Quantitative Treatment Limitations (NQTLs) to ensure the processes, strategies, and evidentiary standards used for applying NQTLs to MH/SUD benefits are no more stringent than the processes, strategies, and evidentiary standards used to apply NQTLs for Medical/Surgical benefits.

Through the final MHPAEA rule, CMS guidance, and technical assistance provided to the state, the Department identified and analyzed five NQTLs across the MH/SUD and Medical/Surgical benefits: Prior Authorization, Concurrent Review, Retrospective Review, Network Provider Admission, and Establishing Charges. Each of these areas was broken down by each of the four benefit categories (inpatient, outpatient, emergency, pharmacy) and questions were asked regarding the processes, strategies, and evidentiary standards used for each benefit category.

The Department's analysis concludes that NQTLs applied to the behavioral health benefit are comparable and applied no more stringently than NQTLs applied to the Medical/Surgical benefit; thus, the Department is compliant with MHPAEA requirements put forth in 42 CFR 438 Subpart K. Please refer to Appendix A of this document for the analysis of each NQTL.

Children’s Health Insurance Program (CHIP) Compliance Documentation

Colorado’s CHIP MCO plans are all fully comprehensive, offering both MH/SUD and Medical/Surgical benefits. As the plans are fully comprehensive, the plans were responsible for conducting their own parity analysis of their MH/SUD and Medical/Surgical benefits. Through the Department’s review of the plans’ analyses, the Department concurs all of Colorado’s CHIP MCO plans are compliant with MHPAEA requirements put forth in 42 CFR 457 Subpart D.

Analysis of Financial Requirements, Quantitative Treatment Limitations, and Aggregate Lifetime and Annual Dollar Limits

None of the CHIP plans utilize any Quantitative Treatment Limitations (QTLs) or Aggregate Lifetime or Annual Dollar Limits (AL/ADLs) for administering the behavioral health services benefit. Financial Requirements (FRs) are not applied more stringently to MH/SUD benefits than Medical/Surgical benefits. Copays for MH/SUD benefits are similar to Medical/Surgical benefit copays, and the annual out-of-pocket maximum applies to all services.

Identifying and Analyzing Non-Quantitative Treatment Limitations

This analysis, per 42 CFR 457.469(d), requires a review of Non-Quantitative Treatment Limitations (NQTLs) to ensure the processes, strategies, and evidentiary standards used for applying NQTLs to MH/SUD benefits are no more stringent than the processes, strategies, and evidentiary standards used to apply NQTLs for Medical/Surgical benefits.

Through the final MHPAEA rule, CMS guidance, and technical assistance provided to the State, the CHIP plans analyzed six NQTLs across the MH/SUD and Medical/Surgical benefits. Each of these areas was broken down by each of the four benefit categories (inpatient, outpatient, emergency, pharmacy) and questions were asked regarding the processes, strategies, and evidentiary standards used for each benefit category.

The Department’s review of the CHIP plans’ analyses confirms NQTLs applied to the behavioral health benefit are comparable and applied no more stringently than NQTLs applied to the Medical/Surgical MCO benefit; thus, the Department is compliant with MHPAEA requirements put forth in 42 CFR 457 Subpart D. Please refer to Appendix B of this document for the analysis of each CHIP NQTL.

Compliant Documentation Requirement

As Colorado’s CHIP program is a separate program from Medicaid, the Department is required to submit a CHIP SPA to demonstrate MHPAEA compliance by June 30, 2019.

Appendix A Medicaid NQTL Analysis

Prior Authorization

Prior Authorization is a requirement that a provider must submit a request before performing a service and may only render it after receiving approval.

Inpatient

The Prior Authorization NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Inpatient benefit category. All Managed Care Entities (MCEs), which includes the RAEs and the MCOs, allow three (3) days for a prior authorization request to be determined, and have substantially similar rationale for prior authorizing inpatient services: monitor overutilization, manage high-cost services, and to determine the appropriate level of care. All benefits are subject to some form of guidelines to determine whether to prior authorize MH/SUD and Medical/Surgical services, either through internal guidelines or a clinical decision support product. MH/SUD services are prior authorized due to the Federal Institute for Mental Disease (IMD) exclusion and contractual requirements to not provide certain MH/SUD services under the capitated behavioral health benefit.

The prior authorization policies are the same for in-network and out-of-network providers for both benefit categories. Providers are also notified of any changes that may occur to prior authorization policies.

Outpatient

The Prior Authorization NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Outpatient benefit category. For example, not all outpatient MH/SUD and Medical/Surgical benefits are required to be prior authorized, and there are exceptions to prior authorization requirements in both benefit categories. MH/SUD and Medical/Surgical benefits are all prior authorized by the direct treatment provider within the fourteen (14) days allowed for a prior authorization request to be determined. All MH/SUD and Medical/Surgical benefits that are prior authorized are done so under the same rationale: monitor overutilization, manage high-cost services, and to determine the appropriate level of care. The prior authorization policies are the same for in-network and out-of-network providers for both benefit categories. Providers are also notified of any changes that may occur to prior authorization policies.

Emergency

Emergency MH/SUD and Medical/Surgical services are not prior authorized; therefore, the stringency test does not apply to this section.

Pharmacy

Per the Department's capitated behavioral health benefit, the RAEs do not pay for behavioral health pharmacy services, which are provided through FFS. The MCOs have a pharmacy benefit that covers both MH/SUD and Medical/Surgical needs and the MCOs affirm that this benefit is administered in a manner that is compliant with MHPAEA.

Concurrent Review

Concurrent Review is a requirement that services be periodically reviewed as they are being provided in order to continue the authorization for the service.

Inpatient

The Concurrent Review NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Inpatient benefit category. For example, MH/SUD and Medical/Surgical services have similar frequencies for when concurrent reviews are performed. Concurrent reviews performed on MH/SUD services do not require a secondary assessment, which is required for certain Medical/Surgical services. MH/SUD and Medical/Surgical services are subject to concurrent reviews for similar rationale: to ensure the member is receiving the appropriate level of care and for fiscal management. MH/SUD and Medical/Surgical benefits are subject to some form of clinical guidelines to determine whether to concurrently review services, either through internal guidelines or a clinical decision support product. The concurrent review policies are the same for in-network and out-of-network providers for both benefit categories. Providers are also notified of any changes that may occur to concurrent review policies.

MH/SUD inpatient benefits are subject to concurrent reviews due to the fact that certain inpatient services are not covered under the capitated behavioral health benefit. Per 42 CFR 438.915(c), MHPAEA does not require a managed care entity to provide a MH/SUD benefit beyond what is contractually required. As the RAEs are not expected to pay for a service outside of their capitated behavioral health benefit under the ACC contractual requirements, this is an expected business practice and does not affect parity.

Outpatient

The Concurrent Review NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Outpatient benefit category. For example, not all MH/SUD and Medical/Surgical benefits are subjected to concurrent reviews. MH/SUD and Medical/Surgical benefits have similar varying frequencies for when concurrent reviews are performed and determined. Concurrent reviews performed on MH/SUD services do not require a secondary assessment, which is required for certain Medical/Surgical services. MH/SUD and Medical/Surgical services are subject to concurrent reviews for similar rationale: to ensure the member is receiving the appropriate level of care and for fiscal management. MH/SUD and Medical/Surgical benefits are subject to some form of clinical guidelines to determine whether to concurrently review services, either through internal guidelines or a clinical decision support product. The concurrent review policies are the same for in-network and out-of-network providers for both benefit categories. Providers are also notified of any changes that may occur to concurrent review policies.

Emergency

MH/SUD and Medical/Surgical emergency services are not concurrently reviewed. Therefore, this section is not applicable to this analysis.

Pharmacy

The MCOs have a pharmacy benefit that covers both MH/SUD and Medical/Surgical needs and the MCOs affirm that this benefit is administered in a manner that is compliant with MHPAEA.

Retrospective Review

Retrospective Review is a protocol for approving a service after it has been delivered.

Inpatient

The Retrospective Review NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Inpatient benefit category. All MH/SUD and Medical/Surgical benefits administered through the MCEs have at least a thirty (30) day timeline for a retrospective review to be performed. Exceptions to retrospective reviews are applied to both benefit categories, and the rationale for performing retrospective reviews is substantially similar for both benefit categories, including medical necessity. Retrospective review policies are the same for in-network and out-of-network providers for both benefit categories. Providers are also notified of any changes that may occur to retrospective review policies. MH/SUD and Medical/Surgical benefits are subject to some form of clinical guidelines to determine whether to retrospectively review services, either through internal guidelines or a clinical decision support product.

Outpatient

The Retrospective Review NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Outpatient benefit category. All MH/SUD and Medical/Surgical benefits administered through the MCOs have at least a thirty (30) day timeline for a retrospective review to be performed. Retrospective review policies are the same for in-network and out-of-network providers for both benefit categories. Providers are also notified of any changes that may occur to retrospective review policies. All services are subject to retrospective reviews for medical necessity.

Emergency

The Retrospective Review NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Emergency benefit category. Occasionally, retrospective reviews are performed on MH/SUD and Medical/Surgical emergency services to determine a member's eligibility, as managed care entities are not contractually required to pay for services for a member that is not in their network. This is an expected business practice and has no impact on the service rendered.

Pharmacy

The MCOs have a pharmacy benefit that covers both MH/SUD and Medical/Surgical needs and the MCOs affirm that this benefit is administered in a manner that is compliant with MHPAEA.

Network Provider Admission

Network Provider Admission is the process of accepting treatment providers into a health plan's network of care professionals.

Inpatient

The Network Provider Admission NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Inpatient benefit category. MH/SUD providers are not limited in participating in provider networks compared to their Medical/Surgical counterparts. For example, all plans have an internal credentialing committee that makes decisions on admitting providers into the network, and there are no exceptions to this process. All the MCEs in-network providers are afforded an appeals process. All providers are subject to National Committee for Quality Assurance (NCQA) guidelines for being admitted into networks, and all providers have their primary source data (licensure, certifications, liability insurance, etc.) verified prior to admission into the network. In addition, providers need to be approved through the Department's provider revalidation process to provide any inpatient MH/SUD or Medical/Surgical services.

Outpatient

The Network Provider Admission NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Outpatient benefit category. All plans have an internal credentialing committee that makes decisions on admitting providers into the network. Some MH/SUD providers are exempted from credentialing committees to ensure behavioral health network adequacy. All in-network providers are afforded an appeal process. All providers are subject to National Committee for Quality Assurance (NCQA) guidelines for being admitted into networks, and all providers have their primary source data (licensure, certifications, liability insurance, etc.) verified prior to admission into the network. In addition, providers need to be approved through the Department's provider revalidation process to provide any outpatient MH/SUD or Medical/Surgical services.

Emergency

As the RAEs do not admit Emergency service providers into their provider networks per their contracts, the Network Provider Admission NQTL cannot be applied more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Emergency benefit category. However, providers need to be approved through the Department's provider revalidation process to provide any Emergency MH/SUD or Medical/Surgical services.

Pharmacy

The MCOs have a pharmacy benefit that covers both MH/SUD and Medical/Surgical needs and the MCOs affirm that this benefit is administered in a manner that is compliant with MHPAEA.

Establishing Charges

Establishing Charges are the methods used for determining usual, customary, and reasonable charges for services.

Inpatient

The Establishing Charges NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Inpatient benefit category. For example, all MCEs have an internal process for establishing charges for all MH/SUD and Medical/Surgical services, and charges are updated as needed. Market values and the Department's fee schedule are taken into account when establishing charges for all MH/SUD and Medical/Surgical services, along with the need to attract an adequate network of providers.

Outpatient

The Establishing Charges NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Outpatient benefit category. For example, all plans have an internal process for establishing charges for all MH/SUD and Medical/Surgical services, and charges are updated as needed. Market values and the Department's fee schedule are taken into account when establishing charges for all MH/SUD and Medical/Surgical services, along with the need to attract an adequate network of providers. MH/SUD and Medical/Surgical service charges are subject to Colorado's Medicaid FFS rate schedule and Relative Value Units (RVU) table when the plans establish charges.

Emergency

The Establishing Charges NQTL is applied no more stringently to MH/SUD benefits than it is to Medical/Surgical benefits in the Emergency benefit category. For example, all plans have an internal process for establishing charges for all MH/SUD and Medical/Surgical services, and charges are updated as needed. Market values and the Department's fee schedule are taken into account when establishing charges for all MH/SUD and Medical/Surgical services.

Pharmacy

The MCOs have a pharmacy benefit that covers both MH/SUD and Medical/Surgical needs and the MCOs affirm that this benefit is administered in a manner that is compliant with MHPAEA.

Appendix B
CHIP NQTL Analysis

Medical Management Standards

All medical management standards for inpatient, outpatient, and pharmacy services are applied to MH/SUD and Medical/Surgical benefits in substantially similar methods. Emergency MH/SUD and Medical/Surgical services do not require prior authorizations.

Provider Admission Standards

All providers must possess up-to-date credentials and be approved through the Department's provider revalidations process to provide any MH/SUD or Medical/Surgical inpatient, outpatient, and emergency services. The CHIP plans' contract with an outside pharmacy vendor to manage the pharmacy MH/SUD and Medical/Surgical benefit.

Step Therapy Protocols

These protocols do not apply to inpatient, outpatient, or emergency services. CHIP plans use step therapy to meet fail-first criteria for both MH/SUD and Medical/Surgical pharmacy services.

Conditioning Benefits on Completion of a Course of Treatment

While recommendations to begin with a conservative course of treatment may be recommended, inpatient, outpatient, and emergency service exclusions are not based on the failure to complete a certain course of treatment.

Restrictions Based on Geographic Location, Facility Type, or Provider Specialty

There are no restrictions that limit the scope or duration of a services placed on MH/SUD and Medical/Surgical inpatient, outpatient, emergency, or pharmacy benefits based on geographic location, facility type, or provider specialty.

Out-of-network Provider Access Standards

Prior authorization is required for MH/SUD and Medical/Surgical benefits for out-of-network providers. Inpatient, outpatient, and pharmacy services all require prior authorization. If a service rendered by an out-of-network provider is approved, the Financial Requirements are the same as services rendered by an in-network provider.