Colorado Medicaid Parity FAQs

The Colorado Department of Health Care Policy and Financing (Department) engaged Myers and Stauffer LC (Myers and Stauffer) to develop reference materials related to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and Colorado Medicaid parity for stakeholders across the state. Myers and Stauffer is a national CPA firm that has assisted government clients for more than 43 years by supporting strategic planning, implementation, monitoring, and evaluation activities related to the delivery and financing of health care and social service programs, as well as partnering with federal and state agencies to perform MHPAEA parity analysis and oversight.

The MHPAEA requires health plans to provide benefits for mental health and substance use disorder (MH/SUD) benefits that are comparable to and no more stringent than that which is provided for medical and surgical (M/S) care. In 2016, the Centers for Medicare and Medicaid Services (CMS) finalized the MH/SUD parity rule[1] for Medicaid and Children's Health Insurance Programs.

In 2019, Colorado passed House Bill 19-1269, creating state-specific authority on MH/SUD parity. State statute[2] mandates annual evaluation and reporting on compliance with parity. In accordance with this legislation, the Department performs analysis of parity compliance and prepares an annual Mental Health and Substance Use Disorder Parity Report, which can be found on the Department's website.

The purpose of this Colorado Medicaid Parity FAQ is to compile frequently asked questions (FAQs) and provide answers regarding parity within the Colorado Medicaid delivery system. These FAQs are intended as an information resource and were first developed in 2021; they have been updated in June 2022 based on stakeholder inquiries received subsequent to the 2021 publication.

Table 1. Colorado Medicaid Parity Frequently Asked Questions

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SECTION	**GENERAL QUESTIONS**
Topic	**Parity Overview**
Question 1	Which programs within Colorado Medicaid does the CMS parity rule apply to?
Answer	CMS finalized the mental health and substance use disorder (MH/SUD) parity rule in 2016 for Medicaid and Children's Health Insurance Programs, which is applicable to coverage provided to Health First Colorado members served through Medicaid **Managed Care Organizations**

[1] Federal Register / Vol. 81, No. 61, Parts 438, 440, 456
[2] Colorado Revised Statutes 25.5-5-421

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	(Rocky Mountain Health Plan Prime and Denver Health Medicaid Choice) or the **Alternative Benefit Plan** (ABP). (As authorized by the Affordable Care Act of 2010, Colorado expanded Medicaid benefits to individuals ages 19 through 64 at or below 133% federal poverty level through an ABP that closely aligns, but does not exactly match, the Medicaid state plan adult benefit package.)
Question 2	What elements of health care coverage does the parity rule place requirements on?
Answer	The CMS parity rule establishes requirements in the following areas: • Aggregate Lifetime (AL) and Annual Dollar Limits (ADLs). • Financial Requirements (FRs) and Quantitative Treatment Limitations (QTLs). • Non-Quantitative Treatment Limitations (NQTLs).
Question 3	What are **Aggregate Lifetime** (AL) and **Annual Dollar Limits** (ADLs), and how do they apply to Colorado Medicaid?
Answer	Aggregate lifetime limits are dollar limitations on the total amount of specified benefits that may be paid under a benefit plan, and annual dollar limits are dollar limitations on the total amount of specified benefits that may be paid in a 12-month period. Colorado Medicaid does not impose any AL or ADLs. As a result, it is not necessary to perform an evaluation of compliance with parity requirements for this component of MHPAEA.
Question 4	What are **Financial Requirements** (FRs), and how do they apply to Colorado Medicaid?
Answer	Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. These are situations where beneficiaries must make payment for services. Colorado Medicaid does not impose FRs on its members. As a result, it is not necessary to perform an evaluation of compliance with parity requirements for this component of MHPAEA.
Question 5	What are **Quantitative Treatment Limitations** (QTLs), and how do they apply to Colorado Medicaid?
Answer	Quantitative treatment limitations are limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment, which are expressed numerically. Quantitative treatment limitations are those that cannot be exceeded due to medical necessity or other factors; if a limitation may be exceeded through medical management processes, it is considered a nonquantitative treatment limitation (NQTL) rather than a QTL. There are no QTLs for Colorado Medicaid's beneficiaries. As a result, it is not necessary to perform an evaluation of compliance with parity requirements for this component of MHPAEA.
Question 6	What are **Nonquantitative Treatment Limitations** (NQTLs), and how do they apply to Colorado Medicaid?

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Answer	Nonquantitative treatment limitations are limits on the scope or duration of treatment that either cannot be expressed numerically or whose numeric value can be exceeded through medical management processes. These include: • Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; • Formulary design for prescription drugs; • Standards for provider admission to participate in a network, including reimbursement rates; • Methods for determining usual, customary, and reasonable charges; • Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); • Exclusions based on failure to complete a course of treatment; and • Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits or services provided.[3] There are various NQTLs applicable to the Colorado Medicaid program. An assessment of compliance with MHPAEA parity requirements for these limits is performed annually.
Question 7	What are the MHPAEA requirements for NQTLs?
Answer	Nonquantitative treatment limitations cannot be applied to mental health or substance use disorder (MH/SUD) benefits unless processes, strategies, evidentiary standards, or other factors used in applying the limitations to MH/SUD benefits are **comparable to**, and are **applied no more stringently than**, those used in applying the limitation for medical and surgical (M/S) benefits. This includes policies and protocols both written and in operation. The assessment of comparability and stringency is performed within classifications of benefits defined by the MHPAEA final rule. The requirements, however, do not mandate equality between the limits applied to MH/SUD and M/S benefits.
Question 8	What are the classifications of benefits used to assess compliance with the parity requirements?
Answer	The CMS final parity rule establishes four classifications used to apply parity rules: Inpatient, Outpatient, Emergency, and Prescription Drugs. Assessment of compliance with parity rules is evaluated within each classification of benefits. This means, parity does not compare benefits between MH/SUD and M/S on a service-by-service basis. Rather, parity compares MH/SUD and M/S services in aggregate for all benefits falling within each classification of benefits. The classifications are defined for Colorado Medicaid as follows:

[3] Federal Register / Vol. 81, No. 61, Part 440 Managed Care, § 440.395

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	Inpatient Treatment as a registered bed patient in a hospital or facility and for whom room and board charges are made, excluding nursing facilities. **Outpatient** All covered services or supplies not included in inpatient, emergency care, or prescription drug categories. **Emergency** All covered emergency services or items (including medications) provided in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting. **Prescription** 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.
Topic	**Parity Oversight**
Question 9	How is parity compliance managed for Colorado Medicaid?
Answer	The Colorado Department of Health Care Policy and Financing (Department) is responsible for monitoring and oversight of the Medicaid Program's compliance with parity requirements. The Department reports to the Colorado legislature and the Centers for Medicare and Medicaid Services (CMS) annually on Medicaid's parity compliance. In order to demonstrate adherence to Colorado law and federal rules, the Department performs an annual evaluation of parity compliance for the program. Reports are posted publically on the Department's website.
Question 10	Is it a violation of parity for members to receive capitated MH/SUD benefits when M/S benefits are provided fee-for-service?
Answer	No. While Colorado's unique delivery system adds complexity to the process of monitoring and evaluating parity, it is not a specific violation of parity for members to receive capitated MH/SUD benefits and fee-for-service M/S benefits. The parity rules require MH/SUD NQTLs to be comparable to and no more stringent than M/S limitations; it is possible to achieve compliance with this requirement within Colorado Medicaid's delivery system.
Topic	**Provider Reimbursement**
Question 11	Does equitable reimbursement equate to compliance with MHPAEA, or is it a violation of parity when pay rates vary between MH/SUD providers that deliver the same service but are licensed differently or between different behavioral health entities (e.g. community mental health centers versus independent behavioral health providers)?
Answer	No. Equitable reimbursement is a statutory payment consideration in Colorado, but it is not based on and does not originate from MHPAEA. Varying reimbursement rates for different MH/SUD providers, or different types of behavioral health entities, is not relevant to or determined by the parity requirements. The requirements focus on parity between MH/SUD and M/S benefits and treatment limitations, rather than standardized pay rates for MH/SUD

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	providers with different licensures. Managed care services rely on appropriate variations in payment to ensure that the network covers the entire care continuum.
Question 12	Is it a violation of parity when reimbursement rates differ between MH/SUD services and M/S services?
Answer	No. Reimbursement rates are expected to vary for different services, and equality is not required by the parity rules. However, the methods used to establish rates and comparability between methods applicable to MH/SUD benefits and M/S benefits are relevant to the requirements. Additionally, difficulties in accessing care that may result from the level of MH/SUD rates are also relevant to the parity requirements.
SECTION	**STAKEHOLDER INQUIRIES**
Topic	**QTLs versus NQTLs**
Question 13	Is the number of visits allowed before triggering prior authorization for additional visits considered a QTL or an NQTL, and why?
Answer	Generally, a key factor that identifies quantifiable limits as NQTLs rather than QTLs is the allowance for exceeding the limitation when determined medically necessary. Limitations that cannot be exceeded are considered QTLs, whereas limitations that can be exceeded are considered NQTLs. Prior authorization policies and procedures are specifically identified as NQTLs in the parity rules, even when there are elements of the medical management policy/process that can be numerically defined. In this case, the prior authorization requirement after a designated number of visits allows for the limitation on covered visits to be exceeded. Therefore, this is considered an NQTL.
Topic	**Utilization Management**
Question 14	When evaluating MH/SUD services that are subject to authorization requirements, what factors must be met to comply with parity?
Answer	To evaluate parity compliance regarding authorization policies/protocols, including MH/SUD services subject to authorization after a certain number of visits, a number of factors must be considered. Parity rules are applied within a classification of benefits (inpatient, outpatient, emergency, or prescription drugs), not service-by-service. This means, the evaluation would consider all services within the classification, then compare MH/SUD authorization policies and protocols to M/S authorization policies and protocols in the classification. Assuming there are MH/SUD services that require authorization at a certain level of utilization, the evaluation would consider whether there are M/S services in the classification that prompt authorization at certain levels of utilization. Further, the evaluation would consider how the levels of utilization (e.g. number of visits or days) prompting authorization were established, as well as how authorization determinations are made. Parity requires assessment of the processes, strategies, evidentiary standards, or other factors used in applying authorization policies. If MH/SUD authorization is comparable to, and applied no more stringently than, the processes,

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	strategies, evidentiary standards, or other factors used in authorizing M/S benefits in the classification, parity compliance is achieved.
Question 15	When assessing parity compliance for prior authorization, what medical procedure is outpatient counseling compared to? Why are services like outpatient counseling not evaluated individually for parity compliance?
Answer	The CMS final rule establishes the parameters for applying parity requirements to an entire classification of benefits (inpatient, outpatient, emergency, or prescription drugs), and not on a service-by-service basis. As such, there is not a specific assessment of outpatient counseling nor identification of a corresponding medical procedure.
Question 16	How is parity for utilization management assessed on inpatient services when M/S services are covered via diagnosis related groups (DRGs) and MH/SUD services are covered under the managed care model?
Answer	Parity requires assessment of the processes, strategies, evidentiary standards, or other factors used in applying utilization management policies regardless of the model from which utilization management is derived. DRG reimbursement carries a financial incentive for health care providers to manage utilization, and provide effective M/S care efficiently. MH/SUD services provided under a managed care model do not carry the same incentives for health care providers to manage utilization. As a result, managed care entities actively manage member care and inpatient utilization of inpatient services. Some utilization management practices in place for inpatient MH/SUD services are not applicable to M/S inpatient services where utilization is managed inherently via the payment mechanism. If the utilization management process for MH/SUD inpatient services is comparable to, and applied no more stringently than, those applicable to M/S inpatient services, parity compliance is achieved.
Question 17	Is it a violation of parity for there to be varying utilization management processes between in-network and out-of-network services or providers?
Answer	The CMS final rule establishes the parameters for applying parity requirements to an entire classification of benefits (inpatient, outpatient, emergency, or prescription drugs), and not on an in-network versus out-of-network basis. It is not a violation of parity for there to be varying processes between these two categories of service providers, as long as the imposition of variances between the two does not result in limitations to MH/SUD services that are not comparable to, or are applied more stringently than, the limitations applicable to M/S services.
Topic	**Provider Reimbursement**
Question 18	Is it a violation of parity that the process of rate setting for M/S involves an advisory committee and the process for MH/SUD does not?
Answer	Parity does not require the rate setting processes to be identical. Parity requirements are focused on ensuring there are not barriers or limitations to MH/SUD benefits that do not exist for, or are more stringent than, those applicable to M/S benefits. The rate setting processes

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	for MH/SUD benefits are comparable to those for M/S benefits when both include input from the providers (either via negotiations with the RAEs or by proxy through the MPRRAC advisory committee). Further, the rate setting processes do not violate parity requirements if there are not limitations or barriers to accessing MH/SUD services.
Topic	**Miscellaneous**
Question 19	Is there a difference between the populations covered by the federal parity law and the state parity law?
Answer	Yes. The federal parity law applies to the populations enrolled in the ABP and the MCOs (see additional description in Question 1). Whereas, state statute applies to "Managed Care Entities", defined as: *"an entity that enters into a contract to provide services in the statewide managed care system, including MCOs, prepaid inpatient health plans, prepaid ambulatory health plans, and PCCM Entities"*. This definition includes members enrolled with the MCOs and the Regional Accountable Entities.
Question 20	Does Colorado's attribution model, which attributes Primary Care Medical Providers (PCMPs) to a specific RAE based on geographic location, violate parity?
Answer	No. The attribution model does not limit MH/SUD services more stringently than M/S services, since Medicaid recipients have freedom of choice in selecting their PCMP. This freedom of choice allows Medicaid recipients to choose a PCMP in a region (network) where their preferred behavioral health provider is covered, or choose a behavioral health provider in a region (network) where their preferred PCMP is covered. Medicaid recipients' choice determines which network they belong to.
Question 21	Is it a violation of parity for there to be varying policies between RAEs for the management of MH/SUD services?
Answer	Parity does not require the RAE processes to be identical. Parity requirements are focused on ensuring there are not barriers or limitations to MH/SUD benefits that do not exist for, or are more stringent than, those applicable to M/S benefits. Variances between the RAEs would not violate parity requirements if they do not result in limitations to MH/SUD benefits that are more stringent than those applied to M/S benefits.