Mental Health Parity and Addiction Equity Act (MHPAEA)

Analysis and Demonstration of Compliance for Colorado’s Medicaid and Children’s Health Insurance Programs
Introduction

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that Health First Colorado (Colorado’s Medicaid Program) 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, roughly 133,000 members in the state of Colorado, the state wants to ensure all Medicaid members have similar access to behavioral health and physical health benefits.

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.

A summary of Colorado’s analysis, conducted by the Colorado Department of Health Care Policy and Financing (Department), is found below. The analysis was conducted by gathering benefit information from the state’s MCOs, Behavioral Health Organizations (BHOs), and CHIP, as well as an analysis of the ABP. 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.
Overview of Colorado’s Medicaid System

The Department administers the Community Behavioral Health Services program, a statewide program that provides comprehensive mental health and substance use disorder services to most Colorado Medicaid members. Members are assigned to a Prepaid Inpatient Health Plan (PIHP) known as a BHO. The state is divided into five regions, and there is one BHO serving each region. MH/SUD services are paid for through a monthly capitation payment. If a member opts out of receiving behavioral health services through the Community Mental Health Services Program, they will then receive State Plan behavioral health services through fee-for-service (FFS), which pays claims outside of the capitation methodology.

Most Members, in addition to a BHO, are enrolled with a Primary Care Case Management (PCCM) entity, known as a Regional Collaborative Care Organization (RCCO). The State pays RCCOs a per-member per-month for each Member they serve, with physical health services paid through FFS. RCCOs do not pay for services directly; they provide care coordination, help Members find community and social services in their area, and support providers in practice improvement and transformation efforts. RCCOs also assist Members with care transitions. The state is divided into seven RCCO regions with one RCCO per region.

There are approximately 133,000 Members who have opted to enroll in capitated MCOs for their medical care. There are two MCOs in the Medicaid program: one in Denver and one in six counties in the western part of the state. Members enrolled in these MCOs are also covered by the Community Behavioral Health Services program.

The State Plan is the document the Department uses 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 states the ability to offer additional services through alternative payment methodologies. The Community Behavioral Health Services Program is authorized through a 1915(b)(3) waiver.

Colorado chose to expand Medicaid through an Alternative Benefit Plan (ABP) under the Affordable Care Act in 2014. Members who became eligible for Medicaid through Medicaid expansion are covered by the Alternative Benefit Plan, which 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 managed care system.

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 methodology. 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.
Beginning July 1, 2018, the Department will no longer have separate systems responsible for physical health and behavioral health services as described above. In Phase II of the Accountable Care Collaborative (ACC), one entity known as the Regional Accountability Entity (RAE) will be responsible for duties currently performed by the RCCOs and BHOs in their region. This change will improve the client experience by creating one point of contact and clear accountability for whole-person care. The RAE will be responsible for managing health care delivery and financial systems. The state will continue to be divided into seven regions to continue to promote innovation, flexibility, and local ownership of the health care delivery system. Members will be automatically enrolled in the RAE through mandatory enrollment.

As none of Colorado’s MCOs are fully comprehensive (offering both MH/SUD and medical/surgical benefits), the Department conducted the analysis using data provided by the MCOs and BHOs.

**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 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**

During this 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 up into two categories: MH/SUD and Medical/Surgical.

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>MH/SUD</th>
<th>Medical/Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>BHO administered for MH, FFS administered for SUD</td>
<td>MCO and FFS administered</td>
</tr>
<tr>
<td>Outpatient</td>
<td>BHO administered for MH/SUD</td>
<td>MCO and FFS administered</td>
</tr>
<tr>
<td>Emergency</td>
<td>BHO administered for MH/SUD</td>
<td>MCO and FFS administered</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>FFS administered for MH/SUD</td>
<td>MCO and FFS administered</td>
</tr>
</tbody>
</table>

BHOs cover inpatient and outpatient behavioral health services for State Plan and MCO enrollees, unless a member opts out of the Community Behavioral Health Services Program and receives FFS behavioral health services. During the Department’s analysis, it was determined
that less than 0.1 percent of Medicaid members were enrolled in an MCO but who were not concurrently enrolled in the Community Behavioral Health Services program.¹

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 State Plan benefit, the Department has determined the ABP compliant with MHPAEA.

**Long-Term Services and 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 Community Behavioral Health Services program does not utilize any Financial Requirements (FRs), Quantitative Treatment Limitations (QTLs), or Aggregate Lifetime or Annual Dollar Limits (AL/ADLs) for administering the behavioral health services benefit. Therefore, the Department is compliant with MHPAEA requirements put forth in 42 CFR 438 Subpart K.

The Department analyzed State Plan services to identify any such limits that could apply to members enrolled in MCOs or the ABP who do not receive services through the Community Behavioral Health Services Program. The Department’s calculations found this accounted for 0.00625 percent of Colorado’s total Medicaid population.

During the analysis, the Department saw the opportunity to ensure alignment of benefits across delivery systems between FFS and the Community Behavioral Health Services program. The Department had previously identified behavioral health limits to be removed to align with changes made to the State Plan; these changes are already underway.

**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

¹ As Colorado’s Medicaid system enters Phase II of the Accountable Care Collaborative (ACC) in July 2018, all Medicaid members will be mandatorily assigned to a Regional Accountable Entity (RAE), thus eliminating members receiving FFS behavioral health services.
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 states, the Department identified and analyzed five NQTLs across the MH/SUD and medical/surgical benefits: Prior Authorization, Retrospective Review, Network Provider Admission, Establishing Charges, and Concurrent Review. 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 states, 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. This SPA will be submitted to CMS for an effective date of October 2, 2017.
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. For example, all plans allow 10 to 14 calendar 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. While MH/SUD services are prior authorized, this is due to the federal Institute for Mental Disease (IMD) exclusion and contractual requirements to not provide certain MH/SUD services under the Community Behavioral Health Services program.

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 with 10-14 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.

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 Community Behavioral Health Services program contracts, the BHOs do not pay for behavioral health pharmacy services, which are provided through FFS; therefore, the stringency test does not apply to this section.

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. For example, MH/SUD benefits have a shorter timeframe for when a retrospective review can be performed on inpatient services.
compared to medical/surgical benefits. 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. 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. For example, MH/SUD benefits have a shorter timeframe for when a retrospective review can be performed on outpatient services compared to medical/surgical benefits. All services are subject to retrospective reviews due to medical necessity and providing the providers the opportunity to obtain authorizations.

**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**

Per the Community Behavioral Health Services program contracts, the BHOs do not pay for behavioral health pharmacy services, which are provided through FFS. Therefore, the stringency test does not apply to this section.

**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 the process. All plans have an appeals process for providers who are denied admission into the network, either internally or through the Department. 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.) subject to review for admission.
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 providers can partake in an appeals process if admission into a network, either internally or with the Department. 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.) subject to review for admission.

Emergency
As the BHOs 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.

Pharmacy
As the Community Behavioral Health Services programs does not cover pharmacy services, the BHOs are not responsible for maintaining a pharmacy network. Therefore, this section is not applicable to this analysis.

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 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. All plans use Colorado’s Medicaid FFS rate schedule when establishing charges for all MH/SUD and medical/surgical services.

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 Community Behavioral Health Services program does not contract for pharmacy services and do not establish charges for services; therefore, this section is not applicable to this analysis.

**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.

MH/SUD inpatient benefits are subject to concurrent reviews due to the fact that certain inpatient services are not covered under the community behavioral health services program. 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 BHOs are not expected to pay for a service outside of their Community Behavioral Health Services program 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 examples, 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.

**Emergency**
MH/SUD and medical/surgical emergency services are not concurrently reviewed. Therefore, this section is not applicable to this analysis.

**Pharmacy**
The Community Behavioral Health Services program does not provide pharmacy services and do not perform any concurrent reviews for MH/SUD pharmacy services. Therefore, this section is not applicable to this analysis.
**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 service. 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 service 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.