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Colorado Department of Health Care Policy and Financing
303 E. 17th Ave.
Denver, CO 80203

Re: Mental Health Parity Request for Public Comment

To Whom It May Concern:

The Colorado Center on Law and Policy dedicates regulatory and legislative advocacy, research and litigation to the fight against poverty. A core aim of CCLP's work is to ensure that Coloradans have access to the Medicaid benefits and services they are eligible for, regardless of the delivery system. Enforcement of federal and state parity is a fundamental part of ensuring access and providing whole-person health. CCLP has been engaged in advocacy to improve parity enforcement in state-regulated plans and Medicaid since 2014.

While we appreciate the opportunity to submit comments on the annual parity analysis for Colorado Medicaid, we note that concerns we have expressed in earlier years through public comment have not been reported publicly –because individual submissions are not themselves made public and because the final reports failed to adequately capture that information. This year, we are submitting these comments and also making them public on our organization's website.

The underlying goal of parity laws is to ensure that the obstacles to accessing behavioral services are no greater than those involved in accessing medical services.

When making these comments, we considered the following: requirements established in federal rules, 45 C.F.R. Parts 146 and 147, that implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 for Medicaid managed care programs and Alternative Benefit Plans; state parity requirements created through Colorado House Bill 19-1269; the Department's full 2022 report on parity, "Mental Health and Substance Use Parity Report" (hereinafter Parity Report); the Myers & Stauffer external assessment, "Mental Health and Substance Use Disorder Parity Report Assessments" (hereinafter M&S Assessment); and the Health Services Advisory Group's "Mental Health Parity Compliance Audit Report" (hereinafter Parity Audit), all available on the parity home page at https://hcpf.colorado.gov/parity.

We appreciate that the state's work on parity can be found in one location, on that parity home page, and that a structure has been designed to do the required analyses. Those are important first steps. The state is now positioned in this next analysis phase to strengthen its analysis as recommended below. That analysis should also identify whether prior violations had been addressed and establish protocols for addressing any violations identified in the 2023 report.

I. The analysis is inadequate and is missing key elements

Our longstanding criticism of the state's analysis comes down to failure to comply with state law and assess factors that involve non-quantitative treatment limitations (NQTLs), *stringency* and parity *in practice or in operation.* CRS 25.5-5-421(1)(c)(I),(II). When discussing the two classes of benefits, we refer to mental health and substance use disorder services (MH/SUD) as "behavioral services" and to medical and surgical services (M/S) as "medical services."

The Department's review of NQTLs has been limited to a review of plan documents, managed care websites, template documents, and interviews with staff at Colorado's managed care entities (MCEs), Regional Accountable Entities and Managed Care Organizations. Those sources do not and cannot provide objective insights into stringency, i.e. whether prior authorization requires substantial documentation or a one-page form, the hurdles providers must meet to join a network and what factors are considered, the frequency and scope of retroactive review, or the frequency that concurrent authorization is needed during a hospitalization.[1] Nor do those plan documents and MCE staff interviews provide insight into parity in practice or in operation, i.e. whether proposed credentialing timelines are actually met or whether out-of-state services are available in theory but are never granted.

Review of plan documents and written policies is an appropriate starting point, but federal regulations require that for NQTLs, stringency and how the limitation actually operates must be assessed. That requirement was established in 2016, through the federal rules. The final MHPAEA rules provide an example of a violation related to stringency, specifically a Medicaid program where prior authorization is required for both behavioral and medical inpatient benefits, but in practice, mental health stays are initially approved for only the first day before more documentation is required, while medical stays were initially approved for seven days. 81 FR 18389 at 18413.

[1] The Parity Report misconstrues the meaning of "stringency," which it uses to refer to the statewide application of prior authorization for inpatient behavioral stays despite the suspension of that requirement for inpatient medical stays. Stringency only applies to *how* a similar NQTL is applied – not whether it exists.

Recommendation:

To comply with federal and state law and assess whether parity requirements are met, the state must take steps to assess how the stringency with which each NQTL is applied, and how the NQTL is applied in practice or in operation. It should analyze and report data on denial rates for prior, concurrent, and retroactive authorization in the two spheres, behavioral and medical; should survey or interview providers on their experience of credentialing, compensation-setting, and utilization management; and should review a sample of case files for factors beyond those considered by HSAG, with those factors to be determined in consultation with a diverse set of stakeholders.

II. Problems are minimized or ignored in the Parity Report

The book-length Parity Report and related documents are lengthy and dense, and readers are likely to rely on the summary section. The summary reports that the MCEs violated parity in only two circumstances, but the full set of documents describes a situation where violations are frequent. We note that at times, what we would categorize as violations are described by the state as permissible because they are consistent with industry standard. However, aligning with industry practice is often in contradiction to the goals of parity laws. Historically, the industry has erected much greater barriers for those seeking behavioral health services, based on a long-standing misconception that people retain personal responsibility for mental health or substance use disorder status, and on deep-seated stigma against people who experience those issues.

An incomplete list of parity violations follows.

The Parity Audit reviewed up to 20 adverse benefit determination records for each RAE, ten inpatient and ten outpatient in most cases.

- The Parity Audit found widespread problems in some RAEs, including failure to provide *any* denial notice, failure to provide a clear reason, failure to provide information on appeal rights in all notices that went to members seeking inpatient services, and provision of a non-compliant reason. (Pages A-2, 3; B-6; F-2, 3, 7, 8; G-4). These parity violations also violate members' due process under the Supreme Court case, Goldberg v. Kelly, and subsequent case law. 397 U.S. 254 (1970).
- *These are parity violations because missing, incomplete, or unclear notices are a barrier to accessing services. A Medicaid member can challenge their medical service denial and have the opportunity to attain, regain or maintain the service pending appeal. The person*

seeking to attain, regain or maintain a behavioral health service is unable or less able to do so when they don't receive adequate notices.

The Parity Report reviews several NQTLs, comparing behavioral and medical NQTLs in a series of charts. Most Medicaid members receive behavioral services from a Regional Accountable Entity and medical services through fee-for-service, an arrangement described in the Parity Report as "Scenario 3."

- All but two inpatient behavioral services require prior authorization, but only a subset of inpatient medical services requires prior authorization. Certain criteria govern whether prior authorization is imposed on medical services. The acknowledged differences in frequency of prior authorization requirements and reasoning behind application of those requirements should be considered a violation of parity. (Appendix A, p. 32).
- Determinations on prior authorization requests for inpatient behavioral health services must be provided within 3 days, while those for inpatient medical services are provided within 1 business day. This should be considered a violation of parity. (Appendix A, p. 32).
- Many outpatient behavioral services are also subject to concurrent review, some at intervals as short as 3-5 days. However, for outpatient medical services, "the frequency depends on member presentation." A footnoted example identifies physical therapy as one such medical service, which would require a new approval every 6 months. This is a violation of parity. (Appendix B, p. 54).
- These are parity violations. because the imposition of prior authorization results in some unknown fraction of services being denied altogether, in the initiation of services being delayed, and because the impact of additional utilization management requirements reduces provider capacity to treat patients and effectively lowers provider compensation for the relevant service.

III. <u>Even when parity violations are acknowledged, the state fails to act promptly to bring the state into compliance or make members whole.</u>

Presumably enforcement is a primary goal of the report, but it appears that the annual reports do not necessarily result in the Department requiring prompt change or make members whole who have been adversely affected. Federal parity law is at best ambiguous regarding a private right of action, leaving the state Medicaid agency chiefly responsible for not just identifying but rectifying errors.

Two egregious violations were identified in the 2022 reports and to our knowledge have not been rectified. Both violations involve imposition of utilization management for inpatient behavioral health services, with the result being that all members who access inpatient services would experience very substantial limitations on inpatient care.

The most widespread violation was the retention of concurrent authorization requirements for behavioral inpatient stays after that requirement was lifted for medical inpatient stays. The Parity Report argues that the strain on hospitals due to COVID put them in a special position. The epidemic of suicide and addiction during the same period puts Coloradans nearly at the same risk of harm. (Combined rates of death for suicide and overdose were about two-thirds the rate of COVID deaths per 100,000, per CCDC data[2], and unlike COVID show no signs of abating).

We would propose that if behavioral health inpatient facilities are "not at risk of system capacity breach" as the report says, that may very well be because of overly stringent gate-keeping through utilization management (Report p. 5, Appendix B, p. 51). As one example, concurrent reviews by RAEs 6 and 7 are conducted every 2-3 days, a rate of frequency that puts an enormous burden on behavioral health providers and prevents those who have life-threatening, chronic behavioral health conditions from getting sustained care.

The second violation, involving Denver Health members, involved high levels of utilization management imposed on inpatient behavioral health services and virtually none on inpatient medical services.

The harms experienced by Medicaid members due to these two parity violations – not to mention those identified in the prior section – are hard to calculate, but overdose deaths or suicides after a discharge that would not have occurred had the hospitalization been for medical reasons, must be considered. Beyond increased mortality, members would have experienced interruptions in care, families would have experienced greater burdens, and costs related to homelessness and criminal justice would have been incurred.

IV. Conclusion

In conclusion, we ask that the state strengthen its analysis to comply with federal requirements to analyze the stringency with which limitations are applied, and to assess how policies actually operate on the ground . That analysis should also identify whether violations from earlier years

[2] https://www.cdc.gov/nchs/fastats/deaths.htm

had been addressed and should establish protocols and timelines for rectifying any violations identified in the 2023 report.

Very truly yours,

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