COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

Dec. 1, 2022

The Honorable Rhonda Fields, Chair
Senate Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Fields:

Enclosed please find a legislative report to the Senate Health and Human Services Committee from the Department of Health Care Policy & Financing as directed by SB 21-137 regarding an audit of denials of authorization for inpatient hospital and residential substance use disorder (SUD) treatment for managed care entities (MCEs).

Section 25.5-5-425 (2), C.R.S. states "Beginning December 1, and each December 1 thereafter, the state department shall submit the results of the audit conducted pursuant to subsection (1) of this section and any recommended changes to the residential and inpatient substance use disorder benefit to the House of Representatives Health and Insurance Committee, The House of Representatives Public and Behavioral Health and Human Services Committee, the Senate Health and Human Services Committee, or their successor committees, and the Joint Budget Committee."

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7796.

Sincerely,

Kim Bimestefer
Executive Director

Enclosure(s): HCPF 2022 MCE Audit Report

Cc: Senator Joann Ginal, Vice Chair, Senate Health and Human Services Committee
Senator Janet Buckner, Senate Health and Human Services Committee
Senator Sonya Jaquez Lewis, Senate Health and Human Services Committee
Senator Barbara Kirkmeyer, Senate Health and Human Services Committee
Senator Cleave Simpson, Senate Health and Human Services Committee
Senator Jim Smallwood, Senate Health and Human Services Committee
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Charlotte Crist, Cost Control & Quality Improvement Office Director, HCPF
Adela Flores-Brennan, Medicaid Director, HCPF
Thomas Leahey, Pharmacy Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bettina Schneider, Finance Office Director, HCPF
Bonnie Silva, Office of Community Living Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dec. 1, 2022

The Honorable Dafna Michaelson Jenet, Chair
House Public & Behavioral Health & Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Michaelson Jenet:

Enclosed please find a legislative report to the Senate Health and Human Services Committee from the Department of Health Care Policy & Financing as directed by SB 21-137 regarding an audit of denials of authorization for inpatient hospital and residential substance use disorder (SUD) treatment for managed care entities (MCEs).

Section 25.5-5-425 (2), C.R.S. states "Beginning December 1, and each December 1 thereafter, the state department shall submit the results of the audit conducted pursuant to subsection (1) of this section and any recommended changes to the residential and inpatient substance use disorder benefit to the House of Representatives Health and Insurance Committee, The House of Representatives Public and Behavioral Health and Human Services Committee, the Senate Health and Human Services Committee, or their successor committees, and the Joint Budget Committee."

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Sincerely,

Kim Bimestefer
Executive Director

Enclosure(s): HCPF 2022 MCE Audit Report

Cc: Representative Emily Sirota, Vice Chair, House Public & Behavioral Health & Human Services Committee
Representative Judy Amabile, House Public & Behavioral Health & Human Services Committee
Representative Mary Bradfield, House Public & Behavioral Health & Human Services Committee
Representative Lisa Cutter, House Public & Behavioral Health & Human Services Committee
Representative Serena Gonzales-Gutierrez, House Public & Behavioral Health & Human Services Committee
Representative Ron Hanks, House Public & Behavioral Health & Human Services Committee
Representative Richard Holtorf, House Public & Behavioral Health & Human Services Committee
Representative Iman Jodeh, House Public & Behavioral Health & Human Services Committee
Representative Rod Pelton, House Public & Behavioral Health & Human Services Committee
Representative Naquetta Ricks, House Public & Behavioral Health & Human Services Committee
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Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dec.1, 2022

The Honorable Susan Lontine, Chair
House Health & Insurance Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Susan Lontine:

Enclosed please find a legislative report to the Senate Health and Human Services Committee from the Department of Health Care Policy & Financing as directed by SB 21-137 regarding an audit of denials of authorization for inpatient hospital and residential substance use disorder (SUD) treatment for managed care entities (MCEs).

Section 25.5-5-425 (2), C.R.S. states "Beginning December 1, and each December 1 thereafter, the state department shall submit the results of the audit conducted pursuant to subsection (1) of this section and any recommended changes to the residential and inpatient substance use disorder benefit to the House of Representatives Health and Insurance Committee, The House of Representatives Public and Behavioral Health and Human Services Committee, the Senate Health and Human Services Committee, or their successor committees, and the Joint Budget Committee."

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

Enclosure(s): 2022 MCE Audit Report

Cc: Representative David Ortiz, Vice Chair, House Health & Insurance Committee
Representative Mark Baisley, House Health & Insurance Committee
Representative Chris Kennedy, House Health & Insurance Committee
Representative Karen McCormick, House Health & Insurance Committee
Representative Kyle Mullica, House Health & Insurance Committee
Representative Patrick Neville, House Health & Insurance Committee
Representative Emily Sirota, House Health & Insurance Committee
Representative Matt Soper, House Health & Insurance Committee
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Jo Donlin, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dec. 1, 2022

The Honorable Julie McCluskie, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Representative McCluskie:

Enclosed please find a legislative report to the Senate Health and Human Services Committee from the Department of Health Care Policy & Financing as directed by SB 21-137 regarding an audit of denials of authorization for inpatient hospital and residential substance use disorder (SUD) treatment for managed care entities (MCEs).

Section 25.5-5-425 (2), C.R.S. states "Beginning December 1, and each December 1 thereafter, the state department shall submit the results of the audit conducted pursuant to subsection (1) of this section and any recommended changes to the residential and inpatient substance use disorder benefit to the House of Representatives Health and Insurance Committee, The House of Representatives Public and Behavioral Health and Human Services Committee, the Senate Health and Human Services Committee, or their successor committees, and the Joint Budget Committee."

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Jo Donlin, at Jo.Donlin@state.co.us or 720-610-7795.

Sincerely,

Kim Bimestefer
Executive Director

Enclosure(s): HCPF 2022 MCE Audit Report

Cc: Senator Chris Hansen, Vice-chair, Joint Budget Committee
Representative Leslie Herod, Joint Budget Committee
Senator Bob Rankin, Joint Budget Committee
Representative Kim Ransom, Joint Budget Committee
Senator Rachel Zenzinger, Joint Budget Committee
Carolyn Kampman, Staff Director, JBC
Robin Smart, JBC Analyst
Lauren Larson, Director, Office of State Planning and Budgeting
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Jo Donlin, Legislative Liaison, HCPF

COLORADO

Department of Health Care Policy & Financing

FY 2022–2023 Inpatient and Residential Substance Use Disorder Service Denial Determination Analysis

November 2022

This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy & Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Background

Beginning January 2021, the Colorado Department of Health Care Policy & Financing (the Department) added substance use disorder (SUD) inpatient hospital and residential state plan benefits to the Regional Accountable Entity (RAE) and Medicaid Managed Care Organization (MCO) capitated contracts. Pursuant to Senate Bill 21-137, which states, "No later than July 1, 2022, the State Department shall contract with an independent third-party vendor to audit 33 percent of all denials of authorization for inpatient hospital and residential SUD treatment for each MCE,"[1-1] the Department contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to conduct the required audit. The requested scope of work was to overread a sample of utilization review (UR) denial determinations for SUD inpatient hospital and residential levels of care, using the American Society of Addiction Medicine (ASAM) levels of care,[1-2] made by Colorado's seven RAEs and one MCO providing behavioral health services (collectively referred to as managed care entities [MCEs]), for which the determinations resulted in a denial or partial denial of the requested service.

The eight MCEs are the seven RAEs which include: RAE 1, Rocky Mountain Health Plans (RMHP); RAE 2, Northeast Health Partners (NHP); RAE 3, Colorado Access (COA); RAE 4, Health Colorado, Inc. (HCI); RAE 5, COA; RAE 6 and RAE 7, Colorado Community Health Alliance (CCHA); and the one MCO, Denver Health Medical Plan (DHMP).

Table 1-1 displays the ASAM level of care, title, and description for each level of care reviewed during the audit.

Table 1-1—ASAM Levels of Care

Level of Care	Title	Description
3.1	Clinically Managed Low-Intensity Residential	24-hour structure with available trained personnel; at least five hours of clinical service/week
3.2WM	Clinically Managed Residential Withdrawal Management	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery
3.5*	Clinically Managed High-Intensity Residential	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare

[1-1] Senate Bill 21-137. Section 11, 25.5-5-425, page 8. Available at: https://leg.colorado.gov/sites/default/files/2021a_137_signed.pdf. Accessed on: Oct 12, 2022.

[1-2] The ASAM levels of care included: 3.1—clinically managed low-intensity residential, 3.2WM—clinically managed residential withdrawal management (WM), 3.3—clinically managed population specific, high intensity residential, 3.5—clinically managed high-intensity residential, 3.7—medically monitored intensive inpatient, and 3.7WM—medically monitored inpatient withdrawal management.

Level of Care	Title	Description
		for outpatient treatment; able to tolerate and use full active milieu or therapeutic community
3.7*	Medically Monitored Intensive Inpatient	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3; sixteen hour/day counselor availability
3.7WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring

*The sample population includes adolescents and adults. The ASAM level of care 3.2WM—clinically managed residential withdrawal management and 3.7WM—medically monitored inpatient withdrawal management are not designated for adolescent populations.

ASAM level of care 3.3 was not included in the MCEs' submitted denial universes for FY 2021–2022 and is therefore not discussed in this report.

Purpose

The purpose of the study was to determine whether the:

1. MCEs properly followed ASAM criteria when making denial determinations for SUD inpatient hospital and residential levels of care.
2. HSAG reviewers agreed with the denial decisions made by each MCE.

Findings

For the 323 total denial cases reviewed:

1. HSAG confirmed that the MCEs followed ASAM criteria when making denial determinations for SUD inpatient hospital and residential levels of care for 100 percent of sample denial cases.
2. HSAG reviewers agreed with the denial decisions made by each MCE for 100 percent of denial cases.

Conclusions

Overall, the MCEs demonstrated consistent and appropriate application of ASAM criteria when making service denial decisions for the sample SUD inpatient hospital and residential levels of care. HSAG reviewers confirmed agreement in 100 percent of denial cases.

2. Methodology

Introduction to SUD Audit Activities

Beginning in July 2022, HSAG used ASAM level of care criteria to determine the accuracy and timeliness of the SUD UR sample denial determinations made by each MCE providing behavioral health care, and to assess whether quality of care may be of concern.

Methodology

HSAG's assessment occurred in five phases:

1. Document request
2. Targeted sampling
3. UR over-read
4. Analysis and report development

Document Request

HSAG requested a data file from each MCE to obtain a list of all denials for inpatient hospital and residential levels of SUD treatment among MCE members. HSAG requested that the data file include one record per denial during the measurement period (fiscal year [FY] 2021–2022), with the following minimum data fields:

- Member name
- Member date of birth (DOB)
- Member identification (ID) number
- Date of service request
- Date of determination
- MCE identifier number
- Requesting facility (provider) name
- Requesting facility National Provider Identifier (NPI) number
- ASAM level of care requested
- ASAM level of care approved
- Length of stay requested
- Determination (e.g., denied)
- Denial type (e.g., administrative, medical necessity, or technical)
- Denial reason (e.g., not medically necessary, out of network provider, insufficient information, etc.)
- Whether or not the denial was appealed, went to a State fair hearing, and the outcome

Sampling Plan

Upon receiving the list of all denials from the MCEs, HSAG reviewed key data fields to assess potential duplication, data completeness, and the distribution of denials by MCE, facility, and ASAM level of care. HSAG used the listing of all denied services for inpatient hospital and residential SUD treatment as a sample frame from which to generate a sample list of cases for each MCE for the over-read activities.

HSAG used a random sampling approach to select no less than 33 percent of denials that occurred per MCE, based on the number of unique denials for inpatient hospital and residential SUD treatment in the sample frame for each MCE. HSAG ensured that the sample cases reflected the widest possible array of denials among facilities, ASAM levels of care, and members.

Before sampling, HSAG counted the number of denials by MCE for inpatient hospital and residential SUD treatment and determined the number of cases needed to meet the 33 percent requirement. Fractional numbers were be rounded up to the nearest whole number of cases to ensure a minimum of 33 percent of denials were reviewed.

HSAG then randomly selected a representative sample of denials for each MCE using the number of sample cases identified in the sample size determination. Cases were then proportionately distributed based on the number of denials within each level of care. For example, if 28 percent of an MCE's denials were attributed to the 3.1 ASAM level of care, 28 percent of the MCE's cases chosen for over-read will reflect denials attributed to the 3.1 ASAM level of care.

After compiling all sampled cases into a single sample denial list per MCE, HSAG assessed the distribution of sampled facilities by MCE, level of care, and members, to ensure that sampled denial cases represented the requesting facilities and members present in the sample frame. When necessary, HSAG drew oversample denial cases during the sampling phase and replaced initially sampled cases with oversample cases to ensure representation from the greatest possible number of SUD treatment facilities.

Utilization Review Documentation

HSAG provided the sample denial lists to each MCE and requested a complete file for each case that included:

- Documentation of when the request for service was received, description of the request, member status, and need.
- Documentation of when the denial determination was made.
- Result of the review (i.e., denied, partial, or limited approval).
- When verbal and/or written notice of adverse benefit determination was provided to the member and to the provider.
- Copies of written notice of adverse benefit determination.

- Copies of information the MCE used to make the UR denial determination, including notes from each reviewer, dates of each review, system notes associated with each point of the review, and documentation of telephonic and/or written communication between reviewers and UR staff, providers, members, and/or authorized representatives.
- Documentation of how the MCE considered each ASAM dimension using the most recent edition of *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* when determining medical necessity.
- Documentation as to whether medication assisted treatment (MAT) was provided as part of the treatment provided.
- Credentials of the MCE reviewer who made the denial determination.

HSAG Review Elements

Using the documentation provided by the MCEs, HSAG determined:

- Whether the information found in the medical records and related documents was sufficient to make an independent UR determination regarding the appropriateness of the prior authorization request and the accuracy of the MCE determination.
- Whether the MCE reviewer used the appropriate criteria.
- Whether the HSAG reviewer agreed/disagreed with the MCE denial determination.
- Whether clinical denial determinations were made by an MCE reviewer with appropriate credentials and expertise in treating the member's condition.
- Whether potential quality of care concerns were documented in the case file.

The HSAG reviewer team consisted of licensed professional counselors (LPCs), licensed professional clinical counselors (LPCCs), a licensed mental health counselor (LMHC), a licensed marriage and family counselor (LMFT), and a licensed clinical social worker (LCSW). Reviewers had clinical experience treating patients with substance use disorders and were trained in using ASAM level of care criteria for utilization review determination. HSAG chose the review team based on specific experience conducting utilization management prior-authorization reviews in another state using ASAM level of care criteria. HSAG reviewers used a two-step process; if the HSAG reviewer did not agree with the MCE determination, the reviewer would refer the case to a medical doctor (MD), doctor of osteopathic medicine (DO), or psychiatrist for a final determination of agreement or disagreement with the MCE denial determination. HSAG reviewers documented results of each review in a format approved by the Department.

HSAG used an interrater reliability process to sample 10 percent of completed reviews from reviewers and ensure that reviewers maintain 95 percent accuracy of HSAG determinations throughout the review project.

Analysis and Report Development

HSAG analyzed the sample record review findings to determine if trends existed for each MCE as well as trends across the eight MCEs. Topics considered in this analysis included:

- Rate of HSAG reviewer agreement with the use of ASAM criteria.
- Rate of HSAG reviewer agreement with MCE denial determinations.
- Potential quality of care concerns.

This report contains the results of the analysis.

3. Overall Results

The results in this section provide an overview across the eight MCEs and 323 sample denial determinations for SUD inpatient hospital and residential services.

The denial sample includes requests for the following ASAM levels of care: 3.1—clinically managed low-intensity residential, 3.2WM—clinically managed residential withdrawal management (WM), 3.5—clinically managed high-intensity residential, 3.7—medically monitored intensive inpatient, and 3.7WM—medically monitored inpatient withdrawal management.

The results below will provide an overview of whether the:

1. MCEs properly followed ASAM criteria when making denial determinations for SUD inpatient hospital and residential levels of care.
2. HSAG reviewers agreed with the denial decision made by each MCE.

Results

1. Adherence to ASAM Criteria for Denial Determinations

HSAG confirmed that the MCEs followed ASAM criteria when making denial determinations for SUD inpatient hospital and residential levels of care for 100 percent of denial cases. Table 3-1 shows the number of MCE denials in the sample and the adjusted number of denials in the sample compared to the number of the denials for which the MCE appropriately applied ASAM criteria.

Table 3-1—MCE Sample Cases and ASAM Criteria Used

MCE	Number of MCE Denials in Sample	Adjusted Number of Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Followed ASAM Criteria
RMHP—RAE 1	18	18	18	100%
NHP—RAE 2	31	26	26	100%
COA—RAE 3	48	48	48	100%
HCI—RAE 4	127	119	119	100%
COA—RAE 5	33	33	33	100%
CCHA—RAE 6	32	32	32	100%
CCHA—RAE 7	18	17	17	100%
DHMP	16	16	16	100%

MCE	Number of MCE Denials in Sample	Adjusted Number of Denials in Sample	Number of Denials for Which the MCE Appropriately Applied ASAM Criteria	Percentage of Denials That Followed ASAM Criteria
Total	**323**	**309**[1]	**309**	**100%**

[1] Due to 14 samples being not applicable, the total applicable sample is 309.

Based on the documentation provided by the MCEs, HSAG reviewers confirmed that in 100 percent of applicable sample denials, the MCEs followed ASAM criteria.

2. Agreement With MCE Denial Determination

HSAG reviewers agreed with the denial decision made by each MCE for 100 percent of denial cases. Table 3-2 displays the number of MCE denials in the sample compared to the number of denials for which HSAG agreed with the MCE decision.

Table 3-2—MCE Sample Cases and Percentage of HSAG Reviewer Agreement

MCE	Number of MCE Denials in Sample	Number of Denials for Which HSAG Agreed With Decision	Percent Agreement
RMHP—RAE 1	18	18	100%
NHP—RAE 2	31	26	100%
COA—RAE 3	48	48	100%
HCI—RAE 4	127	119	100%
COA—RAE 5	33	33	100%
CCHA—RAE 6	32	32	100%
CCHA—RAE 7	18	17	100%
DHMP	16	16	100%
Total	**323**	**309**[1]	**100%**

[1] Due to 14 samples being not applicable, the total applicable sample is 309.

HSAG reviewers agreed with the denial decisions made by the MCEs for 100 percent of denials.

Overarching Strengths

HSAG identified the following overarching strengths in processing denials for inpatient hospital and residential SUD services across the MCEs:

- HSAG reviewers agreed with all denial determinations.
- All eight MCEs reviewed used a two-step process for reviewing sample cases prior to issuing a denial determination. First-level reviewers included by an RN, LAC, LPC, LPCC, LCSW, or other appropriate level of staff. When the first-level reviewer recommended a denial determination, the case was referred a psychiatrist, MD, or DO level MCE staff member to make the final decision.
- All MCEs submitted comprehensive and consistent documentation regarding using ASAM criteria in the process of making denial decisions.
- The clinical review did not identify any quality of care issues.

Recommendations[1]

The primary recommendation from the Department following review of the results is that the State continue to provide standard training for the MCEs to support uniform use of national guidelines.

The American Society of Addiction Medicine is in the process of creating a 4th edition of its national guidelines, which means that there will be new standards rolling out at the national level that will need to be incorporated into the Colorado system. In order to support the uniform application of these updated standard criteria, the Department will provide standardized training for the MCEs, ad hoc technical assistance, and ongoing monitoring to identify any issues that need to be addressed impacting appropriate access to services at the right care, right place, and right time.

The Department has identified with HSAG some related areas for improvement, including the federally required adverse benefit determination notices that must be sent when service requests are denied. Based on a review of the notices and the notice process, the Department has developed recommendations. The Department will:

- Work with the MCEs to ensure a description of ASAM dimensions used to support denial determinations are included in notices.
- Revise the adverse benefit determination standard notice to prompt the MCEs on how to complete all required fields.
- Require MCEs to revise written policies to enhance internal and/or delegation monitoring mechanisms to ensure notices of adverse benefit determinations consistently contain sufficient detail,

[1] Recommendations were determined and written by the Department based on results found in this report.

demonstrate what ASAM criteria was not met for the specific level of care requested, and are provided to members when required.

- Revise the MCE contracts to require MCEs to identify what services would be approved when denying requested services for lack of medical necessity. For example, the RAE can approve any service currently authorized under the behavioral health capitation. For example, if residential services are requested and the RAE determines medical necessity criteria are not met, the RAE would indicate what services would be medically necessary (such as a combination of Multisystemic Therapy[2] and respite services).

[2] Multisystemic Therapy is a high-intensity community-based wraparound service for families.