COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

June 1, 2021

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

Dear Senator Fields:

The Department of Health Care Policy and Financing (Department) is submitting this letter along with the behavioral health, mental health, and substance use disorder annual report, pursuant to C.R.S. section 25.5-5-421.

> *C.R.S. 25.5-5-421. Parity reporting - state department - public input. (1) The state department shall require each MCE contracted with the state department to disclose all necessary information in order for the state department, by June 1, 2020, and by each June 1 thereafter, to submit a report to the health and Insurance Committee and the Public Health Care and Human Services Committee of the House of Representatives, or their successor committees, and to the Health and Human Services Committee of the Senate, or its successor committee, regarding behavioral, mental health, and substance use disorder parity.*

The Department created this year's annual report following the process for determining mental health parity compliance created by CedarBridge, the contractor selected to perform last year's annual report and train the Department to perform subsequent reports. Based on the review of the Colorado Medicaid benefit, the Department determined:

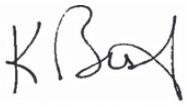
- The written policies and procedures of the Medicaid benefit are in compliance with all federal and state parity laws for all Non-Quantitative Treatment Limitations except for one.

The analysis was informed through stakeholder input sought out specifically for this report as well as acquired throughout the year through various outreach activities. Input was also received from the external quality review analysis required in C.R.S section 25.5-5-421(4), performed by the third-party vendor Health Services Advisory Group.

The attached report includes full details of the Department's analysis.

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 303-866-6912.

Sincerely,



Kim Bimestefer
Executive Director

KB/STB

Enclosure: Behavioral, Mental Health, and Substance Use Disorder Parity Comparative Analysis Report

Cc: Senator Joann Ginal, Vice Chair, Health and Human Services Committee
Senator Sonya Jaquez Lewis, Health and Human Services Committee
Senator Janet Buckner, Health and Human Services Committee
Senator Barbara Kirkmeyer, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
Senator Cleave Simpson, Health and Human Services Committee
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Tracy Johnson, Medicaid Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bonnie Silva, Community Living Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

June 1, 2021

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

Dear Representative Michaelson Jenet:

The Department of Health Care Policy and Financing (Department) is submitting this letter along with the behavioral health, mental health, and substance use disorder annual report, pursuant to C.R.S. section 25.5-5-421.

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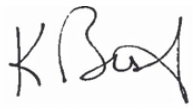

Kim Bimestefer
Executive Director

KB/STB

Enclosure: Behavioral, Mental Health, and Substance Use Disorder Parity Comparative Analysis Report

Cc: Representative Emily Sirota, Vice Chair, Public Health Care and Human Services Committee
Representative Mary Bradford, Public Health Care and Human Services Committee
Representative Lisa Cutter, Public Health Care and Human Services Committee
Representative Serena Gonzales-Gutierrez, Public Health Care and Human Services Committee
Representative Richard Holtorf, Public Health Care and Human Services Committee
Representative Iman Jodeh, Public Health Care and Human Services Committee
Representative Colin Larson, Public Health Care and Human Services Committee
Representative David Ortiz, Public Health Care and Human Services Committee
Representative Rod Pelton, Public Health Care and Human Services Committee
Representative Naquetta Ricks, Public Health Care and Human Services Committee
Representative Dan Woog, Public Health Care and Human Services Committee
Representative Mary Young, Public Health Care and Human Services Committee
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Rachel Reiter, External Relations Division Director, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

June 1, 2021

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

Dear Representative Lontine:

The Department of Health Care Policy and Financing (Department) is submitting this letter along with the behavioral health, mental health, and substance use disorder annual report, pursuant to C.R.S. section 25.5-5-421.

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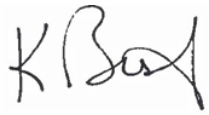

Kim Bimestefer
Executive Director

KB/STB

Enclosure(s): Behavioral, Mental Health, and Substance Use Disorder Parity Comparative Analysis Report

Cc: Representative Yadira Caraveo, Vice Chair, Health and Insurance Committee
Representative Mark Baisley, Health and Insurance Committee
Representative Tonya Van Beber, Health and Insurance Committee
Representative Ron Hanks, Health and Insurance Committee
Representative Dominique Jackson, Health and Insurance Committee
Representative Chris Kennedy, Health and Insurance Committee
Representative Karen McCormick, Health and Insurance Committee
Representative Kyle Mullica, Health and Insurance Committee
Representative David Ortiz, Health and Insurance Committee
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Rachel Reiter, External Relations Division Director, HCPF

Mental Health and Substance Use Disorder Parity Report

In compliance with 25.5-5-421, C.R.S.

June 1, 2021

Table of Contents

Executive Summary

The Colorado Department of Health Care Policy and Financing (Department) created the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for State Fiscal Year 2020-2021 in accordance with Colorado Revised Statutes 25.5-5-421. The MHPAEA is designed to ensure that Medicaid managed care organizations and Medicaid alternative benefit plans providing mental health or substance use disorder (MH/SUD) benefits apply limitations on those benefits that are comparable to and no more stringent than those limitations imposed upon medical and surgical (M/S) benefits in the same classifications. The following comparative analysis was performed across Colorado Medicaid's statewide managed care system, consisting of seven (7) Regional Accountable Entities (RAEs) and two (2) Managed Care Organizations (MCOs), and the Department's fee-for-service (FFS) system to determine the status of parity compliance within the Colorado Medicaid delivery system.

The State of Colorado's Medicaid capitated behavioral health benefit is administered through the Accountable Care Collaborative (ACC). The state is divided into seven regions with a single Managed Care Entity (MCE), the RAE, operating the ACC in each region. The ACC is a hybrid managed care program authorized through a Section 1915(b) waiver approved by the Centers for Medicare & Medicaid Services (CMS). The RAEs function as a Prepaid Inpatient Health Plan (PIHP) for the administration of all ACC members' capitated MH/SUD services, as well as a Primary Care Case Management Entity (PCCM Entity) accountable for the effective and coordinated utilization of fee-for-service M/S Medicaid benefits. The RAEs are responsible for administering Colorado Medicaid's capitated MH/SUD benefit, which includes paying claims and authorizing MH/SUD services. Physical health services are paid fee-for-service by the Department's fiscal agent.

Colorado House Bill 19-1269 provided the Department with funding to contract with an external vendor, CedarBridge, to produce the State Fiscal Year 2019-2020 MHPAEA Report and create a template for the Department's future reports. The process created by CedarBridge was based upon federal parity guidance outlined in the CMS parity toolkit, "Parity Compliance in Mental Health and Substance Use Disorder Parity Requirements for Medicaid and Children's Health Insurance Programs," and in accordance with the requirements in HB19-1269. For this year's report, the Department followed the process for determining mental health parity compliance created by CedarBridge. The Department collected public input throughout the year to help assess how processes, strategies, evidentiary standards, and other factors operate in practice. This public input helped inform the comparative analysis.

The Colorado Medicaid service delivery system has multiple components that add complexity to assessing parity. The analysis requires the comparison of a capitated MH/SUD payment structure to a fee-for-service M/S payment structure. The Department chose to design its coverage in this manner to maximize the breadth of MH/SUD services available to its members. The comparison between MH/SUD and M/S benefits seeks to assess whether the written policies and procedures, in design and applied in practice, affect the ability of Medicaid members to access MH/SUD services.

Summary of Findings

An assessment and comparative analysis of MH/SUD benefit limitations compared to M/S benefit limitations found the written policies and procedures to be parity compliant in all Non-Quantitative Treatment Limitations (NQTLs) except for one. Limited situations were also found where two RAEs were determined not to have followed their written policies, impacting compliance with Availability of Information parity requirements.

The Department's determination was based on the analysis of the following limitations.

Aggregate Lifetime and Annual Dollar Limits

Based on the information collected during the analysis, none of the Managed Care or FFS structures utilize aggregate lifetime or annual dollar limits for MH/SUD benefits and are therefore compliant with parity requirements for these limits.

Financial Requirements and Quantitative Treatment Limitations

Based on the information collected during the analysis, none of the RAEs, MCOs, or the Department utilize financial requirements (FRs) or quantitative treatment limitations (QTLs) for MH/SUD benefits and are therefore compliant with the parity requirements of these limitations.

Non-Quantitative Treatment Limitations

The Department completed an analysis of the non-quantitative treatment limitations (NQTLs) being used by each of the benefit packages. NQTLs are non-numerical limits on the scope or duration of benefits for treatment, such as preauthorization requirements. In accordance with CMS regulations and guidance, the Department conducted an analysis of how each NQTL is used within the broad benefit classifications of inpatient, outpatient, prescription drugs, and emergency care. While there may be differences between individual NQTL policies and procedures and their application to MH/SUD and M/S services within the benefit classifications, the federal requirement is to analyze whether the NQTLs used for MH/SUD within a benefit classification are comparable to and applied no more stringently than those used in the same M/S benefit classification. Written policies and procedures were determined to be parity-compliant in all NQTLs except for one.

During the analysis process, the Department identified that it is not currently in compliance with parity requirements regarding the Concurrent Review NQTL for inpatient hospitalizations, as a result of the temporary suspension of the Inpatient Hospital Review Program (IHRP).

At the beginning of the COVID-19 Public Health Emergency, the Department suspended M/S inpatient hospitalization concurrent reviews to address the surge in critical patient care needs and the risk of hospital system breach due to acute care demand exceeding our hospitals' medical capacity. During the M/S Concurrent Review program suspension, the IHRP underwent a performance review that identified operational and efficiency opportunities. This information ultimately led to the re-procurement of the IHRP vendor and was incorporated into the contractual requirements with the newly-selected vendor. The Department is currently working to finalize improvements to the program prior to IHRP reinstitution, with redesign efforts underway. As part of the redesign efforts, the Department will ensure the new IHRP concurrent review process is compliant with parity. To ensure parity compliance, the Department is also taking this opportunity to assess the MCEs' concurrent

review policies and procedures for MH/SUD inpatient hospitalizations. The target date for reinstituting the IHRP with the program improvements is January 2022, and the Department is working diligently to complete the work earlier if possible.

Mental health parity was not immediately identified as an issue when the IHRP program was paused. The focus at that time was on helping facilitate hospitals' capacity to treat individuals with COVID-19. The Department did not pursue a similar suspension to the MH/SUD inpatient authorization review process because it was not at risk of system capacity breach in the same way that the hospitals were. The Department also required real-time SUD review insights from tracking the use of the newly effective (January 1, 2021) SUD inpatient and residential benefit. These insights needed to be incorporated into the July 1, 2021 inpatient and residential SUD rate adjustments and were important to the Department's efforts to analyze network access, pinpoint areas needing technical assistance, monitor utilization against projections, identify variations in utilizations by RAE region, and confirm that members were being connected to the most effective treatment options. It was determined that continuing the MH/SUD inpatient authorization review process was the best course of action to ensure the health and effectiveness of the new SUD residential benefit and the MH/SUD system as a whole.

Availability of Information

Based on the information collected, the Department verified that the written polices of the RAEs and MCOs are compliant with both requirements for availability of information:

- Criteria for medical necessity determinations regarding MH/SUD benefits are made available to enrollees, potential enrollees, and contracting providers upon request.
- The reasons for any denial of reimbursement or payment for MH/SUD benefits are made available to the beneficiary.

The external quality review audit performed by Health Services Advisory Group (HSAG) identified limited situations where two RAEs had gone beyond the timeframes established in its policy for sending a notice of adverse benefit determination. Additionally, HSAG identified a small number of situations where the RAEs used confusing language in their determination letters or the reason for the denial was difficult to understand. Out of 1,239 combined applicable elements, the MCEs met 1,187 elements for a 96% combined compliance score. In these limited instances, the Department determined that the involved RAEs were not fully compliant with the Availability of Information parity requirements. The Department notified the RAEs of the issues, and the RAEs established plans to eliminate the delays and improve their documentation.

Introduction

The Colorado Department of Health Care Policy and Financing (Department) created the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for State Fiscal Year 2020-2021 in accordance with Colorado Revised Statutes 25.5-5-421. The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and related regulations require State Medicaid agencies that have implemented an Alternative Benefit Plan and/or that deliver services through Managed Care Organizations to ensure MH/SUD benefits are not managed more stringently than M/S benefits.

The Department followed the process for determining mental health parity compliance created by CedarBridge, the contractor selected to perform the State Fiscal Year 2019-2020 MHPAEA Report. The process created by CedarBridge was based upon federal parity guidance outlined in the Centers for Medicare and Medicaid Services (CMS) parity toolkit, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs."[1] The final Medicaid/CHIP parity rule requires analysis of (as depicted in Figure 1):

1. Aggregate lifetime and annual dollar limits (AL/ADLs); and
2. Financial requirements and treatment limitations, which include:
    a. Financial requirements (FRs), such as copayments, coinsurance, deductibles, and out-of-pocket maximums.
    b. Quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits.
    c. Non-quantitative treatment limitations (NQTLs), such as medical management standards, provider network admission standards and reimbursement rates, fail-first policies, and other limits on the scope or duration of benefits; and
3. Availability of information.[1]

Definition of Medical/Surgical and Mental Health/Substance Use Disorder Services

The federal statute and regulations do not identify specific conditions or services as MH/SUD or M/S; instead, states must look to "generally recognized independent standards of current medical practice" to define benefits.

For the purposes of the parity analysis, the Department has adopted the current version (10) of the International Classification of Diseases, Clinical Modification (ICD-10-CM) as the standard for defining MH/SUD services and M/S services. The Department defines MH/SUD benefits as benefits specifically designed to treat a mental health or substance use disorder condition.

[1] CMS Parity Toolkit: https://www.medicaid.gov/sites/default/files/2019-12/parity-toolkit.pdf

- Mental health conditions are those conditions listed in ICD-10 Chapter 5(F), except for subchapter 1 (Mental disorders due to known physiological conditions), subchapter 8 (Intellectual disabilities) and subchapter 9 (Pervasive and specific developmental disorders). The etiology of these conditions is a medical condition – physiological or neurodevelopmental – and treatment would address medical concerns first.

- Substance use disorder benefits are defined as benefits used in the treatment of substance use disorder conditions listed in ICD-10 Chapter 5 (F), subchapter 2 (Mental and Behavioral disorders due to psychoactive substance use).

- Benefits used to treat all other ICD-10 diagnoses are considered M/S.

Benefit Classifications

The final federal regulations specify requirements for FRs and treatment limitations apply to each benefit classification individually. Colorado Medicaid benefits were classified and mapped into four categories, as directed by the CMS Parity Toolkit. The following definitions were used to differentiate benefit classifications:

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.

Prescription Drugs

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.

Emergency Care

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.

Colorado Medicaid Accountable Care Collaborative

The State of Colorado administers Colorado Medicaid through its Accountable Care Collaborative (ACC). The state is divided into seven geographic regions with a single Managed Care Entity, the Regional Accountable Entity (RAE), operating the ACC in each region. The ACC is a hybrid managed care program authorized through a Section 1915(b) waiver with the Centers for Medicare & Medicaid Services (CMS).

The RAEs function as a Prepaid Inpatient Health Plan (PIHP) for the administration of all ACC members' capitated mental health and substance use disorder services, as well as a Primary Care Case Management Entity (PCCM Entity) accountable for the effective and coordinated utilization of fee-for-service M/S Medicaid benefits. The RAEs are responsible for

administering Colorado Medicaid's capitated MH/SUD benefit, which includes paying claims under the capitated MH/SUD benefit and authorizing MH/SUD services. M/S services are paid fee-for-service (FFS) by the Department's fiscal agent. The Department contracts with a third-party vendor to administer Colorado Medicaid's Utilization Management Program for FFS, referred to as the Colorado Prior Authorization Review (Colorado PAR).

In addition, two regions allow members in specific counties to participate in capitated M/S Managed Care Organizations (MCO). In Region 1, the MCO is operated by the RAE, Rocky Mountain Health Plans. In Region 5, the Department contracts directly with the MCO operated by the Denver Health Medical Plan, which is also contracted to function as the MH/SUD PIHP for all members enrolled in the MCO. Denver Health Medical Plan delegates administration of their MH/SUD PIHP to Colorado Access, including utilization management.

The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and related regulations require State Medicaid agencies that have implemented an Alternative Benefit Plan and/or that deliver services through Managed Care Organizations to ensure MH/SUD benefits are not managed more stringently than M/S benefits. This analysis complies with 42 CFR § 438.910 and 42 CFR § 440.395.

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 (FPL) through an Alternative Benefit Plan that closely aligns, but does not exactly match, the Medicaid state plan adult benefit package. As of January 2021, there were 146,964 members in MCOs whose M/S and MH/SUD services are covered through capitation payments. Approximately 501,786 members in the Alternative Benefit Plan receive capitated MH/SUD services, but their M/S services are provided FFS.

As MHPAEA is focused on ensuring members' MH/SUD benefits are not managed more stringently than M/S benefits, the Department's unique structure for the Alternative Benefit Plan creates complexity for the parity determination. Instead of comparing managed care policies and procedures against each other, for the Alternative Benefit Plan the Department compares managed care policies and procedures for a MH/SUD program against a M/S FFS program.

The Department has chosen to provide behavioral health benefits through a managed care program in order to offer members a full continuum of behavioral health services that are not available under federal fee-for-service guidelines, allowing for more flexible service provision. It is only under the federal managed care authority that the Department is able to offer reimbursement for short-term inpatient stays in Institutions for Mental Diseases, peer recovery services, clubhouse and drop-in centers, vocational services, intensive case management, and other alternative services.

The Department goes beyond federal requirements by conducting the MHPAEA comparative analyses across all members enrolled with the seven RAEs and the two MCOs. The Department does not restrict its MHPAEA comparative analyses only to members eligible for the Medicaid Alternative Benefit Plan or in an MCO.

Methodology

Defining Member Scenarios for Analysis

Colorado Medicaid's unique structure for MH/SUD and M/S benefits creates a need to define the various potential member scenarios available. These scenarios are documented in Table 1. Furthermore, Table 2 defines the mechanism for payment of covered benefits by each of the benefit classifications. These steps define the scope of questions and data needed from each respective payer in order to complete a parity analysis.

TABLE 1. POTENTIAL MEMBER SCENARIOS

Member Scenarios (the color of the highlighted bullet points matches the corresponding highlighted classifications in the table below)

- **SCENARIO 1**: Member gets their inpatient and outpatient MH/SUD services, emergency MH services, and M/S benefits through fee-for-service (this is a service-by-service situation).
- **SCENARIO 2**: Member gets their inpatient and outpatient MH/SUD services, emergency MH services through a RAE (Rocky Mountain Health Plans) under a capitated rate and M/S benefits through a managed care organization (Rocky Mountain Health Plan Prime MCO).
- **SCENARIO 3**: Member gets their inpatient and outpatient MH/SUD services, emergency MH services through a RAE under a capitated rate and M/S benefits through fee-for-service.
- **SCENARIO 4**: Member gets inpatient and outpatient MH/SUD services, emergency MH services from Denver Health PIHP and M/S benefits through a managed care organization.

Benefit Map - by classification

TABLE 2. COVERED BENEFITS

	Inpatient	Outpatient	Emergency Care	Prescription Drugs
SCENARIO 1	Med/Surg = FFS MH/SUD = FFS	Med/Surg = FFS MH/SUD = FFS	Med/Surg = FFS MH/SUD = FFS	PBM
SCENARIO 2	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	MCO Managed PBM
SCENARIO 3	Med/Surg = FFS MH/SUD = RAE	Med/Surg = FFS MH/SUD = RAE	Med/Surg = FFS MH/SUD = RAE	PBM
SCENARIO 4	Med/Surg = MCO MH/SUD =PIHP	Med/Surg = MCO MH/SUD = PIHP	Med/Surg = MCO MH/SUD = PIHP	MCO Managed PBM

Tools and Resources to Collect and Analyze Required Data

The Department determined the scope of the parity analysis by researching each benefit plan for the presence of any FRs or QTLs that would require analysis. Colorado Medicaid benefit packages do not currently have any FRs, QTLs, or AL/ADLs for MH/SUD services.

Additionally, a set of NQTLs were identified by comparing each benefit plan, along with stakeholder feedback, to a list of NQTLs outlined in the final Medicaid/parity rule, the parity toolkit, written guidance from CMS, and the Department of Labor regarding the commercial

parity rule (including FAQs and related guidance). The Department utilizes tools and resources based upon those created by CedarBridge to collect and analyze the required NQTL data.

A data request was sent to the Regional Accountable Entities (RAEs), Managed Care Organizations (MCOs), and the Department's Utilization Management to collect policy and procedural detail for key areas, including:

1. Medical Management Standards
    a. Prior Authorization – identify services by name and service code
    b. Concurrent Review
    c. Retrospective Review
    d. Fail First/Step Therapy Protocols
    e. Conditioning Benefits on Completion of a Course of Treatment
    f. Medical Appropriateness Review
    g. Outlier Management
    h. Penalties for Noncompliance
    i. Coding Limitations
    j. Medical Necessity Criteria
2. Provider Admission Standards
    a. Network Provider Admission
    b. Establishing Charges/Reimbursement Rates
    c. Restrictions Based on Geographic Location, Facility Type, or Provider Specialty
3. Provider Access
    a. Network Adequacy Determination
    b. Out-of-Network Provider Access Standards

The Department required responses to the data requests by March 1. The MPHAEA report is accurate and complete through March 1, 2021. Any policy or procedural changes made after that date will be reviewed in an ongoing basis and noted in the following year's MHPAEA Report.

Responses to the data requests were followed with a virtual interview with a team from each RAE and MCO. The interviews provide an opportunity for the Department to ask questions stemming from the review of the data request responses and gain additional insight into the implementation of the policies and procedures.

Review Process for Medical Necessity Criteria

The Department reviewed the medical necessity criteria collected from the RAEs and MCOs both through the written data requests and follow-up interviews to verify the criteria utilized to determine medical necessity for MH/SUD and M/S services. The Department analyzed differences in MH/SUD and M/S medical necessity determinations within the care delivery system.

Review Process for Non-Quantitative Treatment Limitations

The Department prepared a list of common NQTLs that may be in use by the RAEs and the Department for MH/SUD services from the illustrative list of NQTLs in the final Medicaid/parity rule, the parity toolkit, and written guidance from CMS and the Department of Labor regarding the commercial parity rule (including FAQs and related guidance). The

Department also gathered feedback through stakeholder written comments, which the Department used to inform the analysis by either affirming previously identified NQTLs or highlighting other areas that may require analysis. The final list included NQTLs applicable to categories such as medical management standards, network admission standards, and provider access.

The data request for the RAEs, MCOs, and Department's UM included the list of NQTLs identified and asked them to identify any additional NQTLs they apply to MH/SUD services. The request addressed processes, strategies, evidentiary standards and other factors for each of the NQTLs that apply to MH/SUD and M/S services, broken down by benefit classification. The request included prompts to help identify the type of information relevant to the parity analysis.

Review Process for Availability of Information

The requirements for availability of information are as follows:

- Criteria for medical necessity determinations for MH/SUD benefits must be made available to enrollees, potential enrollees, and contracting providers upon request
- The reason for any denial of reimbursement or payment for MH/SUD benefits must be made available to the beneficiary

These requirements apply to all Colorado Medicaid members receiving MH/SUD benefits, whether through FFS, RAEs, or MCOs. The MCEs were required to provide evidence that they are compliant with this parity requirement.

Determining if a FR, QTL, or AL/ADL Will Apply

Based on the information collected during the analysis, the Colorado Medicaid benefit packages impose no financial requirements (FR), quantitative treatment limitations (QTLs), or aggregate lifetime and annual dollar limits (AL/ADLs) on MH/SUD benefits. Should future financial, unit, or dollar limits be imposed, these limitations may need to be reviewed to ensure parity compliance.

Factors Used to Determine an NQTL Will Apply

Parity requires NQTLs not be applied to MH/SUD benefits in any classification unless their application to MH/SUD benefits **are comparable** to and **no more stringent than** the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification. The application standards for any NQTL must be clearly delineated under the policies and procedures of the state, MCO, or Prepaid Inpatient Health Plan (PIHP), as written and in operation.

The CMS Parity Toolkit divides this analysis into two parts:

1. Evaluate the *comparability* of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying the NQTL to MH/SUD benefits and M/S benefits
2. Evaluate the *stringency* with which the processes, strategies, evidentiary standards and other factors (in writing and operation) are applied to MH/SUD benefits and M/S benefits

Following the process outlined in the CMS Parity Toolkit, the Department used the information provided in the data request and interviews with the RAEs, MCOs, and the Department's FFS UM to determine if an NQTL applies and requires analysis. Any identified NQTL is tested for comparability and stringency to ensure it meets parity guidelines. During this analysis, multiple reference points are explored to determine compliance with parity guidelines including: policy follows standard industry practice, when operationalizing procedures there is little to no exception or variation, policy and practice follows established state definitions and guidelines, the staff operationalizing the policy are qualified to make the decisions and complete the tasks assigned and appropriate supervision and oversight is in place to ensure the policy is operationalized as documented.

Evaluation of Parity Compliance in Operation

Colorado House Bill 19-1269, updated the Colorado Revise Statutes 25.5-5-421(4), which requires the Department to contract with an external quality review organization to perform an annual review of the RAEs' and MCOs' policies and procedures in operation:

- "25.5-5-421 (4). The State Department shall contract with an external quality review organization at least annually to monitor MCEs' utilization management programs and policies, including those that govern adverse determinations, to ensure compliance with the MHPAEA. The quality review report must be readily available to the public."

Health Services Advisory Group (HSAG) was the contractor selected to perform this year's annual review of the RAEs' and MCOs' policies and procedures in operation. HSAG's full report can be found on the Department's Regulatory Resource Center webpage.

Updates to the MHPAEA Report

The Department has made many improvements to the MHPAEA Report for State Fiscal Year 2020-2021 to improve the readability and clarity of the document, but more importantly, to increase the accuracy and thoroughness of the analysis.

- Findings from the external quality review are new this year, adding a detailed review of the RAEs and MCOs' policies and procedures in operation.
- The Department added inpatient substance use disorder treatment to the state's Medicaid benefit beginning January 1, 2021. The policies and procedures related to the new SUD benefit were reviewed for parity compliance in this report.
- The 2020 MHPAEA Report incorrectly included a member benefit scenario labeled Scenario 4, which was removed from this year's report. This scenario was determined to be impossible to occur given the Department's use of mandatory attribution and enrollment.

Stakeholder Engagement and Feedback

The Department considers stakeholder feedback vital to the monitoring of mental health and substance use disorder parity. Department staff engage and seek out input in multiple opportunities and formats throughout the year to ensure ongoing compliance with federal and state parity laws, but also to inform the NQTL analyses. Opportunities for engagement and reporting issues include:

- A quarterly hospital forum attended by the Colorado Hospital Association, urban and rural hospitals and the RAEs;
- Communications and complaints received by the Office of Behavioral Health Ombudsman of Colorado;
- Provider and stakeholder outreach to Department staff directly;
- Grievances filed by members that have been escalated to the Department; and
- An electronic form to provide written comments.

The Department received a total of 14 written comments submitted through the electronic form created specifically for this report. The majority of submissions were received from providers, with some feedback also received from advocates.

Stakeholders shared concerns about prior authorization, reimbursement rates, network provider admission, network adequacy determination, member attribution, a non-covered service, and the Department's parity reporting compliance and enforcement. Concerns that touched on parity-related topics were analyzed for compliance. The comments addressing the methods used by the Department for enforcing and reporting on parity compliance fall into other important areas of Medicaid operations, and will be considered for opportunities for process improvement. Additional concerns that covered topics such as member attribution, do not, by definition, rise to the level of parity concerns.

Provider reimbursement rate concerns are commonly raised by stakeholders, including specific concerns about reimbursement based on clinical licensure, and lower provider reimbursement rates for MH/SUD services in comparison to other states or M/S services. First, it was determined that the processes used by the RAEs to establish charges/reimbursement rates for MH/SUD benefits is comparable and no more stringent then that used for M/S benefits in the same classification in writing and in operation. Further still, reimbursement was analyzed for its impact on network adequacy and it was determined that the processes used to maintain network adequacy by the RAEs for MH/SUD benefits was also comparable and no more stringent than the process used for M/S benefits. The Department continually monitors the provider networks and requires the RAEs and MCOs to submit network adequacy plans annually and network adequacy reports quarterly.

Findings

The Department completed an analysis of the non-quantitative treatment limitations (NQTLs) being used in each of the member scenarios and an analysis of whether, for each NQTL, there are differences in policies & procedures, or the application of the policies & procedures for MH/SUD benefits and M/S benefits.

The assessment and comparative analysis of MH/SUD benefit limitations compared to M/S benefit limitations found the written policies and procedures to be parity compliant in all NQTLs except for one. During the analysis process, the Department identified that it is not currently in compliance with parity requirements regarding the Concurrent Review NQTL for inpatient hospitalizations, as a result of the temporary suspension of the Inpatient Hospital Review Program (IHRP).

At the beginning of the COVID-19 Public Health Emergency, the Department suspended M/S inpatient hospitalization concurrent reviews to address the surge in critical patient care needs and the risk of hospital system breach due to acute care demand exceeding our hospitals' medical capacity. During the M/S Concurrent Review program suspension, the IHRP underwent a performance review that identified operational and efficiency opportunities. This information ultimately led to the re-procurement of the IHRP vendor and was incorporated into the contractual requirements with the newly-selected vendor. The Department is currently working to finalize improvements to the program prior to IHRP reinstitution, with redesign efforts underway. As part of the redesign efforts, the Department will ensure the new IHRP concurrent review process is compliant with parity. To ensure parity compliance, the Department is also taking this opportunity to assess the MCEs' concurrent review policies and procedures for MH/SUD inpatient hospitalizations. The target date for reinstituting the IHRP with the program improvements is January 2022, and the Department is working diligently to complete the work earlier if possible.

Mental health parity was not immediately identified as an issue when the IHRP program was paused. The focus at that time was on helping facilitate hospitals' capacity to treat individuals with COVID-19. The Department did not pursue a similar suspension to the MH/SUD inpatient authorization review process because it was not at risk of system capacity breach in the same way that the hospitals were. The Department also required real-time SUD review insights from tracking the use of the newly effective (January 1, 2021) SUD inpatient and residential benefit. These insights needed to be incorporated into the July 1, 2021 inpatient and residential SUD rate adjustments and were important to the Department's efforts to analyze network access, pinpoint areas needing technical assistance, monitor utilization against projections, identify variations in utilizations by RAE region, and confirm that members were being connected to the most effective treatment options. It was determined that continuing the MH/SUD inpatient authorization review process was the best course of action to ensure the health and effectiveness of the new SUD residential benefit and the MH/SUD system as a whole.

Limited situations were found during the external quality review where two RAEs had gone beyond the timeframes established in their written policies for sending a notice of adverse benefit determination, and therefore were determined to be out of parity compliance with the Availability of Information parity requirements. Details are provided

in the External Quality Review Analysis section below. The RAEs were notified of the issues by the Department and a plan was established to address the delays.

Parity Monitoring During Reporting Year

In addition to the review and analysis of policies and procedures performed for the comprehensive annual MHPAEA Report, the Department continually monitors the parity compliance of the RAEs and MCOs throughout the year. Monitoring activities include regular communication with the RAEs and MCOs, meetings and events with stakeholder groups, or direct contact with the Behavioral Health Ombudsman office, practitioners, or members. Any concerns that are raised are analyzed and addressed as they are identified.

The following are some of the changes to policies and procedures made by the RAEs, MCOs, or the Department's FFS UM over the reporting year that warranted a review for parity compliance.

- Beginning March 1, 2021, Colorado Community Health Alliance requires authorization after 20 sessions for the following services: 90832 (30-min psychotherapy), 90834 (45-min psychotherapy), 90837 (60-min psychotherapy), 90846 (family psychotherapy w/o patient) and 90847 (family psychotherapy w/patient).
- Rocky Mountain Health Plans requires authorization on 60-minute psychotherapy (90837) sessions after 12 visits in a calendar year.

Each of these authorization requirements was evaluated and was found to be in-line with comparable prior authorization requirements for M/S services, similar RAE prior authorization requests, and consistent with flexibilities allowed with managed care.

External Quality Review Analysis

Health Services Advisory Group (HSAG) completed their annual review of the RAEs and MCOs' policies and procedures in operation on April 2021. **They determined the MCEs to have a combined 96% compliance score.** The score indicates the level at which the MCEs followed their internal policies related to prior authorization and the reason for denial, notification of determination, time frames for the sending of notices, notice of adverse benefit determinations including required content, use of qualified clinicians when making denial decisions, peer-to-peer review, and use of established authorization criteria. Out of 1,239 combined applicable elements, the MCEs satisfied 1,187 elements. All the MCEs use Department-approved template notices of adverse benefit determination that included the required information and notify members of their right to an appeal and all MCEs followed their policies and procedures regarding consistency and quality of utilization management decisions.

Limited situations were found where two RAEs had gone beyond the timeframes established in their policies for sending a notice of adverse benefit determination. Additionally, HSAG identified some situations of confusing language used by RAEs in their determination letters or the reason for the denial was difficult to understand. Those situations were determined to not be fully parity compliant with the Availability of Information requirements. The RAEs were notified of the issues, and plans were established to eliminate the delays and improve the documentation.

HSAG's full report can be found on the Department's Regulatory Resource Center webpage.

Appendices A through O present each NQTL, the member scenarios, benefit categories (IP - Inpatient; OP - Outpatient; EC – Emergency Care; PD – Prescription Drugs), a summary of any differences found between M/S and MH/SUD benefits in the identified member scenario, and whether or not compliance was determined. Appendix P presents the Availability of Information analysis.

Appendix A – Prior Authorization

Description: Prior Authorization requires a provider submit a request before performing a service and may only render it after receiving approval.

Tools for Analysis: Utilization management policies, timelines for the processing of authorizations, documentation requirements, methods of document submission, and reviewer qualifications.

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP, PD	Yes – OP 1st and 2nd level reviewer credentials are different	Yes
Scenario 2	RMHP & Prime MCO	IP, OP, PD	Yes – PD additional conditions differ	Yes
Scenario 3				
	RAE 1	IP, OP	Yes – IP admit authorization requirements differ	Yes
	RAE 2 & 4	IP, OP	Yes – IP admit authorization requirements differ	Yes
	RAE 3 & 5	IP, OP	Yes – IP admit authorization requirements differ	Yes
	RAE 6 & 7	IP, OP	Yes – IP admit authorization requirements differ	Yes
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP, PD	No	Yes

Scenario 1 – FFS

NQTL: Prior Authorization (IP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Consultation with Department staff

Goals and Rationale: The goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Some of the components of the FFS Utilization Management program, such as the Inpatient Hospital Review Program (IHRP), were initially modified or suspended due to the COVID-19 pandemic to decrease provider burden and ensure members have appropriate and timely access to care and then to enable the Department to redesign the IHRP process.

Process:

MH/SUD and M/S:

The Department has suspended the physical health fee-for-service Inpatient Hospital Review Program (IHRP) requirement for physical health hospital admissions to support hospitals to focus on COVID-19 care. This suspension pertains to admission reviews, admission notifications, concurrent review, and complex case concurrent review.

Finding:

Fee-for-service inpatient prior authorization has been suspended for both MH/SUD and M/S services, therefore the process is the same and is parity compliant.

NQTL: Prior Authorization (OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **Yes.** 1st and 2nd level reviewer credentials are different.	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training materials Consultation with Department staff

Goals and Rationale: The goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Process:

MH/SUD

Prior Authorization requests are only required for outpatient pediatric behavioral therapy (PBT) services.

The FFS UM Vendor utilizes a PAR portal for authorization submission for MH/SUD services. It is available for authorization submission twenty-four (24) hours per day, seven (7) days a week for provider convenience, but authorization requests are not required to be entered after hours, on weekends, or state holidays. The majority of authorization requests are submitted through the PAR portal, that is available to the provider 24/7, while a small subset of providers are permitted to submit requests via secure fax.

For Outpatient MH/SUD PARs (PBT only) the FFS UM Vendor uses state developed and approved criteria to determine appropriateness of outpatient services. In order to ensure compliance with policy and regulations and clinical criteria, the UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. The provider submitted information, including clinical notes, plans of care, treatment notes, assessments, test results, orders, etc. are reviewed for completeness, compliance and medical appropriateness utilizing specific Department policy, guidelines, by the first and second level reviewers. (This review process is only for PBT)

First Level Reviewers for PBT consist of a Board-Certified Behavioral Analyst (BCBA) who may:

- Approve the service as requested based Department approved criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Review).
- Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc.
- First Level Reviewers cannot deny for lack of medical necessity.

Second Level Reviewers for PBT consist of Board-Certified Behavior Analyst-Doctoral (BCBA-Doctoral) who may:

- Approve the service as requested based on Department approved Criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Render either a full or partial denial for lack of medical necessity.

Per Colorado State Rule, the UM FFS Vendor has 10 business days to complete an outpatient PAR review upon receipt of all necessary documentation from the provider or facility. The UM FFS Vendor's average turnaround time is 4 business days.

M/S

Prior Authorization requests are required for the following select outpatient FFS M/S service codes:

- Audiology
- Adult Habilitative Speech Therapy (Alternative Benefit Plan)
- Diagnostic Imaging
- Durable Medical Equipment and Supplies (subset of oxygen and respiratory equipment suspended as of April 1, 2020)
- Medical and Surgical services
- Molecular Testing
- Outpatient Physical, Occupational and Speech Therapies
- Pediatric Long-Term Home Health (Suspended as of July 1, 2020)
- Pediatric Personal Care Services
- Private Duty Nursing (Suspended as of July 1, 2020)
- Synagis
- Vision

The FFS UM Vendor utilizes a PAR portal for authorization submission for M/S services. It is available for authorization submission twenty-four (24) hours per day, seven (7) days a week for provider convenience, but authorization requests are not required to be entered after hours, on weekends, or state holidays. The majority of authorization requests are submitted through the PAR portal, that is available to the provider 24/7, while a small subset of providers are permitted to submit requests via secure fax.

For Outpatient FFS M/S PARs the FFS UM Vendor uses InterQual criteria, or state developed criteria to determine appropriateness of outpatient services. In order to ensure compliance with policy and regulations and clinical criteria, the FFS UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. All Reviewers must review the submitted information and documentation against specific policy, guidelines, and InterQual criteria.

First Level Reviewers consist of Registered Nurses who may:

- Approve the service as requested based on InterQual or Department approved Criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Physician Review).
- Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc.
- First Level Reviewers cannot deny for lack of medical necessity.

Second Level Reviewers consist of Physicians who may:

- Approve the service as requested based on InterQual or Department approved Criteria, Department approved criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Render either a full or partial denial for lack of medical necessity.

Per Colorado State Rule, the UM FFS Vendor has 10 business days to complete an outpatient M/S PAR review upon receipt of all necessary documentation from the provider or facility. The UM FFS Vendor's average turnaround time is 4 business days.

Finding:

While reviews of MH/SUD authorization reviews may be performed by BCBA's (1st level) and BCBA-Doctoral (2nd level) as opposed to nurses (1st level) and physicians (2nd level) for M/S benefits, the application of outpatient prior authorization standards to MH/SUD benefits are comparable to and no more stringent than the processes, strategies, evidentiary standards, or other factors used to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policy are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policy is operationalized as documented.

NQTL: Prior Authorization (PD)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:**	Colorado Medicaid Pharmacy Benefits Colorado Medical Assistance Program Prior Authorization Procedures and Criteria and Quantity Limits

No	
Goals and Rationale: Colorado Medicaid requires prior authorization for all drugs not listed on the preferred drug list (PDL). The PDL is developed based on safety, effectiveness, and clinical outcomes from classes of medications where there are multiple drug alternatives available and supplemental rebates from drug companies, allowing Colorado the ability to provide medications at the lowest possible costs. The department contracts with a third-party vendor to administer Colorado Medicaid's prescription drug utilization management program. **Process:** **MH/SUD and M/S** MH/SUD and M/S medications that are listed as non-preferred agents on the preferred drug list require prior authorizations. Each request is processed within 24 hours, and most phone requests are given the approval/denial decision immediately upon submission. **Finding:** Prescription Drug prior authorization procedures, as written and in operation, are identical for MH/SUD drugs and M/S drugs. Therefore, the application of pharmacy prior authorization standards to MH/SUD benefits are comparable to and no more stringent than the processes, strategies, evidentiary standards, or other factors used to M/S benefits.	

Scenario 2 – RAE 1 and Rocky Mountain Health Plan Prime MCO

NQTL: Prior Authorization (IP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	RMHP Provider Manual RMHP UM Program Description Data request from RMHP Interview with RMHP staff
Goals and Rationale: RMHP's Prior Authorization policies provide the conditions for admission notification as well as the process for prior authorization submission and review. The stated goals for prior authorization are: • Determine if the treatment or service is covered by a Member's health plan • Consider whether it is the right care, at the right time, from the right healthcare practitioner or provider • Compare the Member's medical needs to criteria based on scientific evidence to make decisions **Process:** Prior authorization is NOT required for urgent or emergent (including crisis) admissions for both M/S and MH/SUD Admissions. **MH/SUD** Inpatient Prior Authorization is used for all MH/SUD inpatient level of care stays.	

Inpatient MH/SUD services require notification by the admitting facility of an admission within 24 hours of admission. If a weekend or holiday is involved, then notification must occur the first business day following the weekend or holiday. Prior authorization is required before non-emergent admissions such as Short Term Residential (STR), Long Term Residential (LTR), and Partial Hospitalization (PHP). ALL Physical Health and Behavioral Health ELECTIVE, NON-URGENT/EMERGENT admissions require review and/or Prior authorization to determine medical necessity for appropriate level of care. Post-stabilization care services are also covered. Preauthorization is not required for post-stabilization care. Licensed behavioral health practitioners/Care advocates and registered nurses apply evidence based clinical guidelines (MCG) to determine medical necessity for the admit and continued stay. RMHP registered nurses and licensed clinical staff are authorized to approve services, but may not deny services that do not meet medical necessity criteria. Cases that do not meet guidelines are forwarded to RMHP Medical Direction for review. Per the UM Program Description, page 27, a doctorate level practitioner makes all medical necessity denials. Medical Directors may access additional resources for complex cases, including Advanced Medical Reviews, LLC (AMR). Frequency of review is determined on a case by case basis considering the Member's behavioral health/mental health condition. All Adverse determinations for medical necessity are determined by an RMHP Medical Director.
Amount of time to issue standard determination: Ten calendar days.

For Acute Inpatient levels of care, authorization requests are always received by phone or voicemail. Other inpatient level requests, such as day treatment or residential, are usually faxed because the request requires additional clinical documentation. The criteria utilized to make medical necessity and appropriateness decisions for all UM processes are based on nationally-recognized standards of practice for medical services and are applied on an individual need's basis. RMHP's UM Program bases its decisions on utilization of the most current edition of MCG and approved RMHP guidelines.

M/S
Inpatient M/S services require notification by the admitting facility within 24 hours of admission. If a weekend or holiday is involved, then notification must occur the first business day following the weekend or holiday. Notification is not required for observation or emergency services. Prior authorization is required before non-emergent admissions such as, acute care to acute care transfers, Long Term Acute Care Hospitals (LTACH), Acute Rehabilitation Units (ARUs), Skilled Nursing Facilities (SNFs) and admissions for pediatric feeding programs. ALL Physical Health and Behavioral Health ELECTIVE, NON-URGENT/EMERGENT admissions require review and/or Prior authorization to determine medical necessity for appropriate level of care. Post-stabilization care services are also covered. Preauthorization is not required for post-stabilization care. Licensed clinical staff-Concurrent Review nurses/RN's apply evidenced based clinical guidelines (MCG) to determine medical necessity for the admit and for continued stay. RMHP registered nurses and licensed clinical staff are authorized to approve services, but may not deny services that do not meet medical necessity criteria. Cases that do not meet the guidelines are forwarded to RMHP Medical Direction for review. Medical Directors may access additional resources for complex cases, including Advanced Medical Reviews, LLC (AMR). Frequency of review is determined on a case by case basis considering the Member's medical condition.
Amount of time to issue standard determination: Ten calendar days.

For Acute Inpatient levels of care, authorization requests are always received by phone or voicemail. Other inpatient level requests, such as day treatment or residential, are usually faxed because the request requires additional clinical documentation.

The criteria utilized to make medical necessity and appropriateness decisions for all UM processes are based on nationally-recognized standards of practice for medical services and are applied on an individual needs basis. RMHP's UM Program bases its decisions on utilization of the most current edition of MCG and approved RMHP guidelines. If MCG do not address a particular area, RMHP utilizes other nationally established criteria in making determinations. Other criteria utilized include the American Academy of Obstetrics, Gynecology, or Pediatrics and other nationally-recognized guidelines approved by the CMO, Associate Medical Directors, and MAC.

Finding:
The prior authorization process for inpatient MH/SUD services, in both written procedures and operation, is identical to M/S services. Therefore, the application of inpatient prior authorization standards to MH/SUD benefits are comparable to and no more stringent than the processes, strategies, evidentiary standards, or other factors used for M/S benefits.

NQTL: Prior Authorization (OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	RMHP Provider Manual RMHP Utilization Program Description Data request from RMHP Interview with RMHP staff

Goals and Rationale: RMHP's Prior Authorization policies provide the process for prior authorization submission and review. The stated goals for prior authorization are:

- Determine if the treatment or service is covered by a member's health plan
- Consider whether it is the right care, at the right time, from the right healthcare practitioner or provider
- Compare the member's medical needs to criteria based on scientific evidence to make decisions

Process:

MH/SUD

A few outpatient services are subject to prior authorization review requirements. They are specialized services or treatments, and prior authorization review serves to establish medical appropriateness and necessity of services.

For MH/SUD outpatient levels of care, authorization requests are submitted through RMHP's contracted care management platform provided by Essette, Inc. The criteria utilized to make medical necessity and appropriateness decisions for all UM processes are based on nationally-recognized standards of practice for medical services and are applied on an individual needs basis. RMHP's UM Program bases its decisions on utilization of the most current edition of MCG and approved RMHP guidelines. All requests are initially reviewed by RMHP Care Advocates. RMHP considers the member's medical needs using criteria based on scientific evidence to make utilization management decisions. An RMHP Medical Director

reviews all requests that do not meet these criteria. The Medical Director consults as needed with specialist physicians experienced in the type of care requested. For all requests, providers should anticipate a decision within 10 days.

M/S

For M/S outpatient levels of care, authorization requests are submitted through RMHP's contracted care management platform provided by Essette, Inc. The criteria utilized to make medical necessity and appropriateness decisions for all UM processes are based on nationally-recognized standards of practice for medical services and are applied on an individual need's basis. RMHP's UM Program bases its decisions on utilization of the most current edition of MCG and approved RMHP guidelines. If MCG do not address a particular area, RMHP utilizes other nationally established criteria in making determinations. Other criteria utilized include the American Academy of Obstetrics, Gynecology, or Pediatrics and other nationally-recognized guidelines approved by the CMO, Associate Medical Directors, and MAC.

All requests are initially reviewed by RMHP Care Advocates. RMHP considers the member's medical needs using criteria based on scientific evidence to make utilization management decisions. An RMHP Medical Director or Registered Pharmacist reviews all requests that do not meet these criteria. The Medical Director consults as needed with specialist physicians experienced in the type of care requested. For all requests, providers should anticipate a decision within 10 days.

Finding:

The prior authorization process for outpatient MH/SUD services, in both written procedures and operation, is identical to M/S services. Therefore, the application of outpatient prior authorization standards to MH/SUD benefits are comparable to and no more stringent than the processes, strategies, evidentiary standards, or other factors used to M/S benefits.

NQTL: Prior Authorization (PD)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **Yes:** All drugs determined to need extra safety monitoring require Prior Authorization; additional conditions that determine Prior Authorization inclusion differ.	Data request from RMHP Interview with RMHP staff

Goals and Rationale:
Drugs that are high cost, low utilization or are high utilization with moderate cost receive additional scrutiny to ensure safe and effective use of the drug.

Process:

Rocky Mountain Health Plan's process to evaluate drugs that require Prior Authorization does not consider if the drug is a behavior health or medical indication. All drugs are evaluated based on the same criteria which includes clinical information of the specific

drug, tertiary sources (e.g. National guidelines, FDA), expert opinion, pharmacoeconomic evaluations/health outcomes, and quality of life studies.

MH/SUD
MH/SUD drugs determined to need extra safety monitoring as FDA indicated as 2nd/3rd/4th line, require prior authorizations. Those MH/SUD drugs that have a complex dosing regimen may get prior authorization criteria added to the drug when placed on formulary to ensure safe/effective use of the drug.

M/S
M/S drugs determined to need extra safety monitoring as FDA indicated as 2nd/3rd/4th line, require prior authorizations. For M/S drugs that are high cost, low utilization or high utilization and moderate cost may get prior authorization criteria added to the drug when placed on formulary to ensure safe/effective use of the drug.

Findings:
While the rationale for prior authorization of MH/SUD drugs differs from M/S drugs, review processes are comparable. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented. Further, the review criteria for MH/SUD drugs are applied no more stringently than for M/S drugs.

Scenario 3 – RAE 1 and FFS

NQTL: Prior Authorization (IP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **Yes.** Admit authorization requirements differ	RMHP Provider Manual RMHP UM Program Description Data request from RMHP Interview with RMHP staff Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Consultation with Department staff

Goals and Rationale:
For MH/SUD services, RMHP's Prior Authorization policies provide the conditions for admission notification as well as the process for prior authorization submission and review. The stated goals for prior authorization are as follows.

- Determine if the treatment or service is covered by a member's health plan
- Consider whether it is the right care, at the right time, from the right healthcare practitioner or provider
- Compare the member's medical needs to criteria based on scientific evidence to make decisions

For M/S, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Some of the components of the FFS Utilization Management program, such as the Inpatient Hospital Review Program (IHRP), were initially modified or suspended due to the COVID-19 pandemic to decrease provider burden and ensure members have appropriate and timely access to care and then to enable the Department to redesign the IHRP process.

Process:

MH/SUD
Prior authorization is NOT required for urgent or emergent (including crisis) admissions for MH/SUD Admissions.

Inpatient Prior Authorization is used for all MH/SUD inpatient level of care stays.

Inpatient MH/SUD services require notification by the admitting facility of an admission within 24 hours of admission. If a weekend or holiday is involved, then notification must occur the first business day following the weekend or holiday. Prior authorization is required before non-emergent admissions such as Short Term Residential (STR), Long Term Residential (LTR), and Partial Hospitalization (PHP). ALL Physical Health and Behavioral Health ELECTIVE, NON-URGENT/EMERGENT admissions require review and/or Prior authorization to determine medical necessity for appropriate level of care. Post-stabilization care services are also covered. Preauthorization is not required for post-stabilization care. Licensed behavioral health practitioners/Care advocates and registered nurses apply evidence based clinical guidelines (MCG) to determine medical necessity for the admit and continued stay. RMHP registered nurses and licensed clinical staff are authorized to approve services, but may not deny services that do not meet medical necessity criteria. Cases that do not meet guidelines are forwarded to RMHP Medical Direction for review. Per the UM Program Description, page 27, a doctorate level practitioner makes all medical necessity denials. Medical Directors may access additional resources for complex cases, including Advanced Medical Reviews, LLC (AMR). Frequency of review is determined on a case by case basis considering the Member's behavioral health/mental health condition. All Adverse determinations for medical necessity are determined by an RMHP Medical Director.

Amount of time to issue standard determination: Ten calendar days.

For Acute Inpatient levels of care, authorization requests are always received by phone or voicemail. Other inpatient level requests, such as day treatment or residential, are usually faxed because the request requires additional clinical documentation. The criteria utilized to make medical necessity and appropriateness decisions for all UM processes are based on nationally-recognized standards of practice for medical services and are applied on an individual need's basis. RMHP's UM Program bases its decisions on utilization of the most current edition of MCG and approved RMHP guidelines.

M/S

Prior authorization is NOT required for urgent or emergent admissions for M/S Admissions.

Inpatient Prior Authorization is used for select M/S procedures or services to establish medical necessity. The codes and services that the Department primarily focuses on when determining whether to prior authorize are those procedures, services, or supplies that may or may not be medically necessary, have a more appropriate lower level of care, or have a more appropriate setting and/or have a higher risk for waste, fraud, and abuse. For those services and benefits that are primarily elective and/or are rarely medically necessary, the Department may utilize methods other than prior authorization to decrease unnecessary or inappropriate utilization such as claim edits, closing or placing limits on codes, etc. Procedures that are medically necessary the vast majority of the time with a lower risk for waste, fraud, and abuse are rarely subject to prior authorization.

Finding:
M/S requires prior authorization on select procedures to make sure the procedures and services are medically necessary. MH/SUD does not have procedures, but they do also require prior authorization for services to ensure medical necessity. Both M/S and MH/SUD, most often do not require prior authorization for services that are deemed to be always medically necessary. Additionally, while both look at medical necessity, M/S also looks at less costly options (i.e. does the procedure need to be done in the hospital, convenience of member/caregiver, duplication, timeliness, experimental/investigational/FDA approved). MH/SUD looks to avoid overly invasive services or institutionalizing a member.
So, while differences in the policies and procedures exist, the requirements, processes, and rationale for requiring prior authorization review are comparable and applied no more stringently. Therefore, they are parity compliant.

NQTL: Prior Authorization (OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	RMHP Provider Manual RMHP UM Program Description Data request from RMHP Interview with RMHP staff Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training materials

Goals and Rationale:
For MH/SUD services, RMHP's Prior Authorization policies provide the process for prior authorization submission and review. The stated goals for prior authorization are as follows. Determine if the treatment or service is covered by a member's health plan

- Consider whether it is the right care, at the right time, from the right healthcare practitioner or provider
- Compare the member's medical needs to criteria based on scientific evidence to make decisions

For M/S services, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Process:

MH/SUD
A few outpatient services are subject to prior authorization review requirements. They are specialized services or treatments, and prior authorization review serves to establish medical appropriateness and necessity of services.

For MH/SUD outpatient levels of care, authorization requests are submitted through RMHP's contracted care management platform provided by Essette, Inc. The criteria utilized to make medical necessity and appropriateness decisions for all UM processes are based on nationally-recognized standards of practice for medical services and are applied on an individual needs basis. RMHP's UM Program bases its decisions on utilization of the most current edition of MCG (formerly Milliman Care Guidelines®) and approved RMHP guidelines.

All requests are initially reviewed by RMHP Care Advocates. RMHP considers the member's medical needs using criteria based on scientific evidence to make utilization management decisions. An RMHP Medical Director or Registered Pharmacist reviews all requests that do not meet these criteria. The Medical Director consults as needed with specialist physicians experienced in the type of care requested. For all requests, providers should anticipate a decision within 10 days.

M/S
Prior Authorization requests are required for the following select outpatient FFS M/S service codes:

- Audiology
- Adult Habilitative Speech Therapy (Alternative Benefit Plan)
- Diagnostic Imaging
- Durable Medical Equipment and Supplies (subset of oxygen and respiratory equipment suspended as of April 1, 2020)
- Medical and Surgical services
- Molecular Testing
- Outpatient Physical, Occupational and Speech Therapies
- Pediatric Long-Term Home Health (Suspended as of July 1, 2020)
- Pediatric Personal Care Services
- Private Duty Nursing (Suspended as of July 1, 2020)
- Synagis
- Vision

The FFS UM Vendor utilizes an online PAR portal for authorization submission for M/S services. It is available for authorization submission twenty-four (24) hours per day, seven (7) days a week for provider convenience, but authorization requests are not required to be entered after hours, on weekends, or state holidays. The majority of authorization requests are submitted through the PAR portal, that is available to the provider 24/7, while a small subset of providers are permitted to submit requests via secure fax.

For Outpatient FFS M/S PARs the FFS UM Vendor uses InterQual criteria, or state developed criteria to determine appropriateness of outpatient services. In order to ensure compliance with policy and regulations and clinical criteria, the FFS UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. All Reviewers must review the submitted information and documentation against specific policy, guidelines, and InterQual criteria.

First Level Reviewers consist of Registered Nurses who may:

- Approve the service as requested based on InterQual or Department approved Criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Physician Review).
- Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc.
- First Level Reviewers cannot deny for lack of medical necessity.

Second Level Reviewers consist of Physicians who may:

- Approve the service as requested based on InterQual or Department approved Criteria, Department approved criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Render either a full or partial denial for lack of medical necessity.

Per Colorado State Rule, the UM FFS Vendor has 10 business days to complete an outpatient M/S PAR review upon receipt of all necessary documentation from the provider or facility. The UM FFS Vendor’s average turnaround time is 4 business days.

Finding:
The RAE's outpatient prior authorization timeframes for determination are 10 days for standard and 72 hours for expedited. These timeframes are industry standard, are the same or faster than federal requirements (14 days standard/72 hours expedited) and are consistent with Colorado State Rule (10 days standard/72 hours expedited).

The authorizations used by the RAE are based upon federal regulations, Colorado State Rule, as well as nationally-recognized industry standards of practice. The fee-for-service M/S services and MH/SUD services both require authorization for outpatient services. They all are responsive to urgency posed by the condition of the member, and the policies and procedures applied to MH/SUD and M/S services have not been found to be more stringent nor create a barrier to access to care for members. Therefore, these policies are in compliance with all federal and state parity laws.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Prior Authorization (IP)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **Yes:** Admit authorization requirements differ	Beacon Health Options (Northeast Health Partners & Health Colorado) Provider Handbook R2 & R4 NQTL RAE Survey 2021 Interview with Beacon staff Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR - Inpatient Hospital Review Program Colorado PAR Program provider training materials Consultation with Department staff

Goals and Rationale: Inpatient Prior Authorization is used for all M/S and MH/SUD inpatient level of care stays. Urgent/Emergent services are not subject to prior authorization review.

For MH/SUD services, Beacon's Prior Authorization policies provide the conditions for admission notification as well as the process for prior authorization submission and review. The stated goals for Beacon's utilization management program are:

- Easy and early access to appropriate treatment
- Working collaboratively with participating providers in promoting delivery of quality care according to accepted best-practice standards
- Addressing the needs of special populations, such as children and the elderly
- Identification of common illnesses or trends of illness
- Identification of high-risk cases for intensive care management
- Screening, education, and outreach

Inpatient level of care is the most restrictive for members. The RAE conducts prior authorization reviews to make sure that members could not be safely treated at a lower level of care.

For M/S, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Some of the components of the FFS Utilization Management program, such as the Inpatient Hospital Review Program (IHRP), were initially modified or suspended due to the COVID-19 pandemic to decrease provider burden and ensure members have appropriate and timely access to care and then to enable the Department to redesign the IHRP process.

Process:

MH/SUD

All participating inpatient MH/SUD facilities are responsible to notify Beacon of an inpatient admission within 24 hours of admission. If a weekend or holiday is involved, then notification must occur the first business day following the weekend or holiday. With the exception of urgent/emergent (including crisis) services all MH/SUD inpatient level of care services require prior authorization.

Prior to non-emergency admission and/or beginning treatment, the MH/SUD provider/participating MH/SUD provider must contact Beacon. All members are assigned a Community Mental Health Center (CMHC) within their Regional Accountable Entity (RAE) to help meet the member's MH/SUD needs. The assignment of CMHC is based on the member's registered address and may not match PCP assignment. Facilities contracted for high levels of care are required to communicate with the member's assigned CMHC for all admissions.

All MH/SUD authorizations are submitted through ProviderConnect and reviewed by clinical care managers utilizing diagnosis-based clinical practice guidelines. These guidelines are reviewed and updated every two years by the Beacon Scientific Review Committee. Beacon's process for obtaining authorization, as written in its Higher Levels of Care Authorization Process, is as follows.

1. When a member presents to a facility with behavioral health symptoms, the facility should perform an assessment to determine the member's treatment needs. If a high level of care is deemed medically necessary by the facility reviewer, then the facility should submit the assessment and pertinent clinical information to the member's assigned CMHC. The CMHC will review the clinical information from the facility and assess for the least restrictive level of care.
2. If determined that the facility's recommended level of care is the most appropriate, then the CMHC will contact Beacon Clinical Care Manager (CCM) staff to present the clinical information or give permission for the CCM to take clinical directly from the facility.
3. If the facility is not able to successfully reach the CMHC within two (2) hours from the time that the clinical information is transmitted to the CMHC, then they should contact Beacon CCMs directly via the Access to Care Line. The CCM will review the clinical information and will provide authorization details. The facility can proceed with member admission. Facilities should take appropriate measures to maintain the member safe while the member's case is under review.
4. If determined that the member can be treated at a lower level of care, then the CMHC will offer the alternative services to the facility. If the facility agrees with the recommended alternative services, then they will coordinate transition of care and the CMHC will notify Beacon. If the facility disagrees, then the CMHC will communicate with CCM staff to present clinical information for a Medical Director to review and issue a determination.

At the time of any review, a Medical Director or Peer Reviewer may deny authorization based on the diagnosis, the service requested, or medical necessity criteria. Clinical Care Managers or any other staff members do not have the authority to deny a service. Denials may only be issued by a Medical Director or Peer Reviewer. All authorization determinations are made within timeframes required by Health First Colorado standards (urgent: 72 hours; non-urgent: 10 days).

M/S
Prior authorization is NOT required for urgent or emergent admissions for M/S Admissions.

Inpatient Prior Authorization is used for select M/S procedures or services to establish medical necessity. The codes and services that the Department primarily focuses on when determining whether to prior authorize are those procedures, services, or supplies that may or may not be medically necessary, have a more appropriate lower level of care, or have a more appropriate setting and/or have a higher risk for waste, fraud, and abuse. For those services and benefits that are primarily elective and/or are rarely medically necessary, the Department may utilize methods other than prior authorization to decrease unnecessary or inappropriate utilization such as claim edits, closing or placing limits on codes, etc. Procedures that are medically necessary the vast majority of the time with a lower risk for waste, fraud, and abuse are rarely subject to prior authorization.

Finding:
M/S requires prior authorization on select procedures to make sure the procedures and services are medically necessary. MH/SUD does not have procedures, but they do also require prior authorization for services to ensure medical necessity. Both M/S and MH/SUD, most often do not require prior authorization for services that are deemed to be always medically necessary. Additionally, while both look at medical necessity, M/S also looks at less costly options (i.e. does the procedure need to be done in the hospital, convenience of member/caregiver, duplication, timeliness, experimental/investigational/FDA approved). MH/SUD looks to avoid overly invasive services or institutionalizing a member.
So, while differences in the policies and procedures exist, the requirements, processes, and rationale for requiring prior authorization review are comparable and applied no more stringently. Therefore, they are parity compliant.

NQTL: Prior Authorization (OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training materials Consultation with Department staff Beacon Health Options (Northeast Health Partners & Health Colorado) Provider Handbook R2 & R4 NQTL RAE Survey 2021 Beacon/NHP Outpatient Mental Health Authorization Process Beacon/HCI Outpatient Mental Health Authorization Process Interview with Beacon staff

Goals and Rationale: A few outpatient services are subject to prior authorization review requirements. They are specialized services or treatments, and prior authorization review serves to establish medical appropriateness and necessity of services.

For MH/SUD services, Beacon's Utilization Management policies provide the process for prior authorization submission and review. The stated goals for Beacon's utilization management program are:

- Easy and early access to appropriate treatment
- Working collaboratively with participating providers in promoting delivery of quality care according to accepted best-practice standards
- Addressing the needs of special populations, such as children and the elderly
- Identification of common illnesses or trends of illness
- Identification of high-risk cases for intensive care management
- Screening, education, and outreach

The outpatient services that do require authorization are generally considered non-routine or more complex interventions such as IOP, in-home services, respite, ECT or psych testing. These services are typically more intensive and not appropriate for all members. Therefore, the RAE reviews these instances individually to establish medical necessity.

For M/S services, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Process:

MH/SUD
All MH/SUD authorizations are submitted through ProviderConnect and reviewed by clinical care managers utilizing diagnosis-based clinical practice guidelines. Initial evaluation sessions for outpatient services do not require authorization for providers contracted with Beacon. For all other MH/SUD outpatient services Beacon has adopted the following policies:

- **Sessions 1-25**: No authorization is required for In-Network providers for the first 25 units (total in any combination) of the following codes: 90791, 90832, 90834, 90837, 90846 and 90847. These 25 sessions without authorization are allowed once in a 12-month calendar year.
- **Sessions 26+:** After 25 outpatient psychotherapy units (total in any combination) have been provided, the provider must request additional authorization by completing the Outpatient Review Form and submitting a treatment plan. It is recommended that requests be submitted through ProviderConnect. You may also call the Access to Care Line or submit via clinical fax to 719.538.1439.

With the exception of the initial evaluation and the above codes, all other outpatient codes require prior authorization. At the time of any review, a Medical Director or Peer Reviewer may deny authorization based on the diagnosis, the service requested, or medical necessity criteria. Clinical Care Managers or any other staff members do not have the authority to deny a service. Denials may only be issued by a Medical Director or Peer Reviewer. All authorization determinations are made within timeframes required by Colorado Medicaid standards (urgent: 72 hours; non-urgent: 10 days).

M/S
Prior Authorization requests are required for the following select outpatient FFS M/S service codes:

- Audiology
- Adult Habilitative Speech Therapy (Alternative Benefit Plan)
- Diagnostic Imaging

- Durable Medical Equipment and Supplies (subset of oxygen and respiratory equipment suspended as of April 1, 2020)
- Medical and Surgical services
- Molecular Testing
- Outpatient Physical, Occupational and Speech Therapies
- Pediatric Long-Term Home Health (Suspended as of July 1, 2020)
- Pediatric Personal Care Services
- Private Duty Nursing (Suspended as of July 1, 2020)
- Synagis
- Vision

The FFS UM Vendor utilizes an online PAR portal for authorization submission for M/S services. It is available for authorization submission twenty-four (24) hours per day, seven (7) days a week for provider convenience, but authorization requests are not required to be entered after hours, on weekends, or state holidays. The majority of authorization requests are submitted through the PAR portal, that is available to the provider 24/7, while a small subset of providers are permitted to submit requests via secure fax.

For Outpatient FFS M/S PARs the FFS UM Vendor uses InterQual criteria, or state developed criteria to determine appropriateness of outpatient services. In order to ensure compliance with policy and regulations and clinical criteria, the FFS UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. All Reviewers must review the submitted information and documentation against specific policy, guidelines, and InterQual criteria.

First Level Reviewers consist of Registered Nurses who may:

- Approve the service as requested based on InterQual or Department approved Criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Physician Review).
- Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc.
- First Level Reviewers cannot deny for lack of medical necessity.

Second Level Reviewers consist of Physicians who may:

- Approve the service as requested based on InterQual or Department approved Criteria, Department approved criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Render either a full or partial denial for lack of medical necessity.

Per Colorado State Rule, the UM FFS Vendor has 10 business days to complete an outpatient M/S PAR review upon receipt of all necessary documentation from the provider or facility. The UM FFS Vendor's average turnaround time is 4 business days.

Finding:
The RAE's outpatient prior authorization timeframes for determination are 10 days for standard and 72 hours for expedited. These timeframes are industry standard, are the same or faster than federal requirements (14 days standard/72 hours expedited) and are consistent with Colorado State Rule (10 days standard/72 hours expedited).

The authorizations used by the RAE are based upon federal regulations, Colorado State Rule, as well as nationally-recognized industry standards of practice. The fee-for-service M/S services and MH/SUD services both require authorization for outpatient services. They all are responsive to urgency posed by the condition of the member, and the policies and procedures applied to MH/SUD and M/S services have not been found to be more stringent nor create a barrier to access to care for members. Therefore, these policies are in compliance with all federal and state parity laws.

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Prior Authorization (IP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **Yes:** Admit authorization requirements differ	Colorado PAR - Inpatient Hospital Review Program Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training materials Consultation with Department staff Colorado Access Provider Manual – Utilization Management Program (Section 9) COA CCS302 Medical Criteria for Utilization Review COA CCS307 Utilization Review Determinations COA CCS301 Qualifications for Staff Engaged in Utilization Management Activities Colorado Access Data Request Interview with Colorado Access Staff

Goals and Rationale: Prior authorization review serves to establish medical appropriateness and necessity of services. Inpatient Prior Authorization is used for all M/S and MH/SUD inpatient level of care stays. Urgent/Emergent services are not subject to prior authorization review.

For MH/SUD services, Colorado Access's Utilization Management policies provide the conditions for admission notification as well as the process for prior authorization submission and review. Colorado Access describes Prospective Review, their term for prior authorization, as necessary for the pre-authorization of healthcare services to determine if services or treatments are Medically Necessary, planned in the appropriate setting and will be provided by participating providers, whenever possible.

For M/S, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Some of the components of the FFS Utilization Management program, such as the Inpatient Hospital Review Program (IHRP), were initially modified or suspended due to the COVID-19 pandemic to decrease provider burden and ensure members have appropriate and timely access to care and then to enable the Department to redesign the IHRP process.

Process:

MH/SUD
All participating inpatient MH/SUD facilities are responsible to notify Colorado Access of an inpatient admission within 24 hours of admission. If a weekend or holiday is involved, then notification must occur the first business day following the weekend or holiday.

Consistent with industry standards, Colorado Access requires prior authorization for inpatient behavioral health services. Per state and federal regulations, COA does not perform any utilization review for emergency services.

Requests for authorization of service may be received by phone, fax, or mail. They are initially reviewed by a utilization management service coordinator. Authorization Submissions can be received 24 hours/day. Prospective Review determinations will be made within in a reasonable period of time appropriate to the member's medical condition, no later than ten (10) calendar days after receipt of the request for services. If the provider indicates (or COA determines) that standard prospective timeframes could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, COA will review the request within a reasonable period of time appropriate to the member's medical condition, no later than seventy-two (72) hours after receipt of the request for services.

Authorization requests are reviewed by a Colorado Access medical director and assigned one of four determinations; 1) authorized 2) Pended 3) Adverse Benefit Determination (Denial), and 4) Administrative Denial. Colorado Access uses InterQual criteria for each service type/level of care available (relevant to the services that require prior authorization). If no InterQual Criteria is available, Colorado Access applies the general medical necessity criteria established by COA.

M/S
Prior authorization is NOT required for urgent or emergent admissions for M/S Admissions.

Inpatient Prior Authorization is used for select M/S procedures or services to establish medical necessity. The codes and services that the Department primarily focuses on when determining whether to prior authorize are those procedures, services, or supplies that may or may not be medically necessary, have a more appropriate lower level of care, or have a more appropriate setting and/or have a higher risk for waste, fraud, and abuse. For those services and benefits that are primarily elective and/or are rarely medically necessary, the Department may utilize methods other than prior authorization to decrease unnecessary or inappropriate utilization such as claim edits, closing or placing limits on codes, etc.

Procedures that are medically necessary the vast majority of the time with a lower risk for waste, fraud, and abuse are rarely subject to prior authorization.

Finding:
M/S requires prior authorization on select procedures to make sure the procedures and services are medically necessary. MH/SUD does not have procedures, but they do also require prior authorization for services to ensure medical necessity. Both M/S and MH/SUD, most often do not require prior authorization for services that are deemed to be always medically necessary. Additionally, while both look at medical necessity, M/S also looks at less costly options (i.e. does the procedure need to be done in the hospital, convenience of member/caregiver, duplication, timeliness, experimental/investigational/FDA approved). MH/SUD looks to avoid overly invasive services or institutionalizing a member.
So, while differences in the policies and procedures exist, the requirements, processes, and rationale for requiring prior authorization review are comparable and applied no more stringently. Therefore, they are parity compliant.

NQTL: Prior Authorization (OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training materials Consultation with Department staff Colorado Access Provider Manual – Utilization Management Program (Section 9) COA CCS302 Medical Criteria for Utilization Review COA CCS307 Utilization Review Determinations COA CCS301 Qualifications for Staff Engaged in Utilization Management Activities Colorado Access Data Request Interview with Colorado Access Staff

Goals and Rationale: A few outpatient services are subject to prior authorization review requirements. Prior authorization review serves to establish medical appropriateness and necessity of services.

For MH/SUD services, prior authorization policies are provided in the Colorado Access Utilization Management policies. Colorado Access describes Prospective Review, their term for prior authorization, as necessary for the pre-authorization of healthcare services to determine if services or treatments are Medically Necessary, planned in the appropriate setting and will be provided by participating providers, whenever possible. Routine MH/SUD outpatient services do not require prior authorization. Some specialty and/or higher acuity outpatient services do require prior authorization, consistent with industry standards. Per

state and federal regulations, COA does not perform any utilization review for emergency services.

For M/S services, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Process:

MH/SUD
Requests for authorization of service may be received by phone, fax, or mail. They are initially reviewed by a utilization management service coordinator. Authorization Submissions can be received 24 hours/day. Prospective Review determinations will be made within in a reasonable period of time appropriate to the member's medical condition, no later than ten (10) calendar days after receipt of the request for services. If the provider indicates (or COA determines) that standard prospective timeframes could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, COA will review the request within a reasonable period of time appropriate to the member's medical condition, no later than seventy-two (72) hours after receipt of the request for services.

Authorization requests are reviewed by a Colorado Access medical director and assigned one of four determinations; 1) authorized 2) Pended 3) Adverse Benefit Determination (Denial), and 4) Administrative Denial. Colorado Access uses InterQual criteria for each service type/level of care available (relevant to the services that require prior authorization). If no InterQual Criteria is available, Colorado Access applies the general medical necessity criteria established by this policy.

M/S
Prior Authorization requests are required for the following select outpatient FFS M/S service codes:

- Audiology
- Adult Habilitative Speech Therapy (Alternative Benefit Plan)
- Diagnostic Imaging
- Durable Medical Equipment and Supplies (subset of oxygen and respiratory equipment suspended as of April 1, 2020)
- Medical and Surgical services
- Molecular Testing
- Outpatient Physical, Occupational and Speech Therapies
- Pediatric Long-Term Home Health (Suspended as of July 1, 2020)
- Pediatric Personal Care Services
- Private Duty Nursing (Suspended as of July 1, 2020)
- Synagis
- Vision

The FFS UM Vendor utilizes an online PAR portal for authorization submission for M/S services. It is available for authorization submission twenty-four (24) hours per day, seven (7) days a week for provider convenience, but authorization requests are not required to be entered after hours, on weekends, or state holidays. The majority of authorization requests

are submitted through the PAR portal, that is available to the provider 24/7, while a small subset of providers are permitted to submit requests via secure fax.

For Outpatient FFS M/S PARs the FFS UM Vendor uses InterQual criteria, or state developed criteria to determine appropriateness of outpatient services. In order to ensure compliance with policy and regulations and clinical criteria, the FFS UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. All Reviewers must review the submitted information and documentation against specific policy, guidelines, and InterQual criteria.

First Level Reviewers consist of Registered Nurses who may:

- Approve the service as requested based on InterQual or Department approved Criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Physician Review).
- Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc.
- First Level Reviewers cannot deny for lack of medical necessity.

Second Level Reviewers consist of Physicians who may:

- Approve the service as requested based on InterQual or Department approved Criteria, Department approved criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Render either a full or partial denial for lack of medical necessity.

Per Colorado State Rule, the UM FFS Vendor has 10 business days to complete an outpatient M/S PAR review upon receipt of all necessary documentation from the provider or facility. The UM FFS Vendor’s average turnaround time is 4 business days.

Finding:
The RAE's outpatient prior authorization timeframes for determination are 10 days for standard and 72 hours for expedited. These timeframes are industry standard, are the same or faster than federal requirements (14 days standard/72 hours expedited), and are consistent with Colorado State Rule (10 days standard/72 hours expedited).

The authorizations used by the RAE are based upon federal regulations, Colorado State Rule, as well as nationally-recognized industry standards of practice. The fee-for-service M/S services and MH/SUD services both require authorization for outpatient services. They all are responsive to urgency posed by the condition of the member, and the policies and procedures applied to MH/SUD and M/S services have not been found to be more stringent nor create a barrier to access to care for members. Therefore, these policies are in compliance with all federal and state parity laws.

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Prior Authorization (IP)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **Yes:** Admit authorization requirements differ	CCHA Provider Manual CCHA UM Program Description Interview with CCHA Staff Colorado PAR - Inpatient Hospital Review Program Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training materials Consultation with Department staff

Goals and Rationale:
For MH/SUD services, CCHA's stated goals are to be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation. CCHA's Utilization Management policies provide the conditions for admission notification as well as the process for prior authorization submission and review. The UM Program Description lists the multiple objectives of the Behavioral Health UM Program including ensuring the delivery of quality, medically necessary and appropriate behavioral health care services including outpatient care, inpatient care, and alternative care settings, both in-and out-of-network.

For M/S, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Some of the components of the FFS Utilization Management program, such as the Inpatient Hospital Review Program (IHRP), were initially modified or suspended due to the COVID-19 pandemic to decrease provider burden and ensure members have appropriate and timely access to care and then to enable the Department to redesign the IHRP process.

Process:

MH/SUD
All participating inpatient MH/SUD facilities are responsible to notify CCHA of an inpatient admission within 24 hours of admission, regardless of a holiday or weekend. With the exception of urgent/emergent (including crisis) services, all MH/SUD inpatient level of care services require prior authorization. If the member enters treatment as a John Doe, the provider is exempt from requesting prior auth until they identify who the member is and verify the member's Medicaid. Members who admit as ineligible for Medicaid also do not require prior authorization. In these cases, retroactive requests for authorization are permitted.
CCHA MH/SUD authorization requests are submitted through the Interactive Care Reviewer web portal, fax, and phone. Authorization Submissions can be received 24 hours/day.

Timeframes for completion of prior authorization requests:

Urgent (expedited)	Within 72 hours (3 days) from receipt of request
Non-urgent	Within 10 calendar days from receipt of request
SUD ASAM Level 3.1 through 3.7	Within 72 hours (3 days) from receipt of request
SUD Special Connections	Within 24 hours (1 day) from receipt of request

CCHA has partnered with Anthem for their BH expertise and their criteria to review the medical necessity and appropriateness of behavioral health services is derived primarily from the following sources: Anthem Medical Policies and Clinical Utilization Management Guidelines, MCG Management Guidelines, and American Society of Addiction Medicine (ASAM) guidelines, unless superseded by state requirements or regulatory guidance. In addition to these standards, Anthem may adopt national guidelines produced by healthcare organizations such as individual medical and surgical societies, National Institutes of Health, and the Centers for Disease Control and Prevention. All Anthem Medical Policies and Clinical Utilization Management Guidelines are under the governance of the Medical Operation committee (MOC) and are reviewed annually and updated when appropriate. Behavioral Health Review Criteria are reviewed by the Anthem Behavioral Health Utilization Management Policies and Clinical Practice Guidelines Subcommittee.

Prior Authorization reviews are performed by a team of Care Management/Utilization Management clinicians, who are licensed professionals with training and experience in utilization management. They verify eligibility and benefits in the claim payment system and apply the appropriate criteria to determine whether the service is medically necessary. For those situations where medical necessity is met, the clinician approves the services.

When medical necessity is questioned, or when clinical information needed to make a decision has been requested but not received, the case is referred within the appropriate time frames to the appropriate Medical Director for medical necessity review and determination. The Medical Director makes the determination and documents the results of the medical necessity review. Only the Medical Director can issue a medical necessity denial. The clinician then notifies the treating practitioner and the member of the decision as policy requires. Treating practitioners are notified about the availability of and how to contact a Medical Director (or appropriate practitioner reviewer) to discuss any Utilization Management (UM) denial decisions.

M/S
Prior authorization is NOT required for urgent or emergent admissions for M/S Admissions.

Inpatient Prior Authorization is used for select M/S procedures or services to establish medical necessity. The codes and services that the Department primarily focuses on when determining whether to prior authorize are those procedures, services, or supplies that may or may not be medically necessary, have a more appropriate lower level of care, or have a more appropriate setting and/or have a higher risk for waste, fraud, and abuse. For those services and benefits that are primarily elective and/or are rarely medically necessary, the Department may utilize methods other than prior authorization to decrease unnecessary or inappropriate utilization such as claim edits, closing or placing limits on codes, etc. Procedures that are medically necessary the vast majority of the time with a lower risk for waste, fraud, and abuse are rarely subject to prior authorization.

Finding:

M/S requires prior authorization on select procedures to make sure the procedures and services are medically necessary. MH/SUD does not have procedures, but they do also require prior authorization for services to ensure medical necessity. Both M/S and MH/SUD, most often do not require prior authorization for services that are deemed to be always medically necessary. Additionally, while both look at medical necessity, M/S also looks at less costly options (i.e. does the procedure need to be done in the hospital, convenience of member/caregiver, duplication, timeliness, experimental/investigational/FDA approved). MH/SUD looks to avoid overly invasive services or institutionalizing a member.
So, while differences in the policies and procedures exist, the requirements, processes, and rationale for requiring prior authorization review are comparable and applied no more stringently. Therefore, they are parity compliant.

NQTL: Prior Authorization (OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Consultation with Department staff CCHA Provider Manual CCHA UM Program Description

Goals and Rationale: A few outpatient services are subject to prior authorization review requirements. They are specialized services or treatments, and prior authorization review serves to establish medical appropriateness and necessity of services.

For MH/SUD services, CCHA's stated goals are to be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation. CCHA's Utilization Management policies provide the conditions for admission notification as well as the process for prior authorization submission and review. The UM Program Description lists the multiple objectives of the Behavioral Health UM Program including ensuring the delivery of quality, medically necessary and appropriate behavioral health care services including outpatient care, inpatient care, and alternative care settings, both in-and out-of-network.

For M/S services, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Process:

MH/SUD
CCHA outpatient MH/SUD authorization requests are submitted through the Interactive Care Reviewer web portal, fax, and phone. Authorization Submissions can be received 24 hours/day.

Timeframes for completion of prior authorization requests:

Urgent (expedited)	Within 72 hours (3 days) from receipt of request

Non-urgent	Within 10 calendar days from receipt of request
SUD ASAM Level 3.1 through 3.7	Within 72 hours (3 days) from receipt of request
SUD Special Connections	Within 24 hours (1 day) from receipt of request

CCHA has partnered with Anthem for their BH expertise and their criteria to review the medical necessity and appropriateness of behavioral health services is derived primarily from the following sources: Anthem Medical Policies and Clinical Utilization Management Guidelines, MCG Management Guidelines, and American Society of Addiction Medicine (ASAM) guidelines, unless superseded by state requirements or regulatory guidance. In addition to these standards, Anthem may adopt national guidelines produced by healthcare organizations such as individual medical and surgical societies, National Institutes of Health, and the Centers for Disease Control and Prevention. All Anthem Medical Policies and Clinical Utilization Management Guidelines are under the governance of the Medical Operation committee (MOC) and are reviewed annually and updated when appropriate. Behavioral Health Review Criteria are reviewed by the Anthem Behavioral Health Utilization Management Policies and Clinical Practice Guidelines Subcommittee.

The following procedure codes do not require prior-authorization: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90875, 90876, 96116, 96121, 96130-96139, 96372, 97535, g1076, h0006, h0020, h0033, h0034, h0035, h0045, h2014, h2023-h2032, s3005, s9445, s9485, t1005, t1017, 90791, 90792, 90839, 90940, 98966-98968,h0001-h0005, h0023, h0025, h0031, h0032, h2000, h2011, s9453, s9454, t1007, t1023, 99241-99245, 99201-99443, 90833-90838. Individual and Family Therapy codes 90832, 90834, 90837, 90846 and 90847 do have an authorization requirement after 20 sessions in a calendar year. Some OP codes are subject to prior-authorization. CCHA requires prior-authorization and concurrent reviews for OP codes/treatment modalities that are utilized at higher intensity levels.

Prior Authorization reviews are performed by a team of Care Management/Utilization Management clinicians, who are licensed professionals with training and experience in utilization management. They verify eligibility and benefits in the claim payment system and apply the appropriate criteria to determine whether the service is medically necessary. For those situations where medical necessity is met, the clinician approves the services.

When medical necessity is questioned, or when clinical information needed to make a decision has been requested but not received, the case is referred within the appropriate time frames to the appropriate Medical Director for medical necessity review and determination. The Medical Director makes the determination and documents the results of the medical necessity review. Only the Medical Director can issue a medical necessity denial. The clinician then notifies the treating practitioner and the member of the decision as policy requires. Treating practitioners are notified about the availability of and how to contact a Medical Director (or appropriate practitioner reviewer) to discuss any Utilization Management (UM) denial decisions.

M/S

Prior Authorization requests are required for the following select outpatient FFS M/S service codes:

- Audiology
- Adult Habilitative Speech Therapy (Alternative Benefit Plan)
- Diagnostic Imaging

- Durable Medical Equipment and Supplies (subset of oxygen and respiratory equipment suspended as of April 1, 2020)
- Medical and Surgical services
- Molecular Testing
- Outpatient Physical, Occupational and Speech Therapies
- Pediatric Long-Term Home Health (Suspended as of July 1, 2020)
- Pediatric Personal Care Services
- Private Duty Nursing (Suspended as of July 1, 2020)
- Synagis
- Vision

The FFS UM Vendor utilizes an online PAR portal for authorization submission for M/S services. It is available for authorization submission twenty-four (24) hours per day, seven (7) days a week for provider convenience, but authorization requests are not required to be entered after hours, on weekends, or state holidays. The majority of authorization requests are submitted through the PAR portal, that is available to the provider 24/7, while a small subset of providers are permitted to submit requests via secure fax.

For Outpatient FFS M/S PARs the FFS UM Vendor uses InterQual criteria, or state developed criteria to determine appropriateness of outpatient services. In order to ensure compliance with policy and regulations and clinical criteria, the FFS UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. All Reviewers must review the submitted information and documentation against specific policy, guidelines, and InterQual criteria.

First Level Reviewers consist of Registered Nurses who may:

- Approve the service as requested based on InterQual or Department approved Criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Physician Review).
- Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc.
- First Level Reviewers cannot deny for lack of medical necessity.

Second Level Reviewers consist of Physicians who may:

- Approve the service as requested based on InterQual or Department approved Criteria, Department approved criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Render either a full or partial denial for lack of medical necessity.

Per Colorado State Rule, the UM FFS Vendor has 10 business days to complete an outpatient M/S PAR review upon receipt of all necessary documentation from the provider or facility. The UM FFS Vendor's average turnaround time is 4 business days.

Finding:

The RAE's outpatient prior authorization timeframes for determination are 10 days for standard and 72 hours for expedited. These timeframes are industry standard, are the same or faster than federal requirements (14 days standard/72 hours expedited) and are consistent with Colorado State Rule (10 days standard/72 hours expedited).

The authorizations used by the RAE are based upon federal regulations, Colorado State Rule, as well as nationally-recognized industry standards of practice. The fee-for-service M/S services and MH/SUD services both require authorization for outpatient services. They all are responsive to urgency posed by the condition of the member, and the policies and procedures applied to MH/SUD and M/S services have not been found to be more stringent nor create a barrier to access to care for members. Therefore, these policies are in compliance with all federal and state parity laws.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Prior Authorization (IP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	DHMC Provider Manual DHMC Services Requiring Prior Authorization Colorado Access Provider Manual – Utilization Management Program (Section 9)

Goals and Rationale: Denver Health MCO subcontracts out the operation of the its MH/SUD PIHP to Colorado Access. Inpatient Prior Authorization is used for all inpatient level of care stays. Urgent/Emergent services are not subject to prior authorization review.
For MH/SUD services, Colorado Access's Utilization Management policies provide the conditions for admission notification as well as the process for prior authorization submission and review. Colorado Access describes Prospective Review, their term for prior authorization, as necessary for the pre-authorization of healthcare services to determine if services or treatments are Medically Necessary, planned in the appropriate setting and will be provided by participating providers, whenever possible.

Denver Health's Utilization Management (UM) policies provide the conditions for M/S inpatient admission notification as well as the process for prior authorization submission and review. The stated purpose of the UM Department is to achieve the following objectives for all members:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring and education program. The program is designed to identify patterns of over or under-utilization patterns and inefficient use of resources.
- To assure fair and consistent UM decision making by using evidence-based, decision support criteria from guidelines such as MCG, Hayes and Denver Health Medical Plan, Inc. Medical Policies.
- To focus resources on a timely resolution of identified problems.

Process:

MH/SUD

All participating inpatient MH/SUD facilities are responsible to notify Colorado Access of an inpatient admission within 24 hours of admission. If a weekend or holiday is involved, then notification must occur the first business day following the weekend or holiday.

Consistent with industry standards, Colorado Access requires prior authorization for inpatient behavioral health services. Per state and federal regulations, COA does not perform any utilization review for emergency services.

Requests for authorization of service may be received by phone, fax, or mail. They are initially reviewed by a utilization management service coordinator. Authorization Submissions can be received 24 hours/day. Prospective Review determinations will be made within in a reasonable period of time appropriate to the member's medical condition, no later than ten (10) calendar days after receipt of the request for services. If the provider indicates (or COA determines) that standard prospective timeframes could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, COA will review the request within a reasonable period of time appropriate to the member's medical condition, no later than seventy-two (72) hours after receipt of the request for services.
Authorization requests are reviewed by a Colorado Access medical director and assigned one of four determinations; 1) authorized 2) Pended 3) Adverse Benefit Determination (Denial), and 4) Administrative Denial. Colorado Access uses InterQual criteria for each service type/level of care available (relevant to the services that require prior authorization). If no InterQual Criteria is available, Colorado Access applies the general medical necessity criteria established by COA.

M/S
Inpatient M/S admissions should occur at Denver Health except when prior authorized by the PCP and the Medical Services Department or in the event of a life-threatening emergency when it would be unsafe to transport the Member to Denver Health.

All participating M/S inpatient facilities are responsible to notify DHMC of an inpatient admission within 24 hours of admission. With the exception of urgent/emergent (including crisis) services all M/S inpatient level of care services require prior authorization.
Denver Health's Utilization Management RNs (UM RNs) review preservice requests to determine if the request is a covered benefit and whether or not it meets medical necessity criteria.

i. Standard preservice review determinations are made, and notice is given to the provider and member as expeditiously as the member's health condition requires, but no later than ten (10) calendar days from receipt of the request.
ii. Expedited preservice review determinations are made and notice is given to the provider and member as expeditiously as the member's health condition requires, but no later than 72 hours from the date of request.

The servicing provider or ordering physician is responsible for completing any applicable prior authorization request forms and providing information necessary to determine what is being requested and why it is needed. These requests may be submitted by fax.

a) A Company UM RN reviews the request and requests additional information, as necessary. If additional information or records are needed, the requesting provider and the ordering physician are contacted.

b) The Company UM RN consults the requesting provider and ordering physician prior to making a decision when the request requires additional clarity or other relevant information.
c) If the Company receives a request for services which are considered Wraparound Benefits, the Company UM RN or designee will notify the requesting provider that these services are outside the scope of the contract and will direct the provider that these services are reimbursable under Colorado Health First Medicaid and shall be billed directly to the State Department's fiscal agent by the Provider.

Utilization Review of Medical Services

a) The Company UM RNs perform utilization review to determine eligibility, benefit coverage and medical necessity for requested services. UM RNs use Health First Contract guidelines, MCG Health Care guidelines, InterQual Modules and/or Hayes, Inc. Knowledge Center™ reviews to determine medical necessity is supported by the submitted documentation. In cases in which the situation is not addressed by one or more of the above-mentioned resources, UM RNs confer with the Company Medical Director or their physician designee for guidance.
b) If the member is an EPSDT eligible member, the Company shall approve all services which are medically necessary, even above the usual contract limits, in order to meet the EPSDT member's on-going medical necessity needs. If the medically necessary service is expressly excluded in the contract between Department and the Company, the provider will be referred to Colorado Medicaid service to be covered as a wraparound benefit.
c) Company UM RNs are not able to deny requests which do not meet medical necessity criteria. If a case does not meet medical necessity criteria, the Company RN refers the case to the Company Medical Director or their physician designee.
d) Medical Director or their physician designee reviews all medical necessity decisions that may result in a denial of a service or an authorization of a service that is in an amount, duration, or scope that is less than requested, prior to notifying the provider and member of the Company's decision. The Company Medical Director or his/her physician designee reviews the request for service including all applicable information and documents a decision in the medical record. The Company Medical Director or his/her physician designee has available board-certified physicians from appropriate specialty areas to assist as needed in making denial decisions.
e) Denials based on requests for benefits that are specifically excluded from the benefit package and denials based on the fact that the member is not eligible for benefits under the plan at the time of the request do not require physician review for medical necessity.

Finding:
The requirements and processes for MH/SUD inpatient admission notification, prior authorization submission and determination are comparable to and applied no more stringently than to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented. Therefore, they meet parity requirements.

NQTL: Prior Authorization (OP)	**Evidence used for comparison:**

Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	DHMC Provider Manual DHMC Services Requiring Prior Authorization Colorado Access Provider Manual – Utilization Management Program (Section 9)

Goals and Rationale: Denver Health MCO partners with Colorado Access to operate the Denver Health MH/SUD PIHP.

For MH/SUD services, prior authorization policies are provided in the Colorado Access Utilization Management policies. Colorado Access describes Prospective Review, their term for prior authorization, as necessary for the pre-authorization of healthcare services to determine if services or treatments are Medically Necessary, planned in the appropriate setting and will be provided by participating providers, whenever possible.

Denver Health's Utilization Management (UM) policies provide the process for M/S outpatient service prior authorization submission and review. The stated purpose of the UM Department is to achieve the following objectives for all members:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring and education program. The program is designed to identify patterns of over or under-utilization patterns and inefficient use of resources.
- To assure fair and consistent UM decision making by using evidence-based, decision support criteria from guidelines such as MCG, Hayes and Denver Health Medical Plan, Inc. Medical Policies.
- To focus resources on a timely resolution of identified problems.

Process:

MH/SUD
Routine MH/SUD outpatient services do not require prior authorization. Some specialty and/or higher acuity outpatient services do require prior authorization, consistent with industry standards. Per state and federal regulations, COA does not perform any utilization review for emergency services.

Outpatient MH/SUD requests for authorization of service may be received by Colorado Access by phone, fax, or mail. They are initially reviewed by a utilization management service coordinator. Authorization Submissions can be received 24 hours/day. Prospective Review determinations will be made within in a reasonable period of time appropriate to the member's medical condition, no later than ten (10) calendar days after receipt of the request for services. If the provider indicates (or COA determines) that standard prospective timeframes could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, COA will review the request within a reasonable period of time appropriate to the member's medical condition, no later than seventy-two (72) hours after receipt of the request for services.

Authorization requests are reviewed by a Colorado Access medical director and assigned one of four determinations; 1) authorized 2) Pended 3) Adverse Benefit Determination (Denial), and 4) Administrative Denial. Colorado Access uses InterQual criteria for each service type/level of care available (relevant to the services that require prior

authorization). If no InterQual Criteria is available, Colorado Access applies the general medical necessity criteria established by this policy.

M/S

Denver Health's Utilization Management RNs (UM RNs) review preservice requests to determine if the request is a covered benefit and whether or not it meets medical necessity criteria.

i. Standard preservice review determinations are made, and notice is given to the provider and member as expeditiously as the member's health condition requires, but no later than ten (10) calendar days from receipt of the request.

ii. Expedited preservice review determinations are made and notice is given to the provider and member as expeditiously as the member's health condition requires, but no later than 72 hours from the date of request. The servicing provider or ordering physician is responsible for completing any applicable prior authorization request forms and providing information necessary to determine what is being requested and why it is needed. These requests may be submitted by fax.

a. A Company UM RN reviews the request and requests additional information, as necessary. If additional information or records are needed, the requesting provider and the ordering physician are contacted.
b. The Company UM RN consults the requesting provider and ordering physician prior to making a decision when the request requires additional clarity or other relevant information.
c. If the Company receives a request for services which are considered Wraparound Benefits, the Company UM RN or designee will notify the requesting provider that these services are outside the scope of the contract and will direct the provider that these services are reimbursable under Colorado Health First Medicaid and shall be billed directly to the State Department's fiscal agent by the Provider.

Utilization Review of Medical Services

a. The Company UM RNs perform utilization review to determine eligibility, benefit coverage and medical necessity for requested services. UM RNs use Health First Contract guidelines, MCG Health Care guidelines, and/or Hayes, Inc. Knowledge Center™ reviews to determine medical necessity is supported by the submitted documentation. In cases in which the situation is not addressed by one or more of the above-mentioned resources, UM RNs confer with the Company Medical Director or their physician designee for guidance.
b. If the member is an EPSDT eligible member, the Company shall approve all services which are medically necessary, even above the usual contract limits, in order to meet the EPSDT member's on-going medical necessity needs. If the medically necessary service is expressly excluded in the contract between Department and the Company, the provider will be referred to Colorado Medicaid service to be covered as a wraparound benefit.
c. Company UM RNs are not able to deny requests which do not meet medical necessity criteria. If a case does not meet medical necessity criteria, the Company RN refers the case to the Company Medical Director or their physician designee.
d. Medical Director or their physician designee reviews all medical necessity decisions that may result in a denial of a service or an authorization of a

service that is in an amount, duration, or scope that is less than requested, prior to notifying the provider and member of the Company's decision. The Company Medical Director or his/her physician designee reviews the request for service including all applicable information and documents a decision in the medical record. The Company Medical Director or his/her physician designee has available board-certified physicians from appropriate specialty areas to assist as needed in making denial decisions.

e. Denials based on requests for benefits that are specifically excluded from the benefit package and denials based on the fact that the member is not eligible for benefits under the plan at the time of the request do not require physician review for medical necessity.
f. DHMC utilizes both internally approved guidelines as well as National Criteria Sets; InterQual or MCG. It also uses the Medicare Coverage Database, Department Benefits Collaborative, and Hayes Knowledge Center to determine the medical necessity of requested services.

Finding:
The requirements and processes for MH/SUD outpatient prior authorization submission and determination are comparable to and applied no more stringently than to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented. Therefore, they meet parity requirements.

NQTL: Prior Authorization (PD)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	DHMC Provider Manual DHMC Prior Authorization Approval Criteria

Goals and Rationale: DHMC requires prior authorization/ exception for a select group of drugs not found on its formulary.

Process:

The DHMC/DHMP Pharmacy Department reviews all prior authorization requests/exception requests on a case-by-case basis. Prior authorization criteria are developed following evidence-based criteria including:

1. Safety, including concurrent drug utilization review (cDUR) when applicable
2. Efficacy: the potential outcome of treatment under optimal circumstances
3. Strength of scientific evidence and standards of practice through review of relevant information from the peer-reviewed medical literature, accepted national treatment guidelines, and expert opinion where necessary
4. Cost-Effectiveness: the actual outcome of treatment under real life conditions including consideration of total health care costs, not just drug costs, through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available

5. Relevant benefits of current formulary agents of similar use
6. Any restrictions that should be delineated to assure safe, effective, or proper use of the drug.

The criteria for prior approval for each drug are delineated in the plan's Prior Authorization Approval Criteria.

Finding:
The standards, processes, strategies, evidentiary standards and other factors in writing and operation used for MH/SUD benefits are comparable to and applied no more stringently than M/S benefits.

Appendix B - Concurrent Review

Description: Concurrent Review requires services be periodically reviewed as they are being provided in order to continue the authorization for the service.

Tools for Analysis: Concurrent review utilization management policies, frequency of review, and reviewer qualifications

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP	No	Yes
Scenario 3				
	RAE 1	IP, OP	Yes	No
	RAE 2 & 4	IP, OP	Yes	No
	RAE 3 & 5	IP, OP	Yes	No
	RAE 6 & 7	IP, OP	Yes	No
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP	No	Yes

Scenario 1 – FFS

NQTL: Concurrent Reviews (IP)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff

Goals and Rationale:
The goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Some of the components of the FFS Utilization Management program, such as the Inpatient Hospital Review Program (IHRP), were modified or suspended due to the COVID-19 pandemic to decrease provider burden and ensure members have appropriate and timely access to care.

Process:

MH/SUD and M/S
The Department suspended the fee-for-service Inpatient Hospital Review Program (IHRP) requirement for hospital admissions initially to support hospitals to focus on COVID-19 care and then to enable the Department to redesign the IHRP process. This suspension pertains to admission reviews, admission notifications, concurrent review, and complex case concurrent review.

IHRP is currently suspended, but when it is in operation, Inpatient FFS Concurrent / Continued Stay Reviews are required under IHRP.

Finding:
Concurrent review is not used for FFS MH/SUD or M/S hospitalizations. Therefore, requirements for MH/SUD benefits are comparable to and not more stringent than for M/S benefits, and they meet parity requirements.

Scenario 2 – RAE 1 and Rocky Mountain Health Plan Prime MCO

NQTL: Concurrent Reviews (IP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	RMHP Provider Manual Data request from RMHP Interview with RMHP staff

Goals and Rationale: RMHP defines inpatient concurrent review as the ongoing assessment during a course of treatment. The assessment ensures the continued care is high-quality, medically appropriate, provided effectively and efficiently, and performed at the appropriate level of care.

Process:

Rocky Mountain Health Plans applies the same concurrent review policies to MH/SUD and M/S services.

MH/SUD and M/S:

Inpatient MH/SUD and M/S continued stays require concurrent review; the frequency is based upon the client clinical picture. Concurrent review is conducted during business hours by on-site chart review or by telephonic review. Discharge planning is incorporated within the concurrent review process.
Concurrent review is performed on all notified admissions with a focus on the following categories:

- Admission and continued stay review for medical necessity
- Appropriateness of setting, severity of illness / intensity of service
- Potential case management referrals
- Identified quality management issues
- Medical appropriateness of services
- Extended lengths of stay
- Behavioral health services and admissions
- Potential quality of care issues, e.g., adverse events, are referred to and investigated thoroughly by the Quality Improvement process

Ongoing care provided to a member is reviewed on a periodic basis (every day to one week) either onsite, electronically or telephonically to ensure the continued need for acute care and that the care is in conformance with the member's plan benefits.

Outpatient MH/SUD services and M/S procedures do not require concurrent authorization/review.

Emergency care MH/SUD services and M/S procedures do not require concurrent authorization/review.

Finding:
The requirements and processes for MH/SUD inpatient concurrent reviews are comparable to and applied no more stringently than to M/S benefits.

The policy for concurrent review contains specific focus categories where reviews are performed. While there is specific mention of behavioral services and admissions, the other focus categories create significantly more instances where it is likely M/S inpatient admissions would be reviewed.

Further, the policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented. Therefore, they meet parity requirements.

Scenario 3 – RAE 1 and FFS

NQTL: Concurrent Reviews (IP)	**Evidence used for comparison:**
Complies with Parity Requirements: No **Differences noted between M/S and MH/SUD services:** **Yes. The M/S concurrent review process is currently suspended.**	RMHP Provider Manual RMHP UM Program Description Data request from RMHP Interview with RMHP staff Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff

Goals and Rationale:
RMHP defines MH/SUD inpatient concurrent review as the ongoing assessment during a course of treatment. The assessment ensures the continued care is high-quality, medically appropriate, provided effectively and efficiently, and performed at the appropriate level of care

The FFS UM Vendor is responsible for utilizing nurse and physician reviewers in performing M/S medical necessity reviews to determine compliance to federal and state rules, Department policy, and the medical appropriateness of the request across a range of inpatient and Fee-For-Service benefits.

For M/S, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Some of the components of the FFS Utilization Management program, such as the Inpatient Hospital Review Program (IHRP), were modified or suspended due to the COVID-19 pandemic to decrease provider burden and ensure members have appropriate and timely access to care.

Process:

MH/SUD
Inpatient MH/SUD continued stays require concurrent review; the frequency is based upon the client clinical picture. Concurrent review is conducted during business hours by on-site chart review or by telephonic review. Discharge planning is incorporated within the concurrent review process.
Concurrent review is performed on all notified admissions with a focus on the following categories:

- Admission and continued stay review for medical necessity
- Appropriateness of setting, severity of illness / intensity of service
- Potential case management referrals
- Identified quality management issues
- Medical appropriateness of services
- Extended lengths of stay
- Behavioral health services and admissions
- Potential quality of care issues, e.g., adverse events, are referred to and investigated thoroughly by the Quality Improvement process

Ongoing care provided to a member is reviewed on a periodic basis (every day to one week) either onsite, electronically or telephonically to ensure the continued need for acute care and that the care is in conformance with the member's plan benefits.

Outpatient MH/SUD services do not require concurrent authorization/review.

Emergency care MH/SUD services do not require concurrent authorization/review.

M/S:
The Department suspended the physical health fee-for-service Inpatient Hospital Review Program (IHRP) requirement for physical health hospital admissions, initially to support hospitals to focus on COVID-19 care and then to enable the Department to redesign the IHRP process. This suspension pertains to admission reviews, admission notifications, concurrent review, and complex case concurrent review.

IHRP is currently suspended, but when it is in operation, Inpatient FFS M/S Concurrent/Continued Stay Reviews are required under IHRP.

Finding:
The RAE's concurrent review policies for MH/SUD services follow industry standard practice, the staff operationalizing the policies are qualified to make the decisions and

complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

However, since IHRP is temporarily suspended while undergoing program improvements, there is no comparable M/S concurrent review process.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Concurrent Reviews (IP & OP)	Evidence used for comparison:
Complies with Parity Requirements: No **Differences noted between M/S and MH/SUD services:** **Yes. The M/S concurrent review process is currently suspended.**	Beacon Health Options (Northeast Health Partners & Health Colorado) Provider Handbook R2 & R4 NQTL RAE Survey 2021 Interview with Beacon staff Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff

Goals and Rationale: Beacon defines its inpatient concurrent review process in their "data collection for continued authorization to higher levels of care" policy. Its stated purpose is to collect pertinent clinical data that is necessary to make a medical necessity determination for continued authorization of higher levels of care. The higher levels of care are 23-hour observation, inpatient, ATU, sub-acute, partial hospitalization, residential and day treatment.
Inpatient level of care is the most restrictive for members. The RAE conducts concurrent reviews to make sure that members could not be safely treated at a lower level of care. Concurrent reviews are also critical in successful discharge coordination.

The FFS UM Vendor is responsible for utilizing nurse and physician reviewers in performing M/S medical necessity reviews to determine compliance to federal and state rules, Department policy, and the medical appropriateness of the request across a range of inpatient and Fee-For-Service benefits.

For M/S, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Some of the components of the FFS Utilization Management program, such as the Inpatient Hospital Review Program (IHRP), were modified or suspended due to the COVID-19 pandemic to decrease provider burden and ensure members have appropriate and timely access to care.

Process:

MH/SUD
The MH/SUD practitioners/providers/facilities are responsible for calling Beacon's clinical line to seek continued authorization for MH/SUD higher levels of care treatment.
For inpatient facilities contracted under a case rate agreement, concurrent reviews are conducted less frequently. For per diem authorizations, concurrent review is typically conducted every 3-5 days. Case rate authorizations are typically longer and require concurrent review approximately every 14 days.
Services which are considered "routine" outpatient do not require authorization. Those include: 0510, 0521, 0529, 90791, 90792, 90832, 90834, 90837, 90839, 90846, 90847, 90849, 90853, 96372, H0001, H0002, H0004, H0005, H0006, H0018, H0020, H0023, H0025, H0031-34, H0036-38, H2000, H2014-18, H2021, H2022, H2027, H2030, H2031, S3005, S9445, S9453, S9454, T1007, T1017, T1019, T1023 and all E&M codes. The outpatient services that do require authorization are generally considered non-routine or more complex interventions such as IOP, in-home services, respite, ECT or psych testing. These services are typically more intensive and not appropriate for all members. Therefore, Beacon needs to review these instances individually to establish medical necessity.

CCMs and/or referral line clinicians are available 24 hours a day, seven days a week, 365 days a year and can provide assessments, referrals, and conduct authorization or certification reviews if such processes are unavailable through ProviderConnect.

The following information is gathered:

1. Current level of care
2. Facility (only if it has changed due to transfer to another facility or step to a lower level of care not available at the initial admitting facility).
3. Diagnosis (changes) only from the initial assessment, as per the attending prescriber.
4. Medications (dose, frequency, adherence, side effects, prescribing doctor) for first review and then changes only.
5. Assessments:
    a. Current behaviors that continue to support risk to self, risk to others, or gravely disabled status.
    b. Other pertinent clinical information such as specific behaviors, mental status changes, placement problems, etc. to support the member's need for the current level of care.
    c. Progress as assessed by observable, behavioral changes demonstrating symptom improvement.
    d. Any data missing from the initial authorization.
6. Treatment plan, including measurable goals that monitor and focus on discharge readiness.
7. Documentation of coordination of care if multiple providers involved (Are other providers involved? Who are the providers? Outpatient therapist? Primary Care Physician? Other specialists? Is the authorized facility coordinating care with other providers?)
8. Discharge plan attestation (for first concurrent review after 48 hours of care only)
    a. Has the facility reviewed the discharge plan with the member and family members, if relevant, including having signatures on the discharge plan within 48 hours of admission?

b. If the facility has not obtained a signed discharge plan by member/family within hours, what is the clinical rationale for this omission?
c. Is the facility coordinating care/discussing aftercare needs with the MHC liaison or discharge planner? Who are they talking with and when was the last contact?

9. Documentation of any and all discharge planning issues. Is there a need for Involvement from other agencies to support a successful discharge? (Single Entry Point agencies, Community Centered Boards, Regional Collaborative Care Organizations, Managed Service Organizations, Transportation, etc.?)

A Beacon Clinical Care Manager (CCM) receives the above documentation and renders an authorization decision documenting the timeframe for continued stay in the Beacon UM system.
In instances where the continued stay review by a CCM does not meet medical necessity criteria and/or where questions arise as to elements of a treatment plan or discharge plan, the CCM will forward the case file to a Peer Advisor for review.

Concurrent Review Determination Timeframes

Request Type	Timing	Determination
Concurrent Urgent	>24 hours of authorization expiration	Within 24 hours
Concurrent Urgent	<24 hours from authorization expiration	Within 72 hours
Concurrent Non-Urgent	Prior to authorization term	72 hours/10 calendar days (CO Medicaid)

M/S
The Department suspended the physical health fee-for-service Inpatient Hospital Review Program (IHRP) requirement for physical health hospital admissions initially to support hospitals to focus on COVID-19 care and then to enable the Department to redesign the IHRP process. This suspension pertains to admission reviews, admission notifications, concurrent review, and complex case concurrent review.

IHRP is currently suspended, but when it is in operation Inpatient FFS M/S Concurrent/Continued Stay Reviews are required under IHRP.

Finding:
The RAE's concurrent review policies for MH/SUD services follow industry standard practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

However, since IHRP is temporarily suspended while undergoing program improvements, there is no comparable M/S concurrent review process.

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Concurrent Reviews (IP & OP)	Evidence used for comparison:

Complies with Parity Requirements: No **Differences noted between M/S and MH/SUD services:** **Yes. The M/S concurrent review process is currently suspended.**	Colorado Access Provider Manual – Utilization Management Program (Section 9) COA CCS307 Utilization Review Determinations Colorado Access Data Request Interview with Colorado Access Staff Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff

Goals and Rationale: Colorado Access defines Concurrent Review as the ongoing review of inpatient and outpatient episodes of care to determine if services and/or treatments are medically appropriate, occur in the appropriate setting, and are being administered by appropriate providers. Concurrent Review determinations are based solely on the medical information obtained at the time of the review. The frequency of reviews is based on the severity or complexity of the patient's condition or on the necessary treatment and discharge planning activity regardless of the clinical setting.

The FFS UM Vendor is responsible for utilizing nurse and physician reviewers in performing M/S medical necessity reviews to determine compliance to federal and state rules, Department policy, and the medical appropriateness of the request across a range of inpatient and Fee-For-Service benefits.

For M/S, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Some of the components of the FFS Utilization Management program, such as the Inpatient Hospital Review Program (IHRP), were modified or suspended due to the COVID-19 pandemic to decrease provider burden and ensure members have appropriate and timely access to care.

Process:

MH/SUD
Colorado Access may utilize Concurrent Review for the following MH/SUD service categories:

- Inpatient
  - Acute Treatment Unit
  - Short term Residential
  - Long term Residential
  - Partial Hospitalization
- Outpatient
  - Day Treatment

- MH Intensive Outpatient Services
- SUD Intensive Outpatient Services
- Electroconvulsive Therapy

All requests for ongoing services beyond the initial authorization require reauthorization. Concurrent Review Urgent Care Requests to extend the course of treatment beyond the initial period of time or the number of treatments must be submitted seventy-two (72) hours prior to the expiration date of the original authorization. Concurrent Review urgent care determinations will be made as soon as possible taking into account the member's medical condition and no later than seventy-two (72) hours following the receipt of the request.

M/S
The Department suspended the physical health fee-for-service Inpatient Hospital Review Program (IHRP) requirement for physical health hospital admissions initially to support hospitals to focus on COVID-19 care and then to enable the Department to redesign the IHRP process. This suspension pertains to admission reviews, admission notifications, concurrent review, and complex case concurrent review.

IHRP is currently suspended, but when it is in operation Inpatient FFS M/S Concurrent/Continued Stay Reviews are required under IHRP.

Finding:
The RAE's concurrent review policies for MH/SUD services follow industry standard practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

However, since IHRP is temporarily suspended while undergoing program improvements, there is no comparable M/S concurrent review process.

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Concurrent Reviews (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: No **Differences noted between M/S and MH/SUD services:** **Yes. The M/S concurrent review process is currently suspended.**	CCHA Provider Manual CCHA UM Program Description Interview with CCHA Staff Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff

Goals and Rationale:
For MH/SUD: CCHA's stated goals are to be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation. The UM Program Description lists the multiple objectives of the Behavioral Health UM Program including ensuring the delivery of quality, medically necessary and appropriate behavioral health care services including outpatient care, inpatient care, and alternative care settings, both in-and out-of-network.

In performing concurrent review, CCHA's Care Management/Utilization Management clinicians assess member progress and needs during the episode of care and coordinate such needs prior to discharge to help facilitate a smooth transition for the member between levels of care or home, and to avoid delays in discharge due to unanticipated care needs. Behavioral Health Medical Necessity Criteria is used to determine that the admission and continued length-of-stay are medically necessary for behavioral health, unless superseded by state requirements or regulatory guidance.

The FFS UM Vendor is responsible for utilizing nurse and physician reviewers in performing M/S medical necessity reviews to determine compliance to federal and state rules, Department policy, and the medical appropriateness of the request across a range of inpatient and Fee-For-Service benefits.

For M/S, the goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

Some of the components of the FFS Utilization Management program, such as the Inpatient Hospital Review Program (IHRP), were modified or suspended due to the COVID-19 pandemic to decrease provider burden and ensure members have appropriate and timely access to care.

Process:

MH/SUD
All inpatient MH/SUD services are subject to concurrent review. Frequency of concurrent review requirement varies by the member's clinical presentation, but typically reviews are required every 3 days. Reviews can be initiated by the provider or the RAE and will typically occur 2-3 days prior to the end of the current authorization period. Concurrent reviews are performed by the direct treatment provider.

Timeframes for completion of concurrent review request:

Urgent	Within 72 hours (3 days) from receipt of request
SUD ASAM Level 3.2 WM and 3.7 WM	Within 72 hours (3 days) from receipt of request

CCHA has partnered with Anthem for their BH expertise and their criteria to review the medical necessity and appropriateness of behavioral health services is derived primarily from the following sources: Anthem Medical Policies and Clinical Utilization Management Guidelines, MCG Management Guidelines, and American Society of Addiction Medicine (ASAM) guidelines, unless superseded by state requirements or regulatory guidance. In addition to these standards, Anthem may adopt national guidelines produced by healthcare organizations such as individual medical and surgical societies, National Institutes of

Health, and the Centers for Disease Control and Prevention. All Anthem Medical Policies and Clinical Utilization Management Guidelines are under the governance of the Medical Operation committee (MOC) and are reviewed annually and updated when appropriate. Behavioral Health Review Criteria are reviewed by the Anthem Behavioral Health Utilization Management Policies and Clinical Practice Guidelines Subcommittee. Decisions are made in accordance with currently accepted medical or behavioral health best practices, taking into account special circumstances requiring deviation from the norm.

There is no process for concurrent review of outpatient services. A continuation of services can be requested by the provider, which follows the prior authorization process.

M/S
The Department suspended the physical health fee-for-service Inpatient Hospital Review Program (IHRP) requirement for physical health hospital admissions initially to support hospitals to focus on COVID-19 care and then to enable the Department to redesign the IHRP process. This suspension pertains to admission reviews, admission notifications, concurrent review, and complex case concurrent review.

IHRP is currently suspended, but when it is in operation Inpatient FFS M/S Concurrent/Continued Stay Reviews are required under IHRP.

Finding:
The RAE's concurrent review policies for MH/SUD services follow industry standard practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

However, since IHRP is temporarily suspended while undergoing program improvements, there is no comparable M/S concurrent review process.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Concurrent Reviews (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	DHMC Provider Manual DHMC Policies Utilization Review Determinations including approvals and actions
Goals and Rationale: Denver Health MCO subcontracts out the operation of the its MH/SUD PIHP to Colorado Access. Colorado Access completes concurrent reviews for ongoing MH/SUD inpatient services beyond the initial authorization period. Denver Health MCO is responsible for inpatient M/S concurrent reviews. Denver Health defines concurrent review as reviews for requests for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.	

Process:

MH/SUD
Colorado Access may utilize Concurrent Review for the following inpatient and outpatient MH/SUD service categories.

- Inpatient
  - Acute Treatment Unit
  - Short term Residential
  - Long term Residential
  - Partial Hospitalization
- Outpatient
  - Day Treatment
  - MH Intensive Outpatient Services
  - SUD Intensive Outpatient Services
  - Electroconvulsive Therapy

All requests for ongoing services beyond the initial authorization require reauthorization. Concurrent Review Urgent Care Requests to extend the course of treatment beyond the initial period of time or the number of treatments must be submitted seventy-two (72) hours prior to the expiration date of the original authorization. Concurrent Review urgent care determinations will be made as soon as possible taking into account the member's medical condition and no later than seventy-two (72) hours following the receipt of the request.

M/S
All inpatient M/S admissions will require concurrent review and will only be approved if medically necessary. The UM/Case Management nurses from the Denver Health Medical Services Department will round daily for all in-Patients at Denver Health and perform regular telephone or onsite review for Patients admitted to non-DH facilities. Inpatient facilities are required to provide good clinical information on request to concurrent review nurses.

For standard concurrent reviews, Denver Health makes the determination and notifies the provider and member as expeditiously as the member's health condition requires, but no later than 10 days from the date of the request. For urgent/expedited concurrent review, Denver Health makes a decision within 72 hours of the request.

Finding:
Denver Health uses COA's "concurrent review" policy for both inpatient and outpatient MH/SUD services, which is described as reauthorization, after the expiration of a previous authorization approval. This differs significantly from concurrent review during an authorization period. Given this fact, the policy applied to M/S benefits is more stringent than those applied to MH/SUD benefits. Further, the policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented. Therefore, they meet parity requirements.

Appendix C - Retrospective Review

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

Tools for Analysis: Services/Conditions that trigger retrospective review, utilization management policies, reviewer qualifications

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP	No	Yes
Scenario 3				
	RAE 1	IP, OP	No	Yes
	RAE 2 & 4	IP, OP	No	Yes
	RAE 3 & 5	IP, OP	No	Yes
	RAE 6 & 7	IP, OP	No	Yes
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP	No	Yes

Scenario 1 – FFS

NQTL: Retrospective Reviews (IP & OP)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff

Goals and Rationale: The Department does not currently utilize a retrospective review defined as full reviews of the member's medical records following discharge or discontinuation of services either prior to or post payment of the associated claims.

Process:

MH/SUD and M/S
In some situations, the Department's guidance overrides and allows a retrospective review. And in some cases, a member may not be eligible for Colorado Medicaid at the time of admission, but retroactive eligibility is obtained while the member is hospitalized or post discharge. A retrospective authorization will be required as soon as the inpatient facility becomes aware of the member's eligibility.

Finding:
The Department utilizes the same processes for retrospective review of MH/SUD benefits and M/S benefits, therefore it is parity compliant.

Scenario 2 – RAE 1 and Rocky Mountain Health Plan Prime MCO

NQTL: Retrospective Reviews (IP & OP)	Evidence used for comparison:
Complies with Parity Requirements: Yes Differences noted between M/S and MH/SUD services: No	RMHP Provider Manual Data request from RMHP Interview with RMHP staff

Goals and Rationale: Rocky Mountain Health Plans recognizes and embraces the need for a collaborative and contractual relationship with providers in administering the utilization review program. The program directly benefits our members by establishing and meeting their health care needs in the most efficient delivery possible, and by helping to save cost by using best practices to manage our members individual care. The program policies govern MH/SUD retrospective reviews.

Process:

MH/SUD and M/S:

Rocky Mountain Health Plans applies the same retrospective review policies to MH/SUD and M/S services.

Retrospective review of **inpatient** MH/SUD and M/S services is needed only when concurrent review was not completed, such as when an out-of-state hospital notifies late or submits a claim without notification on admission. Retrospective review ensures that appropriate level of care and quality services were provided.

Retrospective reviews of **outpatient** MH/SUD and M/S services are the rare exception. For example, services that typically require prior authorization will be reviewed when done for urgent/emergent reasons. It requires a retrospective review to determine if the situation was urgent/emergent or if failure to obtain prior authorization of a scheduled and planned service was an oversight. Retrospective review ensures that appropriate level of care and quality services were provided.

Retrospective reviews of MH/SUD and M/S **emergency services** are the rare exception. For example, a service received out of network may be retrospectively reviewed to determine if it were a scheduled and planned service or if a prudent layperson would consider it to be an emergency. Urgent and emergent BH services do not require prospective approval and all emergency room claims are paid without review through the normal claims payment processes.

Finding:
Retrospective Review processes for MH/SUD benefits are comparable to and no more stringent than for M/S benefits

Scenario 3 – RAE 1 and FFS

NQTL: Retrospective Reviews (IP & OP)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	RMHP Provider Manual Data request from RMHP Interview with RMHP staff Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff

Goals and Rationale:
Rocky Mountain Health Plans recognizes and embraces the need for a collaborative and contractual relationship with providers in administering the utilization review program. The program directly benefits our members by establishing and meeting their health care needs in the most efficient delivery possible, and by helping to save cost by using best practices to manage our members individual care. The program policies govern MH/SUD retrospective reviews.

For M/S, the Department does not currently utilize a retrospective review defined as full reviews of the member's medical records following discharge or discontinuation of services either prior to or post payment of the associated claims.

Process:

MH/SUD
Retrospective review of **inpatient** MH/SUD services is needed only when concurrent review was not completed, such as when an out-of-state hospital notifies late or submits a claim without notification on admission.

Retrospective reviews of **outpatient** MH/SUD services are the rare exception. For example, services that typically require prior authorization will be reviewed when done for urgent/emergent reasons. It requires a retrospective review to determine if the situation was urgent/emergent or if failure to obtain prior authorization of a scheduled and planned service was an oversight.

M/S
In some situations, the Department's guidance overrides and allows a retrospective review. And in some cases, a member may not be eligible for Colorado Medicaid at the time of admission, but retroactive eligibility is obtained while the member is hospitalized or post discharge. A retrospective authorization will be required as soon as the inpatient facility becomes aware of the member's eligibility.

Finding:
Retrospective Review processes for MH/SUD benefits are comparable to and no more stringent than for M/S benefits.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Retrospective Reviews (IP & OP)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff Beacon Health Options (Northeast Health Partners & Health Colorado) Provider Handbook R2 & R4 NQTL RAE Survey 2021 Interview with Beacon staff

Goals and Rationale: It is the purpose of the RAE UM program to ensure that our stewardship of the scarce Medicaid funding for behavioral health services leads to improvement in the lives of those we serve, and positively impacts their families and the communities where they live. The program policies govern MH/SUD retrospective reviews.

For M/S, the Department does not currently utilize a retrospective review defined as full reviews of the member's medical records following discharge or discontinuation of services either prior to or post payment of the associated claims.

Process:

MH/SUD
For MH/SUD benefits, the need for retrospective review may occur for a number of reasons. Although every effort is made to conduct reviews and to issue authorizations (where indicated) prior to the delivery of care, if allowed under the benefit plan, there are situations in which Beacon/RAE may conduct a retrospective review. These are circumstances in which the provider/facility failed to request a review for a member in care. Retrospective reviews may only be conducted in one of the following circumstances:

- Member is made Health First Colorado eligible retroactively
- Member's condition at the time of initiation of treatment made it impossible for the provider/facility to obtain enough identifying information to determine Health First Colorado eligibility via the Health First Colorado Web Portal.

Because most outpatient services do not require prior authorization, a network provider can simply bill these services. If the provider is not in network, they can request a

retrospective review/authorization simultaneously with a request for a single case agreement.
For services that typically require prior authorization, a request must be made within 30 days after the requested start date. The provider is at risk that some or all services might be denied, if the medical necessity criteria were not met.

M/S
In some situations, the Department's guidance overrides and allows a retrospective review. And in some cases, a member may not be eligible for Colorado Medicaid at the time of admission, but retroactive eligibility is obtained while the member is hospitalized or post discharge. A retrospective authorization will be required as soon as the inpatient facility becomes aware of the member's eligibility.

Finding:
Retrospective Review processes for MH/SUD benefits are comparable to and no more stringent than for M/S benefits.

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Retrospective Reviews (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Colorado Access Provider Manual – Utilization Management Program (Section 9) COA CCS307 Utilization Review Determinations Interview with Colorado Access Staff Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff

Goals and Rationale:
The COA utilization management program outlines a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, referrals, procedures, or settings. This program's policy's govern MH/SUD retrospective reviews.

For M/S, the Department does not currently utilize a retrospective review defined as full reviews of the member's medical records following discharge or discontinuation of services either prior to or post payment of the associated claims.

Process:

MH/SUD

Colorado Access may subject all MH/SUD services to Retrospective Review, including, but not limited to:

- Inpatient
- Acute Treatment Unit
- Short term Residential
- Long term Residential
- Partial Hospitalization
- Day Treatment
- MH Intensive Outpatient Services
- SUD Intensive Outpatient Services
- Electroconvulsive Therapy
- Psychological Testing

Retrospective reviews for inpatient services are uncommon but can occur in cases where the member's eligibility was retroactive and/or unclear at the time of admission. Otherwise providers are expected to follow the prior authorization and concurrent review practices. This is consistent with industry standards. Per state and federal regulations, COA does not perform any utilization review for emergency services.

Retrospective Review Determinations will occur within a reasonable period of time and no later than thirty (30) calendar days after the date of receiving the review request. The time period for making a Retrospective Review determination begins on the date the request is received by COA regardless if all the information necessary to make the determination accompanies the request. If the determination is adverse to the member, COA will send notification to the member and the member's provider as required by state law and rules and regulation and with the elements contained in this policy and procedure

M/S
In some situations, the Department's guidance overrides and allows a retrospective review. And in some cases, a member may not be eligible for Colorado Medicaid at the time of admission, but retroactive eligibility is obtained while the member is hospitalized or post discharge. A retrospective authorization will be required as soon as the inpatient facility becomes aware of the member's eligibility.

Finding:
The requirements and processes for MH/SUD retrospective review are comparable to and applied no more stringently than to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Retrospective Reviews (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes	CCHA Provider Manual CCHA UM Program Description

Differences noted between M/S and MH/SUD services: **No**	Interview with CCHA Staff Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff

Goals and Rationale:
For MH/SUD services, CCHA's stated goals are to be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation. The UM Program Description lists the multiple objectives of the Behavioral Health UM Program including ensuring the delivery of quality, medically necessary and appropriate behavioral health care services including outpatient care, inpatient care, and alternative care settings, both in-and out-of-network. This program's policy governs MH/SUD retrospective reviews.

For M/S, the Department does not currently utilize a retrospective review defined as full reviews of the member's medical records following discharge or discontinuation of services either prior to or post payment of the associated claims.

Process:

MH/SUD
CCHA uses evidence-based clinical decision support products to determine whether to retrospectively review MH/SUD services. The standard timeline for retrospective review is 30 calendar days from receipt of request, but the timeline may be extended on a case by case basis. All inpatient MH/SUD services are subject to retrospective review. The following outpatient MH/SUD services are subject to retrospective review: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90875, 90876, 96116, 96121, 96130-96139, 96372, 97535, g1076, h0006, h0020, h0033, h0034, h0035, h0045, h2014, h2023-h2032, s3005, s9445, s9485, t1005, t1017, 90791, 90792, 90839, 90940, 98966-98968, h0001-h0005, h0023, h0025, h0031, h0032, h2000, h2011, s9453, s9454, t1007, t1023, 99241-99245, 99201-99443, 90833-90838.

For inpatient services, retrospective review policies are the same for both in-network and out-of-network providers. These polices differ for outpatient services.
Established procedures are followed for all retrospective reviews based on individual member medical necessity, inpatient/outpatient, elective/ urgent/emergent status, timeliness of the request/notification, and precertification requirements.

- If medical necessity review is required and CCHA approved medical necessity criteria does not appear to be met, the case is referred to the appropriate Medical Director for review and determination.
- If the provider contacts CCHA after outpatient care has been rendered and the procedure was emergent (emergency services), the practitioner is advised that no precertification is required for emergency services, and that he/she should submit the claim for payment.

Each type of review request has a different timeframe for completion of the review process. All timeframes begin with the request for review, and end with issuance of the determination. Determinations are rendered in 30 days.

M/S
In some situations, the Department's guidance overrides and allows a retrospective review. And in some cases, a member may not be eligible for Colorado Medicaid at the time of admission, but retroactive eligibility is obtained while the member is hospitalized or post discharge. A retrospective authorization will be required as soon as the inpatient facility becomes aware of the member's eligibility.

Finding:
Retrospective Review processes for MH/SUD benefits are comparable to and no more stringent than for M/S benefits.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Retrospective Reviews (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	DHMP Provider Manual Colorado Access Provider Manual – Utilization Management Program (Section 9)

Goals and Rationale: Denver Health MCO subcontracts out the operation of the its MH/SUD PIHP to Colorado Access. The COA utilization management program outlines a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, referrals, procedures, or settings. This program's policies govern MH/SUD retrospective reviews.

The goal of the Denver Health MCO UM Department is to encourage the highest quality of care, in the most appropriate setting, from the most appropriate Provider. Through the UM program, the Company seeks to avoid over-use and under-use of medical services by making clinical coverage decisions based on available evidence-based guidelines. The program policies govern M/S retrospective reviews.

Process:

MH/SUD
Colorado Access may subject all MH/SUD services to Retrospective Review, including, but not limited to:

- Inpatient Acute Treatment Unit
- Short term Residential
- Long term Residential
- Partial Hospitalization
- Day Treatment
- MH Intensive Outpatient Services

- SUD Intensive Outpatient Services
- Electroconvulsive Therapy
- Psychological Testing

Retrospective reviews for inpatient services are uncommon but can occur in cases where the member's eligibility was retroactive and/or unclear at the time of admission. Otherwise providers are expected to follow the prior authorization and concurrent review practices. This is consistent with industry standards. Per state and federal regulations, COA does not perform any utilization review for emergency services.

Retrospective Review Determinations will occur within a reasonable period of time and no later than thirty (30) calendar days after the date of receiving the review request. The time period for making a Retrospective Review determination begins on the date the request is received by COA regardless if all the information necessary to make the determination accompanies the request. If the determination is adverse to the member, COA will send notification to the member and the member's provider as required by state law and rules and regulation and with the elements contained in this policy and procedure

M/S
DHMC M/S post service review determinations are reviews for care or services that have already been received. The Company makes the determination and notifies the provider and member within 30 calendar days of receipt of the request. As there are no guidelines for post-service reviews for Colorado Medicaid or CHP+ the Company has adopted the rule as stated in 3 C.C.R. § 702-4, series 4-2-17, section 6, item C.

DHMC utilizes identical retrospective review polices for M/S inpatient and outpatient member benefits. DHMC utilizes both internally approved guidelines as well as National Criteria Sets; InterQual or MCG. It also uses the Medicare Coverage Database, Department Benefits Collaborative, and Hayes Knowledge Center to determine the medical necessity of requested services.

Finding:
The requirements and processes for MH/SUD retrospective review are comparable to and applied no more stringently than to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Appendix D - Fail First / Step Therapy Protocols

Description: Health plan policies and protocols that requires steps or failure on a less costly treatment before authorizing a more costly treatment.

Tools for Analysis: Protocols used to determine fail first or step therapy protocols, including which services require these protocols

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	*N/A*	*N/A*	*N/A*
Scenario 2	RMHP & Prime MCO	PD	No	Yes
Scenario 3				
	RAE 1	*N/A*	*N/A*	*N/A*
	RAE 2 & 4	*N/A*	*N/A*	*N/A*
	RAE 3 & 5	*N/A*	*N/A*	*N/A*
	RAE 6 & 7	*N/A*	*N/A*	*N/A*
Scenario 4	Denver PIHP & Denver Health MCO	PD	No	Yes

Plans that do not utilize this NQTL are shown in italics in the above table

Scenario 2 – RAE 1 and Rocky Mountain Health Plan Prime MCO

NQTL: Fail First/Step Therapy (PD)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data request from RMHP Interview with RMHP staff

Goals and Rationale: Drugs that are high cost, low utilization or are high utilization with moderate cost receive additional scrutiny to ensure safe and effective use of the drug.

Process:

MH/SUD and M/S:
Drugs that guidelines supported to be 2nd/3rd/4th line therapies that have the potential to be prescribed as first line therapy may get restrictions that require prior use of certain drugs before approval. A drug that is indicated for first line use may also get a fail first strategy imposed if there are other options considered as safe and effective at a lower cost to ensure effective use of healthcare dollars. There is an exception process to allow the target drug to be used without first fail if the provider makes a case that alternatives would not be appropriate because the patient either tried and failed in a timeframe outside what the health plans records show or alternatives would be contraindicated.

The process to evaluate drugs that require Fail First/Step Therapy does not consider if the drug is a behavior health or medical indication. All drugs are evaluated based on the same criteria which includes clinical information of the specific drug, tertiary sources (e.g.

National guidelines, FDA), expert opinion, pharmacoeconomic evaluations/health outcomes, and quality of life studies.

Finding:
Fail First/Step Therapy policies and processes for MH/SUD benefits are comparable to and no more stringent than for M/S benefits.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Fail First/Step Therapy Protocols (PD)	**Evidence used for comparison:** DHMP Provider Manual DH Step Therapy Approval Criteria - Jan 2021
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: The DMHC step therapy approval criteria manual delineates each of the specific drugs that require step therapy prior to approving the drug. The criteria for use as well as constraints on distribution are illustrated.

Process
DHMC utilizes step therapy approval criteria for 47 specific drugs. Of the 47 drugs, 5 are MH/SUD specific drugs. There are no SUD drugs that have step therapy criteria applied.

Finding:
The policies, processes, and evidentiary standards in writing and operation are comparable and applied no more stringently to MH/SUD drugs than M/S drugs.

Appendix E - Conditioning Benefits on the Completion of a Course of Treatment

Description: Health plan benefits/services conditional on previous treatment completion

Tools for Analysis: Presence of Utilization and Quality Management policies that condition benefits on treatment completion and policy applicability to MH/SUD and M/S benefits

Analysis: No benefit category was shown to be conditioning benefits on a completion of a course of treatment.

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
	N/A	N/A	N/A	N/A

Appendix F - Medical Appropriateness Review

Description: The policy and process the health plan utilizes to determine participant services and benefits

Tools for Analysis: Utilization of clinically validated medical necessity criteria, reviewer qualifications, availability of medical necessity criteria

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP, PD	No	Yes
Scenario 3				
	RAE 1	IP, OP	No	Yes
	RAE 2 & 4	IP, OP	Yes - in addition to licensed physicians, licensed psychologists are able to render medical necessity determinations for MH/SUD benefits	Yes
	RAE 3 & 5	IP, OP	No	Yes
	RAE 6 & 7	IP, OP	No	Yes
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP	No	Yes

Scenario 1 - FFS

NQTL: Medical Appropriateness Reviews (IP & OP)	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff

Goals and Rationale: The implementation of medical appropriateness reviews is the underpinning of a utilization management program. Instituting a review process that is grounded in industry standard best practices and a national standard such as MCG, InterQual, or ASAM allows for consistent application of review standards across a range of member needs and services. In those instances where there is no nationally recognized clinical criteria available, the Department works collaboratively with the UM Vendor to develop evidence based criteria. Further, reviews must conform to state and federal statutes, rules and policy.

Process:

MH/SUD

The policies and process for medical appropriateness reviews for MH/SUD benefits utilize nationally recognized clinical best practice criteria with MCG for Inpatient and InterQual for outpatient benefits. In any instance in which InterQual criteria does not exist or the Department wishes to utilize state specific rules and criteria, the Department works with the UM Vendor to develop criteria based on industry best practices and evidence based clinical guidelines and the Department approves it prior to use of criteria.

In order to ensure compliance with policy and regulations and clinical criteria, the FFS UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. The provider or facility's submitted information, including clinical notes, labs, test results, orders, etc. are reviewed for completeness, compliance and medical appropriateness utilizing specific Department inpatient policy, guidelines, and MCG criteria by the first and second level reviewers.

First Level Reviewers consist of Registered Nurses who may:

- Approve the service as requested based on MCG/Interqual or Department approved criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Physician Review).
- Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc.

First Level Reviewers cannot deny for lack of medical necessity.

Second Level Reviewers consist of Physicians who may:

- Approve the service as requested based on MCG/InterQual or Department approved Criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Render either a full or partial denial for lack of medical necessity.

For Outpatient MH/SUD PARs (PBT only) the FFS UM Vendor uses state developed and approved criteria to determine appropriateness of outpatient services. In order to ensure compliance with policy and regulations and clinical criteria, the UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. The provider submitted information, including clinical notes, plans of care, treatment notes, assessments, test results, orders, etc. are reviewed for completeness, compliance and medical appropriateness utilizing specific Department policy, guidelines, by the first and second level reviewers. (This review process is only for PBT)

First Level Reviewers for PBT consist of a Board-Certified Behavioral Analyst (BCBA) who may:

- Approve the service as requested based Department approved criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or

would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Review).
- Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc.
- First Level Reviewers cannot deny for lack of medical necessity.

Second Level Reviewers for PBT consist of Board-Certified Behavior Analyst-Doctoral (BCBA-Doctoral) who may:
- Approve the service as requested based on Department approved Criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Render either a full or partial denial for lack of medical necessity.

Per Colorado State Rule, the UM FFS Vendor has 10 business days to complete an outpatient PAR review upon receipt of all necessary documentation from the provider or facility. The UM FFS Vendor's average turnaround time is 4 business days.

M/S

The policies and process for medical appropriateness reviews for M/S benefits utilize nationally recognized clinical best practice criteria with MCG for Inpatient and InterQual for outpatient benefits. In any instance in which InterQual criteria does not exist or the Department wishes to utilize state specific rules and criteria, the Department works with the UM Vendor to develop criteria based on industry best practices and evidence based clinical guidelines and the Department approves it prior to use of criteria.

In order to ensure compliance with policy and regulations and clinical criteria, the UM Vendor utilizes First Level Reviewers (nurses) and Second Level Reviewers (physicians) to perform medical necessity reviews. The provider or facility's submitted information, including clinical notes, labs, test results, orders, etc. are reviewed for completeness, compliance and medical appropriateness utilizing specific Department inpatient policy, guidelines, and MCG criteria by the first and second level reviewers.

First Level Reviewers consist of Registered Nurses who may:
- Approve the service as requested based on MCG/Interqual or Department approved Criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Physician Review).
- Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc.
- First Level Reviewers cannot deny for lack of medical necessity.

Second Level Reviewers consist of Physicians who may:
- Approve the service as requested based on MCG/InterQual or Department approved Criteria, and compliance to policies and federal guidelines.

- Request additional information from the Provider to support the request.
- Render either a full or partial denial for lack of medical necessity.

For Outpatient M/S PARs (PBT only) the FFS UM Vendor uses state developed and approved criteria to determine appropriateness of outpatient services. In order to ensure compliance with policy and regulations and clinical criteria, the UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. The provider submitted information, including clinical notes, plans of care, treatment notes, assessments, test results, orders, etc. are reviewed for completeness, compliance and medical appropriateness utilizing specific Department policy, guidelines, by the first and second level reviewers. (This review process is only for PBT)

First Level Reviewers for PBT consist of a Board-Certified Behavioral Analyst (BCBA) who may:

- Approve the service as requested based Department approved criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Review).
- Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc.
- First Level Reviewers cannot deny for lack of medical necessity.

Second Level Reviewers for PBT consist of Board-Certified Behavior Analyst-Doctoral (BCBA-Doctoral) who may:

- Approve the service as requested based on Department approved Criteria, and compliance to policies and federal guidelines.
- Request additional information from the Provider to support the request.
- Render either a full or partial denial for lack of medical necessity.

Per Colorado State Rule, the UM FFS Vendor has 10 business days to complete an outpatient PAR review upon receipt of all necessary documentation from the provider or facility. The UM FFS Vendor’s average turnaround time is 4 business days.

Finding:

The processes followed for MH/SUD, including the two-level review process, are comparable to and applied no more stringently than the processes followed for M/S benefits, and they follow standard industry practice. The staff operationalizing the policies have the necessary level of expertise to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 2 – RAE 1 and Rocky Mountain Health Plan Prime MCO

NQTL: Medical Appropriateness Reviews (IP & OP)	Evidence used for comparison:
Complies with Parity Requirements: Yes Differences noted between M/S and MH/SUD services: No	RMHP Provider Manual Data request from RMHP Interview with RMHP staff

Goals and Rationale: The implementation of medical appropriateness reviews is the underpinning of a utilization management program. Instituting a review process that is grounded in a national standard such as MCG, InterQual, or ASAM allows for consistent application of review standards across a range of member needs and services. Further, reviews must conform to state and federal statutes.
Rocky Mountain Health Plan's goal of all UM activities is to make sure members get the right care at the right place and the right time. This ensures quality of care and timely services.

Process:

MH/SUD and M/S:
UM clinical staff are responsible for reviewing all cases that require clinical judgment, using standardized evidence-based criteria for medical necessity determinations, and following designated procedures for benefit limitations and exclusions.

The UM clinical staff are usually selected from practitioners with knowledge and experience with the relevant health condition, so for MH/SUD the clinical staff are usually licensed medical professionals such as behavioral health practitioners, care advocates, or registered nurses. For M/S, the clinical staff are usually registered nurses and licensed practitioners.

UM clinical staff apply Medicare, Medicaid, and MCG® and internally developed medical policy guidelines as a basis for determining medical necessity and right setting review to assess the appropriateness of a proposed service.

UM clinical staff (first level reviewers) are authorized to approve services but may not deny services that do not meet medical necessity criteria. Cases that do not meet the guidelines are forwarded to RMHP Medical Direction (second level reviewers) for review. Medical Directors may access additional resources for complex cases, including Advanced Medical Reviews, LLC (AMR). Prior authorization is required for all potentially experimental or investigational procedures.

Finding:
The processes followed for MH/SUD, including the two-level review process, are comparable to and applied no more stringently than the processes followed for M/S benefits, and they follow standard industry practice. The staff operationalizing the policies have the necessary level of expertise to make the decisions and complete the tasks

assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

NQTL: Medical Appropriateness Reviews (PD)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes	RMHP Provider Manual
Differences noted between M/S and MH/SUD services:	Data request from RMHP
No	Interview with RMHP staff

Goals and Rationale: The implementation of medical appropriateness reviews is the underpinning of a utilization management program. Instituting a review process that is grounded in a national standard such as MCG, InterQual, or ASAM allows for consistent application of review standards across a range of member needs and services. Further, reviews must conform to state and federal statutes.
Rocky Mountain Health Plan's goal is to ensure every request is reviewed at an appropriate professional level and allows for quickest turn-around-time for our Members and prescribers.

Process:

RMHP has a closed formulary which is intended to promote rational, safe, evidence-based, effective drug therapy. Drugs not on the formulary are not covered unless approved for medical necessity through our exceptions process. Drugs that are not approved by the FDA, experimental/investigational, and certain drugs that treat non-covered indications (infertility, weight-loss) are excluded.

Medical necessity reviews are completed at a variety of medical professional levels. The initial case review (first level review) is completed by a certified pharmacy tech (CPhT) that identifies applicable information from what the prescriber provided. If the CPhT is able to approve, the pharmacy tech will approve. If the CPhT cannot approve based on the guideline criteria, the case is forwarded to a Pharmacist for further review (second level review). The initial review is completed by the pharmacist.
Process is defined by who has the enough medical expertise to understand a request and the documentation provided. Therefore no one without a Pharm.D./M.D. is able to deny a request to ensure medical appropriateness is applied to all requests.

All medical appropriateness reviews occur by the same process from intake to notification whether it is for an MH/SUD or M/S indication.

Finding:
The processes followed for MH/SUD, including the two-level review process, are comparable to and applied no more stringently than the processes followed for M/S benefits, and they follow standard industry practice. The staff operationalizing the policies have the necessary level of expertise to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 3 – RAE 1 and FFS

NQTL: Medical Appropriateness Reviews (IP & OP)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff RMHP Provider Manual Data request from RMHP Interview with RMHP staff

Goals and Rationale: The implementation of medical appropriateness reviews is the underpinning of a utilization management program. Instituting a review process that is grounded in a national standard such as MCG, InterQual, or ASAM allows for consistent application of review standards across a range of member needs and services. Further, reviews must conform to state and federal statutes.
Rocky Mountain Health Plan's goal of all UM activities is to make sure members get the right care at the right place and the right time. This ensures quality of care and timely services.

Process:

MH/SUD
UM clinical staff are responsible for reviewing all cases that require clinical judgment, using standardized evidence-based criteria for medical necessity determinations, and following designated procedures for benefit limitations and exclusions.

The UM clinical staff are usually selected from practitioners with knowledge and experience with the relevant health condition, so for MH/SUD the clinical staff are usually licensed medical professionals such as behavioral health practitioners, care advocates, or registered nurses.

UM clinical staff apply Medicare, Medicaid, and MCG® and internally developed medical policy guidelines as a basis for determining medical necessity and right setting review to assess the appropriateness of a proposed service.

UM clinical staff (first level reviewers) are authorized to approve services but may not deny services that do not meet medical necessity criteria. Cases that do not meet the guidelines are forwarded to RMHP Medical Direction (second level reviewers) for review. Medical Directors may access additional resources for complex cases, including Advanced Medical Reviews, LLC (AMR). Prior authorization is required for all potentially experimental or investigational procedures.

M/S

The FFS UM Vendor utilizes nationally recognized clinical best practice criteria with MCG for Inpatient and InterQual for outpatient benefits. In any instance in which InterQual criteria does not exist or the Department wishes to utilize state specific rules and criteria, the Department works with the UM Vendor to develop criteria based on industry best practices and evidence based clinical guidelines.
In order to ensure compliance with policy and regulations and clinical criteria, the UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. First level reviewers are Registered Nurses while second level reviewers consist of physicians.

Finding:
The processes followed for MH/SUD, including the two-level review process, are comparable to and applied no more stringently than the processes followed for M/S benefits, and they follow standard industry practice. The staff operationalizing the policies have the necessary level of expertise to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Medical Appropriateness Reviews (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **Yes:** In addition to licensed physicians, licensed psychologists are able to render final medical necessity determinations for MH/SUD benefits	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff Beacon Health Options (Northeast Health Partners & Health Colorado) Provider Manual Northeast Health Partners and Health Colorado Data Requests R2 and R4 NQTL RAE Survey 2021 Beacon Policy: CSNT 102.5 Clinical Practice Guidelines & Treatment Guidelines Interview with Beacon staff

Goals and Rationale: The implementation of medical appropriateness reviews is the underpinning of a utilization management program. Instituting a review process that is grounded in a national standard such as MCG, InterQual, or ASAM allows for consistent application of review standards across a range of member needs and services. Further, reviews must conform to state and federal statutes.

Process:

MH/SUD

InterQual and ASAM criteria are used as evidence-based decision support tools to determine medical necessity.

Medical necessity reviews are conducted by licensed clinicians (first level review). These staff are permitted to approve services but cannot deny treatment. If it appears that the member's condition does not meet the medical necessity criteria for the requested services or if the services are needed for a non-covered condition, the case must be benched with a Peer Advisor (second level review) who is either a licensed psychologist or a licensed physician (psychiatrist). All inpatient medical necessity decisions are made by MD/DO staff with specific training and board certification in psychiatry.

M/S
The FFS UM Vendor utilizes nationally recognized clinical best practice criteria with MCG for Inpatient and InterQual for outpatient benefits. In any instance in which InterQual criteria does not exist or the Department wishes to utilize state specific rules and criteria, the Department works with the UM Vendor to develop criteria based on industry best practices and evidence based clinical guidelines.

In order to ensure compliance with policy and regulations and clinical criteria, the UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. First level reviewers are Registered Nurses while second level reviewers consist of physicians.

Finding:
While MH/SUD service medical appropriateness determinations may sometimes be reviewed by licensed psychologist in addition to licensed physicians, the requirements and processes are comparable to and applied no more stringently than M/S reviews. The processes followed for MH/SUD, including the two-level review process, are comparable to and applied no more stringently than the processes followed for M/S benefits, and they follow standard industry practice. The staff operationalizing the policies have the necessary level of expertise to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Medical Appropriateness Reviews (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Colorado Medicaid Rules and Regulations Department Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with Department staff Colorado Access Provider Manual – Utilization Management Interview with Colorado Access Staff

	COA CCS302 Medical Criteria for Utilization Review COA CCS301 Qualifications For Staff Engaged with Utilization Management Activities

Goals and Rationale: The implementation of medical appropriateness reviews is the underpinning of a utilization management program. Instituting a review process that is grounded in a national standard such as MCG, InterQual, or ASAM allows for consistent application of review standards across a range of member needs and services. Further, reviews must conform to state and federal statutes.
Colorado Access' goal of utilization review is to assure the member is being treated in the most clinically appropriate, least restrictive environment.

Process:

MH/SUD
Colorado Access (COA) uses InterQual criteria for Utilization Review (UR) determinations for all lines of business. If there is no InterQual criteria for a particular service, COA uses the statutory definition of medical necessity to guide decision making.

UR staff (first level review) will apply the established criteria or guideline available and consider the individual needs of the member during the review. If no written criteria or guideline is available, the request will be forwarded to a physician reviewer (second level review) for determination as described in COA policy and procedure.
If the UR staff is able to meet the established criteria or guideline, the request will be authorized accordingly. If the UR staff is unable to match the request to the established criteria or guideline, the request will be forwarded to the physician reviewer for determination. If the request requires mandatory physician review, the request will be forwarded to the physician reviewer for determination. COA physician reviewers will consult with the requesting provider when appropriate.

Clinical Qualifications of Utilization Review Staff

A. The Chief Medical Officer and his/her designee shall be a licensed physician and shall have overall responsibility for the clinical integrity of the UM program.
B. Physicians participating in utilization review must hold an active, unrestricted license in Colorado as a doctor of medicine (MD) or doctor of osteopathic medicine (DO). Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a physician with the appropriate clinical expertise in treating the member's condition or disease.
C. Utilization review for medical/physical health services are performed by those with a bachelor's degree in nursing (or related field) and an active Colorado nursing license (RN or LPN).
D. Drug utilization reviews are performed by those with a doctorate degree in pharmacy (PharmD) and an active Colorado pharmacy license.
E. Utilization review for behavioral health services are performance by those with a master's degree in psychology, sociology, or counseling (or related field) and an active Colorado mental health licensure (LPC, LCSW, LMFT, or LAC).

M/S

The FFS UM Vendor utilizes nationally recognized clinical best practice criteria with MCG for inpatient and InterQual for outpatient benefits. In any instance in which InterQual criteria does not exist or the Department wishes to utilize state specific rules and criteria, the Department works with the UM Vendor to develop criteria based on industry best practices and evidence based clinical guidelines.

In order to ensure compliance with policy and regulations and clinical criteria, the UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. First level reviewers are Registered Nurses while second level reviewers consist of physicians.

Finding:
The processes followed for MH/SUD, including the two-level review process, are comparable to and applied no more stringently than the processes followed for M/S benefits, and they follow standard industry practice. The staff operationalizing the policies have the necessary level of expertise to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Medical Appropriateness Reviews (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes	Colorado Medicaid Rules and Regulations
Differences noted between M/S and MH/SUD services:	Department Benefit Policy
No	Colorado PAR Program provider training references
	Colorado PAR - Inpatient Hospital Review Program
	Consultation with Department staff
	CCHA Provider Manual
	CCHA UM Program Description
	Interview with CCHA Staff

Goals and Rationale: The implementation of medical appropriateness reviews is the underpinning of a utilization management program. Instituting a review process that is grounded in a national standard such as MCG, InterQual, or ASAM allows for consistent application of review standards across a range of member needs and services. Further, reviews must conform to state and federal statutes.
CCHA's goal is to maintain the appropriate application of clinical criteria to determine medical necessity of requested services.

Process:

MH/SUD
CCHA has partnered with Anthem for their BH expertise and their criteria to review the medical necessity and appropriateness of behavioral health services is derived primarily from the following sources: Anthem Medical Policies and Clinical Utilization Management

Guidelines, MCG Management Guidelines, and American Society of Addiction Medicine (ASAM) guidelines, unless superseded by state requirements or regulatory guidance.

Prior Authorization reviews are performed by a team of Care Management/Utilization Management clinicians (first level review), who are licensed professionals with training and experience in utilization management. For those situations where medical necessity is met, the clinician approves the services. When medical necessity is questioned, or when clinical information needed to make a decision has been requested but not received, the case is referred within the appropriate time frames to the appropriate Medical Director (second level review) for medical necessity review and determination. The Medical Director makes the determination and documents the results of the medical necessity review. Only the Medical Director can issue a medical necessity denial.

Behavioral Health Care Manager/Utilization Manager (first level reviewer) Qualifications: MS or MA in social work, counseling, nursing or a related behavioral health field; 3 years' experience with facility-based and/or outpatient psychiatric and substance abuse or substance abuse disorder treatment; or any combination of education and experience, which would provide an equivalent background. Current active unrestricted license as an RN, LCSW, LMSW, LMHC, LPC, LBA (as allowed by applicable state laws), LMFT, or Clinical Psychologist, to practice as a health professional within the scope of licensure in applicable states or territory of the United States required.

Behavioral Health Medical Director (second level reviewer) Qualifications:
M.D. or D.O.; Board certification approved by the American Board of Psychiatry and Neurology in Psychiatry, and/or Addictionology as required. Must possess an active unrestricted medical license to practice medicine or a health profession. Minimum of 5 years of clinical experience in behavioral health, utilization management

M/S
The FFS UM Vendor utilizes nationally recognized clinical best practice criteria with MCG for Inpatient and Interqual for outpatient benefits. In any instance in which InterQual criteria does not exist or the Department wishes to utilize state specific rules and criteria, the Department works with the UM Vendor to develop criteria based on industry best practices and evidence based clinical guidelines.
In order to ensure compliance with policy and regulations and clinical criteria, the UM Vendor utilizes First Level Reviewers and Second Level Reviewers to perform medical necessity reviews. First level reviewers are Registered Nurses while second level reviewers consist of physicians.

Finding:
The processes followed for MH/SUD, including the two-level review process, are comparable to and applied no more stringently than the processes followed for M/S benefits, and they follow standard industry practice. The staff operationalizing the policies have the necessary level of expertise to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Medical Appropriateness Reviews (IP & OP)	**Evidence used for comparison:** DHMC Provider Manual DHMC Policy: Clinical Criteria for Utilization Management DHMC Policy: Utilization Review Determinations including approvals and actions Colorado Access Provider Manual – Utilization Management COA CCS302 Medical Criteria for Utilization Review COA CCS301 Qualifications for Staff Engaged in Utilization Management Activites
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: The implementation of medical appropriateness reviews is the underpinning of a utilization management program. Instituting a review process that is grounded in a national standard such as MCG, InterQual, or ASAM allows for consistent application of review standards across a range of member needs and services. Further, reviews must conform to state and federal statutes.

Denver Health MCO subcontracts out the operation of the its MH/SUD PIHP to Colorado Access. Colorado Access' goal of utilization review is to assure the member is being treated in the most clinically appropriate, least restrictive environment.

Process:

MH/SUD
Colorado Access (COA) uses InterQual criteria for Utilization Review (UR) determinations for all lines of business. If there is no InterQual criteria for a particular service, COA uses the statutory definition of medical necessity to guide decision making.

UR staff (first level review) will apply the established criteria or guideline available and consider the individual needs of the member during the review. If no written criteria or guideline is available, the request will be forwarded to a physician reviewer (second level review) for determination as described in COA policy and procedure.
If the UR staff is able to meet the established criteria or guideline, the request will be authorized accordingly. If the UR staff is unable to match the request to the established criteria or guideline, the request will be forwarded to the physician reviewer for determination. If the request requires mandatory physician review, the request will be forwarded to the physician reviewer for determination. COA physician reviewers will consult with the requesting provider when appropriate.

Clinical Qualifications of Utilization Review Staff

A. The Chief Medical Officer and his/her designee shall be a licensed physician and shall have overall responsibility for the clinical integrity of the UM program.
B. Physicians participating in utilization review must hold an active, unrestricted license in Colorado as a doctor of medicine (MD) or doctor of osteopathic medicine (DO). Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a

physician with the appropriate clinical expertise in treating the member's condition or disease.

C. Utilization review for medical/physical health services are performed by those with a bachelor's degree in nursing (or related field) and an active Colorado nursing license (RN or LPN).
D. Drug utilization reviews are performed by those with a doctorate degree in pharmacy (PharmD) and an active Colorado pharmacy license.
E. Utilization review for behavioral health services are performance by those with a master's degree in psychology, sociology, or counseling (or related field) and an active Colorado mental health licensure (LPC, LCSW, LMFT, or LAC).

M/S

For all M/S services, when available and applicable, nationally-accepted, evidenced-based clinical criteria sets are used, including but not limited to, MCG Healthcare guidelines, Wolters Kluwer's UpToDate™ and/or Hayes, Inc. Knowledge Center™ to determine medical necessity. In cases in which the situation is not covered by an MCG Health guideline, Wolters Kluwer's UpToDate™ or Hayes, Inc. Knowledge Center™, case managers confer with other nationally-accepted criteria, such as CMS National Coverage determinations, and/or the Company Policies and Procedures and the Denver Health Medical Plan Medical Director for guidance.

The Company UM RNs perform utilization review to determine eligibility, benefit coverage and medical necessity for requested services. UM RNs use Health First Contract guidelines, MCG Health Care guidelines, and/or Hayes, Inc. Knowledge Center™ reviews to determine medical necessity is supported by the submitted documentation. In cases in which the situation is not addressed by one or more of the above-mentioned resources, UM RNs confer with the Company Medical Director or their physician designee for guidance. Company UM RNs are not able to deny requests which do not meet medical necessity criteria. If a case does not meet medical necessity criteria, the Company RN refers the case to the Company Medical Director or their physician designee.

Medical Director or a physician designee reviews all medical necessity decisions that may result in a denial of a service or an authorization of a service that is in an amount, duration, or scope that is less than requested, prior to notifying the provider and member of the Company's decision. The Company Medical Director or his/her physician designee reviews the request for service including all applicable information and documents a decision in the medical record. The Company Medical Director or his/her physician designee has available board-certified physicians from appropriate specialty areas to assist as needed in making denial decisions.

Finding:

The processes followed for MH/SUD, including the two-level review process, are comparable to and applied no more stringently than the processes followed for M/S benefits, and they follow standard industry practice. The staff operationalizing the policies have the necessary level of expertise to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Appendix G - Outlier Management

Description: The health plan's utilization management policies and processes for determining when a participant's benefits requires additional clinical review and potentially service changes.

Tools for Analysis: Outlier review and Quality Management policies and processes

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP, EC, PD	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP, EC, PD	No	Yes
Scenario 3				
	RAE 1	IP, OP, EC	No	Yes
	RAE 2 & 4	IP, OP	No	Yes
	RAE 3 & 5	IP, OP	No	Yes
	RAE 6 & 7	IP, OP	No	Yes
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	N/A	N/A

Scenario 1 – FFS

NQTL: Outlier Management (IP, OP, EC, & PD)	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations Department Benefit Policy Consultation with Department staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: Outlier management policies determine when a participant's benefit utilization may require additional clinical review and potentially service changes.

Process:

MH/SUD and M/S
The Department's outlier management program for FFS behavioral and physical health has multiple components. These include utilizing a recovery audits contractor (RAC) to review certain claims for the medical appropriateness and billed services. Additionally, the FFS UM Vendor will notify the Department of any concerns regarding waste, fraud, abuse that are identified as a part of the normal review process. And finally, the Department reviews claims for use in future policy setting. The Department has an exception process built into all reviews for members under 21 to comply with EPSDT.

Finding:
The process is the same for MH/SUD and M/S, therefore it is parity compliant.

Scenario 2 – RAE 1 and Rocky Mountain Health Plan Prime MCO

NQTL: Outlier Management (IP, OP, EC, & PD)	Evidence used for comparison:
Complies with Parity Requirements: Yes Differences noted between M/S and MH/SUD services: No	Interview with RMHP staff RMHP Data Request RMHP UM Program Description, p 32-33 RMHP PH52 - Medication Adherence Program – Procedure RMHP PH51 - Medication Review Program - Procedure

Goals and Rationale: Outlier management policies determine when a participant's benefit utilization may require additional clinical review and potentially service changes.

The goal of all Rocky Mountain Health Plan UM activities is to make sure members get the right care at the right place and the right time. This ensures quality of care and timely services. The goal of RMHP's Drug Safety Program is to support prescribers who provide controlled medications to Members by decreasing the risk of duplicate therapy and/or other prescribers of these higher risk medications. In addition, Members enrolled receive additional support with medical and social determinants of health issues. The goal of RMHP's Medication Adherence Program is to increase adherence to chronic medications that have evidence of improving long term outcomes. The goal of RMHP's Medication Review Program is to improve treatment for higher risk and complex members to improve long term outcomes.

Process:

MH/SUD and M/S
RMHP uses MCG guidelines. MCG editors develop care guidelines in strict accordance with the principles of evidence-based medicine. Annually, thousands of references are reviewed and ranked with many unique citations, identifying the most important clinical evidence and using it to expand and refine care guidance. See mcg.com/about/company-overview. Guidelines are developed using specific sources of information such as medical literature to include published research studies, practice guidelines and new editions of textbooks that may be relevant to guideline content. Cited references are graded according to the level of authoritativeness. In addition, in December 2020, RMHP adopted the American Society of Addictive Medicine (ASAM) guidelines for substance use disorder (SUD) benefits. These guidelines are required by the Colorado Department of Health Care Policy and Financing (Department) for the administration of the new substance use disorder (SUD) benefit for RAE and Prime (Medicaid) plans effective 1/1/2021.

RMHP monitors over and underutilization of services to ensure that Members receive necessary and appropriate care. Data are collected from multiple sources including HEDIS® results and Member surveys, appeals and grievance data, quality of care reports, utilization management reports and pharmacy utilization reports.
Data are reviewed, trended, analyzed and interventions are developed and implemented based on outcomes of the analysis. Areas of focus include:

MONITORING OF OVERUTILIZATION

- Concurrent reviews
- Pre-authorizations
- High ER utilization for non-emergent conditions
- Hospitalization for preventable conditions
- Hospital readmission within 30 days of discharge
- Pharmacy overutilization (Opioids)
- Colorado Overutilization Project (COUP)- Medicaid

MONITORING OF UNDERUTILIZATION

- Members identified with Preventative Care and Screening Gaps
- Gaps in Care Reporting (providers)
- Member Education and Incentives
- Encourage annual Wellness Visit
- Provider Attribution Reports
- Pharmacy Underutilization/Medication Management Program
- Disease Management Program(s)

For the prescription drug benefit, there are multiple programs designed to work with Members who have over and underutilization of medications.

1. Drug Safety Program (DSP) seeks to identify Members who have overutilization of drug enforcement agency (DEA) controlled substances. This program focuses on all controlled drugs that can be either BH or medical.
2. Medication Adherence Program (MAP) seeks to identify Members who have underutilization of drugs used to treat chronic medical conditions including diabetes, cholesterol, and more. This program focuses on all controlled drugs that can be either BH or medical.
3. Medication Review Program (MRP) seeks to identify higher risk or complex Members that could benefit from a complete medication review. Members identified are based on number of scripts per month, number of prescribers, etc. This program focuses on all controlled drugs that can be either BH or medical.

Finding:
The outlier management processes for MH/SUD benefits are comparable to and applied no more stringently to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 3 – RAE 1 and FFS

NQTL: Outlier Management (IP, OP, & EC)	**Evidence used for comparison:** Interview with RMHP staff RMHP Data Request RMHP UM Program Description, p 32-33 Consultation with Department staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:**	

No	

Goals and Rationale: Outlier management policies determine when a participant's benefit utilization may require additional clinical review and potentially service changes.

Process:

MH/SUD
RMHP uses MCG guidelines.
MCG editors develop care guidelines in strict accordance with the principles of evidence-based medicine. Annually, thousands of references are reviewed and ranked with many unique citations, identifying the most important clinical evidence and using it to expand and refine care guidance. See mcg.com/about/company-overview.
Guidelines are developed using specific sources of information such as medical literature to include published research studies, practice guidelines and new editions of textbooks that may be relevant to guideline content. Cited references are graded according to level of authoritativeness. In addition, in December 2020, RMHP adopted the American Society of Addictive Medicine (ASAM) guidelines for substance use disorder (SUD) benefits. These guidelines are required by Colorado Department of Health Care Policy Financing (Department) for the administration of the new substance use disorder (SUD) benefit for RAE and Prime (Medicaid) plans effective 1/1/2021.

RMHP monitors over and underutilization of services to ensure that Members receive necessary and appropriate care. Data are collected from multiple sources including HEDIS® results and Member surveys, appeals and grievance data, quality of care reports, utilization management reports and pharmacy utilization reports.
Data are reviewed, trended, analyzed and interventions are developed and implemented based on outcomes of the analysis. Areas of focus include:
MONITORING OF OVERUTILIZATION

- Concurrent reviews
- Pre-authorizations
- High ER utilization for non-emergent conditions
- Hospitalization for preventable conditions
- Hospital readmission within 30 days of discharge
- Pharmacy overutilization (Opioids)
- Colorado Overutilization Project (COUP)- Medicaid

MONITORING OF UNDERUTILIZATION

- Members identified with Preventative Care and Screening Gaps
- Gaps in Care Reporting (providers)
- Member Education and Incentives
- Encourage annual Wellness Visit
- Provider Attribution Reports
- Pharmacy Underutilization/Medication Management Program
- Disease Management Program(s)

M/S
The Department's outlier management program for FFS physical health has multiple components. These include utilizing a recovery audits contractor (RAC) to review certain claims for the medical appropriateness and billed services. Additionally, the FFS UM Vendor will notify the Department of any concerns regarding waste, fraud, abuse that are

identified as a part of the normal review process. And finally, the Department reviews claims for use in future policy setting. The Department has an exception process built into all reviews for members under 21 to comply with EPSDT.

Finding:
The outlier management processes for MH/SUD benefits are comparable to and applied no more stringently to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Outlier Management (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Interview with Beacon staff Beacon Data Request Consultation with Department staff

Goals and Rationale: Outlier management policies determine when a participant's benefit utilization may require additional clinical review and potentially service changes. Northeast Health Partners and Health Colorado use outlier reports to identify patterns of possible over-utilization of services. Identified cases are then subject to additional review to determine whether services are medically necessary. However, no benefit limits are applied.

Process:

MH/SUD
Beacon Health Options, as the delegate for Northeast Health Partners and Health Colorado, currently employs an outlier review process only in two situations:

- Higher than expected utilization of outpatient services; and
- Inpatient services outside of the established case-rate parameters.

For outpatient services, Beacon identifies members who have received more than 25 individual and/or family therapy sessions in a calendar year. The providers for these members are asked to submit clinical information to review the need for ongoing services. The information should include an assessment, treatment plan, and any explanations for the high level of utilization. This information is reviewed by the Peer Advisor to determine if additional services are warranted and/or if the treatment plan needs to be modified. Frequently, these reviews result in a peer-to-peer consultation between the Peer Advisor and the provider. If medical necessity criteria (MNC) are still being met, additional services can be authorized. If MNC are not met, additional services are either denied or reduced in frequency/intensity. In the case of an adverse determination, the provider and member are informed as required by contract and they may pursue appeal options. Previously approved services would not be denied through this outlier review process.

For longer inpatient lengths of stay that fall outside of the usual case-rate parameters, the case will revert to a per diem basis for authorization and payment purposes. As such, it will follow the concurrent review processes.

M/S
The Department's outlier management program for FFS physical health has multiple components. These include utilizing a recovery audits contractor (RAC) to review certain claims for the medical appropriateness and billed services. Additionally, the FFS UM Vendor will notify the Department of any concerns regarding waste, fraud, abuse that are identified as a part of the normal review process. And finally, the Department reviews claims for use in future policy setting. The Department has an exception process built into all reviews for members under 21 to comply with EPSDT.

Finding:
The outlier management processes for MH/SUD benefits are comparable to and applied no more stringently to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Outlier Management (IP & OP)	Evidence used for comparison:
Complies with Parity Requirements: Yes	Interview with Colorado Access staff
Differences noted between M/S and MH/SUD services:	Colorado Access Data Request
No	COA CCS302 Medical Criteria for Utilization Review
	Consultation with Department staff

Goals and Rationale: Outlier management policies determine when a participant's benefit utilization may require additional clinical review and potentially service changes. Colorado Access' goal of outlier review is to assure the member is being treated in the most clinically appropriate, least restrictive environment with services that are reasonably expected to improve the member's behavioral health conditions.

Process:

MH/SUD
COA monitors for outliers with frequent utilization of inpatient services and certain outpatient services. COA considers frequent utilization on a case-by-case basis when evaluating whether continued or additional inpatient services will (or is reasonably expected to) benefit the member in the treatment of their behavioral health condition(s). Per the definition of medical necessity, this is only one of many factors to consider when medical necessity is being evaluated. COA may recommend a different course of treatment if the services being requested are not effective in treating the member's behavioral health condition(s). But no benefit limits are applied.

M/S

The Department's outlier management program for FFS physical health has multiple components. These include utilizing a recovery audits contractor (RAC) to review certain claims for the medical appropriateness and billed services. Additionally, the FFS UM Vendor will notify the Department of any concerns regarding waste, fraud, abuse that are identified as a part of the normal review process. And finally, the Department reviews claims for use in future policy setting. The Department has an exception process built into all reviews for members under 21 to comply with EPSDT.

Finding:
The outlier management processes for MH/SUD benefits are comparable to and applied no more stringently to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Outlier Management (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Interview with CCHA Staff Notes CCHA Data Request CCHA UM Program Description, pg26 Consultation with Department staff

Goals and Rationale: Outlier management policies determine when a participant's benefit utilization may require additional clinical review and potentially service changes.

Process:

MH/SUD:
CCHA is committed to assuring access to health care and services for all participating members. Over-utilization and under-utilization of services are monitored using reports made available to Behavioral Health Management and Quality Management (QM)) Departments by the Performance Management Analysts/ Finance Analysts. CCHA participates in the Colorado Client Over-Utilization Program (COUP).
The results of the reviews are used to help implement strategies to achieve utilization targets consistent with clinical and quality indicators and identify fraud and abuse. The reports are reviewed looking for patterns of over-utilization and/or under-utilization of services with specific attention given to:

- Re-admissions,
- Pharmaceuticals,
- Specialty referrals,
- Emergency Room (ER) utilization,
- Home Health,
- Outpatient Utilization, and
- Inpatient Utilization

M/S

The Department's outlier management program for FFS physical health has multiple components. These include utilizing a recovery audits contractor (RAC) to review certain claims for the medical appropriateness and billed services. Additionally, the FFS UM Vendor will notify the Department of any concerns regarding waste, fraud, abuse that are identified as a part of the normal review process. And finally, the Department reviews claims for use in future policy setting. The Department has an exception process built into all reviews for members under 21 to comply with EPSDT.

Finding:
The outlier management processes for MH/SUD benefits are comparable to and applied no more stringently to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Outlier Management (IP, OP, EC, & PD)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Interview with Denver Health Denver Health Data Request

Goals and Rationale: Outlier management policies determine when a participant's benefit utilization may require additional clinical review and potentially service changes.

Process:

MH/SUD and M/S:

The DHMP Medical Director completes review for out-of-network requests as well as DME and benefits. DHMP does have a process for tracking over and underutilization, the process is managed by the Quality Improvement Director and is reported to the quarterly Quality Management Committee for review, discussion, and potential intervention. DHMP also reviews and monitors for high cost services/claims and will connect those members to the Care Management team for education and support.

Finding:

The outlier management processes for MH/SUD benefits are comparable to and applied no more stringently to M/S benefits. The policies follow standard industry practice, the staff operationalizing the policies are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policies are operationalized as documented.

Appendix H - Penalties for Noncompliance

Description: The policies and protocols that health plans utilize to determine actions derived as a result of provider and participant non-compliance.

Tools for Analysis: Review of plan polices and processes regarding limitation/denial of services and non-compliance with policies.

Analysis: No health plan currently applies penalties for non-compliance in any benefit categories. Failure of a provider or participant to follow required procedures may result in an administrative denial.

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
	N/A	N/A	N/A	N/A

Appendix I – Coding Limitations

Description: The claims processing, coding, and billing standards set by health plans for utilization in their benefit/service selection and payment

Tools for Analysis: Review of the selection and application of industry standard codes for claims processing, coding, and billing (i.e., Uniform Services Coding Manual and/or National Correct Coding Initiative)

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP	No	Yes
Scenario 3				
	RAE 1	IP, OP	No	Yes
	RAE 2 & 4	IP, OP	No	Yes
	RAE 3 & 5	IP, OP	No	Yes
	RAE 6 & 7	IP, OP	No	Yes
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP	No	Yes

Scenario 1 – FFS

NQTL: Coding Limitations (IP & OP)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Department Interviews with key Department staff Department Behavioral Health FFS Benefits Department General Provider Information Manual EPSDT Program Definition Section 1905 of the Social Security Act 42 U.S. Code Sub Chapter XIX - 1396a(a)(42), 1396d(a)(4)(B) and 1396d Fee Schedule for Item Limits

Goals and Rationale: Coding limitations are used for inpatient and outpatient, in accordance with the Colorado Medicaid provider billing manual from the Department for fee-for-service MH/SUD and M/S services and guidance from CMS, such as Medically Unlikely Edits (MUE).

Process:

MH/SUD
Some services and supplies that require a PAR may have coding and unit limitations that can be found on the Colorado Fee Schedule and billing manuals.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for members 20 years of age and younger who are enrolled with Colorado's Medicaid Program.

For outpatient services Providers still need to ensure that they are meeting all other requirements for the benefit and PAR process

Providers may submit a request for code for a service or supply that is not a covered benefit, or exceeds limitations of the benefit, of Colorado Medicaid as part of the EPSDT exception process, which will then undergo a review for compliance and medical necessity by the UM Vendor. Service and/or unit limitations found on the Fee Schedule may not be applicable under EPSDT.

M/S
Some services and supplies that require a PAR may have coding and unit limitations that can be found on the Colorado Fee Schedule and billing manuals.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for members 20 years of age and younger who are enrolled with Colorado's Medicaid Program.

For outpatient services Providers still need to ensure that they are meeting all other requirements for the benefit and PAR process

Providers may submit a request for code for a service or supply that is not a covered benefit, or exceeds limitations of the benefit, of Colorado Medicaid as part of the EPSDT exception process, which will then undergo a review for compliance and medical necessity by the UM Vendor. Service and/or unit limitations found on the Fee Schedule may not be applicable under EPSDT.

Finding:
Coding limitations follow the same process for M/S benefits and MH/SUD service benefits.

Scenario 2 – RAE 1 and Rocky Mountain Health Plan Prime MCO

NQTL: Coding Limitations (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Rocky Mountain Health Plans Interview with RMHP staff Uniform Service Coding Standards Manual – Jan 2021 RMHP/ Department Contract RMHP BH Provider Manual
Goals and Rationale: Coding limitations are used for inpatient and outpatient, in accordance with the Uniform Service Coding Standards Manual for MH/SUD. RMHP does not utilize coding limitations beyond what is appropriate for a provider and is a benefit of the	

members plan. Provider contracts are limited to services within the scope of practice and covered benefits.

Process:

MH/SUD
RAEs are required in contract to provide or arrange for the provision of all medically necessary covered services as detailed in Section 14.5, represented by procedures listed in the Uniform Service Coding Standards Manual, for all diagnoses indicated in Exhibit I Capitated Behavioral Health Benefit Covered Services and Diagnoses. The Colorado Capitated MH/SUD Benefit under the Accountable Care Collaborative covered service categories are defined according to the Colorado Medicaid State Plan (required services) and MH/SUD Program 1915 (b)(3) Waiver (alternative or (b)(3) services). All Colorado Capitated MH/SUD Benefit under the Accountable Care Collaborative covered procedure codes are categorized as either State Plan (SP), (b)(3), or both.

M/S
Rocky Mountain Health Plans uses the CMS HCPCS to identify services provided to its members. The HCPCS includes codes identified in the Physician's Current Procedural Terminology (CPT) and codes developed by CMS. The claims processing system uses the CMS-mandated National Correct Coding Initiative (NCCI) to impose nationally recognized and standardized limits for M/S services.

Finding:
Coding limitations follow the same process for M/S benefits under the MCO and the RAE for MH/SUD benefits.

Scenario 3 – RAE 1 and FFS

NQTL: Coding Limitations (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from RMHP Interview with key RMHP staff Interview with key Department staff Uniform Service Coding Standards Manual – Jan 2021 RMHP/ Department Contract RMHP BH Provider Manual Department General Provider Information Manual
Goals and Rationale: Coding limitations are used for inpatient and outpatient in accordance with the Uniform Service Coding Standards Manual for MH/SUD services, the Colorado Medicaid provider billing manual from the Department for fee-for-service M/S services, and guidance from CMS such as Medically Unlikely Edits (MUE).	

RMHP does not utilize coding limitations beyond what is appropriate for a provider and is a benefit of the members plan. Provider contracts are limited to services within the scope of practice and covered benefits.

Process:

MH/SUD
RAEs are required in contract to provide or arrange for the provision of all medically necessary covered services as detailed in Section 14.5, represented by procedures listed in the Uniform Service Coding Standards Manual, for all diagnoses indicated in Exhibit I Capitated Behavioral Health Benefit Covered Services and Diagnoses. The Colorado Capitated MH/SUD Benefit under the Accountable Care Collaborative covered service categories are defined according to the Colorado Medicaid State Plan (required services) and MH/SUD Program 1915 (b)(3) Waiver (alternative or (b)(3) services). All Colorado Capitated MH/SUD Benefit under the Accountable Care Collaborative covered procedure codes are categorized as either State Plan (SP), (b)(3), or both.

M/S
Fee-for-Service benefits are defined according to the Colorado Medicaid State Plan. The Colorado Medicaid program uses the CMS HCPCS to identify services provided to Colorado Medicaid members. The HCPCS includes codes identified in the Physician's Current Procedural Terminology (CPT) and codes developed by CMS. Updates and revisions to HCPCS listings are documented in the Provider Bulletins.

Finding:
Coding limitations follow similar processes for M/S benefits under FFS and the RAE for MH/SUD benefits.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Coding Limitations (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Northeast Health Partners and Health Colorado Interview with key Northeast Health Partners, Health Colorado, and Beacon Health Options staff Interview with key Department Staff Uniform Service Coding Standards Manual - Jan 2021 NHP/Department Contract HCI/Department Contract Colorado Department General Provider Information Manual
Goals and Rationale: Coding limitations are used for inpatient and outpatient in accordance with the Uniform Service Coding Standards Manual for MH/SUD services, the	

Colorado Medicaid provider billing manual from the Department for fee-for-service M/S services, and guidance from CMS such as Medically Unlikely Edits (MUE).

Process:
MH/SUD
RAEs are required in contract to provide or arrange for the provision of all medically necessary covered services as detailed in Section 14.5, represented by procedures listed in the Uniform Service Coding Standards Manual, for all diagnoses indicated in Exhibit I Capitated Behavioral Health Benefit Covered Services and Diagnoses. Allowable codes are determined by Department and are listed in Appendix C of the most recent version of the Uniform Service Coding Standards Manual. Beacon Health Options manages the billing codes for Northeast Health Partners and Health Colorado. All coding configuration is memorialized by the Beacon Configuration team. Any changes to configuration must be documented in writing with review/sign-off by various parties (clinical, network, claims, the client, and account management.) Configuration/coding change requests require written evidence from the state (ex: The USCM or Department memo).

M/S
Fee-for-Service benefits are defined according to the Colorado Medicaid State Plan. The Colorado Medicaid program uses the CMS HCPCS to identify services provided to Colorado Medicaid members. The HCPCS includes codes identified in the Physician's Current Procedural Terminology (CPT) and codes developed by CMS. Updates and revisions to HCPCS listings are documented in the Provider Bulletins.

Finding:
Coding limitations follow similar processes for M/S benefits under FFS and the RAE for MH/SUD benefits

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Coding Limitations (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Colorado Access Interview with key Colorado Access staff Interview with key Department Staff Uniform Service Coding Standards Manual – Jan 2021 COA/ Department Contract Department General Provider Information Manual

Goals and Rationale: Coding limitations are used for inpatient and outpatient in accordance with the Uniform Service Coding Standards Manual for MH/SUD services, the Colorado Medicaid provider billing manual from the Department for fee-for-service M/S services, and guidance from CMS such as Medically Unlikely Edits (MUE).

Process:

MH/SUD
RAEs are required in contract to provide or arrange for the provision of all medically necessary covered services as detailed in Section 14.5, represented by procedures listed in the Uniform Service Coding Standards Manual, for all diagnoses indicated in Exhibit I Capitated Behavioral Health Benefit Covered Services and Diagnoses. The Colorado Capitated MH/SUD Benefit under the Accountable Care Collaborative covered service categories are defined according to the Colorado Medicaid State Plan (required services) and MH/SUD Program 1915 (b)(3) Waiver (alternative or (b)(3) services). All Colorado Capitated MH/SUD Benefit under the Accountable Care Collaborative covered procedure codes are categorized as either State Plan (SP), (b)(3), or both.

M/S
Fee-for-Service benefits are defined according to the Colorado Medicaid State Plan. The Colorado Medicaid program uses the CMS HCPCS to identify services provided to Colorado Medicaid members. The HCPCS includes codes identified in the Physician's Current Procedural Terminology (CPT) and codes developed by CMS. Updates and revisions to HCPCS listings are documented in the Provider Bulletins.

Finding:
Coding limitations follow similar processes for M/S benefits under FFS and the RAE for MH/SUD benefits.

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Coding Limitations (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from CCHA Interview with key CCHA staff CCHA Provider Manual, p48 Data Request from Department Interviews with key Department staff CCHA/ Department Contract Uniform Service Coding Standards Manual – Jan 2021 Department General Provider Information Manual

Goals and Rationale: Coding limitations are used for inpatient and outpatient in accordance with the Uniform Service Coding Standards Manual for MH/SUD services, the Colorado Medicaid provider billing manual from the Department for fee-for-service M/S services, and guidance from CMS such as Medically Unlikely Edits (MUE).

Process:
MH/SUD
RAEs are required in contract to provide or arrange for the provision of all medically necessary covered services as detailed in Section 14.5, represented by procedures listed in

the Uniform Service Coding Standards Manual, for all diagnoses indicated in Exhibit I Capitated Behavioral Health Benefit Covered Services and Diagnoses.
Colorado Community Health Alliance uses standardized codes. HCPCS, sometimes referred to as national codes, provides coding for a wide variety of services. The principal coding levels are referred to as Level I and Level II:

- Level I: CPT codes maintained by the American Medical Association (AMA) and represented by five numeric digits.
- Level II: Codes that identify products, supplies and services not included in the CPT codes, such as ambulance supplies and durable medical equipment (DME). Level II codes sometimes are called the alphanumeric codes because they consist of a single alphabetical letter followed by four numeric digits.

M/S
Fee-for-Service benefits are defined according to the Colorado Medicaid State Plan. The Colorado Medicaid program uses the CMS HCPCS to identify services provided to Colorado Medicaid members. The HCPCS includes codes identified in the Physician's Current Procedural Terminology (CPT) and codes developed by CMS. Updates and revisions to HCPCS listings are documented in the Provider Bulletins.

Finding:
Coding limitations follow similar processes for M/S benefits under FFS and the RAE for MH/SUD benefits.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Coding Limitations (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Denver Health Interview with Denver Health staff Uniform Service Coding Standards Manual – Jan 2021 Denver Health/ Department Contract Denver Health Provider Manual

Goals and Rationale: Denver Health MCO subcontracts out the operation of the its MH/SUD PIHP to Colorado Access. Coding limitations are used for inpatient and outpatient, in accordance with the Denver Health provider billing manual for fee-for-service M/S services and the Uniform Service Coding Standards Manual for MH/SUD services.

Process:

MH/SUD
RAEs are required in contract to provide or arrange for the provision of all medically necessary covered services as detailed in Section 14.5, represented by procedures listed in the Uniform Service Coding Standards Manual, for all diagnoses indicated in Exhibit I Capitated Behavioral Health Benefit Covered Services and Diagnoses. The Colorado Capitated MH/SUD Benefit under the Accountable Care Collaborative covered service categories are defined according to the Colorado Medicaid State Plan (required services) and MH/SUD Program 1915 (b)(3) Waiver (alternative or (b)(3) services). All Colorado

Capitated MH/SUD Benefit under the Accountable Care Collaborative covered procedure codes are categorized as either State Plan (SP), (b)(3), or both.

M/S
Denver Health MCO uses the Department billing code for M/S codes that are used for the fee-for-service coverage of members. NCCI edits are also applied to procedure codes submitted.

Finding:
Coding limitations follow substantially similar processes for MH/SUD and M/S.

Appendix J - Medical Necessity Criteria

Description: Use and applicability of Health plan standards and review policies that determines enrollment and authorization for benefits/services.

Tools for Analysis: Protocols for selection of criteria (i.e., utilization of industry standard criteria) to assess medical necessity for M/S and MH/SUD benefits. Review of Compliance with Department defined medical necessity criteria and directives.

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	N/A	N/A	N/A	N/A
Scenario 2	RMHP & Prime MCO	IP, OP, PD	No	Yes
Scenario 3				
	RAE 1	IP, OP	No	Yes
	RAE 2 & 4	IP, OP	No	Yes
	RAE 3 & 5	IP, OP	No	Yes
	RAE 6 & 7	IP, OP	No	Yes
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP, PD	No	Yes

Scenario 1 – FFS

Per interviews with Department staff, no medical necessity criteria are applied on fee-for-service MH/SUD claims. Claims are paid upon submission in compliance with all billing rules and policies.

Scenario 2 – RAE 1 and Rocky Mountain Health Plan Prime MCO

NQTL: Medical Necessity Criteria (IP & OP)	**Evidence used for comparison:** Data Request from RMHP Interview with RMHP staff RMHP UM Program Description RMHP Clinical Criteria for UM Decisions Medicaid Directives and Bulletins
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: Rocky Mountain Health Plan's Utilization Management (UM) Program is designed to ensure that medical and behavioral health services rendered to Members are medically necessary and appropriate, cost-effective, and in conformance with the benefits of the Plan. The Program is designed to assist Members, Practitioners and Providers with tools and services for the delivery of the right care, at the right time, by the right provider, in the right place for the best value.

Medical necessity criteria for inpatient and outpatient services are applied to MH/SUD and M/S services for members in RAE 1 and Rocky Prime, the Rocky Mountain Health Plan Prime MCO using Medicaid Directives and Bulletins, RMHP, MCG and Evicore Clinical policies. Requirements for medical necessity criteria are set forth by the National Committee for Quality Assurance (NCQA), Dual Special Needs Program (DSNP), Regional Accountability

Entity (RAE), and the Quality Improvement Program requirements contained within 42 CFR Section 438.310-370 and 42 CFR §422.152 as described in the Center for Medicaid and Medicare Managed Care Manual.

Process:

MH/SUD:

RMHP uses evidence-based decision support products: MCG guidelines. RMHP modifies these guidelines to reflect the most current evidence-based information applicable to the service that may not have yet been incorporated into the national standard. Typically, a modification is only made to make coverage more generous or less restrictive (e.g., prior authorization removed because evidence no longer supports it, or the national standard does not reflect the patient characteristics of the population served). Less than 5 percent of the guidelines RMHP uses for purposes of determining medical necessity have been modified. The hierarchy of guidelines/criteria used is as follows:
Medicaid Directives and Bulletins, MCG, RMHP Clinical Policies, Medicare Coverage guidelines
Page 4-5 C. 1-5 of Clinical Criteria for UM Decisions
A. Medicaid and Child Health Plan Plus (CHP+)
1) Medicaid Directives and Bulletins are applied where they exist.
2) RMHP Clinical Policies are applied in the event criteria exist in MCG® and RMHP Clinical Policy.
3) MCG® guidelines are used for reviews other than durable medical equipment (DME), orthotics, or prosthetics.
4) Medicare Coverage Guidelines are applied to requests for DME, orthotics, and prosthetics in the absence of guidance in Medicaid Bulletins or the RMHP Medicaid ASO contract.
5) Reviewers deny as "Not a Benefit" procedures that are designated as Not a Benefit per Colorado Medicaid Fee Schedule or other Department documentation.

In addition, in December 2020 RMHP adopted the American Society of Addictive Medicine (ASAM) guidelines for substance use disorder (SUD) benefits. These guidelines are required by Colorado Department of Health Care Policy Financing (Department) for the administration of the new substance use disorder (SUD) benefit for RAE and Prime (Medicaid) plans effective 1/1/2021.

RMHP uses MCG guidelines for behavioral health criteria to establish medical necessity for inpatient and outpatient mental health services. Some outpatient mental health services require prior authorization for determination of medical necessity; list published at https://www.rmhp.org/i-am-a-provider/provider-resources/prior-authorization. Planned out of network services require prior authorization. Urgent/emergent (including crisis) services do not require prior auth.

Urgent and emergent (including crisis) services do not require prospective review and all emergency room claims are paid without review through the normal claims payment processes.

M/S:
RMHP uses MCG criteria to establish medical necessity for M/S services. RMHP follows Medicaid Directives and Bulletins where they exist. In the absence thereof, RMHP, MCG and

Evicore Clinical Policies are applied. Reviewers deny as "Not a Benefit" procedures that are designated as Not a Benefit per the Colorado Medicaid Fee Schedule or other Department documentation. In addition, CMS LCD/LCA/NCDs and other regulatory information, along with current scientific literature may be applied. External board-certified consultation by members of the RMHP physician network and/or the AMR organization is available to RMHP internal licensed practitioner reviewers. EviCore Healthcare guidelines are used for radiology and genetic/molecular testing prior authorization requests.

Finding:
Medical necessity criteria for MH/SUD and M/S benefits are established in a substantially similar manner and follow industry standard methods.

NQTL: Medical Necessity Criteria (PD)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from RMHP Interview with RMHP staff RMHP Clinical Criteria for UM Decisions RMHP UM Program Description Medicaid Directives and Bulletins

Goals and Rationale: The goal is to provide access to therapies in an efficient design that balances guideline driven treatment with healthcare spend. Utilizing guideline directed treatments to maximize value for the healthcare system (e.g. patient/ prescriber/ insurance/ pharmacy).

Medical Necessity criteria for pharmaceuticals are applied to MH/SUD and M/S services for members in RAE 1 and Rocky Prime, the Rocky Mountain Health Plan Prime MCO, using pharmacy & therapeutics committee review processes that are identical.

Process:

MH/SUD and M/S
Pharmacy Criteria for medical necessity is determined during P&T (pharmacy & therapeutics committee) review of the drug. Criteria is developed from various sources including but not limited to FDA approved PI, clinical guidelines (AASLD, NCCN, ADA, etc.), clinical trials, and professional opinion. Requirements are communicated via the formulary and drug specific forms that outline criteria. There is also an exception process that allows members/providers to ask for a drug that is not included on the formulary called a formulary exception (FE). When either an UM request or FE request is submitted, review of the case occurs to decide if coverage is appropriate. An UM request has more specific guidelines to follow, whereas an FE requires a provider to make the case that either formulary options would not be appropriate due to specific member requirements (contraindicated) or that at least two formulary options have already been tried and failed due to lack of efficacy or adverse effect.

Finding:
Medical necessity criteria for MH/SUD and M/S benefits are established in a substantially similar manner and follow industry standard methods.

Scenario 3 – RAE 1 and FFS

NQTL: Medical Necessity Criteria (IP & OP)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from RMHP Interview with RMHP staff RMHP Clinical Criteria for UM Decisions RMHP UM Program Description Medicaid Directives and Bulletins Data Request from Department and UM Vendor Interview with Department and UM Vendor staff

Goals and Rationale: Rocky Mountain Health Plan's Utilization Management (UM) Program is designed to ensure that medical and behavioral health services rendered to Members are medically necessary and appropriate, cost-effective, and in conformance with the benefits of the Plan. The Program is designed to assist Members, Practitioners and Providers with tools and services for the delivery of the right care, at the right time, by the right provider, in the right place for the best value.

Medical necessity criteria for inpatient and outpatient services are applied to MH/SUD services for members in RAE 1 using Medicaid Directives and Bulletins, RMHP, MCG and Evicore Clinical policies.

For inpatient and outpatient M/S services, the fee-for-service criteria are applied by the FFS UM Vendor.

Process:

MH/SUD:
RMHP uses evidence-based decision support products: MCG guidelines. RMHP modifies these guidelines to reflect the most current evidence-based information applicable to the service that may not have yet been incorporated into the national standard. Typically, a modification is only made to make coverage more generous or less restrictive (e.g., prior authorization removed because evidence no longer supports it, or the national standard does not reflect the patient characteristics of the population served). Less than 5 percent of the guidelines RMHP uses for purposes of determining medical necessity have been modified. The hierarchy of guidelines/criteria used is as follows:
Medicaid Directives and Bulletins, MCG, RMHP Clinical Policies, Medicare Coverage guidelines
Page 4-5 C. 1-5 of Clinical Criteria for UM Decisions
A. Medicaid and Child Health Plan Plus (CHP+)
1) Medicaid Directives and Bulletins are applied where they exist.
2) RMHP Clinical Policies are applied in the event criteria exist in MCG® and RMHP Clinical Policy.

3) MCG® guidelines are used for reviews other than durable medical equipment (DME), orthotics, or prosthetics.
4) Medicare Coverage Guidelines are applied to requests for DME, orthotics, and prosthetics in the absence of guidance in Medicaid Bulletins or the RMHP Medicaid ASO contract.
5) Reviewers deny as "Not a Benefit" procedures that are designated as Not a Benefit per Colorado Medicaid Fee Schedule or other Department documentation.

In addition, in December 2020 RMHP adopted the American Society of Addictive Medicine (ASAM) guidelines for substance use disorder (SUD) benefits. These guidelines are required by Colorado Department of Health Care Policy Financing (Department) for the administration of the new substance use disorder (SUD) benefit for RAE and Prime (Medicaid) plans effective 1/1/2021.

RMHP uses MCG guidelines for behavioral health criteria to establish medical necessity for inpatient and outpatient mental health services. Some outpatient mental health services require prior authorization for determination of medical necessity; list published at https://www.rmhp.org/i-am-a-provider/provider-resources/prior-authorization. Planned out of network services require prior authorization.

Urgent and emergent (including crisis) services do not require prospective review and all emergency room claims are paid without review through the normal claims payment processes.

M/S
The FFS UM Vendor handles medical necessity determinations for medical/surgical fee-for-service claims.

The UM vendor adheres to the definition of medical necessity as defined in 10 C.C.R. § 2505-10: 8.076.1.8 and 8.280.4.E.

The FFS UM Vendor uses InterQual standards to assist with specific medical necessity determinations for outpatient physical health claims. When IHRP is in operation, the FSS UM Vendor uses MCG standards for inpatient claims. If there is no Interqual or MCG criteria available, state-specific criteria, based in industry best practice and evidenced based research, is utilized. In addition, for any members aged 20 and under, the Vendor must utilize EPSDT guidelines and definition when determining a review outcome.

Finding:
RMHP and Department use substantially the same process to determine medical necessity for MH/SUD and M/S benefits respectively. Both use industry standard clinical criteria and no difference was found in application of the criteria. Therefore, they are compliant with parity requirements.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Medical Necessity Criteria (IP & OP)	Evidence used for comparison:

Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Northeast Health Partners and Health Colorado Interview with Beacon Health Options, Northeast Health Partners and Health Colorado Beacon Policy: 202L-Medical Necessity Determinations-FY20-21 Data Request from Department and UM Vendor Interview with Department and UM Vendor Staff

Goals and Rationale: Medical necessity criteria for all benefit categories are applied to MH/SUD services for members in the RAE using standards from InterQual and ASAM. For inpatient and outpatient M/S services, the fee-for-service criteria are applied by the Department's FFS UM Vendor.

Process:

MH/SUD
Beacon Health Options uses InterQual and ASAM criteria are used as evidence-based decision support tools to determine medical necessity. Beacon Health Options, defines medical necessity according to the same statutory definition established by the Department in 10 C.C.R. § 2505-10: 8.076.1.8.

For MH/SUD services, this definition is considered along with the RAE's medical necessity criteria. Medical necessity reviews are conducted by licensed clinicians. These staff are permitted to approve services but cannot deny treatment. If it appears that the member's condition does not meet the medical necessity criteria for the requested services or if the services are needed for a non-covered condition, the case must be benched with a Peer Advisor who is either a licensed psychologist or a licensed physician (psychiatrist). If services are determined to not meet MNC, they are provisionally denied, and the requesting provider is informed.

The requesting provider is offered an opportunity to complete a peer-to-peer reconsideration call with the Peer Advisor to provide additional clinical information that might be relevant to the decision. This must be completed within 24 hours of notification. If the provider elects to not complete a peer-to-peer reconsideration, or if the reconsideration process does not change the decision of the Peer Advisor, the adverse benefit determination becomes final. The member or his/her representative retain the right to appeal this decision through the established appeal processes.

Authorization and utilization management review is not conducted for **emergent services**.

M/S
The FFS UM Vendor handles medical necessity determinations for medical/surgical fee-for-service claims.

The UM vendor adheres to the definition of medical necessity as defined in 10 C.C.R. § 2505-10: 8.076.1.8 and 8.280.4.E.

The FFS UM Vendor uses InterQual standards to assist with specific medical necessity determinations for outpatient physical health claims. When IHRP is in operation, the FSS UM Vendor uses MCG standards for inpatient claims. If there is no Interqual or MCG criteria available, state-specific criteria, based in industry best practice and evidenced based research, is utilized. In addition, for any members aged 20 and under, the Vendor must utilize EPSDT guidelines and definition when determining a review outcome.

Finding:
The application of medical necessity criteria was found to be substantially similar for MH/SUD and M/S benefits. Both use the same statutory definition of medical necessity and use industry standard clinical criteria. They are compliant with parity requirements.

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Medical Necessity Criteria (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Colorado Access Interview with Colorado Access staff COA CCS302 Medical Criteria for Utilization Review Data Request from Department and UM Vendor Interview with Department and UM Vendor Staff

Goals and Rationale: The goal of utilization review is to assure the member is being treated in the most clinically appropriate, least restrictive environment.

Process:

MH/SUD
Colorado Access uses the State of Colorado's statutory definition of medical necessity as defined in 10 C.C.R. § 2505-10: 8.076.1.8. In 2020, they updated their definition to match the Department's definition.

COA reviews MH/SUD inpatient services according to InterQual Criteria and the applicable statutory definition of medical necessity. InterQual is a national, evidence-based tool for utilization review criteria. COA does not have any internally developed guidelines.

Routine MH/SUD outpatient services do not require a review for medical appropriateness.

Per state and federal regulations, COA does not perform any utilization review for **emergency services**.

M/S

The FFS UM Vendor handles medical necessity determinations for medical/surgical fee-for-service claims.

The UM vendor adheres to the definition of medical necessity as defined in 10 C.C.R. § 2505-10: 8.076.1.8 and 8.280.4.E.

The FFS UM Vendor uses InterQual standards to assist with specific medical necessity determinations for outpatient physical health claims. When IHRP is in operation, the FSS UM Vendor uses MCG standards for inpatient claims. If there is no Interqual or MCG criteria available, state-specific criteria, based in industry best practice and evidenced based research, is utilized. In addition, for any members aged 20 and under, the Vendor must utilize EPSDT guidelines and definition when determining a review outcome.

Finding:
Medical necessity determinations for MH/SUD and M/S follow similar processes. Both use the same statutory definition of medical necessity and use industry standard clinical criteria. They are compliant with parity requirements.

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Medical Necessity Criteria (IP & OP)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from CCHA Interview with CCHA staff CCHA UM Program Description, p11-12 CCHA Provider Manual, p22 Data Request from Department and UM Vendor Interview with Department and UM Vendor Staff

Goals and Rationale: For MH/SUD, CCHA's Behavioral Health UM Program follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. These procedures apply to prior-authorization, clinical intake, concurrent, and retrospective reviews.

Process:

MH/SUD
The CCHA MH/SUD UM Program uses the statutory definition of medical necessity as defined in 10 C.C.R. § 2505-10: 8.076.1.8.

CCHA has partnered with Anthem for their BH expertise and their criteria to review the medical necessity and appropriateness of behavioral health services is derived primarily from the following sources: Anthem Medical Policies and Clinical Utilization Management Guidelines, MCG Management Guidelines, and American Society of Addiction Medicine (ASAM) guidelines, unless superseded by state requirements or regulatory guidance. In

addition to these standards, Anthem may adopt national guidelines produced by healthcare organizations such as individual medical and surgical societies, National Institutes of Health, and the Centers for Disease Control and Prevention. All Anthem Medical Policies and Clinical Utilization Management Guidelines are under the governance of the Medical Operation committee (MOC) and are reviewed annually and updated when appropriate. Behavioral Health Review Criteria are reviewed by the Anthem Behavioral Health Utilization Management Policies and Clinical Practice Guidelines Subcommittee. The Behavioral Health UM Program follows established procedures for applying medical necessity criteria based on individual member needs and an assessment of the availability of services within the local delivery system. These procedures apply to precertification, clinical intake, concurrent, and retrospective reviews. Utilization Management clinicians collect and review relevant clinical information to determine if the level of service requested meets medical necessity criteria. Criteria can be accessed via CCHA Provider Website.

Emergency services do not require authorization or review.

M/S
The FFS UM Vendor handles medical necessity determinations for medical/surgical fee-for-service claims.

The UM vendor adheres to the definition of medical necessity as defined in 10 C.C.R. § 2505-10: 8.076.1.8 and 8.280.4.E.

The FFS UM Vendor uses InterQual standards to assist with specific medical necessity determinations for outpatient physical health claims. When IHRP is in operation, the FSS UM Vendor uses MCG standards for inpatient claims. If there is no Interqual or MCG criteria available, state-specific criteria, based in industry best practice and evidenced based research, is utilized. In addition, for any members aged 20 and under, the Vendor must utilize EPSDT guidelines and definition when determining a review outcome.

Finding:
Medical necessity determinations for MH/SUD and M/S follow similar processes. Both use the same statutory definition of medical necessity and use industry standard clinical criteria. They comply with parity requirements.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Medical Necessity Criteria (IP, OP, & PD)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Denver Health Data Request from Colorado Access Interview with Denver Health staff Interview with Colorado Access staff COA CCS302 Medical Criteria for Utilization Review

	Denver Health Policy: "Clinical Criteria for Utilization Management Decisions"

Goals and Rationale: Denver Health MCO subcontracts out the operation of the its MH/SUD PIHP to Colorado Access and they make medical necessity determinations.
Denver Health makes medical necessity determinations for M/S benefits.

Process:

MH/SUD
Colorado Access uses the statutory definition of medical necessity as defined in 10 C.C.R. § 2505-10: 8.076.1.8. In 2020, they updated their definition to match the Department's definition.

COA reviews MH/SUD inpatient services according to InterQual Criteria and the applicable statutory definition of medical necessity. InterQual is a national, evidence-based tool for utilization review criteria. COA does not have any internally developed guidelines.

Routine MH/SUD outpatient services do not require a review for medical appropriateness.

Per state and federal regulations, COA does not perform any utilization review for **emergency services**.

M/S
Denver Health uses the definition of medical necessity as defined in 10 C.C.R. § 2505-10: 8.076.1.8 and 8.280.4.E.

Denver Health follows its policy: "Clinical Criteria for Utilization Management Decisions"

C. Current Criteria for Medical Necessity
   1. *National Criteria Sets* – The Company continues to maintain contracts for use of national criteria sets. The current contracts are with MCG Health Care guidelines and Hayes, Inc. Knowledge Center.
   2. For MCG, the contract includes the following modules:
      - Ambulatory Care (includes Durable Medical Equipment and Procedures)
      - Inpatient Medical and Surgical Care (STAC and LTAC)
      - General Recovery Guidelines (SNF, Acute Rehabilitation)
      - Multiple Condition Management
      - Recovery Facility Care
      - Home Care
      - Chronic Care
      - MH/SUD Guidelines (Pediatric, Adult and Geriatric)
   3. *MCG Health Care guidelines* – All CM/UM clinical staff are trained on using MCG care guidelines criteria to evaluate cases for medical necessity. The selection of national criteria set is reviewed and approved by the UMC on an annual basis.
   4. *Denver Health Managed Care Criteria:* The Denver Health Managed Care Division has established clinical criteria for some services for which there are not clear National Criteria or for which the National Criteria cannot be applied appropriately to the CHP+ and DHMC member population.
   5. *Hayes Knowledge Center:* The Company has a current contract for access to Hayes Knowledge Center. This resource is useful in determining medical necessity for

newer technology – criteria which are often not yet included in a national criterion set like MCG.

6. *Medicare Coverage Database:* The Medicare Coverage Database contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles and proposed NCD decisions. The database also includes several other types of National Coverage policy related documents, including National Coverage Analyses (NCAs), Coding Analyses for Labs (CLAs), Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) proceedings and Medicare coverage guideline documents. Although CHP+ and MCD plans are not restricted by Medicare Coverage Determinations, the determinations are well researched and provide a frame of reference for making appropriate decisions.
7. *Colorado Department of Health Care Policy & Financing (Department) Benefits Collaborative:* The Colorado Department Benefits Collaborative is a set of Benefit Coverage Standards that have been approved by the Colorado State Medicaid Director and are in effect.
8. *Other Nationally Recognized Criteria:* From time-to-time a service is requested that does not have clear medical necessity criteria in any of the sources mentioned above. In these cases, UM staff refers to guidelines from national professional organizations and from large commercial health plans, such as Anthem and Aetna, whose policies and criteria are available to the public online.
9. Durable Medical Equipment (DME) medical necessity criteria and standards are described in *Guidelines for the Ordering and Authorization of Durable Medical Equipment and Consumable Supplies.*

Finding:
Medical necessity determinations for MH/SUD and M/S follow similar processes. Both use the same statutory definition of medical necessity and use industry standard clinical criteria. They are compliant with parity requirements.

Appendix K – Network Provider Admission

Description: Network Provider Admission is the process of recruitment, credentialing, and accepting treatment providers into a health plan's network of care professionals.

Tools for Analysis: Review and analysis of provider network selection criteria for network admission. Process and procedure for credentialing and recredentialing of MH/SUD and M/S providers. Provider appeals process. Utilization of national accrediting standards

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP, EC, PD	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP, EC, PD	No	Yes
Scenario 3				
	RAE 1	IP, OP, EC	No	Yes
	RAE 2 & 4	IP, OP, EC	No	Yes
	RAE 3 & 5	IP, OP, EC	No	Yes
	RAE 6 & 7	IP, OP, EC	No	Yes
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	No	Yes

Scenario 1 - FFS

NQTL: Network Provider Admission (IP, OP, EC & PD)	**Evidence used for comparison:** Data Request from Department; Consultation with Department staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: Network provider admission standards are in place to ensure providers meet a standard set of criteria and are known to Department prior to billing for Medicaid services.

Process:

The Fee-For-Service Medicaid provider enrollment process uses a validation process based on federal requirements (i.e. practitioner must be licensed to enroll, etc.) for all providers that includes revalidation at least every 5 years.

Finding:
There is no notable difference between network admission requirements for fee-for-service MH/SUD and M/S providers. It is best practice and federal regulations require the Medicaid program to have processes for admitting providers into their network.

Scenario 2 – RAE 1 and Rocky Mountain Health Plan Prime MCO

NQTL: Network Provider Admission (IP, OP, EC & PD)	Evidence used for comparison:
Complies with Parity Requirements: Yes Differences noted between M/S and MH/SUD services: No	Data Request from RMHP Interview with RMHP staff

Goals and Rationale: Network provider admission standards are in place to ensure providers meet a standard set of criteria and are known to RMHP prior to billing for Medicaid services. In establishing and maintaining our network of providers, RMHP endeavors to provide care within a reasonable travel time and distance to Members.

Rocky Mountain Health Plans (RMHP) has a network that is supported by written agreements and is sufficient to meet the requirements for every Member's access to care to:

- Serve all primary care and care coordination needs;
- Serve all behavioral health needs; and
- Allow for adequate Member choice among providers.

Process:

RMHP accepts any willing provider who meets their credentialing and quality standards and is willing to accept and negotiate reasonable reimbursement for services. Out of network providers are neither credentialed or admitted to the network.

Finding:
There is no notable difference between the RMHP network admission requirements for MH/SUD providers and those for Rocky Mountain Health Plans Prime MCO for M/S providers. It is best practice and federal regulations require that the MCEs have processes for admitting providers into their networks.

Scenario 3 – RAE 1 and FFS

NQTL: Network Provider Admission (IP, OP, & EC)	Evidence used for comparison:
Complies with Parity Requirements: Yes Differences noted between M/S and MH/SUD services: No	Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff RMHP RAE and PRIME Network Adequacy Plan SFY 2020-21

Goals and Rationale: Network provider admission standards are in place to ensure providers meet a standard set of criteria and are known to RMHP prior to billing for Medicaid services. In establishing and maintaining our network of providers, RMHP endeavors to provide care within a reasonable travel time and distance to Members.

Rocky Mountain Health Plans (RMHP) has a network that is supported by written agreements and is sufficient to meet the requirements for every Member's access to care to:

- Serve all primary care and care coordination needs;
- Serve all behavioral health needs; and
- Allow for adequate Member choice among providers.

Process:

MH/SUD:
RMHP accepts any willing Medicaid enrolled provider who meets their credentialing and quality standards and is willing to accept and negotiate reasonable reimbursement for services. Credentialing occurs every 3 years. Out of network providers are neither credentialed or admitted to the network.

M/S:
The Fee-For-Service M/S Medicaid provider enrollment process uses a validation process based on federal requirements (i.e. practitioner must be licensed to enroll, etc.) for all providers that includes revalidation at least every 5 years.

Finding:
There is no notable difference between the RMHP network admission requirements for MH/SUD providers in the RAE and those for the Department for M/S fee-for-service providers. While the processes may differ in some ways, it is best practice and federal regulations require both the Medicaid program and MCEs to have processes for admitting providers into their networks.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Network Provider Admission (IP, OP, & EC)	**Evidence used for comparison:** Data Request from Northeast Health Partners, Health Colorado, and Beacon Health Options Beacon Policy: N_CR206.13 Primary Source Verification Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: Network provider admission standards are in place to ensure providers meet a standard set of criteria and are known to Northeast Health Partners, Health Colorado, and Beacon Health Options prior to billing for Medicaid services.

Process:

MH/SUD:
All providers must possess up-to-date credentials and be approved through the Department's provider revalidation process to provide any MH/SUD Inpatient or Outpatient services. A supplementary credentialing process is performed by the RAE. Beacon Health Options, as the delegate for Northeast Health Partners and Health Colorado, accepts any willing provider who meets their credential standards and is willing to accept and negotiate reasonable reimbursement for services.

M/S:
The Fee-For-Service M/S Medicaid provider enrollment process uses a validation process based on federal requirements (i.e. practitioner must be licensed to enroll, etc.) for all providers that includes revalidation at least every 5 years.

Finding:
There is no notable difference between the Northeast Health Partners, Health Colorado, and Beacon Health Options network admission requirements for MH/SUD providers in the RAE and those for the Department for M/S fee-for-service providers. While the processes may differ in some ways, it is best practice and federal regulations require both the Medicaid program and MCEs to have processes for admitting providers into their networks.

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Network Provider Admission (IP, OP, & EC)	Evidence used for comparison:
Complies with Parity Requirements: Yes Differences noted between M/S and MH/SUD services: No	Data Request from Colorado Access Interview with Colorado Access staff Colorado Access Provider Credentialing and Recredentialing - CR301 Colorado Access Becoming a Provider FAQs

Goals and Rationale: Network provider admission standards are in place to ensure providers meet a standard set of criteria and are known to Colorado Access prior to billing for Medicaid services.

Process:

MH/SUD:
Colorado Access accepts any willing provider who meets their credential standards and is willing to accept and negotiate reasonable reimbursement for services. Providers are required to validate with the state of Colorado to participate in their network. COA follows NCQA Credentialing Standards, and providers that serve members in the inpatient and emergency setting are not in the scope of credentialing.

M/S:
The Fee-For-Service M/S Medicaid provider enrollment process uses a validation process based on federal requirements (i.e. practitioner must be licensed to enroll, etc.) for all providers that includes revalidation at least every 5 years.

Finding:
There is no notable difference between the Colorado Access network admission requirements for MH/SUD providers in the RAE and those for the Department for M/S fee-for-service providers. While the processes may differ in some ways, it is best practice and federal regulations require both the Medicaid program and MCEs to have processes for admitting providers into their networks.

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Network Provider Admission (IP, OP, & EC)	Evidence used for comparison: Data Request from CCHA; Interview with CCHA staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: Network provider admission standards are in place to ensure providers meet a standard set of criteria and are known to CCHA prior to billing for Medicaid services. CCHA's stated purpose is to establish a standard set of measures for determining overall provider accessibility that is sufficient in number, geographic distribution and types of providers to ensure that all covered services, including an appropriate range of preventative, primary care and behavioral health services, are accessible to meet the needs of enrollment.

Process:

MH/SUD:
CCHA accepts any willing provider who meets their credential standards and is willing to accept and negotiate reasonable reimbursement for services. Per contract, CCHA submits documentation to the Department demonstrating compliance with network adequacy, including an annual Network Adequacy Plan, and quarterly Network Report.

M/S:
The Fee-For-Service M/S Medicaid provider enrollment process uses a validation process based on federal requirements (i.e. practitioner must be licensed to enroll, etc.) for all providers that includes revalidation at least every 5 years.

Findings:
There is no notable difference between the CCHA network admission requirements for MH/SUD providers in the RAE and those for the Department for M/S fee-for-service providers. While the processes may differ in some ways, it is best practice and federal regulations require both the Medicaid program and MCEs to have processes for admitting providers into their networks.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Network Provider Admission (IP, OP, EC & PD)	Evidence used for comparison: Data Request from Denver Health; Interview with Denver Health staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: Network provider admission standards are in place to ensure providers meet a standard set of criteria and are known to Denver Health prior to billing for Medicaid services.
Denver Health MCO subcontracts out the operation of the its MH/SUD PIHP to Colorado Access. Denver Health MCO manages the M/S benefit.

Process:
Colorado Access accepts any willing provider who meets their credential standards and is willing to accept and negotiate reasonable reimbursement for services. Providers are required to validate with the state of Colorado to participate in their network. COA follows NCQA Credentialing Standards, and providers that serve members in the inpatient and emergency setting are not in the scope of credentialing.

Finding:
There is no notable difference between the Colorado Access network admission requirements for MH/SUD providers in the RAE and those for Denver Health for M/S managed care providers. It is best practice and federal regulations require that the MCEs have processes for admitting providers into their networks.

Appendix L - Establishing Charges/Reimbursement Rates

Description: The process by which a health plan establishes charges/reimbursement rates of payment for participant services rendered by providers

Tools for Analysis: Review of charge establishment standards to ensure timely access to care and sufficient network adequacy. Alignment of charges based on provider type and specialty

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP, EC, PD	Yes – Different processes for MH/SUD and M/S	Yes
Scenario 2	RMHP & Prime MCO	IP, OP, EC, PD	No	Yes
Scenario 3				
	RAE 1	IP, OP, EC	No	Yes
	RAE 2 & 4	IP, OP, EC	No	Yes
	RAE 3 & 5	IP, OP, EC	No	Yes
	RAE 6 & 7	IP, OP, EC	No	Yes
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	No	Yes

Scenario 1 - FFS

NQTL: Establishing Charge/ Reimbursement Rates (IP)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **Yes.** Different processes for M/S and MH/SUD	Data Request from Department Consultation with Department staff

Goals and Rationale: The process used to establish charges/reimbursement rates of payment for participant services should be industry standard and attract an adequate network of providers.

Process:

MH/SUD
The Department uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations and capital overhead expense expectations.

M/S
The Department uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted. Each hospital has a base rate

calculated from their Medicare base rates. The average cost of service at a hospital is multiplied by other factors.

Finding:
Though the processes are different, both processes are industry standard and substantially similar in their application.

NQTL: Establishing Charge/ Reimbursement Rates (OP)	**Evidence used for comparison:** Data Request from Department; Consultation with Department staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: The process used to establish charges/reimbursement rates of payment for participant services should be industry standard and attract an adequate network of providers.

Process:

For MH/SUD and M/S services, the Department uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations.

Finding:
The rate setting process for MH/SUD and M/S services is identical.

NQTL: Establishing Charge/ Reimbursement Rates (EC)	**Evidence used for comparison:** Data Request from Department; Consultation with Department staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: The process used to establish charges/reimbursement rates of payment for participant services should be industry standard and attract an adequate network of providers.

Process:

For MH/SUD and M/S services, the Department uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted.

Each hospital has a base rate calculated from their Medicare base rates. The average cost of service at a hospital is multiplied by other factors.

Finding:
The rate setting process for MH/SUD and M/S services is identical.

NQTL: Establishing Charge/ Reimbursement Rates (PD)	**Evidence used for comparison:** Data Request from Department; Consultation with Department staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: The process used to establish charges/reimbursement rates of payment for participant services should be industry standard and attract an adequate network of providers.

Process:

For MH/SUD and M/S prescribed pharmaceuticals, the Department bases the payment on an average acquisition cost with a multiplier. If the average acquisition cost is unavailable, the Department uses the average wholesale cost with a multiplier.

For MH/SUD and M/S physician administered pharmaceuticals, the rate is based off Medicare data. Fees are updated quarterly. If data is not available, the Department uses the Medicare Average Sales Price (ASP) minus 4.5%.

Finding:
The processes for MH/SUD service rate setting are comparable, follow industry standard practices and no more stringent than those used for M/S and therefore comply with parity requirements.

Scenario 2 – RAE 1 and Rocky Mountain Health Plan Prime MCO

NQTL: Establishing Charge/ Reimbursement Rates (IP, OP, EC, & PD)	**Evidence used for comparison:** Data Request from RMHP; Interview with RMHP staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: The process used to establish charges/reimbursement rates of payment for participant services should be industry standard and attract an adequate network of providers.

Process:

MH/SUD and M/S:
For inpatient, outpatient, and emergency care services, RMHP determines Usual and Customary and or Reasonable Charges on the basis of Provider Type and credentials for the scope of care that they are licensed to provide. Additionally, RMHP determines Usual and Customary charges and or Reasonable charges on the basis of practice location or region within the State.

For prescription drug services, RMHP uses lesser of three logic to determine the price. Members are charged the lesser of AWP/MAC price, copay, or usual and customary (U/C) price. Copays are based on the tier structure of the benefit while the price reimbursed to the pharmacy is negotiated by the PBM.

Finding:
The process used by RMHP for MH/SUD services is industry standard, comparable and no more stringent than that used for MCO M/S services and is therefore compliant with parity requirements.

Scenario 3 – RAE 1 and FFS

NQTL: Establishing Charge/ Reimbursement Rates (IP, OP, & EC)	**Evidence used for comparison:** Data Request from RMHP Interview with RMHP staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: The process used to establish charges/reimbursement rates of payment for participant services should be industry standard and attract an adequate network of providers.

Process:

MH/SUD:
RMHP may determine Usual and Customary and or Reasonable Charges on the basis of Provider Type and credentials for the scope of care that they are licensed to provide. Additionally, RMHP may determine Usual and Customary charges and or Reasonable Charges on the basis of practice location or region within the State. Rates are based upon State fee schedules and/or rates received from the State. RMHP uses its network adequacy monitoring process to ensure that the rates do not compromise access for its members and make adjustments based on need expressed through the network reporting.

M/S:
For inpatient and emergency care services, the Department uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted. Each hospital has a base rate calculated from their Medicare base rates. The

average cost of service at a hospital is multiplied by other factors. For outpatient services, the Department uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations and capital overhead expense expectations.

Finding:
The process used by RMHP is industry standard, comparable and no more stringent than that used by the Department for FFS M/S services and is therefore compliant with parity requirements.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Establishing Charge/ Reimbursement Rates (IP, OP, & EC)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes	Data Request from Northeast Health Partners
Differences noted between M/S and MH/SUD services:	Data Request from Health Colorado
No	Beacon Policy: PRCO_003_Network Development and Access Standards
	Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options

Goals and Rationale: The process used to establish charges/reimbursement rates of payment for participant services should be industry standard and attract an adequate network of providers.

Process:

MH/SUD
Beacon, as designee for NHP and HCI, uses the "usual and customary or reasonable charges" standard for its rate setting process. The rate structure also substantially follows rates established by the Department for fee-for service behavioral health services. Beacon regularly reviews current provider fee schedules to align with the RAE market and any future recruitment strategies. Discussion of rates and incentives are frequent in the most recent Network Adequacy Report. Beacon Health Options is tying the rates to the ability to recruit and retain the network needed to meet the requirements established by the Department. Beacon has made adjustments to rates in regions where recruitment or access is more challenging.

M/S
For inpatient and emergency care services, the Department uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted. Each hospital has a base rate calculated from their Medicare base rates. The average cost of service at a hospital is multiplied by other factors. For outpatient services, the Department uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations and capital overhead expense expectations.

Finding:

The process used by Northeast Health Partners and Health Colorado is industry standard, comparable and no more stringent than that used by the Department for FFS M/S services and is therefore compliant with parity requirements.

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Establishing Charge/ Reimbursement Rates (IP, OP, & EC)	**Evidence used for comparison:** Data Request from Colorado Access Interview with Colorado Access
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: The process used to establish charges/reimbursement rates of payment for participant services should be industry standard and attract an adequate network of providers.

Process:

MH/SUD
Colorado Access has a standard rate guide that dictates base rates for all network and out-of-network providers. These rates are offered and negotiated to all providers. All CMHCs are reimbursed based on their current Unit Cost Reports, as directed by the Department. Rates are automatically updated annually when CMS and Colorado Medicaid update. Updates were made in 2020/2021 for Community Mental Health Centers.

MH rates differ from SUD rates due to rates for SUD established in part by the Department; and room and board are excluded for SUD.

M/S
For inpatient and emergency care services, the Department uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted. Each hospital has a base rate calculated from their Medicare base rates. The average cost of service at a hospital is multiplied by other factors. For outpatient services, the Department uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations and capital overhead expense expectations.

Finding:
The process used by Colorado Access is industry standard, comparable and no more stringent than that used by the Department for fee-for-service M/S services and is therefore compliant with parity requirements.

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Establishing Charge/ Reimbursement Rates (IP, OP, & EC)	Evidence used for comparison:
Complies with Parity Requirements: Yes Differences noted between M/S and MH/SUD services: No	Data Request from CCHA Interview with CCHA staff

Goals and Rationale: Colorado Community Health Alliance's goal is to establish charges/reimbursement rates of payment for participant services that attract an adequate network of providers.

Process:

MH/SUD
CCHA has an internal process for establishing charges for services. Charges are updated when necessary due to per diem and DRG updates. The rationale for determining these charges includes past and present market costs, as well as the Medicaid fee schedule. The plan uses Colorado's Medicaid Fee-For-Service (FFS) rate schedule to determine how much it will charge for services. The plan considers Colorado's Relative Value Units (RVU) table when establishing charges for CMHPs.

M/S
For inpatient and emergency care services, the Department uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted. Each hospital has a base rate calculated from their Medicare base rates. The average cost of service at a hospital is multiplied by other factors. For outpatient services, the Department uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations and capital overhead expense expectations.

Finding: CCHA follows a process that is industry standard and comparable to the process used by the Department and is applied no more stringently so it is compliant with parity requirements.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Establishing Charge/ Reimbursement Rates (IP, OP, EC and PD)	Evidence used for comparison:
Complies with Parity Requirements: Yes Differences noted between M/S and MH/SUD services: No	Data Request from Denver Health Interview with Denver Health staff

Goals and Rationale: The process used to establish charges/reimbursement rates of payment for participant services should be industry standard and attract an adequate network of providers.

Denver Health MCO subcontracts out the operation of the its MH/SUD PIHP to Colorado Access.

Process:

MH/SUD
Colorado Access has a standard rate guide that dictates base rates for all network and out-of-network providers. These rates are offered and negotiated to all providers. All CMHCs are reimbursed based on their current Unit Cost Reports, as directed by the Department. Rates are automatically updated annually when CMS and Colorado Medicaid update. Updates were made in 2020/2021 for Community Mental Health Centers.

MH rates differ from SUD rates due to rates for SUD established in part by the Department; and room and board are excluded for SUD.

M/S
When working with contracted network providers and potential one-time agreement providers, DHMP negotiates rates with each entity and always begins with adhering to rates listed in the Medicaid Fee Schedule. DHMP's largest provider is the DHHA system, whom DHMP pays a per member per month capitation for.

Finding:
The process used by Colorado Access for MH/SUD is industry standard, comparable and applied no more stringently than the process used by Denver Health for M/S for setting its rates and is compliant with parity requirements.

Appendix M - Restrictions Based on Geographic Location, Facility Type, Provider Specialty

Description: Health plan policies on recruitment, credentialing, and enrollment of network providers to include any exclusionary criteria.

Tools for Analysis: Review an analysis of provider network selection criteria for network admission. Process and procedure for credentialing and recredentialing of MH/SUD and M/S providers. Provider appeals process. Utilization of national accrediting standards.

Analysis: No health plans currently place restrictions based on geographic location, facility type, or provider specialty. Some plans utilized unclear language, which was identified in the 2020 MHPAEA report. In response, all plans reviewed their policies and procedures and updated where necessary to ensure clarity.

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined

Appendix N - Network Adequacy Determination

Description: The health plan's policy and protocols for determining the sufficiency of the provider network to substantiate participant needs, timely access to care, provider diversity, and compliance with applicable regulations and contract standards.

Tools for Analysis: Review of provider adequacy policies to include timely access to care as well as target provider counts and diversity. Frequency of adequacy reviews and reports to Department.

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP, EC, PD	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP, EC, PD	No	Yes
Scenario 3				
	RAE 1	IP, OP, EC, PD	No	Yes
	RAE 2 & 4	IP, OP, EC, PD	No	Yes
	RAE 3 & 5	IP, OP, EC, PD	No	Yes
	RAE 6 & 7	IP, OP, EC, PD	No	Yes
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	No	Yes

Scenario 1 – FFS

NQTL: Network Adequacy Determination (IP, OP, EC & PD)	Evidence used for comparison: Data Request from Department
Complies with Parity Requirements: Yes Differences noted between M/S and MH/SUD services: No	

Goals and Rationale: The Department is responsible for maintaining network adequacy to substantiate participant needs, ensure timely access to care, diversity of providers and compliance with applicable regulations and contract standards.

Process:
MH/SUD and M/S:
The Department maintains policies and reporting for provider adequacy using the "any willing provider" standard and that apply the same to MH/SUD and M/S providers. Reporting is required at least quarterly.

Finding:
The process is identical for MH/SUD and M/S providers in all benefit categories, therefore they meet parity requirements.

Scenario 2 – RAE 1 and Rocky Mountain Health Plans

NQTL: Network Adequacy Determination (IP, OP, EC & PD)	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with RMHP staff RMHP Network Adequacy Plan FY20-21 RMHP FY 20-21 Q1 Report
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: RMHP is responsible for maintaining network adequacy to substantiate participant needs, ensure timely access to care, diversity of providers and compliance with applicable regulations and contract standards. Their stated goals are to provide a provider network that meets the care needs of members and to provide as wide access as needed to ensure Members can easily fill their prescriptions with enough oversight to prevent potential fraud.

Process:
RMHP contracts with all willing inpatient facilities and regularly measure adequacy against State benchmarks. RMHP uses the same process for maintaining network adequacy for RAE MH/SUD benefits and PRIME MCO M/S benefits. Quarterly Network Analysis reports are submitted quarterly for both RAE and Prime.
According to the contract between the Department and RMHP, a network adequacy plan along with supporting documents is required to be submitted annually and shall reflect current and future network planning and will include at a minimum:

- A description of how the Provider Network will be maintained, monitored, and incentivized to provide adequate access to quality services for all Members
- Physical accessibility characteristics of the Provider Network
- Number of network Providers by Provider type and area(s) of expertise
- Number of network Providers accepting new Medicaid Members by provider type
- Geographic location of providers in relationship to where Medicaid Members live
- Cultural and language expertise of providers
- Number of providers offering after-hours and weekend appointment availability to Medicaid members
- Standards that will be used to determine the appropriate caseload for providers and how this will be continually monitored and reported to the department to ensure standards are being met and maintained across the Contractor's Provider Network
- Caseload for Behavioral Health Providers
- Number of Behavioral Health Providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region
- A description of how RMHP's network of providers and other community resources meet the needs of the member population in the Contractor's Region, specifically including a description of how Members in special populations are able to access care.

Finding:
RMHP applies the same industry standard process to maintain network adequacy for RAE MH/SUD benefits and Prime MCO M/S benefits, therefore they meet parity requirements.

Scenario 3 – RAE 1 and FFS

NQTL: Network Adequacy Determination (IP, OP, EC & PD)	Evidence used for comparison:
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from RMHP Interview with RMHP staff RMHP Network Adequacy Plan FY20-21 RMHP FY 20-21 Q1 Report

Goals and Rationale: RMHP is responsible for maintaining network adequacy to substantiate participant needs, ensure timely access to care, diversity of providers and compliance with applicable regulations and contract standards. Their stated goals are to provide a provider network that meets the care needs of members and to provide as wide access as needed to ensure Members can easily fill their prescriptions with enough oversight to prevent potential fraud.

Process:

MH/SUD:
RMHP contracts with all willing inpatient facilities and regularly measure adequacy against State benchmarks. The process for maintaining network adequacy for MH/SUD services is similar to the process the Department uses to maintain network adequacy for M/S services. According to the contract between the Department and RMHP, a network adequacy plan along with supporting documents is required to be submitted annually and shall reflect current and future network planning and will include at a minimum:

- A description of how the Provider Network will be maintained, monitored, and incentivized to provide adequate access to quality services for all Members
- Physical accessibility characteristics of the Provider Network
- Number of network Providers by Provider type and area(s) of expertise
- Number of network Providers accepting new Medicaid Members by provider type
- Geographic location of providers in relationship to where Medicaid Members live
- Cultural and language expertise of providers
- Number of providers offering after-hours and weekend appointment availability to Medicaid members
- Standards that will be used to determine the appropriate caseload for providers and how this will be continually monitored and reported to the department to ensure standards are being met and maintained across the Contractor's Provider Network
- Caseload for Behavioral Health Providers
- Number of Behavioral Health Providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region
- A description of how RMHP's network of providers and other community resources meet the needs of the member population in the Contractor's Region, specifically including a description of how Members in special populations are able to access care.

M/S:

The Department maintains policies and reporting for provider adequacy for M/S providers. Reporting is required at least quarterly.

Findings:
RMHP's process for maintaining network adequacy is industry standard and is the same process that the Department uses, therefore they meet parity requirements.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Network Adequacy Determination (IP, OP, EC & PD)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Northeast Health Partners, Health Colorado, and Beacon Health Options Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options Beacon Policy: PRCO_003_Network Development and Access Standards R2 Network Adequacy Plan R4 Network Adequacy Plan

Goals and Rationale: Beacon Health Options is responsible for maintaining Northeast Health Partners and Health Colorado's network adequacy to substantiate participant needs, ensure timely access to care, diversity of providers and compliance with applicable regulations and contract standards. Beacon's stated purpose is to provide guidance to ensure network adequacy for the regional organization by closely monitoring development and access of the Health First Colorado provider network in the region and add providers based on overall network density and membership needs.

Process:
The process Beacon Health Options follows for maintaining network adequacy for MH/SUD services is similar to the process the Department uses to maintain network adequacy for M/S services. According to the contract between the Department and both Northeast Health Partners and Health Colorado, a network adequacy plan along with supporting documents is required to be submitted annually and shall reflect current and future network planning and will include at a minimum:

- A description of how the Provider Network will be maintained, monitored, and incentivized to provide adequate access to quality services for all Members
- Physical accessibility characteristics of the Provider Network
- Number of network Providers by Provider type and area(s) of expertise
- Number of network Providers accepting new Medicaid Members by provider type
- Geographic location of providers in relationship to where Medicaid Members live
- Cultural and language expertise of providers
- Number of providers offering after-hours and weekend appointment availability to Medicaid members
- Standards that will be used to determine the appropriate caseload for providers and how this will be continually monitored and reported to the department to ensure standards are being met and maintained across the Contractor's Provider Network

- Caseload for Behavioral Health Providers
- Number of Behavioral Health Providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region
- A description of how RMHP's network of providers and other community resources meet the needs of the member population in the Contractor's Region, specifically including a description of how Members in special populations are able to access care.

Quarterly reporting to the Department by each RAE is also required.

M/S:
The Department maintains policies and reporting for provider adequacy for M/S providers. Reporting is required at least quarterly.

Finding:
Northeast Health Partners, Health Colorado and Beacon Health Options use industry standard processes and standards to maintain an adequate network for MH/SUD benefits. Their process is similar to the process used by the Department for M/S benefits, and they apply those processes no more stringently. Therefore, they meet parity requirements.

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Network Adequacy Determination (IP, OP, EC & PD)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Colorado Access Interview with Colorado Access staff COA R3 Network Adequacy Plan FY20-21 COA R5 Network Adequacy Plan FY20-21

Goals and Rationale: Colorado Access is responsible for maintaining network adequacy to substantiate participant needs, ensure timely access to care, diversity of providers and compliance with applicable regulations and contract standards.

Process:

MH/SUD:
The process Colorado Access follows for maintaining network adequacy for MH/SUD services is similar to the process the Department uses to maintain network adequacy for M/S services. According to the contract between the Department and Colorado Access, a network adequacy plan along with supporting documents is required to be submitted annually and shall reflect current and future network planning and will include at a minimum:

- A description of how the Provider Network will be maintained, monitored, and incentivized to provide adequate access to quality services for all Members
- Physical accessibility characteristics of the Provider Network
- Number of network Providers by Provider type and area(s) of expertise
- Number of network Providers accepting new Medicaid Members by provider type

- Geographic location of providers in relationship to where Medicaid Members live
- Cultural and language expertise of providers
- Number of providers offering after-hours and weekend appointment availability to Medicaid members
- Standards that will be used to determine the appropriate caseload for providers and how this will be continually monitored and reported to the department to ensure standards are being met and maintained across the Contractor's Provider Network
- Caseload for Behavioral Health Providers
- Number of Behavioral Health Providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region
- A description of how Colorado Access's network of providers and other community resources meet the needs of the member population in the Contractor's Region, specifically including a description of how Members in special populations are able to access care.

Quarterly reporting to the Department is also required.

M/S:
The process for maintaining network adequacy for MH/SUD services is similar to the process the Department uses to maintain network adequacy for M/S services. The Department maintains policies and reporting for provider adequacy for M/S providers. Reporting is required at least quarterly.

Finding:
Colorado Access uses industry standard processes to ensure network adequacy for MH/SUD benefits in a similar and no more stringent manner than the processes used by the Department for M/S benefits, therefore they meet parity requirements.

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Network Adequacy Determination (IP, OP, EC & PD)	**Evidence used for comparison:** Data Request from CCHA Interview with CCHA staff R6 Network Adequacy Plan FY 20-21 R6 FY 20-21 Q1 Report R7 Network Adequacy Plan FY 20-21 R7 FY 20-21 Q1 Report
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	

Goals and Rationale: Colorado Community Health Alliance is responsible for maintaining network adequacy to substantiate participant needs, ensure timely access to care, diversity of providers and compliance with applicable regulations and contract standards.

Process:

The process for maintaining network adequacy for MH/SUD services is similar to the process the Department uses to maintain network adequacy for M/S services. According to the

contract between the Department and CCHA, a network adequacy plan along with supporting documents is required to be submitted annually and shall reflect current and future network planning and will include at a minimum:

- A description of how the Provider Network will be maintained, monitored, and incentivized to provide adequate access to quality services for all Members
- Physical accessibility characteristics of the Provider Network
- Number of network Providers by Provider type and area(s) of expertise
- Number of network Providers accepting new Medicaid Members by provider type
- Geographic location of providers in relationship to where Medicaid Members live
- Cultural and language expertise of providers
- Number of providers offering after-hours and weekend appointment availability to Medicaid members
- Standards that will be used to determine the appropriate caseload for providers and how this will be continually monitored and reported to the department to ensure standards are being met and maintained across the Contractor's Provider Network
- Caseload for Behavioral Health Providers
- Number of Behavioral Health Providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region
- A description of how RMHP's network of providers and other community resources meet the needs of the member population in the Contractor's Region, specifically including a description of how Members in special populations are able to access care.

Quarterly network adequacy reviews are also required to be submitted to the Department.

M/S:
The Department maintains policies and reporting for provider adequacy for M/S providers. Reporting is required at least quarterly.

Finding:
CCHA uses an industry standard process for maintaining network adequacy for MH/SUD benefits and it is very similar to the process used by the Department for M/S, therefore they are compliant with parity requirements.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Network Adequacy Determination (IP, OP, EC & PD)	**Evidence used for comparison:** Data Request from Denver Health Interview with Denver Health Interview with Colorado Access
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	
Goals and Rationale: Denver Health is responsible for maintaining network adequacy to substantiate participant needs, ensure timely access to care, diversity of providers and compliance with applicable regulations and contract standards.	

Denver Health MCO subcontracts out the operation of the its MH/SUD PIHP to Colorado Access.

Process:

MH/SUD
Denver Health contracts its behavioral health network adequacy responsibilities to Colorado Access. The process for maintaining network adequacy for MH/SUD services is similar to the process Denver Health uses to maintain network adequacy for M/S services. According to the contract between the Department and Denver Health a network adequacy plan along with supporting documents is required to be submitted annually and shall reflect current and future network planning and will include at a minimum:

- A description of how the Provider Network will be maintained, monitored, and incentivized to provide adequate access to quality services for all Members
- Physical accessibility characteristics of the Provider Network
- Number of network Providers by Provider type and area(s) of expertise
- Number of network Providers accepting new Medicaid Members by provider type
- Geographic location of providers in relationship to where Medicaid Members live
- Cultural and language expertise of providers
- Number of providers offering after-hours and weekend appointment availability to Medicaid members
- Standards that will be used to determine the appropriate caseload for providers and how this will be continually monitored and reported to the department to ensure standards are being met and maintained across the Contractor's Provider Network
- Caseload for Behavioral Health Providers
- Number of Behavioral Health Providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region
- A description of how RMHP's network of providers and other community resources meet the needs of the member population in the Contractor's Region, specifically including a description of how Members in special populations are able to access care.

Quarterly reporting to the Department is also required.

M/S
Denver Health maintains policies and reporting for provider adequacy for M/S providers. Reporting is required at least quarterly.

Finding:
The processes for M/S and MH/SUD are very similar and industry standard for maintaining network adequacy, therefore they are compliant with parity requirements.

Appendix O - Out-of-Network Provider Access Standards

Description: Policies and protocols that health plans utilize to ensure participant timely access and medically necessary care, where unavailable through in-network providers

Tools for Analysis: Review of out-of-network provider policies and procedures to include timely access to medically necessary services. Utilization and frequency of single case agreements

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP, EC	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP, EC, PD	No	Yes
Scenario 3				
	RAE 1	IP, OP, EC	No	Yes
	RAE 2 & 4	IP, OP, EC	No	Yes
	RAE 3 & 5	IP, OP, EC	No	Yes
	RAE 6 & 7	IP, OP, EC	No	Yes
Scenario 4	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	No	Yes

Scenario 1 – FFS

NQTL: Out-of-Network Provider Access Standards (IP, OP, & EC)	**Evidence used for comparison:** Data Request from Department Consultation with Department staff
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	
Goals and Rationale: These policies and protocols ensure members timely access and medically necessary care, where unavailable through in-network providers. **Process:** The Department requires providers to enroll with Health First Colorado and meet all enrollment requirements for their specific provider type prior to billing for services. **Finding:** This policy and approach apply to both MH/SUD and M/S benefits in the same manner.	

Scenario 2 – RAE 1 and Rocky Mountain Health Plans

NQTL: Out-of-Network Provider Access Standards (IP, OP, EC & PD)	**Evidence used for comparison:**

Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from RMHP Interview with RMHP staff RMHP Website Provider FAQs RMHP Provider Manual

Goals and Rationale: These policies and protocols ensure members timely access and medically necessary care, where unavailable through in-network providers.

Process:

MH/SUD:
From the Provider Manual, under Member Choice of Providers, RMHP states:
Members and families can choose any RMHP Provider who is licensed, credentialed and enrolled with the Colorado Department of Health Care Policy and Financing for the necessary service(s). A Member may request that a provider be considered to join the relevant RAE. In cases of a Member already in treatment with a provider at the time the Member obtains RMHP eligibility, for the purpose of continuity of care, the Member's provider may request a Single Case Agreement and treatment may be continued. In cases involving special needs, RMHP may offer a Single Case Agreement to any other provider meeting the specialty or cultural requirement and who meets our credentialing and quality criteria. Under certain circumstances Members may request an out-of-network provider. These circumstances may include:

1. The service or type of provider the Member needs is not available in our network.
2. The network provider refuses to provide the treatment requested by the Member on moral or religious grounds.
3. The Member's primary provider determines that going to a network provider would pose a risk to the Member.
4. The Member has personal or social contact with the available network provider(s) that would make it inappropriate to pursue a treatment relationship.
5. The State determines that other circumstances warrant out-of-network treatment.

Emergent care is allowed out of network for all services.

M/S:
Per the member manual for Rocky Prime, "most services out of RMHP's network" require prior authorization. The member is also told under "Hospital Care" that "If you need care at a hospital, but it is not an emergency, you must go to an in-network hospital."

Finding:
The requirements to receive prior approval to access MH/SUD services out-of-network is substantially similar to the requirements for M/S services.

Scenario 3 – RAE 1 and FFS

NQTL: Out-of-Network Provider Access Standards (IP, OP, & EC)	**Evidence used for comparison:**

Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from RMHP Interview with RMHP staff RMHP Website Provider FAQs RMHP Provider Manual

Goals and Rationale: These policies and protocols ensure members timely access and medically necessary care, where unavailable through in-network providers.

Process:

MH/SUD:
From the Provider Manual, under Member Choice of Providers, RMHP states:
Members and families can choose any RMHP Provider who is licensed, credentialed and enrolled with the Colorado Department of Health Care Policy and Financing for the necessary service(s). A Member may request that a provider be considered to join the relevant RAE. In cases of a Member already in treatment with a provider at the time the Member obtains RMHP eligibility, for the purpose of continuity of care, the Member's provider may request a Single Case Agreement and treatment may be continued. In cases involving special needs, RMHP may offer a Single Case Agreement to any other provider meeting the specialty or cultural requirement and who meets our credentialing and quality criteria. Under certain circumstances Members may request an out-of-network provider. These circumstances may include:

1. The service or type of provider the Member needs is not available in our network.
2. The network provider refuses to provide the treatment requested by the Member on moral or religious grounds.
3. The Member's primary provider determines that going to a network provider would pose a risk to the Member.
4. The Member has personal or social contact with the available network provider(s) that would make it inappropriate to pursue a treatment relationship.
5. The State determines that other circumstances warrant out-of-network treatment.

Emergent care is allowed out of network for all services.

M/S:
The Department requires providers to enroll as providers for fee-for-service providers prior to billing for services.

Finding:
Both the Department for M/S and the RAE for MH/SUD require providers to enroll in-network or secure a Single Case Agreement prior to billing for services, so the requirements and processes appear substantially similar.

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Out-of-Network Provider Access Standards (IP, OP, & EC)	**Evidence used for comparison:**

Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Northeast Health Partners Data Request from Health Colorado Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options Beacon Policy: 274L – Request for Out of Network Provider

Goals and Rationale: These policies and protocols ensure members timely access and medically necessary care, where unavailable through in-network providers.

Process:

MH/SUD
Prior authorization is required for MH/SUD for out-of-network providers. Inpatient and outpatient 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.

Northeast Health Partners and Health Colorado delegate this function to Beacon Health Options. Beacon has a policy and procedure specific for the RAE to process requests for covered services through an out of network provider in a timely manner (see 274L_Request for Out of Network Provider). This policy details the approval process and situations for which Single Case Agreements are approved for covered services by an out-of-network provider. In the member handbook, members are informed that they can ask to see a provider who may not be listed in the provider directory (see Health First Colorado Member Handbook). Providers are sent an individual contract (SCA_Letter_Practitioner and SCA_Letter _Facilities). The SCA letters reference the provider handbook that informs providers that they may not bill members for any services covered by Medicaid.

The policy gives provision for both a Medicaid recipient and an out-of-network provider may make the request for service.

No authorization is required for emergency services.

M/S
The Department requires providers to enroll as providers for fee-for-service providers prior to billing for services.

Finding:
Both the Department for M/S and the RAE for MH/SUD require providers to enroll in-network or secure a Single Case Agreement prior to billing for services, so the requirements and processes appear substantially similar.

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Out-of-Network Provider Access Standards (IP, OP, & EC)	Evidence used for comparison:

Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Data Request from Colorado Access Interview with Colorado Access staff COA Provider Manual. Utilization Management Section. CCS309 Emergency and Post-Stabilization Services
Goals and Rationale: These policies and protocols ensure members timely access and medically necessary care, where unavailable through in-network providers. COA allows for out-of-network utilization where clinically appropriate but aims to use network providers whenever possible in order to contain costs and assure the quality of services rendered. **Process:** **MH/SUD:** COA requires prior authorization for all services rendered with an out-of-network provider. If the COA is unable to accommodate the request for services with a network provider (e.g., due to geography, provider specialty, or continuity of care), then the services are authorized for the out-of-network provider. This is consistent with industry standards. COA covers **emergency services** without prior authorization, regardless of whether the services are obtained within or outside COA's provider network. **M/S:** The Department requires providers to enroll as providers for fee-for-service providers prior to billing for services. **Finding:** Both the Department for M/S and the RAE for MH/SUD require providers to enroll in-network or secure a Single Case Agreement prior to billing for services, so the requirements and processes appear substantially similar.	

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Out-of-Network Provider Access Standards (IP, OP, & EC)	**Evidence used for comparison:** Data Request from CCHA
Complies with Parity Requirements: Yes **Differences noted between M/S and MH/SUD services:** **No**	Interview with CCHA staff Provider Network Adequacy and Access Standards operating policy Behavioral Health Emergency Services operating policy
Goals and Rationale: These policies and protocols ensure members timely access and medically necessary care, where unavailable through in-network providers. **Process:**	

MH/SUD:
CCHA allows out-of-network providers to bill for services if a member requires a medically necessary service that is not available from an in-network provider. Out-of-network providers are issued an authorization if they agree to CCHA's rate schedule. If they do not agree to CCHA's rate schedule, CCHA will issue a Single Case Agreement for a negotiated rate along with corresponding authorization.

CCHA will cover and pay for **Emergency Services and Care**, regardless of whether the entity furnishing the services is a participating provider.

M/S:
The Department requires providers to enroll as providers for fee-for-service providers prior to billing for services.

Finding:
Both the Department for M/S and the RAE for MH/SUD require providers to enroll in-network or secure a Single Case Agreement prior to billing for services, so the requirements and processes appear substantially similar.

Scenario 4 – Denver Health PIHP and Denver Health MCO

NQTL: Out-of-Network Provider Access Standards (IP, OP, EC & PD)	**Evidence used for comparison:**
Complies with Parity Requirements: Yes	Data Request from Denver Health
Differences noted between M/S and MH/SUD services:	Interview with Denver Health staff
No	DHMP Services Requiring Prior Authorization

Goals and Rationale: These policies and protocols ensure members timely access and medically necessary care, where unavailable through in-network providers.

Denver Health MCO subcontracts out the operation of the its MH/SUD PIHP to Colorado Access.

Process:

MH/SUD:
COA requires prior authorization for all services rendered with an out-of-network provider. If the COA is unable to accommodate the request for services with a network provider (e.g., due to geography, provider specialty, or continuity of care), then the services are authorized for the out-of-network provider. This is consistent with industry standards.

COA covers **emergency services** without prior authorization, regardless of whether the services are obtained within or outside COA's provider network.

M/S:

Denver Health Medicaid Plan is a closed network system and Denver Health Managed Care members are expected to receive services in network at Denver Health locations or providers with agreements with DHMC. Out-of-network providers are required to submit a prior authorization for services in order to ensure being properly paid for providing services to a DHMC member. Per Department guidelines, Medicaid members cannot be billed for a Medicaid covered service and must be validated with the state.

Finding:
Denver Health Managed Care and the PIHP have substantially similar standards for handling out-of-network provider access and are compliant with parity.

Appendix P - Availability of Information

All Colorado Medicaid Members receiving MH/SUD benefits, whether through FFS, RAEs, or MCOs are required to be provided with: 1) the criteria utilized to determine medical necessity and 2) the reason for denial of payment or reimbursement for MH/SUD services. The requirements for availability of information are as follows:

- Criteria for medical necessity determinations regarding MH/SUD benefits must be made available to enrollees, potential enrollees, and contracting providers upon request
- The reasons for any denial of reimbursement or payment for MH/SUD benefits must be made available to the beneficiary

All plans reviewed have provided substantial evidence that they are compliant with this parity requirement.

Category	Criteria for Medical Necessity	Reasons for Denial
Fee-For-Service	Established by contract with the FFS UM vendor. The definition for medical necessity is mandated by the state and the criteria are agreed to in contract. Specifics of InterQual's proprietary medical necessity criteria is not publicly available. But for MH/SUD, PBT criteria is accessible on the Department's website and made available to enrollees, potential enrollees and contracting providers upon request.	The Colorado Medicaid member handbook delineates the policy and process for notifying members of the reason for denial of payment. *For any decision that affects Colorado Medicaid coverage or services, providers and members receive a letter. The letter is called a **Notice of Action** or a **Notice of Adverse Benefit Determination**. It tells members what the decision is, why the decision was made, and how to appeal if members disagree.* *For members under age 21, any medical necessity denial states how the member did not meet any special consideration under EPSDT.*
RAE 1	The process and criteria for medical necessity decision making is delineated in the RMHP Provider Manual – Care Management Decision Making section.	
RAE 2 & 4	The Beacon Health Options manual states: "Beacon's clinical criteria, also known as medically necessary criteria, are based on nationally recognized resources, including	Beacon Health Options utilizes the Colorado Medicaid member handbook which delineates the policy and process for notifying members of the reason for denial of payment or reimbursement.

Category	Criteria for Medical Necessity	Reasons for Denial
	but not limited to, those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), MCG (formerly known as Milliman Care Guidelines), and the Centers for Medicare and Medicaid Services (CMS). For management of substance use services, Beacon uses ASAM criteria. Beacon's medically necessary criteria are reviewed at least annually, and during the review process, Beacon will leverage its Scientific Review Committee to provide input on new scientific evidence when needed. Medical necessity criteria is reviewed and approved by Beacon's Corporate Medical Management Committee (CMMC) and the Executive Oversite Committee (EOC). Beacon Provider Clinical Tools Network providers are given an opportunity to comment or give advice on development or adoption of UM criteria and on instructions for applying the criteria. These comments and opinions are solicited through practitioner participation on committees and through provider requests for review. Beacon facilitates discussions with outside senior consultants in the field as well as other practicing professionals. Beacon also	*For any decision that affects Colorado Medicaid coverage or services, members receive a letter. The letter is called a* ***Notice of Action*** *or a* ***Notice of Adverse Benefit Determination****. It tells members what the decision is, why the decision was made, and how to appeal if members disagree.*

Category	Criteria for Medical Necessity	Reasons for Denial
	leverages various criteria sets from other utilization management organizations and third-party payers. In addition, Beacon disseminates criteria sets via the website, provider manual, provider forums, newsletters, and individual training sessions. Upon request, members are provided copies of Beacon's medical necessity criteria free of charge. Medically necessary criteria may vary according to individual state and/or contractual requirements and member benefit coverage. Use of other substance use criteria other than ASAM is required in some jurisdictions. Access to the Beacon's medical necessity criteria is available on the *website*. Visit the ASAM website to order a copy of the ASAM criteria."	
RAE 3 & 5	COA policy CCS302 outlines the procedures for making medical necessity criteria readily available to beneficiaries and providers. A. *All Utilization Review criteria are available to members, potential members, and affected practitioners upon request.* *New or revised criteria are published and disseminated in the applicable provider manuals and on the company web page.*	COA policy CCS302 outlines the procedures for notifying members of denial of reimbursement or payment as well as the reason for denial. *All adverse benefit determination notifications sent to members and providers include instructions on how to obtain a copy of the criteria used in the review.*
RAE 6 & 7	CCHA adopts Federal and State of Colorado Laws and regulations that pertain to the rights of members and ensure that its staff and network providers take those rights into account when furnishing services to members.	CCHA adopts Federal and State of Colorado Laws and regulations that pertain to the rights of members and ensure that its staff and network providers take those rights into account when furnishing services to members.
Denver Health PIHP	COA policy CCS302 outlines the procedures for making medical necessity criteria readily available to beneficiaries and providers.	COA policy CCS302 outlines the procedures for notifying members of denial of reimbursement or payment as well as the reason for denial

Category	Criteria for Medical Necessity	Reasons for Denial
	B. All Utilization Review criteria are available to members, potential members, and affected practitioners upon request. *New or revised criteria are published and disseminated in the applicable provider manuals and on the company web page.*	*All adverse benefit determination notifications sent to members and providers include instructions on how to obtain a copy of the criteria used in the review.*