COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

September 1, 2020

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 received an extension to submit the parity report due to delays in securing a vendor to conduct the first annual report. CedarBridge Group was contracted to conduct this year's analysis and train the Department for subsequent reports. Based on their review of Colorado Medicaid, the CedarBridge Group found:

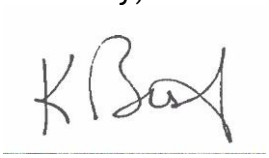
- The Department's Medicaid managed care entities are in compliance with federal and state parity laws.
- The Medicaid benefit, in its entirety, is in compliance with all federal and state parity laws.

Stakeholder input was used to inform CedarBridge Group's analysis pursuant to C.R.S. section 25.5-5-421(2). While the statute required engagement of stakeholders with expertise in managed care, the Department provided opportunities for stakeholders of all types to submit their input. The Department hosted two virtual townhall meetings and created a web form to collect feedback from members, providers, and all other interested stakeholders. Additional details of the feedback received from stakeholders can be accessed in the Stakeholder Engagement Report, available on the Department's Managed Care Resource website: https://www.colorado.gov/pacific/hcpf/regulatory-resource-center

While CedarBridge Group determined parity compliance, they identified opportunities to prevent potential future parity compliance violations. Recommendations included aligning prior authorization determination timelines, standardizing medical necessity processes, and ensuring appropriate member access to providers. The Department will coordinate with the managed care entities to research CedarBridge Group's recommendations to determine which are appropriate for implementation. For full details of CedarBridge Group's analysis, please see the attached report.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Nina Schwartz at Nina.Schwartz@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 Faith Winter, Vice Chair, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
Senator Joann Ginal, Health and Human Services Committee
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
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
Nina Schwartz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

September 1, 2020

The Honorable Jonathan Singer, Chair
House Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Singer:

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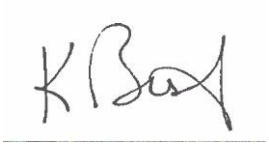

Kim Bimestefer
Executive Director

KB/stb

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

Cc: Representative Dafna Michaelson Jenet, Vice Chair, Public Health Care and Human Services Committee
Representative Yadira Caraveo, 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 Sonya Jacquez Lewis, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Colin Larson, Public Health Care and Human Services Committee
Representative Larry Liston, Public Health Care and Human Services Committee
Representative Kyle Mullica, Public Health Care and Human Services Committee
Representative Rod Pelton, Public Health Care and Human Services Committee
Representative Emily Sirota, 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
Nina Schwartz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

September 1, 2020

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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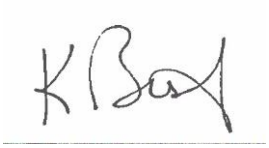

Kim Bimestefer
Executive Director

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 Susan Beckman, Health and Insurance Committee
Representative Janet Buckner, Health and Insurance Committee
Representative Dominique Jackson, Health and Insurance Committee
Representative Kerry Tipper, Health and Insurance Committee
Representative Kyle Mullica, Health and Insurance Committee
Representative Matt Soper, Health and Insurance Committee
Representative Brianna Titone, Health and Insurance Committee
Representative Perry Will, Health and Insurance Committee
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Nina Schwartz, Legislative Liaison, HCPF

COLORADO
Department of Health Care Policy & Financing

BEHAVIORAL, MENTAL HEALTH, AND SUBSTANCE USE DISORDER PARITY COMPARATIVE ANALYSIS REPORT

JULY 31, 2020

PRODUCED BY

CEDARBRIDGE GROUP

TABLE OF CONTENTS

EXECUTIVE SUMMARY

CedarBridge was contracted by the Colorado Department of Health Care Policy and Financing (Department) to collaborate with the Department and stakeholders with relevant knowledge in designing and creating an Annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for State Fiscal Year 2019-2020. The MHPAEA is designed to ensure Medicaid managed care organizations and Medicaid alternative benefit plans providing mental health or substance use disorder (MH/SUD) benefits impose offer benefits that are no more stringent than those imposed upon medical and surgical benefits (M/S) in the same classifications. Our team was directed to conduct comparative analyses across Colorado Medicaid's statewide managed care system, consisting of seven (7) Regional Accountable Entities (RAEs) and two (2) Managed Care Organizations (MCOs), to determine the status of parity compliance within the Colorado Medicaid delivery system.

The State of Colorado administers Colorado's Medicaid program through its Accountable Care Collaborative (ACC). The state is divided into seven regions with a single Managed Care Entity, 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 mental health and substance use disorder (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 medical and surgical 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.

CedarBridge followed federal parity guidance as 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 completed the analysis in accordance with Colorado House Bill 19-1269. The Non-Quantitative Treatment Limits (NQTL) analysis incorporates public input received. Per the CMS Parity Toolkit, NQTLs are limits on the scope and duration of benefits, such as prior authorization or network admission standards. CedarBridge, in collaboration with the Department, collected meaningful public input to help assess how processes, strategies, evidentiary standards, and other factors operate in practice through a multi-pronged stakeholder outreach approach.

The Colorado Medicaid service delivery system has multiple components that add complexity to assessing parity. The analysis requires the comparison of a capitation payment structure to a fee-for-service payment structure. While multi-faceted, the comparison seeks to assess whether the written policies and procedures and how they are applied in practice affect the ability of a Medicaid member to access services.

Our assessment and comparative analysis of MH/SUD benefit limitations compared to M/S benefit limitations found no instances of parity compliance violations. This report outlines how, in written policies and in operation, the Department's and the Statewide Managed Care System's MH/SUD benefits are applied no more stringently than M/S benefits, in relation to:

- Benefit coverage
- Quantitative treatment limitations
- Non-quantitative treatment limitations
- Factors used to design treatment limitations, such as evidentiary standards and medical necessity criteria
- Other items identified through stakeholder engagement.

SUMMARY OF FINDINGS

AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS

The Colorado Medicaid benefit packages do not impose aggregate lifetime or annual dollar limits. This negates the need to conduct these aspects of the parity review.

QUANTITATIVE TREATMENT LIMITATIONS

The Colorado Medicaid benefit packages impose no quantitative treatment limitations (QTLs) for MH/SUD benefits. This negates the need to evaluate parity compliance with respect to quantitative treatment limits.

NON-QUANTITATIVE TREATMENT LIMITATIONS

CedarBridge completed an analysis of the non-quantitative treatment limitations (NQTLs) being used by each of the benefit packages and completed an analysis of whether, for each NQTL, there are differences in policies, procedures or the application of the policies and procedures in operation for MH/SUD benefits and M/S benefits. No instances of parity compliance violations were found, however CedarBridge did identify recommendations for improvements in the efficiency of the delivery system and processes for preventing issues that can lead to a parity compliance violation. Recommendations include:

- While all RAEs utilize MH/SUD prior authorization determination timelines in compliance with statute, it is recommended that all are brought into alignment with comparable medical/surgical timelines.
- Require the RAEs and MCOs to use the statutory definition of medical necessity in applying their policies and processes.
- Require that MH/SUD providers not be restricted from participation in the network by geographic location, facility type, or specialty.
- It is unclear who may request authorization for service for out-of-network services. We recommend the Department consider mandating through contract that both a provider and a member may request authorization for out-of-network services for specified reasons.

AVAILABILITY OF INFORMATION

The responsible entities for Colorado Medicaid benefit packages provided substantial evidence that they 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.

INTRODUCTION

CedarBridge followed guidance as 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]

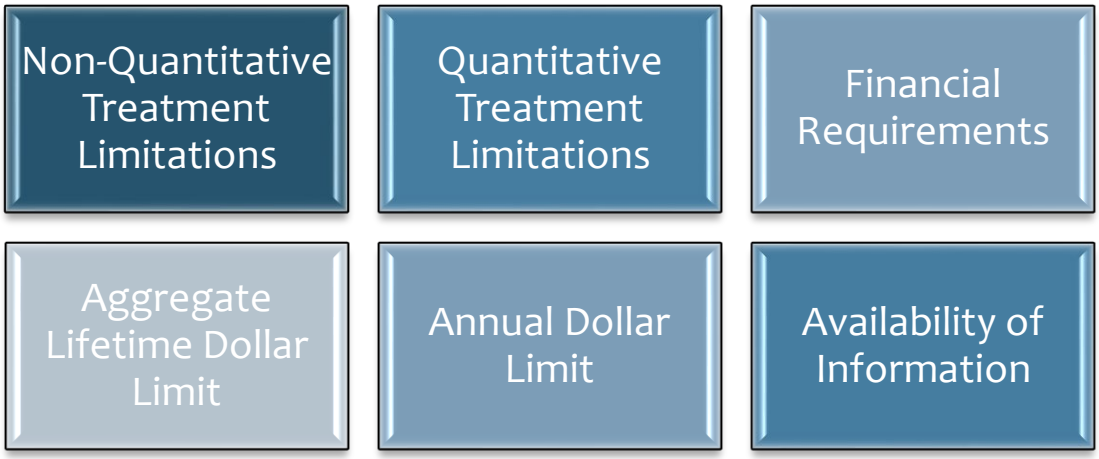

Figure 1. Required Components of Parity Analysis

In addition to the analysis required by CMS, Colorado HB 19-1269 imposes additional requirements:

1. The analysis should include public input from stakeholders who have competency in benefit and delivery systems, utilization management, managed care contracting, data and reporting, and compliance and audits; and
2. Each Managed Care Entity (MCE) must disclose all necessary information for the Department to prepare a report, regarding behavioral, mental health, and substance use disorder parity.

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

DEFINITION OF MEDICAL/SURGICAL AND MENTAL HEALTH/SUBSTANCE USE DISORDER SERVICES

The federal statute and regulations do not identify specific conditions 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 of Healthcare Policy and Financing (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.

- 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.

ACRONYMS

AL – Aggregate Lifetime Dollar Limit

ADL – Annual Dollar Limit

FR – Financial Requirement

M/S – Medical/Surgical

MH/SUD – Mental Health/Substance Use Disorder

NQTL – Non-Quantitative Treatment Limitation

QTL – Qualitative Treatment Limitation

- Substance use disorder benefits means benefits for 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.

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.

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 Hospital Authority, which is also contracted to function as the MH/SUD PIHP for all members enrolled in the MCO.

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. The Department has approximately 120,000 members in MCOs whose M/S and MH/SUD services are covered through capitation payments. Approximately 318,000 members in the Alternative Benefit Plan receive capitated MH/SUD services, but their M/S services are provided fee-for-service.

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 an unusual situation. 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 fee-for-service 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. 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.

In Colorado, the Department goes above and beyond federal requirements and conducts its MHPAEA comparative analyses across all members enrolled with the seven (7) RAEs and the two (2) MCOs. The Department does not restrict its MHPAEA comparative analyses only to members eligible for the Medicaid Alternative Benefit Plan or in an MCO.

STAKEHOLDER ENGAGEMENT AND FEEDBACK

A key feature of Colorado HB 19-1269 (C.R.S. 25.5-5-421) requires the Department to consider stakeholder feedback received as a component of the NQTL analyses. Stakeholders shared concerns about utilization management, administrative burden, network adequacy, reimbursement rates, credentialing, accurate and timely payment, and Department oversight and communications. Some concerns, by definition, do not rise to the level of parity concerns (i.e. Department oversight and communications). Other concerns touched on parity-related topics. However, once CedarBridge analyzed the data, these concerns did not signal non-compliance with MHPAEA or Colorado law. These issues have been shared with the Department for further operational assessment with any eye towards program improvement.

For example, stakeholders voiced concern that the Department reimburses MH/SUD benefits through capitation and M/S benefits through fee-for-service, which theoretically could create inequities. There were at least two areas of the parity analysis that touched on this concern. First, it was determined that

the process 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. Second, this feedback was considered in analyzing network adequacy and it was determined that the process 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.

METHODOLOGY

DEFINING MEMBER SCENARIOS FOR ANALYSIS

Prior to beginning the parity analysis, CedarBridge documented the potential member scenarios available in the Colorado ACC for MH/SUD as well as M/S benefits (Table 1). Further, we defined the mechanism for payment of covered benefits by each of the benefit classifications (Table 2). This step was particularly important in defining the scope of questions and data needed from each respective payer.

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 outpatient MH/SUD services, inpatient and emergency care MH services, and M/S benefits through fee-for-service (this is a service-by-service situation).
- **SCENARIO 2**: Member gets outpatient MH/SUD services and inpatient/emergency care 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 outpatient MH/SUD services and inpatient/emergency care MH services through a RAE under a capitated rate and M/S benefits through fee-for-service.
- **SCENARIO 4**: Member gets outpatient MH/SUD services and inpatient/emergency care MH services through fee-for-service and M/S benefits through a managed care organization (this is a service-by-service situation).
- **SCENARIO 5**: Member gets outpatient MH/SUD services and inpatient/emergency care MH services from Denver Health PIHP (Prepaid Inpatient Health Plan) 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 = FFS	Med/Surg = MCO MH/SUD = FFS	Med/Surg = MCO MH/SUD = FFS	PBM
SCENARIO 5	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

In defining the scope of the parity analysis, CedarBridge began by researching each benefit plan to determine the presence of any FRs or QTLs that would require analysis. Colorado does not currently have any FRs or QTLs for MH/SUD services.

Additionally, a broad 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). CedarBridge developed tools and resources to collect and analyze the required NQTL data. Our process began with a data request for Regional Accountable Entities (RAEs), Managed Care Organizations (MCOs), and the Department 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
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

Responses to the data requests were followed with an interview with a team from each RAE and MCO, which focused on Medical Necessity and how the Provider Network is handled. The CedarBridge team also discussed with the RAEs and MCOs any possible improvements to the process.

During the interviews, we also addressed areas of HB19-1269 that are not in the CMS toolkit:

- "**25.5-5-421. Parity Reporting – State Department – Public Input (2)** By October 1, 2019, for purposes of obtaining meaningful public input during the assessment process, the state department shall seek input from stakeholders who may have competency in benefit and delivery systems, utilization management, managed care contracting, data and reporting, or compliance and audits. The department shall consider the input received in conducting the analyses and the report development."

- "**25.5-5-422. Medication-assisted treatment – limitations on MCEs – definition.**
  (1) As used in this section, "FDA" means the Food and Drug Administration in the United States Department of Health and Human Services"
  (2) Notwithstanding any provision of law to the contrary, beginning January 1, 2020, MCEs that provide prescription drug benefits for the treatment of substance use disorders shall, for prescription medications that are on the carrier's formulary:
    (a) Not impose prior authorization requirements on any prescription medication approved by the FDA for the treatment of substance use disorders.
    (b) Not impose any step therapy requirements as a prerequisite for coverage for a prescription medication approved by the FDA for the treatment of substance use disorders; and
    (c) Not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medications and services were court ordered.

REVIEW PROCESS FOR MEDICAL NECESSITY CRITERIA

After collecting the medical necessity criteria used by the RAEs and MCOs, both through the written data request and the follow-up interviews, CedarBridge was able to review the medical necessity criteria used by each for MH/SUD and physical health services. It is important to note, any area of medical necessity could be an opportunity for exploration. The key is to look for differences in the way M/S and MH/SUD determine an individual meets the definition of requiring a medically necessary service/s within the care delivery system.

REVIEW PROCESS FOR NON-QUANTITATIVE TREATMENT LIMITATIONS

Based on the illustrative list of NQTLs 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), CedarBridge identified a list of common NQTLs that may be in use by the RAEs and HCPF for MH/SUD services. As outlined in HB 19-1269, additional feedback was received through stakeholder interviews, written comments, and public listening sessions. This feedback was used to either affirm previously discovered NQTLs or identify other areas that may require analysis.

This final list included NQTLs related to medical management, benefits coverage, provider network admission, and prescription drugs. Following this exploratory work, CedarBridge prepared a request for information to the RAEs, MCOs, and HCPF that included the list of NQTLs identified and asked them to identify any additional NQTLs they apply to MH/SUD services. The requests addressed processes, strategies, evidentiary standards and other factors in writing and operation for each of the NQTLs that apply to MH/SUD and M/S services, broken down by benefit classification. The requests included prompts to help identify the type of information relevant to the parity analysis.

COST ANALYSIS IF A FINANCIAL REQUIREMENT OR QUANTITATIVE TREATMENT LIMITATION APPLIES

The Colorado Medicaid benefit packages impose no quantitative treatment limitations (QTLs) for MH/SUD benefits. This negates the need to evaluate parity compliance with respect to quantitative treatment limits. Should future financial or unit limits be imposed, these limitations may need to be reviewed to ensure parity compliance.

FACTORS USED TO DETERMINE AN NQTL WILL APPLY

Parity requires NQTL's 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, we used the request for information and the interviews with the RAEs, MCOs, and representatives of HCPF to determine if an NQTL applies and requires further explanation. Anytime a NQTL is present, it must be tested for comparability and stringency to ensure it meets parity guidelines. During this analysis, CedarBridge looked at multiple reference points 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.

FINDINGS AND RECOMMENDATIONS

CedarBridge did not identify parity violations in its analysis. However, CedarBridge identified several changes that would be helpful in future parity analyses. These policies are differences in the system that would appear to bring inconsistency where it isn't necessary and could be rectified through contract or operational changes with minimal effort.

Prior Authorization

- While all RAEs utilize MH/SUD determination timelines in compliance with statute, it is recommended all RAEs are brought into alignment with comparable M/S timelines.

Medical Necessity

- For MH/SUD fee-for-service claims, consider contracting with the current FFS UM vendor, eQhealth or establishing another UM contract that follows the same process to handle MH/SUD claims that are paid fee-for-service.
- The Department should require the RAEs and MCOs to use the statutory definition of medical necessity in applying their policies and processes.

Restrictions Based on Geographic Location, Facility Type, or Provider Specialty

- The Department should require that MH/SUD providers not be restricted from participation in the network by geographic location, facility type, or specialty.

Out-of-Network Providers Access Standards

- It is not clear that both a provider and a member may request authorization for out-of-network services. We recommend the Department consider mandating through contract that both a provider and a member may request authorization for out-of-network services for specified reasons.

Appendices A through O present each NQTL, the member scenarios, benefit categories (IP - In Patient; OP - Out Patient; 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. Review of policies and processes on medication assisted therapies to ensure compliance with Colorado law.

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	HCPF, eQHealth Solutions	IP, OP	Yes – 1st and 2nd level reviewer credentials are different	Yes
	Magellan	PD	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP, PD	Yes – additional conditions differ	Yes
Scenario 3				
	RAE 1	IP, OP	Yes – Review completion timeframes differ	Yes
	RAE 2 & 4	IP, OP	Yes – Authorization Determination timeframes differ	Yes
	RAE 3 & 5	IP, OP	Yes – Authorization Determination timeframes differ	Yes
	RAE 6 & 7	IP, OP	Yes – Authorization Determination timeframes differ	Yes
Scenario 4				
	FFS & RMHP Prime MCO	IP, OP	No	Yes
	FFS & Denver Health MCO	IP, OP	Yes – Authorization Determination timeframes differ	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP, PD	No	Yes

Scenario 1 – FFS

NQTL: Prior Authorization (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the inpatient benefit category, with the exception of urgent/emergent (including crisis).	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations

	HCPF Benefit Policy Colorado PAR Program provider training references Consultation with HCPF staff

Goals and Rationale: The Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program, consisting of the Colorado Prior Authorization Review (Colorado PAR) and Inpatient Hospital Review Programs (IHRP). eQHealth Solutions reviews for medical necessity for IHRP which includes some inpatient MD/SUD admissions for members not yet attributed to a RAE and all FFS M/S admissions. PARs are required for all inpatient levels of care with the exception of inpatient admissions related to labor and delivery and rehabilitation facilities on the exclusion bypass list. All PARs are reviewed for compliance with federal and state rules and medical appropriateness based on nationally recognized best practices and clinical guidelines. The inpatient hospital review program's stated goals are:

- Improve members' quality of care
- Facilitate better care planning and inpatient care transitions
- Ensure appropriate hospitalizations
- Improve service utilization
- Improve coding accuracy
- Provide timely, accurate information to the Department's partners who can directly assist members with highest needs

Process:

MH/SUD

All participating inpatient MH/SUD facilities are responsible to notify the Department's FFS UM Vendor, eQHealth 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. Notification is not required for observation or emergency services. eQHealth requires a PAR for all MH/SUD inpatient level of care if a member is not yet attributed to a RAE, or the service provided does not fall under Department's capitated services. If the services are emergent or urgent (including crisis services) then an admission review is required within 24 hours of the members stabilization. EQHealth utilizes the PAR portal, eQSuite® 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. Requests are through a dedicated online portal, or 278 daily files to eQSuite, and a small subset of exempt Providers may submit requests through fax.

For IHRP, the UM Vendor uses MCG criteria to determine appropriateness of inpatient admissions. 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 or facility's submitted information, including clinical notes, labs, test results, orders, etc. are reviewed for completeness, compliance and medical appropriateness utilizing specific HCPF 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 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 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.

For both nurse and physician reviews the completion timeframe is 1 business day from when all necessary documentation is provided for IHRP.

M/S

All participating inpatient M/S facilities are responsible to notify the Department's FFS UM Vendor, eQHealth of an inpatient admission within 24 hours of admission. Notification is not required for observation, and emergency services require an admission review within 24 hours of members stabilization.

EQHealth utilizes the online PAR portal, eQSuite® 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. Requests are submitted by fax, a dedicated portal, or 278 daily files to eQSuite.

For IHRP, the UM FFS Vendor uses MCG criteria to determine appropriateness of inpatient admissions. 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 or facility's submitted information, including clinical notes, labs, test results, orders, and any other pertinent clinical documentation as requested by the FFS UM Vendor are reviewed for completeness, compliance and medical appropriateness utilizing specific HCPF 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 or Department approved Criteria, 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 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.

For both nurse and physician reviews the completion timeframe is 1 business day from when all necessary documentation is provided for IHRP.

Finding:

Inpatient notification as well as prior authorization submission, determination, and reviewer requirements and processes are identical for MH/SUD benefits and M/S benefits. 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (OP)	**Differences noted between M/S and MH/SUD services:** **Yes.** 1st and 2nd level reviewer credentials are different
Benefits included: This NQTL applies to the outpatient benefit category.	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training materials Consultation with HCPF staff

Goals and Rationale: The Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program; the Colorado Prior Authorization Review program (Colorado PAR). Federal rules, regulation and legislation, Colorado state rules and regulations, and benefit specific policy in addition to nationally recognized criteria (InterQual) govern reviews of outpatient PARs. PARs are required for select FFS MH/SUD and FFS M/S outpatient services.

Process:

MH/SUD

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

EQHealth utilizes the PAR portal, eQSuite® 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 eQSuite, secure, HIPAA compliant 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 HCPF 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 (BCBS-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
- Medical and Surgical services
- Molecular Testing
- Outpatient Physical, Occupational and Speech Therapies
- Pediatric Long-Term Home Health
- Pediatric Personal Care Services

- Private Duty Nursing
- Synagis
- Vision

EQHealth utilizes the PAR portal, eQSuite® 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 eQSuite, secure, HIPAA compliant 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; when operationalized there is little to no exception or variation in the procedures, the staff operationalizing the policy are qualified to make

<table>
<tr><td colspan="2">the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policy is operationalized as documented.</td></tr>
<tr><td>Recommendations: None</td><td>Complies with Parity Requirements: Yes</td></tr>
<tr><td>NQTL: Prior Authorization (PD)</td><td>Differences noted between M/S and MH/ SUD services:
No</td></tr>
<tr><td>Benefits included: This NQTL applies to the Prescription Drug benefit category.</td><td>Evidence used for comparison:
Colorado Medicaid Pharmacy Benefits
Colorado Medical Assistance Program
Prior Authorization Procedures and Criteria and Quantity Limits</td></tr>
<tr><td colspan="2">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.

Process:

MH/SUD
MH/SUD 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.

M/S
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.</td></tr>
<tr><td>Recommendations: None</td><td>Complies with Parity Requirements: Yes</td></tr>
</table>

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

NQTL: Prior Authorization (IP)	Differences noted between M/S and MH/ SUD services: No
Benefits included: **This NQTL applies to all inpatient benefit categories.**	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 • RMHP Utilization Management Policies Data request from RMHP Interview with RMHP staff

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

MH/SUD

All participating MH/SUD inpatient facilities are required to notify RMHP 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. This includes Acute Inpatient Psych; Inpatient Detox; Observation; Residential Treatment; Structured Outpatient/IOP; Partial Hospitalization; and Outpatient Detox. Notification is not required for observation or emergency services. With the exception of urgent/emergent (including crisis) services all MH/SUD inpatient level of care services require prior authorization.

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 (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 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, facilities should anticipate a decision within 48 hours.

M/S

All participating M/S inpatient facilities are required to notify RMHP 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. Notification is not required for observation or emergency services.

With the exception of urgent/emergent (including crisis) services all M/S inpatient level of care services require prior authorization. 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 (formerly Milliman Care Guidelines®) 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 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, facilities should anticipate a decision within 48 hours.

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.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (OP)	**Differences noted between M/S and MH/ SUD services:** **No**
Benefits included: This NQTL applies to all outpatient benefit categories.	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 • RMHP Utilization Management Policies RMHP Outpatient Clinical & DME Preauthorization Training Material Data request from RMHP Interview with RMHP 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. 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

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 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 (formerly Milliman Care Guidelines®) 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (PD)	**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.
Benefits included: This NQTL applies to all Prescription Drug benefit categories.	**Evidence used for comparison:** 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
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; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1 and FFS

NQTL: Prior Authorization (IP)	**Differences noted between M/S and MH/ SUD services:** **Yes**. Review completion timeframes differ
Benefits included: This NQTL applies to all inpatient benefit categories.	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 Data request from RMHP Interview with RMHP staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Consultation with HCPF 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, 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

The Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program, consisting of the Colorado Prior Authorization Review (Colorado PAR) and Inpatient Hospital Review Programs (IHRP). eQHealth Solutions reviews for medical necessity for IHRP which includes all FFS M/S admissions. Notification and Prior Authorization Policies for M/S services are delineated by the Colorado PAR Program's Inpatient Hospital Review Program (IHRP). Stated Goals for IHRP are:

- Improve members' quality of care
- Facilitate better care planning and inpatient care transitions
- Ensure appropriate hospitalizations
- Improve service utilization
- Improve coding accuracy

Process:

MH/SUD

All participating inpatient MH/SUD facilities are responsible to notify RMHP 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.

For MH/SUD 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 (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 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. In cases where a prior authorization requires additional questions or is denied for a MH/SUD request, an RMHP Psychiatrist would complete the review and render a final determination. For all requests, facilities should anticipate a decision within 48 hours (2 business days).

M/S

All participating inpatient M/S facilities are responsible to notify the Department's FFS UM Vendor, eQHealth of an inpatient admission within 24 hours of admission. Notification is not required for observation, and emergency services require an admission review within 24 hours of members stabilization.

EQHealth utilizes the online PAR portal, eQSuite® 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. Requests are submitted by fax, a dedicated portal, or 278 daily files to eQSuite.

For IHRP, the UM FFS Vendor uses MCG criteria to determine appropriateness of inpatient admissions. 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 or facility's submitted information, including clinical notes, labs, test results, orders, and any other pertinent clinical documentation as requested by the FFS UM Vendor are reviewed for completeness, compliance and medical appropriateness utilizing specific HCPF 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 or Department approved Criteria, 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 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.

For both nurse and physician reviews the completion timeframe is 1 business day from when all necessary documentation is provided for IHRP.

Finding:

The requirements and processes for MH/SUD and M/S inpatient admission notification, prior authorization submission and determination are comparable. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

While MH/SUD services have longer timelines for rendering an authorization decision, all MH/SUD and M/S inpatient stays require prior authorization and the requirements and processes are **comparable** and applied **no more stringently**. In addition, all timeframes for rendering a decision comply with Colorado Medicaid standards.

Recommendations: While all MH/SUD determination timelines are in compliance with statute, it is recommended all timelines are brought into alignment with comparable M/S timelines.	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (OP)	**Differences noted between M/S and MH/ SUD services:** **No**
Benefits included: This NQTL applies to all outpatient benefit categories.	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 Data request from RMHP Interview with RMHP staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy

	Colorado PAR Program provider training materials

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, 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 Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program; the Colorado Prior Authorization Review program (Colorado PAR). Federal rules, regulation and legislation, Colorado state rules and regulations, and benefit specific policy in addition to nationally recognized criteria (InterQual) govern reviews of outpatient PARs. PARs are required for select FFS M/S outpatient services.

Process:

MH/SUD

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
- Medical and Surgical services
- Molecular Testing
- Outpatient Physical, Occupational and Speech Therapies
- Pediatric Long-Term Home Health
- Pediatric Personal Care Services

- Private Duty Nursing
- Synagis
- Vision

EQHealth utilizes the PAR portal, eQSuite® 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 eQSuite, secure, HIPAA compliant 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 requirements and processes for MH/SUD and M/S outpatient service prior authorization submission and determination are comparable. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.
While MH/ SUD services have longer timelines for rendering an authorization decision, the requirements and processes are **comparable** and applied **no more stringently** than M/S reviews. In addition, all timeframes for rendering a decision comply with Colorado Medicaid standards.

Recommendations: None	Complies with Parity Requirements: Yes

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Prior Authorization (IP)	Differences noted between M/S and MH/ SUD services: **Yes:** Authorization Determination timeframes differ
Benefits included: This NQTL applies to all inpatient benefit categories.	**Evidence used for comparison:** Beacon Health Options (Northeast Health Partners & Health Colorado) Provider Manual Interview with Beacon staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR - Inpatient Hospital Review Program Colorado PAR Program provider training materials Consultation with HCPF 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 prior authorization are:

- Easy and early access to appropriate treatment
- Working collaboratively with participating MH/SUD 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

For M/S services, the Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program, consisting of the Colorado Prior Authorization Review (Colorado PAR) and Inpatient Hospital Review Programs (IHRP). eQHealth Solutions reviews for medical necessity for IHRP which includes all FFS M/S admissions. Notification and Prior Authorization Policies for M/S services are delineated by the Colorado PAR Program's Inpatient Hospital Review Program (IHRP). Stated Goals for IHRP are:

- Improve members' quality of care
- Facilitate better care planning and inpatient care transitions
- Ensure appropriate hospitalizations
- Improve service utilization

- Improve coding accuracy

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 Provider Connect 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. The process for obtaining authorization is as follows.

1. When a member presents to a facility with MH/SUD 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 Colorado Medicaid standards (urgent: 72 hours, non-urgent 10 days).

M/S

All participating inpatient M/S facilities are responsible to notify the Department's FFS UM Vendor, eQHealth of an inpatient admission within 24 hours of admission. Notification is not required for observation, and emergency services require an admission review within 24 hours of members stabilization.

EQHealth utilizes the online PAR portal, eQSuite® 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. Requests are submitted by fax, a dedicated portal, or 278 daily files to eQSuite.

For IHRP, the UM FFS Vendor uses MCG criteria to determine appropriateness of inpatient admissions. 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 or facility's submitted information, including clinical notes, labs, test results, orders, and any other pertinent clinical documentation as requested by the FFS UM Vendor are reviewed for completeness, compliance and medical appropriateness utilizing specific HCPF 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 or Department approved Criteria, 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 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.

For both nurse and physician reviews the completion timeframe is 1 business day from when all necessary documentation is provided for IHRP.

Finding:

The requirements and processes for MH/SUD and M/S inpatient admission notification, prior authorization submission and determination are comparable. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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. While MH/ SUD services have longer timelines for rendering an authorization decision, all MH/SUD and M/S inpatient stays require prior authorization and the requirements and processes are **comparable** and applied **no more stringently** than M/S reviews. In addition, all timeframes for rendering a decision comply with Colorado Medicaid Standards.	
Recommendations: **While all MH/SUD determination timelines are in compliance with statute, it is recommended all timelines are brought into alignment with comparable M/S timelines**	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (OP)	**Differences noted between M/S and MH/ SUD services:** **No**
Benefits included: This NQTL applies to all outpatient benefit categories.	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training materials Consultation with HCPF staff Beacon Health Options (Northeast Health Partners & Health Colorado) Provider Manual Outpatient Mental Health Authorization Process for RAE 2, Northeast Health Partners Outpatient Mental Health Authorization Process for RAE 4, Health Colorado 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. Beacon's stated goals for prior authorization are:

- Easy and early access to appropriate treatment
- Working collaboratively with participating MH/SUD 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

For M/S services, the Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program; the Colorado Prior Authorization Review program (Colorado PAR). Federal rules, regulation and legislation, Colorado state rules and regulations, and benefit specific policy in addition to nationally recognized criteria (InterQual) govern reviews of outpatient PARs. PARs are required for select FFS M/S outpatient services.

Process:

MH/SUD
All MH/SUD authorizations are submitted through Provider Connect and reviewed by clinical care managers utilizing diagnosis-based clinical practice guidelines. Initial evaluation sessions for outpatient services do not require authorization for our contracted providers. 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 Provider Connect. 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
- Medical and Surgical services
- Molecular Testing
- Outpatient Physical, Occupational and Speech Therapies
- Pediatric Long-Term Home Health
- Pediatric Personal Care Services
- Private Duty Nursing
- Synagis
- Vision

EQHealth utilizes the PAR portal, eQSuite® 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 eQSuite, secure, HIPAA compliant 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 requirements and processes for MH/SUD and M/S outpatient service prior authorization submission and determination are comparable. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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. While MH/ SUD services have longer timelines for rendering an authorization decision, the requirements and processes are **comparable** and applied **no more stringently** than M/S reviews. In addition, all timeframes for rendering a decision comply with Colorado Medicaid standards.

Recommendations: None	Complies with Parity Requirements: Yes

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Prior Authorization (IP)	Differences noted between M/S and MH/SUD services: **Yes:** Authorization Determination timeframes differ
Benefits included: This NQTL applies to all inpatient benefit categories.	**Evidence used for comparison:** Colorado PAR - Inpatient Hospital Review Program Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training materials Consultation with HCPF staff Colorado Access Provider Manual – Utilization Management Interview with Colorado Access 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, Colorado Access's Utilization Management policies provide the conditions for admission notification as well as the process for prior authorization submission and review.

For M/S services, the Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program, consisting of the Colorado Prior Authorization Review (Colorado PAR) and Inpatient Hospital Review Programs (IHRP). eQHealth Solutions reviews for medical necessity for IHRP which includes all FFS M/S admissions. Notification and Prior Authorization Policies for M/S services are delineated by the Colorado PAR Program's Inpatient Hospital Review Program (IHRP). Stated Goals for IHRP are:

- Improve members' quality of care
- Facilitate better care planning and inpatient care transitions
- Ensure appropriate hospitalizations
- Improve service utilization
- Improve coding accuracy

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.

With the exception of urgent/emergent (including crisis) services, all MH/SUD inpatient level of care services require prior authorization.

MH/SUD authorization requests are submitted by fax to Colorado Access and initially reviewed by a utilization management service coordinator. Authorization Submissions can be received 24 hours/day. All authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

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

All participating inpatient M/S facilities are responsible to notify the Department's FFS UM Vendor, eQHealth of an inpatient admission within 24 hours of admission. Notification is not required for observation, and emergency services require an admission review within 24 hours of members stabilization..

EQHealth utilizes the online PAR portal, eQSuite® 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. Requests are submitted by fax, a dedicated portal, or 278 daily files to eQSuite.

For IHRP, the UM FFS Vendor uses MCG criteria to determine appropriateness of inpatient admissions. 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 or facility's submitted information, including clinical notes, labs, test results, orders, and any other pertinent clinical documentation as requested by the FFS UM Vendor are reviewed for completeness, compliance and medical appropriateness utilizing specific HCPF 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 or Department approved Criteria, 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 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.

For both nurse and physician reviews the completion timeframe is 1 business day from when all necessary documentation is provided for IHRP.

Finding:

The requirements and processes for MH/SUD and M/S inpatient admission notification, prior authorization submission and determination are comparable. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

While MH/ SUD services have longer timelines for rendering an authorization decision, the requirements and processes are **comparable** and applied **no more stringently** than M/S reviews. In addition, all timeframes for rendering a decision comply with Colorado Medicaid standards.

Recommendations: **While all MH/SUD determination timelines are in compliance with statute, it is recommended all timelines are brought into alignment with comparable M/S timelines.**	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to all outpatient benefit categories.	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training materials Consultation with HCPF staff Colorado Access Provider Manual – Utilization Management 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.

For M/S services, the Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program; the Colorado Prior Authorization Review program (Colorado PAR). Federal rules, regulation and legislation, Colorado state rules and regulations, and benefit specific policy in addition to nationally recognized criteria (InterQual) govern reviews of outpatient PARs. PARs are required for select FFS M/S outpatient services.

Process:

MH/SUD
Outpatient MH/SUD authorization requests are submitted by fax to Colorado Access and initially reviewed by a utilization management service coordinator. Authorization Submissions can be received 24 hours/day. All authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).
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
- Medical and Surgical services
- Molecular Testing
- Outpatient Physical, Occupational and Speech Therapies
- Pediatric Long-Term Home Health
- Pediatric Personal Care Services
- Private Duty Nursing
- Synagis
- Vision

EQHealth utilizes the PAR portal, eQSuite® 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 eQSuite, secure, HIPAA compliant 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 requirements and processes for MH/SUD and M/S outpatient service prior authorization submission and determination are comparable. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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. While MH/ SUD services have longer timelines for rendering an authorization decision, the requirements and processes are comparable and applied no more stringently than M/S reviews. In addition, all timeframes for rendering a decision comply with Colorado Medicaid standards.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Prior Authorization (IP)	Differences noted between M/S and MH/SUD services: **Yes:** Authorization Determination timeframes differ
Benefits included: This NQTL applies to all inpatient benefit categories.	**Evidence used for comparison:** CCHA Provider Manual CCHA UM Program Description Interview with CCHA Staff Colorado PAR - Inpatient Hospital Review Program Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training materials Consultation with HCPF staff

Goals and Rationale: For MH/SUD services, CCHA's Utilization Management policies provide the conditions for admission notification as well as the process for prior authorization submission and review. The purpose of the Behavioral Health (BH) UM Program is to ensure that eligible members receive the most clinically appropriate behavioral health care and services in the most efficient manner possible and to enhance consistency in reviewing cases by providing a framework for clinical decision making.

For M/S services, the Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program, consisting of the Colorado Prior Authorization Review (Colorado PAR) and Inpatient Hospital Review Programs (IHRP). eQHealth Solutions reviews for medical necessity for IHRP which includes all FFS M/S admissions. Notification and Prior Authorization Policies for M/S services are delineated by the Colorado PAR Program's Inpatient Hospital Review Program (IHRP). Stated Goals for IHRP are:

- Improve members' quality of care
- Facilitate better care planning and inpatient care transitions
- Ensure appropriate hospitalizations
- Improve service utilization
- Improve coding accuracy

Process:

MH/SUD

All participating inpatient MH/SUD facilities are responsible to notify CCHA 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.
CCHA MH/SUD authorization requests are submitted through the Interactive Care Reviewer web portal. Authorization Submissions can be received 24 hours/day. All authorization requests are processed within 10 calendar days (72 hours for cases deemed urgent).

The criteria to review the medical necessity and appropriateness of MH/SUD services is derived primarily from two sources: Anthem Medical Policies and Clinical Utilization Management Guidelines and MCG Management 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.

Prior Authorization reviews are performed by a team of Care 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

All participating inpatient M/S facilities are responsible to notify the Department's FFS UM Vendor, eQHealth of an inpatient admission within 24 hours of admission. Notification is not required for observation, and emergency services require an admission review within 24 hours of members stabilization.

EQHealth utilizes the online PAR portal, eQSuite® 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. Requests are submitted by fax, a dedicated portal, or 278 daily files to eQSuite.

For IHRP, the UM FFS Vendor uses MCG criteria to determine appropriateness of inpatient admissions. 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 or facility's submitted information, including clinical notes, labs, test results, orders, and any other pertinent clinical documentation as requested by the FFS UM Vendor are reviewed for completeness, compliance and medical appropriateness utilizing specific HCPF 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 or Department approved Criteria, 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 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.

For both nurse and physician reviews the completion timeframe is 1 business day from when all necessary documentation is provided for IHRP.

Finding:

The requirements and processes for MH/SUD and M/S inpatient admission notification, prior authorization submission and determination are comparable. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

While MH/ SUD services have longer timelines for rendering an authorization decision, the requirements and processes are **comparable** and applied **no more stringently** than M/S reviews. In addition, all timeframes for rendering a decision comply with Colorado Medicaid standards.

Recommendations: While all MH/SUD determination timelines are in compliance with statute, it is recommended all timelines are brought into alignment with comparable M/S timelines.	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to all outpatient benefit categories.	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Consultation with HCPF 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 Utilization Management policies provide the process for prior authorization submission and review. The purpose of the Behavioral Health (BH) UM Program is to ensure that eligible members receive the most clinically appropriate behavioral health care and services in the most efficient manner possible and to enhance consistency in reviewing cases by providing a framework for clinical decision making.

For M/S services, the Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program; the Colorado Prior Authorization Review program (Colorado PAR). Federal rules, regulation and legislation, Colorado state rules and regulations, and benefit specific policy in addition to nationally recognized criteria (InterQual) govern reviews of outpatient PARs. PARs are required for select FFS M/S outpatient services.

Process:

MH/SUD
CCHA outpatient MH/SUD authorization requests are submitted through the Interactive Care Reviewer web portal. Authorization Submissions can be received 24 hours/day. All authorization requests are processed within 10 calendar days (72 hours for cases deemed urgent).
The criteria to review the medical necessity and appropriateness of MH/SUD services is derived primarily from two sources: Anthem Medical Policies and Clinical Utilization Management Guidelines and MCG Management 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.

Prior Authorization reviews are performed by a team of Care 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
- Medical and Surgical services
- Molecular Testing
- Outpatient Physical, Occupational and Speech Therapies
- Pediatric Long-Term Home Health
- Pediatric Personal Care Services
- Private Duty Nursing
- Synagis
- Vision

EQHealth utilizes the PAR portal, eQSuite® 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 eQSuite, secure, HIPAA compliant 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 requirements and processes for MH/SUD and M/S outpatient service prior authorization submission and determination are comparable. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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. While MH/ SUD services have longer timelines for rendering an authorization decision, the requirements and processes are comparable and applied no more stringently than M/S reviews. In addition, all timeframes for rendering a decision comply with Colorado Medicaid standards.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 – FFS (MH/SUD) + Rocky Mountain Health Plan Prime MCO (M/S)

NQTL: Prior Authorization (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to inpatient category	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Policies Consultation with HCPF staff RMHP Provider Manual Interview with RHMP Staff

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

For inpatient MD/SUD admissions, the Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program, consisting of the Colorado Prior Authorization Review (Colorado PAR) and Inpatient Hospital Review Programs (IHRP). eQHealth Solutions completes reviews for medical necessity for members not yet attributed to a RAE. Notification and Prior Authorization Policies for MH/SUD services are delineated by the Colorado PAR Program's Inpatient Hospital Review Program (IHRP). Stated Goals for IHRP are:

- Improve members' quality of care
- Facilitate better care planning and inpatient care transitions
- Ensure appropriate hospitalizations
- Improve service utilization
- Improve coding accuracy

For M/S services, RMHP's Prior Authorization policies provide the conditions for admission notification as well as the process for prior authorization submission and review for M/S benefits. 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

All participating inpatient MH/SUD facilities are responsible to notify eQHealth 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. Notification is not required for observation or emergency services. eQHealth requires a PAR for all MH/SUD inpatient level of care if a member is not yet attributed to a RAE, or the service provided does not fall under Department's capitated services. If the services are emergent or urgent (including crisis services) then an admission review is required within 24 hours of the members stabilization.

EQHealth utilizes the PAR portal, eQSuite® 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. Requests are through a dedicated online portal, or 278 daily files to eQSuite, and a small subset of exempt Providers may submit requests through fax.

For IHRP, the UM Vendor uses MCG criteria to determine appropriateness of inpatient admissions. 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 or facility's submitted information, including clinical notes, labs, test results, orders, etc. are reviewed for completeness, compliance and medical appropriateness utilizing specific HCPF 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 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 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.

For both nurse and physician reviews the completion timeframe is 1 business day from when all necessary documentation is provided for IHRP.

M/S

All participating inpatient M/S facilities are responsible to notify RMHP 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.

For M/S Acute Inpatient levels of care, authorization requests are always received by phone or voicemail. Other inpatient level requests 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 (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 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, facilities should anticipate a decision within 48 hours (2 business days).

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; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to outpatient category	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references

	Consultation with HCPF staff RMHP Provider Manual Interview with RHMP 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, the Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program; the Colorado Prior Authorization Review program (Colorado PAR). Federal rules, regulation and legislation, Colorado state rules and regulations, and benefit specific policy in addition to nationally recognized criteria (InterQual) govern reviews of outpatient PARs. PARs are only required for Pediatric Behavioral Therapy (PBT).

For M/S services, 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

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

EQHealth utilizes the PAR portal, eQSuite® 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 eQSuite, secure, HIPAA compliant 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 HCPF 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 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 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

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 (formerly Milliman Care Guidelines®) 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 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; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 – FFS (MH/SUD) + Denver Health MCO (M/S)

NQTL: Prior Authorization (IP)	Differences noted between M/S and MH/SUD services: No
Benefits included: This NQTL applies to the Inpatient category	**Evidence used for comparison:** DHMC Provider Manual DHMC "services requiring prior authorization" Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR Policies - Inpatient Hospital Review Program Consultation with HCPF staff

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

For inpatient MD/SUD admissions, the Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program, consisting of the Colorado Prior Authorization Review (Colorado PAR) and Inpatient Hospital Review Programs (IHRP). eQHealth Solutions completes reviews for medical necessity for members not yet attributed to a RAE. Notification and Prior Authorization Policies for MH/SUD services are delineated by the Colorado PAR Program's Inpatient Hospital Review Program (IHRP). Stated Goals for IHRP are:

- Improve members' quality of care
- Facilitate better care planning and inpatient care transitions
- Ensure appropriate hospitalizations
- Improve service utilization
- Improve coding accuracy

For M/S services, Denver Health Medicaid Choice's (DMHC) Utilization Management (UM) policies provide the conditions for 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 eQHealth 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. Notification is not required for observation or emergency services. eQHealth requires a PAR for all MH/SUD inpatient level of care if a member is not yet attributed to a RAE, or the service provided does not fall under Department's capitated services. If the services are emergent or urgent (including crisis services) then an admission review is required within 24 hours of the members stabilization.

EQHealth utilizes the PAR portal, eQSuite® 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. Requests are through a dedicated online portal, or 278 daily files to eQSuite, and a small subset of exempt Providers may submit requests through fax.

For IHRP, the UM Vendor uses MCG criteria to determine appropriateness of inpatient admissions. 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 or facility's submitted information, including clinical notes, labs, test results, orders, etc. are reviewed for completeness, compliance and medical appropriateness utilizing specific HCPF 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 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 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.

For both nurse and physician reviews the completion timeframe is 1 business day from when all necessary documentation is provided for IHRP.

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.

The Company's Utilization Management RNs (UM RNs) review preservice requests to determine if the request is a covered benefit and whether 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 HCPF 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; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to outpatient category	**Evidence used for comparison:** DHMC Provider Manual DHMC "services requiring prior authorization" Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Consultation with HCPF staff

Goals and Rationale: A few outpatient services are subject to prior authorization review requirements for both M/S and MH/SUD services. They are specialized services or treatments, and prior authorization review serves to establish medical appropriateness and necessity of services.

For MH/SUD services, the Department contracts with an external, third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to administer Colorado Medicaid's Utilization Management Program; the Colorado Prior Authorization Review program (Colorado PAR). Federal rules, regulation and legislation, Colorado state rules and regulations, and benefit specific policy in addition to nationally recognized criteria (InterQual) govern reviews of outpatient PARs. PARs are only required for Pediatric Behavioral Therapy (PBT).

For M/S services, DHMC's Utilization Management (UM) policies provide 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

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

EQHealth utilizes the PAR portal, eQSuite® 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 eQSuite, secure, HIPAA compliant 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 HCPF 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 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 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

Denver Health MCO Utilization Management RNs (UM RNs) review preservice requests to determine if the request is a covered benefit and whether 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 HCPF 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 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; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Prior Authorization (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the inpatient benefit category	**Evidence used for comparison:** DHMC Provider Manual DHMC "services requiring prior authorization" https://www.denverhealthmedicalplan.org/sites/default/files/2020-04/Services%20Requiring%20Prior%20Authorization%202020_All%20LOBs%20F%20v4.508.pdf
Goals and Rationale: Denver Health MCO partners with Colorado Access to operate the Denver Health MH/SUD PIHP. 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 MH/SUD admission notification as well as the process for prior authorization submission and review.	

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.

With the exception of urgent/emergent (including crisis) services, all MH/SUD inpatient level of care services require prior authorization.

MH/SUD authorization requests are submitted by fax to Colorado Access and initially reviewed by a utilization management service coordinator. Authorization Submissions can be received 24 hours/day. All authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

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 HCPF 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; when operationalized there is little to no exception or variation in the procedures, 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Outpatient benefit category	**Evidence used for comparison:** DHMC Provider Manual DHMC "services requiring prior authorization" https://www.denverhealthmedicalplan.org/sites/default/files/2020-04/Services%20Requiring%20Prior%20Authorization%202020_All%20LOBs%20F%20v4.508.pdf

Goals and Rationale: Denver Health MCO partners with Colorado Access to operate the Denver Health MH/SUD PIHP. A select set of Outpatient services require prior authorization. Denver Health's Utilization Management (UM) policies provide the process for MH/SUD and 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

Outpatient MH/SUD authorization requests are submitted by fax to Colorado Access and initially reviewed by a utilization management service coordinator. Authorization Submissions can be received 24 hours/day. All authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following

the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

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 HCPF 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, HCPF 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; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Prior Authorization (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to all Prescription Drug benefit categories.	**Evidence used for comparison:** DHMC Provider Manual DHMC Pharmacy "Prior Authorization Approval Criteria" https://www.denverhealthmedicalplan.org/sites/default/files/2020-03/Medicaid%20Choice.CHP%20Prior%20Authorization%20Criteria%202Q2020.pdf
Goals and Rationale: DHMC requires prior authorization/ exception for a select group of drugs not found on its formulary.	

Process:

Prior authorization criteria are developed following evidence-based criteria including:

a. Safety, including concurrent drug utilization review (cDUR) when applicable
b. Efficacy: the potential outcome of treatment under optimal circumstances
c. 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
d. 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
e. Relevant benefits of current formulary agents of similar use
f. 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

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	HCPF/eQHealth	IP	No	Yes
Scenario 2	RMHP & Prime MCO	IP	No	Yes
Scenario 3				
	RAE 1	IP	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				
	FFS & RMHP Prime MCO	IP, OP	No	Yes
	FFS & Denver Health MCO	IP, OP	No	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP	No	Yes

Scenario 1 – FFS

NQTL: Concurrent Reviews (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient benefit category	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff
Goals and Rationale: eQHealth Solutions is the contracted FFS UM vendor and is responsible for utilizing nurse and physician reviewers in performing MH/SUD PARs as well as 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.

Process:

MH/SUD
Concurrent/Continued Stay Reviews are required when a MH/SUD Prior Authorization has been approved and the member remains in the hospital at day four (4) overnight following the admission. These requests will be submitted at day four (4) of the member's hospitalization. A Provider should submit documentation that supports the hospital stay for Day 4. Day one (1) is considered the day that the member is admitted to an inpatient setting, and a Concurrent Review would be entered on day four (4) if the member remains admitted as inpatient.

Complex Case Reviews are required when the Concurrent Review diagnosis includes one of the following high-risk diagnoses: Neonate, Sepsis, Respiratory Failure and/or Pneumonia. Complex Case Reviews includes a more thorough review of supporting documentation to facilitate improved care coordination with Department partners, improve discharge planning and increase reporting capabilities around high-risk diagnosis. Concurrent and Complex Case Reviews currently do not result in denial of payment by the Department, but the additional data that is collected is shared from the UM Vendor to the Department and RAEs to facilitate improved care coordination and discharge planning. Complex Case reviews are completed within 4 business days.

M/S
Concurrent/Continued Stay Reviews are required when a M/S Prior Authorization has been approved and the member remains in the hospital at day four (4) overnight following the admission. These requests will be submitted at day four (4) of the member's hospitalization. A Provider should submit documentation that supports the hospital stay for Day 4. Day one (1) is considered the day that the member is admitted to an inpatient setting, and a Concurrent Review would be entered on day four (4) if the member remains admitted as inpatient.

Complex Case Reviews are required when the Concurrent Review diagnosis includes one of the following high-risk diagnoses: Neonate, Sepsis, Respiratory Failure and/or Pneumonia. Complex Case Reviews includes a more thorough review of supporting documentation to facilitate improved care coordination with Department partners, improve discharge planning and increase reporting capabilities around high-risk diagnosis. Concurrent and Complex Case Reviews currently do not result in denial of payment by the Department, but the additional data that is collected is shared from the UM Vendor to the Department and RAEs to facilitate improved care coordination and discharge planning. Complex Case reviews are completed within 4 business days but at this time do not result in an approval or denial of payment.

Finding:

Concurrent review requirements are identical. Therefore, requirements for MH/SUD benefits are **comparable to** and **not more stringent than** for M/S benefits.

Recommendations: None	**Complies with Parity Requirements: Yes**

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

NQTL: Concurrent Reviews (IP)	Differences noted between M/S and MH/SUD services: No
Benefits included: This NQTL applies to the Inpatient benefit category	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 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:

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.

M/S

Inpatient 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

- 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.

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; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1 and FFS

NQTL: Concurrent Reviews (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient benefit category	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 Data request from RMHP Interview with RMHP staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF 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

eQHealth Solutions is the contracted FFS UM vendor and 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.

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.

M/S
Inpatient FFS M/S Concurrent/Continued Stay Reviews are required under IHRP when a Prior Authorization has been approved and the member remains in the hospital at day four (4).

These requests will be submitted at day four (4) of the member's hospitalization. A Provider should submit documentation that supports the hospital stay for Day 4. Day one (1) is considered the day that the member is admitted to an inpatient setting, and a Concurrent Review would be entered on day four (4) if the member remains admitted as inpatient.

Complex Case Reviews are required when the Concurrent Review diagnosis includes one of the following high-risk diagnoses: Neonate, Sepsis, Respiratory Failure and/or Pneumonia. Complex Case Reviews includes a more thorough review of supporting documentation to facilitate improved care coordination with Department partners and improve discharge planning and increase reporting capabilities around high-risk diagnosis. Concurrent and Complex Case Reviews currently do not result in denial of payment by the Department, but the additional data that is collected is shared from the UM Vendor to the Department and RAEs to facilitate improved care coordination and discharge planning. Complex Case reviews are completed within 4 business days.

Finding:

The requirements and processes for inpatient MH/SUD concurrent review are **comparable to** and applied **no more stringently** than to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Concurrent Reviews (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient category	**Evidence used for comparison:** Beacon Health Options (Northeast Health Partners & Health Colorado) Provider Manual https://s18637.pcdn.co/wp-content/uploads/sites/26/Provider-Handbook.pdf Interview with Beacon staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF 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.

eQHealth Solutions is the contracted FFS UM vendor and 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.

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. 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 Clinical Care Manager (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

Inpatient FFS M/S Concurrent/Continued Stay Reviews are required under IHRP when a Prior Authorization has been approved and the member remains in the hospital at day four (4).

These requests will be submitted at day four (4) of the member's hospitalization. A Provider should submit documentation that supports the hospital stay for Day 4. Day one (1) is considered the day that the member is admitted to an inpatient setting, and a Concurrent Review would be entered on day four (4) if the member remains admitted as inpatient. Complex Case Reviews are required when the Concurrent Review diagnosis includes one of the following high-risk diagnoses: Neonate, Sepsis, Respiratory Failure and/or Pneumonia. Complex Care Reviews includes a more thorough review of supporting documentation to facilitate improved care coordination with Department partners and improve discharge planning and increase reporting capabilities around high-risk diagnosis. Concurrent and Complex Case Reviews currently do not result in denial of payment by the Department, but the additional data that is collected is shared from the UM Vendor to the Department and RAEs to facilitate improved care coordination and discharge planning. Complex Case reviews are completed within 4 business days. **Finding:** The requirements and processes for inpatient MH/SUD concurrent review are **comparable to** and applied **no more stringently** than to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Concurrent Reviews (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the inpatient benefit category	**Evidence used for comparison:** Colorado Access Provider Manual – Utilization Management http://3b0c642hkugknal3z1xrpau1-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/01-21-125-1219E_COA-Provider-Manual-Section-9-UM_FINAL.pdf Interview with Colorado Access Staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff

Goals and Rationale: Colorado Access utilizes concurrent review for ongoing MH/SUD services beyond the initial authorization period.

eQHealth Solutions is the contracted FFS UM vendor and 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.

Process:

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

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

All requests for ongoing services beyond the initial authorization require reauthorization. Providers are required to complete and submit the appropriate prior authorization form and fax at least one business day prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility. Providers must phone or fax clinical information supporting the medical necessity of the continued stay within one working day of the request for information from Colorado Access. Authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

M/S
Inpatient FFS M/S Concurrent/Continued Stay Reviews are required under IHRP when a Prior Authorization has been approved and the member remains in the hospital at day four (4).

These requests will be submitted at day four (4) of the member's hospitalization. A Provider should submit documentation that supports the hospital stay for Day 4. Day one (1) is considered the day that the member is admitted to an inpatient setting, and a Concurrent Review would be entered on day four (4) if the member remains admitted as inpatient.

Complex Case Reviews are required when the Concurrent Review diagnosis includes one of the following high-risk diagnoses: Neonate, Sepsis, Respiratory Failure and/or Pneumonia. Complex Care Reviews includes a more thorough review of supporting documentation to facilitate improved care coordination with Department partners and improve discharge planning and increase reporting capabilities around high-risk diagnosis. Concurrent and Complex Case Reviews currently do not result in denial of payment by the Department, but the additional data that is collected is shared from the UM Vendor to the Department and RAEs to facilitate improved care coordination and discharge planning. Complex Case reviews are completed within 4 business days.

Finding: The requirements and processes for MH/SUD inpatient concurrent reviews are **comparable to** and applied **no more stringently** than to M/S benefits. COA's policy is referencing reauthorization, after the expiration of a previous authorization approval. This differs significantly from the 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; when operationalized there is little to no exception or variation in the procedures, 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Concurrent Reviews (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the outpatient benefit category	**Evidence used for comparison:** Colorado Access Provider Manual – Utilization Management http://3b0c642hkugknal3z1xrpau1-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/01-21-125-1219E_COA-Provider-Manual-Section-9-UM_FINAL.pdf Interview with Colorado Access Staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Consultation with HCPF staff
Goals and Rationale: Colorado Access utilizes concurrent review for ongoing MH/SUD services beyond the initial authorization period. eQHealth Solutions is the contracted UM vendor and 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. **Process:** **MH/SUD** Colorado Access may utilize Concurrent Review for the following outpatient MH/SUD service categories.	

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

All requests for ongoing services beyond the initial authorization require reauthorization. Providers are required to complete and submit the appropriate prior authorization form and fax at least one business day prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility. Providers must phone or fax clinical information supporting the medical necessity of the continued stay within one working day of the request for information from Colorado Access. Authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

M/S

The Department does not current have a requirement for concurrent review for FFS outpatient M/S services.

Finding:

COA's policy is referencing reauthorization, after the expiration of a previous authorization approval. This differs significantly from the concurrent review during an authorization period. Given this fact, the requirements and processes for outpatient MH/SUD concurrent review are **comparable to** and applied **no more stringently** than to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Concurrent Reviews (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the inpatient benefit category	**Evidence used for comparison:** CCHA Provider Manual CCHA UM Program Description

	Interview with CCHA Staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff

Goals and Rationale: CCHA's rationale for MH/SUD service concurrent review is 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.

eQHealth Solutions is the contracted FFS UM vendor and 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.

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. Concurrent reviews are performed by the direct treatment provider. Determination is issued within 72 hours.

M/S
Inpatient FFS M/S Concurrent/Continued Stay Reviews are required under IHRP when a Prior Authorization has been approved and the member remains in the hospital at day four (4).

These requests will be submitted at day four (4) of the member's hospitalization. A Provider should submit documentation that supports the hospital stay for Day 4. Day one (1) is considered the day that the member is admitted to an inpatient setting, and a Concurrent Review would be entered on day four (4) if the member remains admitted as inpatient.

Complex Case Reviews are required when the Concurrent Review diagnosis includes one of the following high-risk diagnoses: Neonate, Sepsis, Respiratory Failure and/or Pneumonia. Complex Care Reviews includes a more thorough review of supporting documentation to facilitate improved care coordination with Department partners and improve discharge planning and increase reporting capabilities around high-risk diagnosis. Concurrent and Complex Case Reviews currently do not result in denial of payment by the Department, but the additional data that is collected is shared from the UM Vendor to the Department and RAEs to facilitate improved care coordination and discharge planning. Complex Case reviews are completed within 4 business days.

Finding:

The requirements and processes for inpatient MH/SUD concurrent review are **comparable to** and applied **no more stringently** than to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 – FFS (MH/SUD) + Rocky Mountain Health Plan Prime MCO (RMHP) (M/S)

NQTL: Concurrent Reviews (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the inpatient benefit category	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff RMHP Provider Manual – Updated January 2020 Data request from RMHP Interview with RMHP staff

Goals and Rationale: eQHealth Solutions is the contracted UM vendor and is responsible for utilizing nurse and physician reviewers in performing MH/SUD 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.

RMHP defines M/S 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:

MH/SUD
Inpatient FFS MH/SUD Concurrent/Continued Stay Reviews are required under IHRP when a Prior Authorization has been approved and the member remains in the hospital at day four (4).

These requests will be submitted at day four (4) of the member's hospitalization. A Provider should submit documentation that supports the hospital stay for Day 4. Day one (1) is considered the day that the member is admitted to an inpatient setting, and a Concurrent Review would be entered on day four (4) if the member remains admitted as inpatient.

Concurrent Reviews currently do not result in denial of payment by the Department, but the additional data that is collected is shared from the UM Vendor to the Department and RAEs to facilitate improved care coordination and discharge planning.

M/S

Inpatient 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.

Finding:

The requirements and processes for inpatient MH/SUD concurrent review are **comparable to** and applied **no more stringently** than to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 – FFS (MH/SUD) + Denver Health MCO (M/S)

NQTL: Concurrent Reviews (IP)	Differences noted between M/S and MH/SUD services: No
Benefits included: This NQTL applies to the inpatient benefit category	**Evidence used for comparison:** DHMC Provider Manual DHMC Policies-Utilization Review Determinations including approvals and actions Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff

Goals and Rationale: eQHealth Solutions is the contracted UM vendor and is responsible for utilizing nurse and physician reviewers in performing MH/SUD 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.

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

Inpatient MH/SUD Concurrent/Continued Stay Reviews are required when a Prior Authorization has been approved and the member remains in the hospital at day four (4) overnight following the admission. There are no exceptions for the concurrent review process.

These requests will be submitted at day four (4) of the member's hospitalization. A Provider should submit documentation that supports the hospital stay for Day 4. Day one (1) is considered the day that the member is admitted to an inpatient setting, and a Concurrent Review would be entered on day four (4) if the member remains admitted as inpatient.

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:

The requirements and processes for inpatient MH/SUD concurrent review are **comparable to** and applied **no more stringently** than to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Concurrent Reviews (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the inpatient benefit category	**Evidence used for comparison:** DHMC Provider Manual DHMC Policies Utilization Review Determinations including approvals and actions

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

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

All requests for ongoing services beyond the initial authorization require reauthorization. Providers are required to complete and submit the appropriate prior authorization form and fax at least one business day prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility. Providers must phone or fax clinical information supporting the medical necessity of the continued stay within one working day of the request for information from Colorado Access. Authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

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:

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

COA's policy is referencing 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; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

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	HCPF/eQHealth	IP, OP	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP, EC	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				
	FFS & RMHP Prime MCO	IP, OP	No	Yes
	FFS & Denver Health MCO	IP, OP	No	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP	No	Yes

Scenario 1 – FFS

NQTL: Retrospective Reviews (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the inpatient and outpatient benefit categories	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff
Goals and Rationale: The Colorado Prior Authorization Review – Inpatient Hospital Review Program (IHRP) defines retrospective reviews 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
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.

M/S
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.

At the time of this report, the retrospective review process for MH/SUD and M/S benefits has been suspended due to the Covid-19 pandemic.

Recommendations: None	**Complies with Parity Requirements: Yes**

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

NQTL: Retrospective Reviews (IP, OP & EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient, outpatient, and emergency care benefit categories	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 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
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 review ensures that appropriate level of care and quality services were provided.

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. Retrospective review ensures that appropriate level of care and quality services were provided.
Retrospective reviews of MH/SUD 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.

M/S
Retrospective review of inpatient 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 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 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.

Finding:

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

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1 and FFS

NQTL: Retrospective Reviews (IP, OP and EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient, outpatient, and emergency care benefit categories	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 Data request from RMHP

	Interview with RMHP staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF 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. M/S retrospective review policies are defined in the Colorado Prior Authorization Review – Inpatient Hospital Review Program (IHRP) 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.
Retrospective reviews of MH/SUD 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.

M/S
For M/S benefits, there are cases where 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 at 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.

At the time of this report, the retrospective review process for FFS M/S benefits has been suspended due to the Covid-19 pandemic.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Retrospective Reviews (IP, OP & EC)	Differences noted between M/S and MH/SUD services: No
Benefits included: This NQTL applies to the Inpatient, outpatient, and emergency care benefit categories	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff Beacon Health Options (Northeast Health Partners & Health Colorado) Provider Manual https://s18637.pcdn.co/wp-content/uploads/sites/26/Provider-Handbook.pdf 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.

M/S retrospective review policies are defined in the Colorado Prior Authorization Review – Inpatient Hospital Review Program (IHRP) 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:

- The facility was unable to define that the patient was a RAE member due to patient's mental status
- The member's eligibility was approved retrospectively following the admission
- Provision of emergency room assessment and care.

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
For M/S benefits, there are cases where 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 at 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.

At the time of this report, the retrospective review process for FFS M/S benefits has been suspended due to the Covid-19 pandemic.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Retrospective Reviews (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient benefit category	**Evidence used for comparison:** Colorado Access Provider Manual – Utilization Management http://3b0c642hkugknal3z1xrpau1-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/01-21-125-1219E_COA-Provider-Manual-Section-9-UM_FINAL.pdf Interview with Colorado Access Staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF 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.	

M/S retrospective review policies are defined in the Colorado Prior Authorization Review – Inpatient Hospital Review Program (IHRP) 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

All requests for ongoing services beyond the initial authorization require reauthorization. Providers are required to complete and submit the appropriate prior authorization form and fax at least one business day prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility. Providers must phone or fax clinical information supporting the medical necessity of the continued stay within one working day of the request for information from Colorado Access. Authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

M/S
For M/S benefits, there are cases where 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 at 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; when operationalized there is little to no exception or variation in the procedures, 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.

At the time of this report, the retrospective review process for FFS M/S benefits has been suspended due to the Covid-19 pandemic.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Retrospective Reviews (OP & EC)	Differences noted between M/S and MH/SUD services: No
Benefits included: This NQTL applies to the outpatient, and emergency care benefit categories	Evidence used for comparison: Colorado Access Provider Manual – Utilization Management http://3b0c642hkugknal3z1xrpau1-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/01-21-125-1219E_COA-Provider-Manual-Section-9-UM_FINAL.pdf Interview with Colorado Access Staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF 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.

M/S retrospective review policies are defined in the Colorado Prior Authorization Review – Inpatient Hospital Review Program (IHRP) 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 of the following MH/SUD services to Retrospective Review, including, but not limited to:

- Day Treatment
- MH Intensive Outpatient Services
- SUD Intensive Outpatient Services
- Electroconvulsive Therapy
- Psychological Testing

All requests for ongoing services beyond the initial authorization require reauthorization. Providers are required to complete and submit the appropriate prior authorization form and fax at least one business day prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility. Providers must phone or fax clinical information supporting the medical necessity of the continued stay within one working day of the request for information from Colorado Access. Authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which

a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

M/S
For M/S benefits, there are cases where a member may not be eligible for Colorado Medicaid at the time of admission, but retroactive eligibility is obtained post discharge. A retrospective authorization will be required as soon as the 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; when operationalized there is little to no exception or variation in the procedures, 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.

At the time of this report, the retrospective review process for FFS M/S benefits has been suspended due to the Covid-19 pandemic.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Retrospective Reviews (IP, OP & EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient, outpatient, and emergency care benefit categories	**Evidence used for comparison:** Colorado Access Provider Manual – Utilization Management http://3b0c642hkugknal3z1xrpau1-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/01-21-125-1219E_COA-Provider-Manual-Section-9-UM_FINAL.pdf Interview with Colorado Access Staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF 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.	

M/S retrospective review policies are defined in the Colorado Prior Authorization Review – Inpatient Hospital Review Program (IHRP) 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

All requests for ongoing services beyond the initial authorization require reauthorization. Providers are required to complete and submit the appropriate prior authorization form and fax at least one business day prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility. Providers must phone or fax clinical information supporting the medical necessity of the continued stay within one working day of the request for information from Colorado Access. Authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

M/S
For M/S benefits, there are cases where 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 at 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; when operationalized there is little to no exception or variation in the procedures, 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.

At the time of this report, the retrospective review process for FFS M/S benefits has been suspended due to the Covid-19 pandemic.

Recommendations: None	Complies with Parity Requirements: Yes

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Retrospective Reviews (IP, OP & EC)	Differences noted between M/S and MH/SUD services: No
Benefits included: This NQTL applies to the Inpatient, outpatient, and emergency care benefit categories	Evidence used for comparison: CCHA Provider Manual CCHA UM Program Description Interview with CCHA Staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff

Goals and Rationale: The goals of the Behavioral Health UM program include: (1) ensuring adequacy of service availability and accessibility to eligible members; (2) maximizing appropriate behavioral health care relative to medical necessity guidelines and policy; and (3) monitoring over- and/or under-utilization of behavioral health services (4)ensuring timeliness of determinations and notifications to member and provider of adverse benefit determinations (5) monitoring and minimizing ER utilization with specific focus on behavioral health diagnosis(6) reduction in re-admission to BH. This program's policy's govern MH/SUD retrospective reviews.

M/S retrospective review policies are defined in the Colorado Prior Authorization Review – Inpatient Hospital Review Program (IHRP) 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 days 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 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
For M/S benefits, there are cases where 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 at 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

At the time of this report, the retrospective review process for FFS M/S benefits has been suspended due to the Covid-19 pandemic.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 – FFS (MH/SUD) and Rocky Mountain Health Plan Prime MCO (RMHP)(M/S)

NQTL: Retrospective Reviews (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient and outpatient benefit categories	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 Data request from RMHP Interview with RMHP staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy

	Colorado PAR Program provider training references Consultation with HCPF staff

Goals and Rationale: MH/SUD retrospective review policies are defined in the Colorado Prior Authorization Review – Inpatient Hospital Review Program (IHRP) 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.

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 M/S retrospective reviews.

Process:

MH/SUD
For MH/SUD benefits, there are some cases where 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 at post discharge. A retrospective authorization will be required as soon as the inpatient facility becomes aware of the member's eligibility.

M/S
Retrospective review of inpatient 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 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 reviews of 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.

Finding:

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

At the time of this report, the retrospective review process for FFS MH/SUD benefits has been suspended due to the Covid-19 pandemic.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 – FFS (MH/SUD) + Denver Health MCO (M/S)

NQTL: Retrospective Reviews (IP & OP)	Differences noted between M/S and MH/SUD services: No
Benefits included: This NQTL applies to the Inpatient and outpatient benefit categories	**Evidence used for comparison:** DMHC Provider Manual Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff

Goals and Rationale: MH/SUD retrospective review policies are defined in the Colorado Prior Authorization Review program 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.

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
For MH/SUD benefits, there are some cases where 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 at post discharge. A retrospective authorization will be required as soon as the inpatient facility becomes aware of the member's eligibility.

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 CCR 702-4, series 4-2-17, section 6, item C.

DHMC utilizes both internally approved guidelines as well as National Criteria Sets; InterQual or MCG. It also uses the Medicare Coverage Database, HCPF Benefits Collaborative, and Hayes Knowledge Center to determine the medical necessity of requested services. The timeline for determination is 30 days.

Finding: Retrospective Review processes for MH/SUD benefits are comparable to and no more stringent than for M/S benefits. At the time of this report, the retrospective review process for FFS MH/SUD benefits has been suspended due to the Covid-19 pandemic.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Retrospective Reviews (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the inpatient and outpatient benefit category	**Evidence used for comparison:** DHMC Provider Manual DHMC Pharmacy "Prior Authorization Approval Criteria" https://www.denverhealthmedicalplan.org/sites/default/files/2020-03/Medicaid%20Choice.CHP%20Prior%20Authorization%20Criteria%202Q2020.pdf

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

All requests for ongoing services beyond the initial authorization require reauthorization. Providers are required to complete and submit the appropriate prior authorization form and fax at least one business day prior to the expiration of the previous authorization. Providers are responsible for tracking their authorization start dates, end dates, number of units used, and member eligibility. Providers must phone or fax clinical information supporting the medical necessity of the continued stay within one working day of the request for information from Colorado Access. Authorization requests are processed as expeditiously as the enrollee's health condition requires and within the specific line of business requirements, which are within 10 calendar days (72 hours for cases in which a Provider, or Colorado Access, determine that following the standard authorization timeframe could seriously jeopardize the member's life or health or his or her ability to attain, maintain, or regain maximum function).

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 CCR 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, HCPF 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; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

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	HCPF/eQHealth	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	OP	No	Yes
	RAE 6 & 7	N/A	*N/A*	*N/A*
Scenario 4				
	FFS & RMHP Prime MCO	N/A	*N/A*	*N/A*
	FFS & Denver Health MCO	N/A	*N/A*	*N/A*
Scenario 5	Denver PIHP & Denver Health MCO	PD	No	Yes

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

NQTL: Fail First/Step Therapy (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Prescription Drug benefit category.	**Evidence used for comparison:** 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:** For both M/S and MH/SUD 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.

Finding:

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

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Fail First/Step Therapy (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to all Outpatient category.	**Evidence used for comparison:** Colorado Access Data Response

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 programs policy's govern MH/SUD fail first/step therapy guidelines.

Process:

Step Therapy is only used for Psychological Testing. COA recommends members receive a diagnostic psychiatric evaluation (with a board-certified psychiatrist) prior to authorizing psychological testing. The rationale is a psychiatric evaluation is more comprehensive, leads to clinically actionable findings, and is less restrictive than standard psychological testing protocols (usually 8-12 hours of testing), which present a burden on patients and caregivers. Most MH/SUD diagnoses can be established by a psychiatrist in a far shorter service duration and be directly connected to initiation or change in treatment.

Though we received the above response concerning MH/SUD outpatient services, we do not define this protocol as a fail first/step therapy policy.

Finding:

This policy references a specific requirement where an assessment is required prior to initiation of testing. The requirement that an assessment be completed prior to further treatment is a standard industry practice across MH/SUD and M/S services. Therefore, the requirements and processes for

the fail first/step therapy for MH/SUD benefits are **comparable to** and applied **no more stringently** than to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Fail First/Step Therapy Protocols (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to all Prescription Drug benefit categories.	**Evidence used for comparison:** DHMC Provider Manual DMHC Step Therapy Approval Criteria https://www.denverhealthmedicalplan.org/sites/default/files/2020-03/Medicaid%20Choice.CHP%20Step%20Therapy%20Criteria_2Q2020.pdf
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 (MH/SUD & M/S):** DHMC utilizes step therapy approval criteria for 39 specific drugs. Of the 39 drugs, 6 are MH/SUD specific drugs. **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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

APPENDIX E - CONDITIONING BENEFITS ON A 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	HCPF/eQHealth	IP, OP	No	Yes
Scenario 2	RMHP & Prime MCO	IP, OP, EC, 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				
	FFS & RMHP Prime MCO	IP, OP	No	Yes
	FFS & Denver Health MCO	IP, OP	No	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP	No	Yes

Scenario 1 – FFS

NQTL: Medical Appropriateness Reviews (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient and outpatient benefit categories	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF 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

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 HCPF 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 HCPF 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 (BCBS-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 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 HCPF 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 HCPF 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 (BCBS-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 requirements and processes for MH/SUD medical appropriateness reviews are **comparable to** and applied **no more stringently** than to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

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

NQTL: Medical Appropriateness Reviews (IP, OP & EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the inpatient, outpatient, and emergency care benefit categories	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 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.

Process:

MH/SUD

The criteria utilized to make MH/SUD medical necessity and appropriateness decisions for all RMHP UM processes are based on nationally-recognized standards of practice for medical services and are applied on an individual need 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. Concurrent Review nurses apply clinical guidelines to determine medical necessity for the admit and for continued stay. 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).

M/S

The criteria utilized to make M/S medical necessity and appropriateness decisions for all RMHP UM processes are based on nationally-recognized standards of practice for medical services and are

applied on an individual need 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. Concurrent Review nurses apply clinical guidelines to determine medical necessity for the admit and for continued stay. 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).

Finding:

The requirements and processes for MH/SUD medical appropriateness reviews are **comparable to** and applied **no more stringently** than to M/S benefits. The policies follow standard industry practice, when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Medical Appropriateness Reviews (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Prescription Drug benefit category	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 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.

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.

Finding:

The requirements and processes for MH/SUD medical appropriateness reviews for prescription drugs are **comparable to** and applied **no more stringently** than to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures,

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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1 and FFS

NQTL: Medical Appropriateness Reviews (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient and outpatient categories	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff RMHP Provider Manual – Updated January 2020 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.

Process:

MH/SUD

The criteria utilized to make MH/SUD medical necessity and appropriateness decisions for all RMHP UM processes are based on nationally-recognized standards of practice for medical services and are applied on an individual need 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. Concurrent Review nurses apply clinical guidelines to determine medical necessity for the admit and for continued stay. 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).

M/S

EQHealth Solutions is the contracted FFS UM vendor for the Department's M/S services Fee-for-service plan. The 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 Medical Appropriateness Review criteria for MH/SUD benefits are **comparable** to and applied **no more stringentl**y to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: **It is recommended that the Department determine and ensure alignment of the chosen nationally recognized, clinical best practice criteria.**	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Medical Appropriateness Reviews (IP & OP)	**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
Benefits included: This NQTL applies to the Inpatient and outpatient categories	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff Beacon Health Options (Northeast Health Partners & Health Colorado) Provider Manual https://s18637.pcdn.co/wp-content/uploads/sites/26/Provider-Handbook.pdf 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
Beacon's clinical criteria for MH/SUD services, also known as medically necessary criteria, are based on nationally recognized resources, including 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.
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).

M/S
EQHealth Solutions is the contracted FFS UM vendor for the Department's M/S services Fee-for-service plan. The 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 policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Medical Appropriateness Reviews (IP & OP)	Differences noted between M/S and MH/SUD services: No
Benefits included: This NQTL applies to the Inpatient and outpatient categories	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF staff Colorado Access Provider Manual – Utilization Management http://3b0c642hkugknal3z1xrpau1-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/01-21-125-1219E_COA-Provider-Manual-Section-9-UM_FINAL.pdf Interview with Colorado Access 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

Colorado Access (COA) makes Utilization Review determinations based on professionally recognized written criteria or established guidelines and specifies the procedures to apply those criteria in an appropriate and consistent manner. COA utilizes nationally recognized clinical criteria and relevant community standards of care for utilization review. COA first purchased InterQual criteria in 1998. COA has maintained annual licensure for InterQual criteria and uses these criteria for Utilization Review determinations for all lines of business. If InterQual does not have criteria for a service or level of care, Colorado Access applies its own criteria.

COA assures that all clinical decision-making criteria are consistent with the Clinical Practice and Preventative Health Guidelines reviewed and approved by the COA Health Strategy Committee. COA ensures that any UM criteria or service limitations for MH/SUD are no more restrictive than the predominant UM criteria or service limitations under the M/S benefits for the same treatment classification.

M/S

EQHealth Solutions is the contracted FFS UM vendor for the Department's M/S services Fee-for-service plan. The 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 Medical Appropriateness Review criteria for MH/SUD benefits are **comparable** to and applied **no more stringentl**y to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Medical Appropriateness Reviews (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient and outpatient categories	**Evidence used for comparison:** Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF 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.

Process:

MH/SUD

For MH/SUD benefits, CCHA has partnered with Anthem for their BH expertise. The criteria to review the medical necessity and appropriateness of MH/SUD services is derived primarily from two sources:

Anthem Medical Policies and Clinical Utilization Management Guidelines and MCG Management 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.

M/S

EQHealth Solutions is the contracted FFS UM vendor for the Department's M/S services Fee-for-service plan. The 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 Medical Appropriateness Review criteria for MH/SUD benefits are **comparable** to and applied **no more stringentl**y to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 – FFS and Rocky Mountain Health Plan Prime MCO (M/S)

NQTL: Medical Appropriateness Reviews (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient and outpatient benefit categories	**Evidence used for comparison:** RMHP Provider Manual – Updated January 2020 Data request from RMHP Interview with RMHP staff Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF 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
EQHealth Solutions is the contracted FFS UM vendor for the Department's MH/SUD services Fee-for-service plan, where a RAE has not been assigned. The 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 for inpatient services. For outpatient services first level reviewers are BCBA's while second level reviewers are BCBA-Doctoral Level clinicians.

M/S
The criteria utilized to make M/S medical necessity and appropriateness decisions for all RMHP UM processes are based on nationally-recognized standards of practice for medical services and are applied on an individual need 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.

Concurrent Review nurses apply clinical guidelines to determine medical necessity for the admit and for continued stay. 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).

Finding:

The Medical Appropriateness Review criteria for MH/SUD benefits are **comparable** to and applied **no more stringentl**y to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 - FFS (MH/SUD) + Denver Health MCO(M/S)

NQTL: Medical Appropriateness Reviews (IP & OP)	**Differences noted between M/S and MH/SUD services:** No

Benefits included: This NQTL applies to the Inpatient and outpatient benefit categories	**Evidence used for comparison:** DMHC Provider Manual DHMC Policies Clinical Criteria for Utilization Management Utilization Review Determinations including approvals and actions Colorado Medicaid Rules and Regulations HCPF Benefit Policy Colorado PAR Program provider training references Colorado PAR - Inpatient Hospital Review Program Consultation with HCPF 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

EQHealth Solutions is the contracted FFS UM vendor for the Department's MH/SUD services Fee-for-service plan, where a RAE has not been assigned. The vendor utilizes nationally recognized clinical best practice criteria with MCG for Inpatient and InterQual for outpatient benefits. In any instance in which InterQual or MCG 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 for inpatient services. For outpatient services first level reviewers are BCBA's while second level reviewers are BCBA-Doctoral Level clinicians.

M/S

For 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 (DHMP) 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 Medical Appropriateness Review criteria for MH/SUD benefits are **comparable** to and applied **no more stringentl**y to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Medical Appropriateness Reviews (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the inpatient and outpatient benefit category	**Evidence used for comparison:** DHMC Provider Manual DHMC Policies Clinical Criteria for Utilization Management Utilization Review Determinations including approvals and actions

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 partners with Colorado Access (COA) to operate the Denver Health MH/SUD PIHP.

Process:

MH/SUD
Colorado Access (COA) makes Utilization Review determinations based on professionally recognized written criteria or established guidelines and specifies the procedures to apply those criteria in an appropriate and consistent manner. COA utilizes nationally recognized clinical criteria and relevant community standards of care for utilization review. COA first purchased InterQual criteria in 1998. COA has maintained annual licensure for InterQual criteria and uses these criteria for Utilization Review determinations for all lines of business. If InterQual does not have criteria for a service or level of care, Colorado Access applies its own criteria.

COA assures that all clinical decision-making criteria are consistent with the Clinical Practice and Preventative Health Guidelines reviewed and approved by the COA Health Strategy Committee. COA ensures that any UM criteria or service limitations for MH/SUD are no more restrictive than the predominant UM criteria or service limitations under the M/S benefits for the same treatment classification.

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 Medical Appropriateness Review criteria for MH/SUD benefits are **comparable** to and applied **no more stringentl**y to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

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	*HCPF/eQHealth*		*N/A*	*N/A*
Scenario 2	*RMHP & Prime MCO*		*N/A*	*N/A*
Scenario 3				
	RAE 1		*N/A*	*N/A*
	RAE 2 & 4	IP, OP	No	Yes
	RAE 3 & 5		*N/A*	*N/A*
	RAE 6 & 7	IP, OP	No	Yes
Scenario 4				
	FFS & RMHP Prime MCO		*N/A*	*N/A*
	FFS & Denver Health MCO		*N/A*	*N/A*
Scenario 5	*Denver PIHP & Denver Health MCO*		*N/A*	*N/A*

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

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Outlier Management (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient and outpatient benefit categories	**Evidence used for comparison:** Interview with Beacon staff Beacon Data Request Consultation with HCPF 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** Beacon Health Options 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 utilizes an overutilization management program in part, based on data derived from eQsuite, the contracted FFS UM vendor as well as HCPF claims data. Cases exhibiting high cost or high utilization are referred for further review, through the complex case review program. eQHealth provides reporting to the Department on inappropriate levels of care or inpatient stays that exceed normal standards. The department analyzes this data for use in future policy setting. At this time, no denial of services or payment would occur as a result of this practices.

Finding:

The outlier management processes for MH/SUD benefits are **comparable** to and applied **no more stringentl**y to M/S benefits. The policies follow standard industry practice; when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Outlier Management (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: This NQTL applies to the Inpatient and outpatient benefit categories	**Evidence used for comparison:** Interview with CCHA Staff Notes CCHA 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:

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 MH/SUD 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 utilizes an overutilization management program in part, based on data derived from eQsuite, the contracted FFS UM vendor as well as HCPF claims data. Cases exhibiting high cost or high utilization are referred for further review, through the complex case review program. eQsuite provides reporting to the Department on inappropriate levels of care or inpatient stays that exceed normal standards. The department analyzes this data for use in future policy setting. No denial of services or payment would occur as a result of this practices.

Finding:

The outlier management processes for MH/SUD benefits are **comparable** to and applied **no more stringentl**y to M/S benefits. The policies follow standard industry practice, when operationalized there is little to no exception or variation in the procedures, 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

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.

	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	HCPF/eQHealth	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				
	FFS & RMHP Prime MCO	IP, OP	No	Yes
	FFS & Denver Health MCO	IP, OP	No	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP	No	Yes

Scenario 1 – FFS

NQTL: Coding Limitations (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to inpatient and outpatient benefit categories**	**Evidence used for comparison:** Data Request from HCPF Interviews with key HCPF staff https://www.colorado.gov/pacific/hcpf/behavioral-ffs https://www.colorado.gov/pacific/hcpf/gen-info-manual EPSDT Program Definition Section 1905 of the Social Security Act

	42 U.S. Code SubCharter 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 HCPF for fee-for-service MH/SUD and M/S services.

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.

Recommendations: None	**Complies with Parity Requirements: Yes**

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

NQTL: Coding Limitations (IP & OP)	Differences noted between M/S and MH/SUD services: No
Benefits included: **This NQTL applies to inpatient and outpatient benefit categories.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with key Rocky Mountain Health Plans staff https://www.rmhp.org/-/media/RMHPdotOrg/Files/PDF/Provider/Commonly-used-forms/RMHP-BH-Provider-Manual.ashx https://www.colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%20Jan%202019%20-%20December%2031%2C%202018.pdf

Goals and Rationale: Coding limitations are used for inpatient and outpatient, in accordance with the Uniform Service Coding Standards Manual for MH/SUD.

Process:

MH/SUD
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 medical/surgical benefits under the MCO and the RAE for MH/SUD benefits.

Recommendations: None	Complies with Parity Requirements: Yes

Scenario 3 – RAE 1 and FFS

NQTL: Coding Limitations (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to inpatient and outpatient benefit categories.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with key Rocky Mountain Health Plans staff Interview with key HCPF staff https://www.rmhp.org/-/media/RMHPdotOrg/Files/PDF/Provider/Commonly-used-forms/RMHP-BH-Provider-Manual.ashx https://www.colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%20Jan%202019%20-%20December%2031%2C%202018.pdf https://www.colorado.gov/pacific/hcpf/gen-info-manual

Goals and Rationale: Coding limitations are used for inpatient and outpatient in accordance with the Colorado Medicaid provider billing manual from HCPF for fee-for-service M/S services and the Uniform Service Coding Standards Manual for MH/SUD services.

Process:

MH/SUD
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 medical/surgical benefits under FFS and the RAE for MH/SUD benefits.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 2 & 4 and FFS

NQTL: Coding Limitations (IP & OP)	Differences noted between M/S and MH/SUD services: No
Benefits included: **This NQTL applies to inpatient and outpatient benefit categories.**	**Evidence used for comparison:** 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 HCPF Staff http://www.coaccess.com/documents/Provider%20Manual%20Section%206.pdf https://www.colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%20Jan%202019%20-%20December%2031%2C%202018.pdf https://www.colorado.gov/pacific/hcpf/gen-info-manual

Goals and Rationale: Coding limitations are used for inpatient and outpatient in accordance with the Colorado Medicaid provider billing manual from HCPF for fee-for-service M/S services and the Uniform Service Coding Standards Manual for MH/SUD services.

Process:

MH/SUD

Beacon Health Options manages the billing codes for Northeast Health Partners and Health Colorado. They follow the Uniform Services Coding Manual as to allowed coding configuration. 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 HCPF 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 medical/surgical benefits under FFS and the RAE for MH/SUD benefits

Recommendations: None	Complies with Parity Requirements: Yes

Scenario 3 – RAE 3 & 5 and FFS

NQTL: Coding Limitations (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to inpatient and outpatient benefit categories.**	**Evidence used for comparison:** Data Request from Colorado Access Interview with key Colorado Access staff Interview with key HCPF Staff https://s18637.pcdn.co/wp-content/uploads/sites/25/Provider-Handbook.pdf https://www.colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%20Jan%202019%20-%20December%2031%2C%202018.pdf https://www.colorado.gov/pacific/hcpf/gen-info-manual
Goals and Rationale: Coding limitations are used for inpatient and outpatient services, in accordance with the Colorado Medicaid provider billing manual from HCPF for fee-for-service M/S services and the Uniform Service Coding Standards Manual for MH/SUD services. **Process:** **MH/SUD** 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 medical/surgical benefits under FFS and the RAE for MH/SUD benefits.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 6 & 7 and FFS

NQTL: Coding Limitations (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to inpatient and outpatient benefit categories.**	**Evidence used for comparison:** Data Request from CCHA Interview with key CCHA staff Data Request from HCPF Interviews with key HCPF staff https://www.cchacares.com/media/1402/aco-pm-0006-20-annual-review-co-provider-manual_final_w_cover.pdf https://www.colorado.gov/pacific/hcpf/gen-info-manual

Goals and Rationale: Coding limitations are used for inpatient and outpatient services in accordance with the Colorado Medicaid provider billing manual from the Department for fee-for-service M/S services and the Uniform Service Coding Standards Manual for MH/SUD services.

Process:

MH/SUD

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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 – FFS (MH/SUD) and Rocky Mountain Health Plan Prime MCO (M/S)

NQTL: Coding Limitations (IP & OP)	Differences noted between M/S and MH/SUD services: No
Benefits included: **This NQTL applies to inpatient and outpatient benefit categories.**	**Evidence used for comparison:** Data Request from Denver Health and Rocky Mountain Health Plans Interview with Denver Health staff Interview with Rocky Mountain Health Plans staff Data Request from HCPF Interviews with key HCPF staff https://www.denverhealthmedicalplan.org/sites/default/files/2019-05/Provider%20Manual%202019.pdf https://www.colorado.gov/pacific/hcpf/gen-info-manual

Goals and Rationale: There are members of the Denver Health and Rocky Mountain Health Plans MCOs that receive individual services through the Department's fee-for-service structure. Coding limitations are used for inpatient and outpatient services, in accordance with the Colorado Medicaid provider billing manual from the Department for fee-for-service M/S services and the Uniform Service Coding Standards Manual for MH/SUD services.

Process:

MH/SUD
Denver Health and Rocky Mountain Health Plan Prime MCO use coding programs that contain complete sets of rules that correspond to CPT-4, HCPCS, ICD-10, AMA, and CMS guidelines as well as industry standards, medical policy and literature, and NCCI (National Correct Coding Initiative) edits and rules for medical/surgical benefits. Providers are required to submit claims in accordance with these rules.

M/S
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. The claims processing system uses the CMS-mandated National Correct Coding Initiative (NCCI) to impose nationally recognized and standardized limits for MH/SUD services.

Codes are added and deleted based on the annual revisions of CPT. Revisions to HCPCS listings are documented in Provider Bulletins issued by HCPF and HCPCS publications are replaced annually.

Finding: Coding limitations follow similar processes for medical/surgical benefits under the managed care organizations and under FFS for MH/SUD benefits.
Recommendations: None / **Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO – Denver Health and PIHP

NQTL: Coding Limitations (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to inpatient and outpatient benefit categories.**	**Evidence used for comparison:** Data Request from Denver Health Interview with Denver Health staff https://www.denverhealthmedicalplan.org/sites/default/files/2019-05/Provider%20Manual%202019.pdf

Goals and Rationale: Members in the Denver Health plan receive most MH/SUD services through the RAE. 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
The RAE uses HCPCS to identify services provided to eligible recipients. HCPCS codes (Level 1) include CPT codes. The claims transaction system utilizes the CMS-mandated Correct Coding Initiative (CCI) edits and American Medical Association's (AMA) Current Procedural Terminology (CPT) guidelines to evaluate coding accuracy.

M/S
Denver Health MCO uses the HCPF billing code for medical/surgical 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 the RAE and Denver Health PIHP.

Recommendations: None	**Complies with Parity Requirements: Yes**

APPENDIX J - MEDICAL NECESSITY

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 Colorado HCPF 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, 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	Yes – Colorado access is using a different definition of medical necessity	Yes
	RAE 6 & 7	IP, OP, EC, PD	No	Yes
Scenario 4				
	FFS & RMHP Prime MCO	IP, OP, EC	No	Yes
	FFS & Denver Health MCO	IP, OP, EC	No	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	Yes – Colorado access is using a different definition of medical necessity	Yes

Scenario 1 – FFS

Per interviews with HCPF staff, no medical necessity criteria are applied on fee-for-service MH/SUD claims. Claims are paid as submitted.

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

NQTL: Medical Necessity (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to inpatient and outpatient benefits**	**Evidence used for comparison:** Data Request from RMHP

	Interview with RMHP staff Medicaid Directives and Bulletins: https://www.colorado.gov/hcpf/bulletins

Goals and Rationale: Medical necessity criteria for inpatient services are applied to MH/SUD and physical health 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.

Process:

MH/SUD
For MH services, RMHP uses Optum to apply the following MH/SUD criteria to establish medical necessity for inpatient and outpatient MH services:

a. Adults - American Association of Community Psychiatrist's Level of Care Utilization System (LOCUS) Adult Version 20
b. Children ages 6-17 - American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument (CASII) Version 4.1
c. Children 0-5 years of age - American Academy of Child and Adolescent Psychiatry's Early Childhood Service Intensity Instrument.

For SUD services, RMHP uses Optum to apply the American Society of Addiction Medicine (ASAM) criteria to establish medical necessity for inpatient and outpatient SUD services.

M/S
For M/S benefits, (addresses both in network and out of network) 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 HCPF 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. RAE and Prime members use the statewide network of providers and request prior authorization to go out of network.

Finding:

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

Recommendations: None	**Complies with Parity Requirements: Yes**

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

NQTL: Medical Necessity (EC)	**Differences noted between M/S and MH/SUD services:** **No**

Benefits included: **This NQTL applies to emergency care benefits.**	**Evidence used for comparison:** Data Request from RMHP Interview with RMHP staff
Goals and Rationale: Medical Necessity criteria for emergency care 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. **Process:** **MH/SUD** Emergency MH services are generally covered without review, while applying legally recognized "prudent layperson" logic when applicable, such as determining if out-of-network services were urgent or emergent. Emergency SUD services are generally covered without review, while applying legally recognized "prudent layperson" logic when applicable, such as determining if out-of-network services were urgent or emergent. **M/S** Emergency M/S services are generally covered without review, while applying legally recognized "prudent layperson" logic when applicable, such as determining if out-of-network services were urgent or emergent. **Finding:** The processes followed for defining and applying medical necessity for MH/SUD and M/S services are substantially similar and comply with parity requirements.	
Recommendations: None	**Complies with Parity Requirements: Yes**

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

NQTL: Medical Necessity (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to Prescription Drug benefits.**	**Evidence used for comparison:** Data Request from RMHP Interview with RMHP staff https://www.colorado.gov/hcpf/bulletins
Goals and Rationale: Medical Necessity criteria for pharmaceuticals are applied to MH/SUD and physical health 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

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.

MH Criteria for medical necessity is determined during P&T (pharmacy & therapeutics committee) review of the drug. Criteria are developed from various sources including but not limited to FDA approved PI, clinical guidelines (APA, AAP, etc.), clinical trials, and professional opinion. Requirements are communicated via the formulary and drug specific forms that outline specific 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 or FE is submitted, review of the case occurs to decide if coverage is appropriate. UM 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.

SUD criteria for medical necessity is determined during P&T (pharmacy & therapeutics committee) review of the drug. Criteria are developed from various sources including but not limited to FDA approved PI, clinical guidelines (ASAM), clinical trials, and professional opinion. 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. UM and 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.

M/S

M/S 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 or FE is submitted, review of the case occurs to decide if coverage is appropriate. UM 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1

NQTL: Medical Necessity (IP & OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to inpatient and outpatient benefits**	**Evidence used for comparison:** Data Request from RMHP Interview with RMHP staff Data Request from HCPF and UM Vendor Interview with HCPF and UM Vendor staff

Goals and Rationale: 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 Department's UM vendor, eQHealth Solutions.

Process:

MH/SUD
RMHP uses Optum to apply the following MH/SUD criteria to establish medical necessity for inpatient MH/SUD services:

a. Adults - American Association of Community Psychiatrist's Level of Care Utilization System (LOCUS) Adult Version 20
b. Children ages 6-17 - American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument (CASII) Version 4.1
c. Children 0-5 years of age - American Academy of Child and Adolescent Psychiatry's Early Childhood Service Intensity Instrument.

For SUD services, RMHP uses Optum to apply the American Society of Addiction Medicine (ASAM) criteria to establish medical necessity for inpatient SUD services.

M/S
eQHealth Solutions, the HCPF 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 Colorado Statue 10 CCR 2505-10 8.076.1.8 and 8.280.4.E:

8. Medical necessity means that a Medical Assistance program good or service:
   a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.
   b. Is provided in accordance with generally accepted professional standards for health care in the United States.
   c. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
   d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
   e. Is delivered in the most appropriate setting(s) required by the client's condition.
   f. Is not experimental or investigational; and
   g. Is not more costly than other equally effective treatment options.

Per an interview with HCPF staff and further data gathering from eQHealth Solutions, CedarBridge was able to determine that eQHealth Solutions uses both InterQual and MCG standards to assist with specific medical necessity determinations for physical health 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 eQHealth/HCPF use substantially the same process to determine medical necessity for MH/SUD and M/S benefits respectively and are compliant with parity. Though no difference was found in application of criteria, the use of different clinical criteria by the different RAEs and HCPF's UM vendor could allow for different determinations based solely on differences in criteria and it is recommended those criteria be required to be the same.

Recommendations:	**Complies with Parity Requirements: Yes**
HCPF should seek to standardize medical necessity criteria used by RAEs and their UM vendor to the same InterQual/MCG or InterQual/ASAM standard.	

Scenario 3 – RAE 1

NQTL: Medical Necessity (EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to emergency care benefits.**	**Evidence used for comparison:** Data Request from RMHP

	Interview with RMHP staff Medicaid Directives and Bulletins: https://www.colorado.gov/hcpf/bulletins

Goals and Rationale: Medical Necessity criteria for emergency care are applied to MH/SUD services for members in RAE 1 using Medicaid Directives and Bulletins, RMHP, MCG and Evicore Clinical policies. Medical Necessity criteria for emergency care are applied to medical/surgical services for members in RAE 1 by HCPF's UM vendor, eQHealth Solutions.

Process:

MH/SUD
Emergency MH services are generally covered without review, while applying legally recognized "prudent layperson" logic when applicable, such as determining if out-of-network services were urgent or emergent.

Emergency SUD services are generally covered without review, while applying legally recognized "prudent layperson" logic when applicable, such as determining if out-of-network services were urgent or emergent.

M/S
Emergency M/S services are generally covered without review. The UM vendor adhere to the definition of medical necessity as defined in Colorado Statue 10 CCR 2505-10 8.076.1.8 and 8.280.4.E:

8. Medical necessity means that a Medical Assistance program good or service:
   a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.
   b. Is provided in accordance with generally accepted professional standards for health care in the United States.
   c. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
   d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
   e. Is delivered in the most appropriate setting(s) required by the client's condition.
   f. Is not experimental or investigational; and
   g. Is not more costly than other equally effective treatment options.

Per an interview with HCPF staff and further data gathering from the eQHealth, it was determined that eQHealth uses both InterQual and MCG standards to assist with specific medical necessity determinations for physical health claims.

Finding:

RMHP and eQHealth use substantially the same process for defining and applying medical necessity for emergency care for MH/SUD and M/S benefits. Though no difference was found in application of criteria, the use of different clinical criteria by the different RAEs and HCPF's UM vendor could allow

for different determinations based solely on differences in criteria and it is recommended those criteria be required to be the same.	
Recommendations: **HCPF should seek to standardize medical necessity criteria used by RAEs and their UM vendor to the same InterQual/MCG or InterQual/ASAM standard.**	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1

NQTL: Medical Necessity (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to Prescription Drug benefits.**	**Evidence used for comparison:** Data Request from RMHP Interview with RMHP staff https://www.colorado.gov/hcpf/bulletins

Goals and Rationale: Medical Necessity criteria for pharmaceuticals are applied to MH/SUD services for members in RAE 1 pharmacy & therapeutics committee review processes.

Process:

MH/SUD

Pharmacy Criteria for medical necessity is determined during HCPF 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. A 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.

SUD criteria for medical necessity is determined during HCPF P&T (pharmacy & therapeutics committee) review of the drug. Criteria are developed from various sources including but not limited to FDA approved PI, clinical guidelines (ASAM), clinical trials, and professional opinion. 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. UM and 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.

M/S

M/S medical necessity is determined during HCPF 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 or FE is submitted, review of the case occurs to decide if coverage is appropriate. UM 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:

The medical necessity process for MH/SUD and M/S prescription drug benefits is substantially similar and is in compliance with parity.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 2 & 4

NQTL: Medical Necessity (IP, OP, EC, & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to inpatient, outpatient, emergency care, and Prescription Drug benefit categories.**	**Evidence used for comparison:** Data Request from Northeast Health Partners and Health Colorado Interview with Beacon Health Options, Northeast Health Partners and Health Colorado Data Request from HCPF and UM Vendor Interview with HCPF and UM Vendor Staff
Goals and Rationale: Medical necessity criteria for all benefit categories are applied to MH/SUD services for members in RAE 1 using standards from InterQual and ASAM. For inpatient and outpatient medical/surgical services, the fee-for-service criteria are applied by the Department's UM vendor, eQHealth Solutions. **Process:**	

MH/SUD

The RAE, Beacon Health Options and the UM vendor define medical necessity according to the same definition established by the Colorado Department of Healthcare Policy and Financing. A medically necessary service is one that:

1. Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.
2. Is provided in accordance with generally accepted professional standards for health care in the United States.
3. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
4. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
5. Is delivered in the most appropriate setting(s) required by the client's condition.
6. Is not experimental or investigational.
7. Is not costlier than other equally effective treatment options.

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.

M/S

HCPF contracts with an external third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to determine medical necessity for fee-for-service M/S benefits.

Per an interview with HCPF staff and further data gathering from eQHealth Solutions, CedarBridge was able to determine that eQHealth Solutions uses both InterQual and MCG standards to assist with specific medical necessity determinations for physical health 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. Though no difference was found in application of criteria, the use of different clinical

criteria by the different RAEs and HCPF's UM vendor could allow for different determinations based solely on differences in criteria and it is recommended those criteria be required to be the same.	
Recommendations: **HCPF should seek to standardize medical necessity criteria used by RAEs and their UM vendor to the same InterQual/MCG or InterQual/ASAM standard.**	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 3 & 5

NQTL: Medical Necessity (IP, OP, EC, & PD)	**Differences noted between M/S and MH/SUD services:** **Yes. The medical necessity definition used for MH/SUD is different from the definition for M/S.**
Benefits included: **This NQTL applies to inpatient, outpatient, emergency care, and Prescription Drug benefit categories.**	**Evidence used for comparison:** Data Request from Colorado Health Access Interview with Colorado Health Access staff Data Request from HCPF and UM Vendor Interview with HCPF and UM Vendor Staff

Goals and Rationale: Medical necessity determinations for MH/SUD and M/S follow similar processes. Colorado Community Health Alliance makes medical necessity determinations for RAE 6 & 7. The Department contracts with an external third-party Utilization Management (UM) vendor, eQHealth Solutions, to determine medical necessity for fee-for-service M/S benefits for these members.

Process:

MH/SUD
While the definition used by Colorado Access has substantial similarities to the state definition, there are irregularities that could cause the application of the definition in practice to be different from the application of the statute definition.

Those covered mental health, or SUD services which are determined under the applicable Utilization Management (UM) Program to be:

1. Appropriate, necessary, and reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the symptoms, pain, or suffering of a diagnosed medical condition, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability

The statute reads "will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an

illness, condition, injury or disability. This may include a course of treatment that includes mere observation or no treatment at all." The exclusion of "symptoms" does not allow for consistent application with statute. The other missing clause is included in this definition as #10 and is substantially similar.

2. Consistent with the symptoms, diagnosis, and treatment of a member's medical condition

While this clause may be desirable, it is not consistent with the statutory definition.

3. Within standards of scientific evidence and good medical practice using current clinical principles and processes within the organized medical community of the treating provider

While this clause may be desirable, it is not consistent with the statutory definition.

4. Clinically appropriate in terms of type, frequency, extent, site, and duration

Substantially consistent with statutory definition.

5. Not primarily for the economic benefit of the provider or primarily for the convenience of the member, caretaker, or the treating provider

Substantially consistent with statutory definition

6. Consistent with the Utilization Management Program and policies, Quality Management Program and policies, and program benefit requirements applicable to the program benefits under which the covered services are rendered

While this clause may be desirable, it is not consistent with the statutory definition.

7. Delivered in the most appropriate setting required by the member's condition and cost-effective service or supply consistent with generally accepted medical standards of care; failure to provide the service would adversely affect the member's health. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member's condition, and that safe, cost effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.

While this clause may be desirable, it is not consistent with the statutory definition.

8. Not experimental, investigational, unproven, unusual, or not customary

This clause is similar to the statutory definition, but goes further by including "unproven, unusual or not customary". The inclusion of these additional categories does not allow for consistent application with the statute.

9. Not solely for cosmetic purposes

While desirable, this is not part of the statutory definition.

10. May include a course of treatment that includes mere observation or no treatment at all

Substantially consistent with statutory definition included in #1

M/S
HCPF contracts with an external third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to determine medical necessity for fee-for-service M/S benefits.

Per an interview with HCPF staff and further data gathering from eQHealth Solutions, CedarBridge was able to determine that eQHealth Solutions uses both InterQual and MCG standards to assist with specific medical necessity determinations for physical health 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.

M/S prescription drug medical necessity is determined during HCPF 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).

Finding:

While the definitions are different, there was no evidence that in application this definition resulted in differences in determinations of medical necessity for MH/SUD services. The process complies with parity requirements. Though no difference was found in application of criteria, the use of different clinical criteria by the different RAEs and HCPF's UM vendor could allow for different determinations based solely on differences in criteria and it is recommended those criteria be required to be the same.

Recommendations:	**Complies with Parity Requirements: No**
HCPF should require Colorado Access to use the statutory definition of medical necessity in applying its policies and processes. **HCPF should seek to standardize medical necessity criteria used by RAEs and their UM vendor to the same InterQual/MCG or InterQual/ASAM standard.**	

Scenario 3 – RAE 6 & 7

NQTL: Medical Necessity (IP, OP, EC, & PD)	Differences noted between M/S and MH/SUD services: No
Benefits included: **This NQTL applies to inpatient, outpatient, emergency care, and Prescription Drug benefit categories.**	**Evidence used for comparison:** Data Request from Colorado Community Health Alliance Interview with Colorado Community Health Alliance Data Request from HCPF and UM Vendor Interview with HCPF and UM Vendor Staff

Goals and Rationale: Medical necessity determinations for MH/SUD and M/S follow similar processes. Colorado Community Health Alliance makes medical necessity determinations for RAE 6 & 7. HCPF contracts with an external third-party Utilization Management (UM) vendor, eQHealth Solutions, to determine medical necessity for fee-for-service M/S benefits for these members.

Process:

MH/SUD

The CCHA MH/SUD UM Program uses the statutory definition of medical necessity and follows established procedures for applying medical necessity criteria, MCG Management Guidelines, unless superseded by state requirements or regulatory guidance, 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.

Clinical information for making determinations of coverage may include, but not be limited to:

1) Office and/or hospital records
2) A history of the presenting problem
3) Clinical exam(s)
4) Results from diagnostic testing
5) Treatment plans and progress notes
6) Psychosocial history
7) Consultations with the treating practitioner(s)
8) Evaluations from other health care practitioners and providers
9) Laboratory results
10) Rehabilitation evaluations
11) Criteria related to request
12) Information regarding benefits for services and/or procedures
13) Information regarding the local delivery system
14) Member's characteristics and information
15) Information from responsible family member(s)
16) Member's safety issues

17) Community support services to promote recovery

M/S
HCPF contracts with an external third-party FFS Utilization Management (UM) Vendor, eQHealth Solutions, to determine medical necessity for fee-for-service M/S benefits.

Per an interview with HCPF staff and further data gathering from eQHealth Solutions, CedarBridge was able to determine that eQHealth Solutions uses both InterQual and MCG standards to assist with specific medical necessity determinations for physical health 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.

M/S prescription drug medical necessity is determined during HCPF 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).

Finding:

While the definitions are different, there was no evidence that in application this definition resulted in differences in determinations of medical necessity for MH/SUD services. The process complies with parity requirements. Though no difference was found in application of criteria, the use of different clinical criteria by the different RAEs and HCPF's UM vendor could allow for different determinations based solely on differences in criteria and it is recommended those criteria be required to be the same.

Recommendations: **HCPF should seek to standardize medical necessity criteria used by RAEs and their UM vendor to the same InterQual/MCG or InterQual/ASAM standard.**	**Complies with Parity Requirements: Yes**

Scenario 4 -- FFS (MH/SUD) and Rocky Mountain Health Plan Prime MCO (M/S)
FFS (MH/SUD) and Denver Health (M/S)

NQTL: Medical Necessity (IP, OP, & EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to inpatient, outpatient, and emergency care benefits**	**Evidence used for comparison:** Data Request from RMHP

	Data Request from Denver Health Data Request from HCPF Interview with RMHP staff Interview with Denver Health staff Consultation with HCPF staff

Goals and Rationale: Medical necessity criteria for inpatient and outpatient services are applied to physical health services for members in the Denver Health MCO and Rocky Prime, the Rocky Mountain Health Plan MCO using Medicaid Directives and Bulletins, RMHP, MCG and Evicore Clinical policies.

Process:

MH/SUD
The Department manages medical necessity determinations for inpatient and outpatient MH/SUD fee-for-service benefits that are not managed by the RAEs, using the statutory definition.

M/S
For M/S, DHMC follows the MCG care guidelines to determine medical necessity.

For M/S benefits, (addresses both in network and out of network) 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 HCPF 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. RAE and Prime members use the statewide network of providers and request prior authorization to go out of network.

Finding:

The processes used by the state, Denver Health and Rocky Prime are substantially similar and meet the requirements of parity.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Medical Necessity (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **Yes. The medical necessity definition used for MH/SUD is different from the definition for M/S.**
Benefits included:	**Evidence used for comparison:**

This NQTL applies to inpatient, outpatient, emergency care, and Prescription Drug benefit categories.	Data Request from Denver Health Data Request from Colorado Access Interview with Denver Health staff Interview with Colorado Access staff Denver Health Policy: "Clinical Criteria for Utilization Management Decisions"

Goals and Rationale: Medical necessity determinations for MH/SUD and M/S follow similar processes. MH/SUD management is subcontracted to Colorado Access and they make medical necessity determinations. Denver Health makes medical necessity determinations for M/S benefits.

Process:

MH/SUD

While the definition used by Colorado Access has substantial similarities to the state definition, there are irregularities that could cause the application of the definition in practice to be different from the application of the statute definition.

Those covered mental health, or SUD services which are determined under the applicable Utilization Management (UM) Program to be:

1. Appropriate, necessary, and reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the symptoms, pain, or suffering of a diagnosed medical condition, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability

The statute reads "will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, condition, injury or disability. This may include a course of treatment that includes mere observation or no treatment at all." The exclusion of "symptoms" does not allow for consistent application with statute. The other missing clause is included in this definition as #10 and is substantially similar.

2. Consistent with the symptoms, diagnosis, and treatment of a member's medical condition

While this clause may be desirable, it is not consistent with the statutory definition.

3. Within standards of scientific evidence and good medical practice using current clinical principles and processes within the organized medical community of the treating provider

While this clause may be desirable, it is not consistent with the statutory definition.

4. Clinically appropriate in terms of type, frequency, extent, site, and duration

Substantially consistent with statutory definition.

5. Not primarily for the economic benefit of the provider or primarily for the convenience of the member, caretaker, or the treating provider

Substantially consistent with statutory definition

6. Consistent with the Utilization Management Program and policies, Quality Management Program and policies, and program benefit requirements applicable to the program benefits under which the covered services are rendered

While this clause may be desirable, it is not consistent with the statutory definition.

7. Delivered in the most appropriate setting required by the member's condition and cost-effective service or supply consistent with generally accepted medical standards of care; failure to provide the service would adversely affect the member's health. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member's condition, and that safe, cost effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.

While this clause may be desirable, it is not consistent with the statutory definition.

8. Not experimental, investigational, unproven, unusual, or not customary

This clause is similar to the statutory definition, but goes further by including "unproven, unusual or not customary". The inclusion of these additional categories does not allow for consistent application with the statute.

9. Not solely for cosmetic purposes

While desirable, this is not part of the statutory definition.

10. May include a course of treatment that includes mere observation or no treatment at all

Substantially consistent with statutory definition included in #1.

M/S
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 (HCPF) Benefits Collaborative:* The Colorado HCPF 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:

While the definitions are different, there was no evidence that in application this definition resulted in differences in determinations of medical necessity for MH/SUD services. The process complies with parity requirements.

Recommendations:	**Complies with Parity Requirements: Yes**
HCPF should require Colorado Access to use the statutory definition of medical necessity in applying its policies and processes.	

HCPF should seek to standardize medical necessity criteria used by RAEs and their UM vendor to the same InterQual/MCG or InterQual/ASAM standard.	

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	HCPF/eQHealth	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				
	FFS & RMHP Prime MCO	IP, OP, EC, PD	No	Yes
	FFS & Denver Health MCO	IP, OP, EC, PD	No	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	No	Yes

Scenario 1 - FFS

NQTL: Network Provider Admission **(IP, OP, EC & PD)**	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories**	**Evidence used for comparison:** Data Request from HCPF Consultation with HCPF staff
Goals and Rationale: Network provider admission standards are in place to ensure providers meet a standard set of criteria and are known to HCPF prior to billing for Medicaid services. **Process:**	

The fee-for-service MH/SUD and M/S health plans do not limit provider participation beyond basic enrollment requirements (i.e. practitioner must be licensed to enroll, etc.). There is not a cap on the number of providers allowed to enroll and provide services. There is no notable difference between network admission requirements for fee-for-service MH/SUD and M/S providers.	
Recommendations: None	**Complies with Parity Requirements: Yes**

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

NQTL: Network Provider Admission (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans 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. **Process:** RMHP accepts any willing provider who meets their credential standards and is willing to accept and negotiate reasonable reimbursement for services. 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1

NQTL: Network Provider Admission (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans 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. **Process:**	

RMHP accepts any willing provider who meets their credential standards and is willing to accept and negotiate reasonable reimbursement for services. 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 2 & 4

NQTL: Network Provider Admission (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Northeast Health Partners, Health Colorado, and Beacon Health Options Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options staff
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:** Northeast Health Partners, Health Colorado and Beacon Health Options accept any willing provider who meets their credential standards and is willing to accept and negotiate reasonable reimbursement for services. 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 RAEs and those for the Department for M/S fee-for-service providers.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 3 & 5

NQTL: Network Provider Admission (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Colorado Access Interview with Colorado Access staff

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:** Colorado Access accepts any willing provider who meets their credential standards and is willing to accept and negotiate reasonable reimbursement for services. 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 6 & 7

NQTL: Network Provider Admission (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Colorado Community Health Alliance Interview with Colorado Community Health Alliance staff
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:** Colorado Community Health Alliance accepts any willing provider who meets their credential standards and is willing to accept and negotiate reasonable reimbursement for services. There is no notable difference between the Colorado Community Health Alliance network admission requirements for MH/SUD providers in the RAE and those for the Department for M/S fee-for-service providers.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 -- FFS (MH/SUD) and Rocky Mountain Health Plan Prime MCO (M/S)
FFS (MH/SUD) and Denver Health (M/S)

NQTL: Network Provider Admission (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**

Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from HCPF Data Request from Denver Health Data Request from Rocky Mountain Health Plans
Goals and Rationale: Network provider admission standards are in place to ensure providers meet a standard set of criteria and are known to HCPF, Denver Health and Rocky Mountain Health Plans prior to billing for Medicaid services. **Process:** The Department's MH/SUD fee-for-service system does not limit provider participation beyond basic enrollment requirements (i.e. practitioner must be licensed to enroll, etc.). There is no notable difference between the Department network admission requirements for MH/SUD providers in the fee-for-service system and those for Denver Health and Rocky Mountain Health Plans for M/S fee-for-service providers.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Network Provider Admission (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Denver Health Interview with Denver Health staff
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. **Process:** MH/SUD management to Colorado Access. Colorado Access accepts any willing provider who meets their credential standards and is willing to accept and negotiate reasonable reimbursement for services. 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

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	HCPF/eQHealth	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, 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				
	FFS & RMHP Prime MCO	IP, OP, EC, PD	No	Yes
	FFS & Denver Health MCO	IP, OP, EC, PD	No	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	No	Yes

Scenario 1 - FFS

NQTL: Establishing Charge/Reimbursement Rates (IP)	**Differences noted between M/S and MH/SUD services:** **Yes – Different processes for M/S and MH/SUD**
Benefits included: **This NQTL applies to the inpatient benefit category.**	**Evidence used for comparison:** Data Request from HCPF Consultation with HCPF staff
Goals and Rationale: The Department should establish charges/reimbursement rates of payment for participant services in a no more restrictive manner for MH/SUD services than for M/S services. **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.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the outpatient benefit category.**	**Evidence used for comparison:** Data Request from HCPF Consultation with HCPF staff
Goals and Rationale: The Department should establish charges/reimbursement rates of payment for participant services in a no more restrictive manner for MH/SUD services than for M/S services. **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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the emergency care benefit category.**	**Evidence used for comparison:**

	Data Request from HCPF Consultation with HCPF staff
Goals and Rationale: The Department should establish charges/reimbursement rates of payment for participant services in a no more restrictive manner for MH/SUD services than for M/S services. **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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the prescription drug benefit category.**	**Evidence used for comparison:** Data Request from HCPF Consultation with HCPF staff
Goals and Rationale: The Department should establish charges/reimbursement rates of payment for participant services in a no more restrictive manner for MH/SUD services than for M/S services. **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, HCPF 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

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

NQTL: Establishing Charge/Reimbursement Rates (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the inpatient benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff

Goals and Rationale: Rocky Mountain Health Plans should use industry standard processes to establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

1. **M/S** (addresses both in network and out of network)
   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.
2. **MH**
   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.
3. **SUD**
   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.

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.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the outpatient benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans

	Interview with Rocky Mountain Health Plans staff

Goals and Rationale: Rocky Mountain Health Plans should use industry standard processes to establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

1. **M/S** (addresses both in network and out of network)
   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.
2. **MH**
   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.
3. **SUD**
   RMHP 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.

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.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the emergency care benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff

Goals and Rationale: Rocky Mountain Health Plans should use industry standard processes to establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

1. **M/S**
   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.
2. **MH**
   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.
3. **SUD**
   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.

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.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the Prescription Drug drug benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff

Goals and Rationale: Rocky Mountain Health Plans should use industry standard processes to establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1

NQTL: Establishing Charge/Reimbursement Rates (IP)	Differences noted between M/S and MH/SUD services: No
Benefits included: **This NQTL applies to the inpatient benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff

Goals and Rationale: Rocky Mountain Health Plans should use industry standard processes to establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

Rocky Mountain Health Plans uses the "usual and customary or reasonable charges" standard for its rate setting process. 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.

1. **MH**
   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 may determine Usual and Customary charges and or Reasonable Charges on the basis of practice location or region within the State.
2. **SUD**
   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 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 process used by RMHP is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.

Recommendations: None	Complies with Parity Requirements: Yes

NQTL: Establishing Charge/Reimbursement Rates (OP)	Differences noted between M/S and MH/SUD services: No
Benefits included: **This NQTL applies to the outpatient benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff

Goals and Rationale: Rocky Mountain Health Plans should use industry standard processes to establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

Rocky Mountain Health Plans uses the "usual and customary or reasonable charges" standard for its rate setting process. 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.

1. **MH**
   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.
2. **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.

For 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 process used by RMHP is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.

Recommendations: None	Complies with Parity Requirements: Yes

NQTL: Establishing Charge/Reimbursement Rates (EC)	Differences noted between M/S and MH/SUD services: No
Benefits included: **This NQTL applies to the emergency care benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff

Goals and Rationale: Rocky Mountain Health Plans should use industry standard processes to establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

Rocky Mountain Health Plans uses the "usual and customary or reasonable charges" standard for its rate setting process. 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.

1. **MH**
   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.

2. **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.

For 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 process used by RMHP is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**
NQTL: Establishing Charge/Reimbursement Rates (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the prescription drug benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff

Goals and Rationale: Rocky Mountain Health Plans should use industry standard processes to establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

Rocky Mountain Health Plans uses the "usual and customary or reasonable charges" standard for its rate setting process. 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.

1. **MH**
   For a claim to be paid at point-of-sale, the pharmacy must be included in the pharmacy network. Direct member reimbursement (DMR) is a process that may allow for out of network claims to reimburse the member if criteria is met and options are limited at the time of service.

2. **SUD**
   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.

For M/S prescribed pharmaceuticals, HCPF 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 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 ASP minus 4.5%.

Finding:

The process used by RMHP is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 2 & 4

NQTL: Establishing Charge/Reimbursement Rates (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the inpatient benefit category.**	**Evidence used for comparison:** Data Request from Northeast Health Partners Data Request from Health Colorado Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options
Goals and Rationale: Northeast Health Partners and Health Colorado should establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.	

Process:

MH/SUD
Beacon uses the "usual and customary or reasonable charges" standard for its rate setting process. The rate structure also substantially follows rates established by HCPF 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 HCPF. Beacon has made adjustments to rates in regions where recruitment or access is more challenging.

M/S
For M/S services, HCPF 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 process used by Northeast Health Partners and Health Colorado is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the outpatient benefit category.**	**Evidence used for comparison:** Data Request from Northeast Health Partners Data Request from Health Colorado Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options

Goals and Rationale: Northeast Health Partners and Health Colorado should establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

MH/SUD
Beacon uses the "usual and customary or reasonable charges" standard for its rate setting process. The rate structure also substantially follows rates established by HCPF 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 HCPF. Beacon has made adjustments to rates in regions where recruitment or access is more challenging.

M/S
For M/S services, HCPF 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 HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the emergency care benefit category.**	**Evidence used for comparison:** Data Request from Northeast Health Partners Data Request from Health Colorado Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options

Goals and Rationale: Northeast Health Partners and Health Colorado should establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

MH/SUD
Beacon uses the "usual and customary or reasonable charges" standard for its rate setting process. The rate structure also substantially follows rates established by HCPF 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 HCPF. Beacon has made adjustments to rates in regions where recruitment or access is more challenging.

M/S
For M/S services, HCPF 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 process used by Northeast Health Partners and Health Colorado is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the prescription drug benefit category.**	**Evidence used for comparison:** Data Request from Northeast Health Partners Data Request from Health Colorado Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options

Goals and Rationale: Northeast Health Partners and Health Colorado should establish charges/reimbursement rates of payment for participant services in a comparable and no more restrictive manner for MH/SUD services than for M/S services.

Process:

MH/SUD

Beacon uses the "usual and customary or reasonable charges" standard for its rate setting process. The rate structure also substantially follows rates established by HCPF 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 HCPF. Beacon has made adjustments to rates in regions where recruitment or access is more challenging.

M/S

For M/S prescribed pharmaceuticals, HCPF bases the payment on an average acquisition cost with a multiplier. If the average acquisition cost is unavailable, HCPF uses the average wholesale cost with a multiplier.

For M/S physician administered pharmaceuticals, the rate is based off Medicare data. Fees are updated quarterly. If data is not available, HCPF uses the Medicare ASP minus 4.5%.

Finding: The process used by Northeast Health Partners and Health Colorado is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 3 & 5

NQTL: Establishing Charge/Reimbursement Rates (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the inpatient benefit category.**	**Evidence used for comparison:** Data Request from Colorado Access Interview with Colorado Access

Goals and Rationale: Colorado Access should establish charges/reimbursement rates of payment for participant services in a no more restrictive manner for MH/SUD services than for M/S services.

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.

Colorado Access Policy PNS216 – Provider Reimbursement Rates states:

> Colorado Access reimburses providers for approved covered services based on either the contracted rate (for participating providers, including those with a single case agreement) or based on the non-participating provider rates set in this policy.

The policy also outlines the non-par rates.

M/S
For M/S services, HCPF 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 process used by Colorado Access is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.	
Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the outpatient benefit category.**	**Evidence used for comparison:** Data Request from Colorado Access Interview with Colorado Access
Goals and Rationale: Colorado Access should establish charges/reimbursement rates of payment for participant services in a no more restrictive manner for MH/SUD services than for M/S services. **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. Colorado Access Policy PNS216 – Provider Reimbursement Rates states: > Colorado Access reimburses providers for approved covered services based on either the contracted rate (for participating providers, including those with a single case agreement) or based on the non-participating provider rates set in this policy. The policy also outlines the non-par rates. **M/S** For 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 process used by Colorado Access is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.	
Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (EC)	Differences noted between M/S and MH/SUD services: No
Benefits included: **This NQTL applies to the emergency care benefit category.**	**Evidence used for comparison:** Data Request from Colorado Access Interview with Colorado Access

Goals and Rationale: Colorado Access should establish charges/reimbursement rates of payment for participant services in a no more restrictive manner for MH/SUD services than for M/S services.

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.

Colorado Access Policy PNS216 – Provider Reimbursement Rates states:

> Colorado Access reimburses providers for approved covered services based on either the contracted rate (for participating providers, including those with a single case agreement) or based on the non-participating provider rates set in this policy.

The policy also outlines the non-par rates.

M/S
For 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 process used by Colorado Access is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.

Recommendations: None	Complies with Parity Requirements: Yes

NQTL: Establishing Charge/Reimbursement Rates (PD)	Differences noted between M/S and MH/SUD services: No
Benefits included:	**Evidence used for comparison:** Data Request from Colorado Access

This NQTL applies to the prescription drug benefit category.	Interview with Colorado Access

Goals and Rationale: Colorado Access should establish charges/reimbursement rates of payment for participant services in a no more restrictive manner for MH/SUD services than for M/S services.

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.

Colorado Access Policy PNS216 – Provider Reimbursement Rates states:

> Colorado Access reimburses providers for approved covered services based on either the contracted rate (for participating providers, including those with a single case agreement) or based on the non-participating provider rates set in this policy.

The policy also outlines the non-par rates.

M/S
For 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 M/S physician administered pharmaceuticals, the rate is based off Medicare data. Fees are updated quarterly. If data is not available, HCPF uses the Medicare ASP minus 4.5%.

Finding:

The process used by Colorado Access is industry standard, comparable and no more stringent than that used by HCPF for fee-for-service M/S services and is therefore compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 6 & 7

NQTL: Establishing Charge/Reimbursement Rates (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the inpatient benefit category.**	**Evidence used for comparison:** Data Request from Colorado Community Health Alliance

	Interview with Colorado Community Health Alliance staff
Goals and Rationale: Colorado Community Health Alliance should establish charges/reimbursement rates of payment for participant services a in no more restrictive manner for MH/SUD services than for M/S services. **Process:** **MH/SUD** The plan 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 desire is to attract an adequate network of providers when developing its approach to establishing charges is considered. 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 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:** CCHA follows a process that is industry standard and comparable to the process used by HCPF and is applied no more stringently so it is compliant with parity requirements.	
Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the outpatient benefit category.**	**Evidence used for comparison:** Data Request from Colorado Community Health Alliance Interview with Colorado Community Health Alliance staff
Goals and Rationale: Colorado Community Health Alliance should establish charges/reimbursement rates of payment for participant services a in no more restrictive manner for MH/SUD services than for M/S services. **Process:**	

MH/SUD
The plan 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 desire is to attract an adequate network of providers when developing its approach to establishing charges is considered. 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 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:

CCHA follows a process that is industry standard and comparable to the process used by HCPF and is applied no more stringently so it is compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to emergency care benefit category.**	**Evidence used for comparison:** Data Request from Colorado Community Health Alliance Interview with Colorado Community Health Alliance staff

Goals and Rationale: Colorado Community Health Alliance should establish charges/reimbursement rates of payment for participant services a in no more restrictive manner for MH/SUD services than for M/S services.

Process:

MH/SUD
The plan 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 desire is to attract an adequate network of providers when developing its approach to establishing charges is considered. 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.

M/S
For 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:

CCHA follows a process that is industry standard and comparable to the process used by HCPF and is applied no more stringently so it is compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 -- FFS (MH/SUD) and Rocky Mountain Health Plan Prime MCO (M/S)
FFS (MH/SUD) and Denver Health (M/S)

NQTL: Establishing Charge/Reimbursement Rates (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the inpatient benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Data Request from Denver Health Data Request from HCPF Interview with Rocky Mountain Health Plans staff Interview with Denver Health staff Consultation with HCPF staff

Goals and Rationale: The Department should establish charges/reimbursement rates of payment for participant services in no more restrictive a manner for MH/SUD services than for M/S services.

Process:

MH/SUD
For MH/SUD 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.

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: The process used by HCPF is substantially similar and no more stringent than the process used by Rocky Mountain Health Plans and Denver Health for M/S services and is compliant with parity requirements.
Recommendations: None | **Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the outpatient benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Data Request from Denver Health Data Request from HCPF Interview with Rocky Mountain Health Plans staff Interview with Denver Health staff Consultation with HCPF staff

Goals and Rationale: The Department should establish charges/reimbursement rates of payment for participant services in no more restrictive a manner for MH/SUD services than for M/S services.

Process:

MH/SUD
For MH/SUD 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.

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:

The process used by HCPF is substantially similar and no more stringent than the process used by Rocky Mountain Health Plans and Denver Health for M/S services and is compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the emergency care benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Data Request from Denver Health Data Request from HCPF Interview with Rocky Mountain Health Plans staff Interview with Denver Health staff Consultation with HCPF staff
Goals and Rationale: The Department should establish charges/reimbursement rates of payment for participant services in no more restrictive a manner for MH/SUD services than for M/S services. **Process:** **MH/SUD** For MH/SUD 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. **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:** The process used by HCPF is substantially similar and no more stringent than the process used by Rocky Mountain Health Plans and Denver Health for M/S services and is compliant with parity requirements.	
Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Establishing Charge/Reimbursement Rates (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the prescription drug category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Data Request from Denver Health

	Data Request from HCPF Interview with Rocky Mountain Health Plans staff Interview with Denver Health staff Consultation with HCPF staff
Goals and Rationale: The Department should establish charges/reimbursement rates of payment for participant services in no more restrictive a manner for MH/SUD services than for M/S services. **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 ASP minus 4.5%. **Finding:** The process used by HCPF is substantially similar and no more stringent than the process used by Rocky Mountain Health Plans and Denver Health for M/S services and is compliant with parity requirements.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Establishing Charge/Reimbursement Rates (IP, OP, EC and PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Denver Health Interview with Denver Health staff
Goals and Rationale: Denver Health should establish charges/reimbursement rates of payment for participant services in a no more restrictive manner for MH/SUD services than for M/S services. **Process:** **MH/SUD** Denver Health contracts out its behavioral health services to Colorado Access. Colorado Access has a standard rate guide that dictates base rates for all network and non-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 HCPF.	

Colorado Access Policy PNS216 – Provider Reimbursement Rates states:

> Colorado Access reimburses providers for approved covered services based on either the contracted rate (for participating providers, including those with a single case agreement) or based on the non-participating provider rates set in this policy.

The policy also outlines the non-par rates.

M/S
Denver Health Managed Care is a full risk, capitated plan that pays the Medicaid rates for services. One-time agreements with providers that designate out of network rates can be negotiated.

Finding:

The process used by Colorado Access is industry standard, comparable and applied no more stringently than the process used by Denver Health for setting its rates and is compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

APPENDIX M - RESTRICTIONS BASED ON GEOGRAPHIC LOCATION, FACILITY TYPE, OR 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.

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	*HCPF/eQHealth*		*N/A*	*N/A*
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	Yes	Yes
	RAE 6 & 7	IP, OP, EC, PD	No	Yes
Scenario 4				
	FFS & RMHP Prime MCO	IP, OP, EC, PD	No	Yes
	FFS & Denver Health MCO	IP, OP, EC, PD	No	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	Yes	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: Restrictions Based on Geographic Location, Facility Type or Provider Specialty (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the inpatient benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff
Goals and Rationale: Rocky Mountain Health Plans is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place.	

Process:

M/S (addresses both in network and out of network)
RAE and Prime members use the statewide network of validated providers https://www.HealthFirstcolorado.com/find-doctors/ for inpatient M/S services. Requests for out of network services require prior authorization. Some medical necessity criteria require appropriate medical or surgical specialization and credentialing to perform a procedure. RMHP contracts with facilities and providers that are classified and certified to provide appropriate types, levels, and quality care to our membership.

MH
RAE and Prime, members use the statewide network of validated providers https://www.HealthFirstcolorado.com/find-doctors/ for inpatient MH hospital services. Some medical necessity criteria require appropriate MH specialization and credentialing to provide services. RMHP contracts with facilities and providers that are classified and certified to provide appropriate types, levels, and quality care to our membership.

SUD
RAE and Prime members use the statewide network of validated providers https://www.HealthFirstcolorado.com/find-doctors/ for inpatient SUD hospital services. Some medical necessity criteria require appropriate Mental Health MHP contracts with facilities and providers that are classified and certified to provide appropriate types, levels, and quality care to our membership.

Finding:

In all benefit categories, Rocky Mountain Health Plans ensures network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. The plan is in compliance with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the outpatient benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff
Goals and Rationale: Rocky Mountain Health Plans is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place.	

Process:

M/S (in network and out of network)
RAE, Prime and CHP+, members use the statewide network of validated providers https://www.Health Firstcolorado.com/find-doctors/
for outpatient M/S services. Requests for out of network services require prior authorization. Some medical necessity criteria require appropriate medical or surgical specialization and credentialing to perform a procedure. RMHP contracts with facilities and providers that are classified and certified to provide appropriate types, levels, and quality care to our membership.

MH
RAE, Prime and CHP+, members use the statewide network of validated providers https://www.Health Firstcolorado.com/find-doctors/ for outpatient MH hospital services. Some medical necessity criteria require appropriate MH specialization and credentialing to provide services. RMHP contracts with facilities and providers that are classified and certified to provide appropriate types, levels, and quality care to our membership.

SUD
RAE, Prime and CHP+, members use the statewide network of validated providers https://www.Health Firstcolorado.com/find-doctors/ for outpatient SUD hospital services. Some medical necessity criteria require appropriate Mental Health specialization and credentialing to provide services. RMHP contracts with facilities and providers that are classified and certified to provide appropriate types, levels, and quality care to our membership.

Finding:

In all benefit categories, Rocky Mountain Health Plans ensures network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. The plan is in compliance with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty (EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the emergency care category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff
Goals and Rationale: Rocky Mountain Health Plans is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place.	

Process:

M/S
There are no restrictions on M/S emergency services based on geographic location nationally, and RMHP contracts with facilities and specialists that are classified and certified to provide appropriate types, levels, and quality care to our membership. There are no limitations to emergency services limiting the scope or duration of service.

MH
There are no restrictions on MH emergency services based on geographic location nationally, and RMHP contracts with facilities and specialists that are classified and certified to provide appropriate types, levels, and quality care to our membership. There are no limitations to emergency services limiting the scope or duration of service.

SUD
There are no restrictions on SUD emergency services based on geographic location nationally, and RMHP contracts with facilities and specialists that are classified and certified to provide appropriate types, levels, and quality care to our membership. There are no limitations to emergency services limiting the scope or duration of service.

Finding:

In all benefit categories, Rocky Mountain Health Plans ensures network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. The plan is in compliance with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the prescription drug category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff
Goals and Rationale: Rocky Mountain Health Plans is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place.	

Process: In network: The nationwide network allows the Member to have no restrictions on location for retail pharmacy. Specialty and Home delivery pharmacies are limited to Optum Specialty and Optum Home Delivery as preferred. Out of network: Would have to pay out of pocket and request coverage via a DMR **Finding:** In all benefit categories, Rocky Mountain Health Plans ensures network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. The plan is in compliance with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty (IP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the inpatient benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff

Goals and Rationale: Rocky Mountain Health Plans is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place.

Process:

MH
RAE and Prime members use the statewide network of validated providers https://www.HealthFirstcolorado.com/find-doctors/ for inpatient MH hospital services. Some medical necessity criteria require appropriate MH specialization and credentialing to provide services. RMHP contracts with facilities and providers that are classified and certified to provide appropriate types, levels, and quality care to our membership.

SUD
RAE and Prime members use the statewide network of validated providers https://www.HealthFirstcolorado.com/find-doctors/ for inpatient SUD hospital services. Some medical necessity criteria require appropriate MH specialization and credentialing to provide services. RMHP contracts with

facilities and providers that are classified and certified to provide appropriate types, levels, and quality care to our membership. **Finding:** In all benefit categories, Rocky Mountain Health Plans ensures network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. The plan is in compliance with parity requirements. Under this Category, HCPF manages the M/S benefits and do not impose any restrictions based on geographic location, facility type or provider specialty.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty (OP)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the outpatient benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff
Goals and Rationale: Rocky Mountain Health Plans is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. **Process:** **MH** RAE and Prime members use the statewide network of validated providers https://www.HealthFirstcolorado.com/find-doctors/ for outpatient MH hospital services. Some medical necessity criteria require appropriate MH specialization and credentialing to provide services. RMHP contracts with facilities and providers that are classified and certified to provide appropriate types, levels, and quality care to our membership. **SUD** RAE and Prime members use the statewide network of validated providers https://www.Health Firstcolorado.com/find-doctors/ for outpatient SUD hospital services. Some medical necessity criteria require appropriate MH specialization and credentialing to provide services. RMHP contracts with facilities and providers that are classified and certified to provide appropriate types, levels, and quality care to our membership.	

Finding: In all benefit categories, Rocky Mountain Health Plans ensures network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. The plan is in compliance with parity requirements. Under this Category, HCPF manages the M/S benefits and do not impose any restrictions based on geographic location, facility type or provider specialty.	
Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty (EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the emergency care category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff

Goals and Rationale: Rocky Mountain Health Plans is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place.

Process:

M/S
There are no restrictions on M/S emergency services based on geographic location nationally, and RMHP contracts with facilities and specialists that are classified and certified to provide appropriate types, levels, and quality care to our membership. There are no limitations to emergency services limiting the scope or duration of service.

MH
There are no restrictions on MH emergency services based on geographic location nationally, and RMHP contracts with facilities and specialists that are classified and certified to provide appropriate types, levels, and quality care to our membership. There are no limitations to emergency services limiting the scope or duration of service.

SUD
There are no restrictions on SUD emergency services based on geographic location nationally, and RMHP contracts with facilities and specialists that are classified and certified to provide appropriate types, levels, and quality care to our membership. There are no limitations to emergency services limiting the scope or duration of service.

Finding: In all benefit categories, Rocky Mountain Health Plans ensures network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. The plan is in compliance with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty (PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to the prescription drug benefit category.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff
Goals and Rationale: Rocky Mountain Health Plans is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. **Process:** In network: Our nationwide network allows the Member to have no restrictions on location for retail pharmacy. Specialty and Home delivery pharmacies are limited to Optum Specialty and Optum Home Delivery as preferred. Out of network: Would have to pay out of pocket and request coverage via a DMR **Finding:** In all benefit categories, Rocky Mountain Health Plans ensures network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. The plan is in compliance with parity requirements. Under this Category, HCPF manages the M/S benefits and do not impose any restrictions based on geographic location, facility type or provider specialty.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 2 & 4

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty	Differences noted between M/S and MH/SUD services: No
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Northeast Health Partners Data Request from Health Colorado Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options

Goals and Rationale: Northeast Health Partners and Health Colorado are responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place.

Process:

The RAE and Beacon accepts all qualifying providers within the region. Beacon engages specialty provider groups and facilities throughout the State of Colorado based on the identified need through the network monitoring, such as providers who have:

- A unique specialty or clinical expertise.
- License to prescribe in all areas: APRN/APN, NP, PA, MD/DO (Board Certified Child and Adult Psychiatrists).
- Capability to treat in a foreign language, ASL, and/or, have specific cultural experience.
- Capability of billing both Medicare and Medicaid.
- Practice located in regional organization's service areas considered rural or frontier where there are fewer providers.
- Telemedicine, especially for prescriber services.
- Alignment with primary care and co-located in an integrated model.
- Capability to serve unique populations and disorders.
- Specialties such as Intellectual Disabilities, Autism, Members with Traumatic Brain Injuries, or other groups that provide behavioral health services in addition to their non-covered specialty. Also, providers with experience in specialty care, long-term services and supports (LTSS) providers, managed service organizations and their networks of SUD providers, dental and other ancillary providers; or
- Behavioral health providers that span inpatient, outpatient, and all other covered mental health and SUD services.

Findings:

In all benefit categories, the RAEs and Beacon Health Options ensure network selection criteria, the process for recruitment, credentialing and enrollment of providers are applied in such a manner to allow for open access to the network. Under this Category, HCPF manages the M/S benefits and do not impose any restrictions based on geographic location, facility type or provider specialty.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 3 & 5

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty	**Differences noted between M/S and MH/SUD services:** **Yes**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Colorado Access Interview with Colorado Access staff

Goals and Rationale: Colorado Access is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place.

Process:

MH/SUD
COA policy number PNS 202 – Selection and Retention of Providers states:

In establishing and maintaining the provider network, the following factors are taken into consideration:

- The anticipated enrollment.
- The expected utilization of services, taking into consideration the characteristic and health care needs of specific populations represented in the enrolled population.
- Standards of appropriate case load for providers.
- The numbers, types and specialties of providers required to furnish the contracted services.
- The number of network providers who are not accepting new patients.
- The geographic locations of providers and members, considering the distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities; and
- The racial and ethnic communities being served.

M/S
Under this Category, HCPF manages the M/S benefits and do not impose any restrictions based on geographic location, facility type or provider specialty.

Finding: It is not clear from the wording of the policy how these factors are taken into consideration. If new providers are not approved based on geographic location, facility type or specialty, this would be more restrictive than the HCPF standard and would be a challenge for parity compliance. However, no evidence was found that the policy was being applied in a more stringent way that restricted the network in this manner and is therefore compliant with parity.

Recommendations: **HCPF should request Colorado Access to clarify this policy to make clear that MH/SUD providers are not restricted from participation in the network by geographic location, facility type or specialty.**	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 6 & 7

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request for CCHA Interview with CCHA Staff
Goals and Rationale: Colorado Community Health Alliance is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. **Process:** CCHA admits providers and facilities that meet HCPF's requirements to enroll as a Medicaid provider and are able to meet CCHA's credentialing requirements. They are required by HCPF to have a statewide network; thus, they do not restrict provider enrollment based on geographic location. **Finding:** This process is comparable and applied no more stringently than the HCPF fee-for-service, "any willing provider" process and is in compliance with parity.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 -- FFS (MH/SUD) and Rocky Mountain Health Plan Prime MCO (M/S)

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff
Goals and Rationale: HCPF is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place. **Process:** HCPF accepts any willing provider and uses the same process for maintaining network adequacy for MH/SUD and M/S benefits with no geographic, facility type or provider specialty restrictions. For inpatient and outpatient services, both Denver Health and Rocky Mountain Health Plans use the statewide network of validated providers for M/S services. For emergency care, there are no restrictions. **Finding:** As Rocky Mountain Health Plans uses the same "any willing provider" standard as HCPF, there is no substantial difference noted and the process complies with parity requirements.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 -- FFS (MH/SUD) and Denver Health (M/S)

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty	**Differences noted between M/S and MH/SUD services:** **YES**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data request from Denver Health Interview with Denver Health staff
Goals and Rationale: HCPF is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place.	

Process: HCPF accepts any willing provider and uses the same process for maintaining network adequacy for MH/SUD and M/S benefits with no geographic, facility type or provider specialty restrictions. For inpatient and outpatient services, Denver Health uses a closed network of providers for M/S services, managed by the MCO. For emergency care, there are no restrictions. **Finding:** As Denver Health is more restrictive with respect to M/S than HCPF is with its "any willing provider" standard with respect to MH/SUD, the process complies with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Restrictions Based on Geographic Location, Facility Type or Provider Specialty	**Differences noted between M/S and MH/SUD services:** **Yes**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Denver Health Interview with Denver Health staff

Goals and Rationale: Denver Health is responsible for ensuring network selection criteria, the process for recruitment, credentialing and enrollment of network providers do not include exclusionary criteria by geography, facility type or provider specialty and that an appropriate appeals process is in place.

Process:

MH/SUD
Denver Health contracts out the management of MH/SUD services to Colorado Access.

COA policy number PNS 202 – Selection and Retention of Providers states:

> In establishing and maintaining the provider network, the following factors are taken into consideration:
> - The anticipated enrollment.
> - The expected utilization of services, taking into consideration the characteristic and health care needs of specific populations represented in the enrolled population.
> - Standards of appropriate case load for providers.

- The numbers types and specialties of providers required to furnish the contracted services.
- The number of network providers who are not accepting new patients.
- The geographic locations of providers and members, considering the distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities; and
- The racial and ethnic communities being served.

M/S

Denver Health, by policy, does not make credentialing and credentialing decisions based on the type of procedure or patient in which a practitioner specializes, but their network is closed and restricted to a certain geography by design.

Finding:

It is not clear from the wording of the policy how these factors are taken into consideration. If new providers are not approved based on geographic location, facility type or specialty, this would be more restrictive than the Denver Health standard and would be a challenge for parity compliance. However, no evidence was found that these processes are applied more stringently for MH/SUD than for M/S benefits.

Recommendations:	**Complies with Parity Requirements: Yes**
HCPF should request Denver Health to clarify this policy to make clear that MH/SUD providers are not restricted from participation in the network by geographic location, facility type or specialty.	

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	HCPF/eQHealth	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				
	FFS & RMHP Prime MCO	IP, OP, EC, PD	No	Yes
	FFS & Denver Health MCO	IP, OP, EC, PD	No	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	No	Yes

Scenario 1 – FFS

NQTL: Network Adequacy Determination (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from HCPF
Goals and Rationale: HCPF 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 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 2 – RAE 1 and Rocky Mountain Health Plans

NQTL: Network Adequacy Determination	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans RMHP Network Adequacy Plan https://www.colorado.gov/pacific/sites/default/files/ACC%20RAE%205%20FY1920%20Network%20Adequacy%20Plan%202020.pdf

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.

Process:

According to the contract between HCPF 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.

The Department maintains policies and reporting for provider adequacy for M/S providers. Reporting is required at least quarterly.

Finding:

RMHP uses the same process for MH/SUD and as the MCO does for M/S benefits to maintain network adequacy.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1

NQTL: Network Adequacy Determination	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans RMHP Network Adequacy Plan https://www.colorado.gov/pacific/sites/default/files/ACC%20RAE%205%20FY1920%20Network%20Adequacy%20Plan%202020.pdf

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.

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 HCPF 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.

The Department maintains policies and reporting for provider adequacy for M/S providers. Reporting is required at least quarterly.

Findings:

RMHP uses the same process as HCPF for maintaining network adequacy and meets parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 2 & 4

NQTL: Network Adequacy Determination	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Northeast Health Partners, Health Colorado, and Beacon Health Options Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options Network Adequacy Plan https://www.colorado.gov/pacific/sites/default/files/ACC%20RAE%205%20FY1920%20Network%20Adequacy%20Plan%202020.pdf

Goals and Rationale: Northeast Health Partners and Health Colorado are 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 HCPF 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 is also required. Both Northeast Health Partners and Health Colorado contract out responsibility for network adequacy to Beacon Health Options.

Per the plan submitted to the Department:

> Beacon Health Options' goal is to ensure network adequacy by closely monitoring development and access of the Colorado Medicaid provider network in the region and adding providers based on overall network density and membership needs. This includes providers who have demonstrated experience providing care using a patient-centered model, clinical specialty, cultural background or licensure level and meet criteria for participation in the network. Beacon, on behalf of the regional organization will create, administer, and maintain a network of behavioral health providers, building on the network of Medicaid providers, to serve the needs of its members.
>
> The network of behavioral health providers will be monitored to meet or exceed the network time and distance standards. Given that our region contains significant rural membership, Beacon is also implementing programs such as C-PAC and telehealth services to support the work of our networks. Beacon will expand the network considering member enrollment and changes within the network.

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 and apply those processes no more stringently than the processes HCPF uses for M/S benefits.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 3 & 5

NQTL: Network Adequacy Determination	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Colorado Access Interview with Colorado Access staff COA Network Adequacy Plan https://www.colorado.gov/pacific/sites/default/files/ACC%20RAE%205%20FY1920%20Network%20Adequacy%20Plan%202020.pdf

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:

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 HCPF 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. Per their plan:

> Colorado Access has a long-standing and vibrant statewide behavioral health network with greater than 6,900 providers. In preparing for transition from BHO to RAE, Colorado Access determined that our existing BHO contracts would maintain legal force once COA began operations as a RAE. This means that behavioral health provider contracts that were executed with ABC Denver and ABC NE are still valid under the RAE…As such, our network of behavioral health providers continues uninterrupted and is the footing for our RAE efforts to ensure adequate access to behavioral health services for our members. This existing network includes contracted relationships with every Community Mental Health Center in the state, hospital systems, behavioral health providers who are integrated with PCMPs, IMDs and independent behavioral health providers, statewide.

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 HCPF for M/S benefits.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 6 & 7

NQTL: Network Adequacy Determination	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Colorado Community Health Alliance Interview with Colorado Community Health Alliance staff CCHA Network Adequacy Plan

	https://www.colorado.gov/pacific/sites/default/files/ACC%20RAE%207%20FY1920%20Network%20Adequacy%20Plan%202020.pdf

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 HCPF 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 reporting to the Department is also required. Per the most recent CCHA plan:

> CCHA aims to maintain a network that offers members ample choice and continuity of care across services. CCHA strives to accomplish this not only through our maintenance and monitoring activities but also through our attention to provider support and partnership. CCHA takes a "come as you are" approach with regard to contracting with providers in good standing, which allows practices of all sizes to participate in the ACC program to the degree in which they are comfortable. Once partnered with CCHA, PCMP practices and providers that participate in CCHA's Provider Incentive and Value-Based Payment programs have the opportunity to receive quarterly payments for their engagement with members and CCHA. HCPF 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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 -- FFS (MH/SUD) and Rocky Mountain Health Plan Prime MCO (M/S) FFS (MH/SUD) and Denver Health (M/S)

NQTL: Network Adequacy Determination	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from HCPF Data Request from Denver Health Data Request from Rocky Mountain Health Plans Consultation with HCPF staff Interview with Denver Health staff Interview with Rocky Mountain Health Plans staff

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:

The Department maintains policies and reporting for provider adequacy of fee-for-service MH/SUD providers that are very similar to the reporting requirements for Denver Health and Rocky Mountain Health Plans for M/S providers. Reporting is required at least quarterly.

Finding:

As the processes are all very similar, the processes are in compliance with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Network Adequacy Determination	**Differences noted between M/S and MH/SUD services:** **No**

Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Denver Health Interview with Denver Health Interview with Colorado Access

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.

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 HCPF 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.

Per the Colorado Access annual plan:

> Colorado Access has a long-standing and vibrant statewide behavioral health network with greater than 6,900 providers. In preparing for transition from BHO to RAE, Colorado Access determined that our existing BHO contracts would maintain legal force once COA began operations as a RAE. This means that behavioral health provider contracts that were executed with ABC Denver and ABC NE are still valid under the RAE…As such, our network of behavioral health providers continues uninterrupted and is the footing for our RAE efforts to ensure

adequate access to behavioral health services for our members. This existing network includes contracted relationships with every Community Mental Health Center in the state, hospital systems, behavioral health providers who are integrated with PCMPs, IMDs and independent behavioral health providers, statewide.

M/S
Denver Health maintains policies and reporting for provider adequacy for M/S providers. Reporting is required at least quarterly.

Finding:

As the processes are all very similar and standard for maintaining network adequacy, they are compliant with parity requirements.

Recommendations: None	**Complies with Parity Requirements: Yes**

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	HCPF/eQHealth	IP, OP, EC	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				
	FFS & RMHP Prime MCO	IP, OP, EC, PD	No	Yes
	FFS & Denver Health MCO	IP, OP, EC, PD	No	Yes
Scenario 5	Denver PIHP & Denver Health MCO	IP, OP, EC, PD	No	Yes

Scenario 1 – FFS

NQTL: Out-of-Network Provider Access Standards (IP, OP, & EC)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all inpatient, outpatient, and emergency care**	**Evidence used for comparison:** Data Request from HCPF Consultation with HCPF staff
Goals and Rationale: Policies and protocols are needed to ensure members timely access and medically necessary care, where unavailable through in-network providers. **Process:** HCPF has an "any willing provider" policy and approach and attempts to have very low barriers to entry for any provider who wants to be a part of the Medicaid network.	

Finding: This policy and approach apply to both MH/SUD and M/S benefits in the same manner.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 2 – RAE 1 and Rocky Mountain Health Plans

NQTL: Out-of-Network Provider Access Standards (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** No
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff Website FAQs: https://www.rmhp.org/i-am-a-provider/questions-faqs

Goals and Rationale: Policies and protocols are needed to ensure members timely access and medically necessary care, where unavailable through in-network providers.

Process:

Per the Rocky Mountain Health Plans website FAQs:

Are out-of-network behavioral health providers able to provide services to RMHP patients?

No. All non-emergent services provided by out-of-network behavioral health providers must be authorized prior to the service being provided.

However, the provider manual states under the "Member Choice of Providers" section that "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." There are also additional criteria listed where a Member may request an out-of-network provider. These circumstances 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.

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.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 1

NQTL: Out-of-Network Provider Access Standards (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Rocky Mountain Health Plans Interview with Rocky Mountain Health Plans staff Website FAQs: https://www.rmhp.org/i-am-a-provider/questions-faqs

Goals and Rationale: Policies and protocols are needed to ensure members timely access and medically necessary care, where unavailable through in-network providers.

Process:

Per the Rocky Mountain Health Plans website FAQs:

Are out-of-network behavioral health providers able to provide services to RMHP patients?

No. All non-emergent services provided by out-of-network behavioral health providers must be authorized prior to the service being provided.

However, the provider manual states under the "Member Choice of Providers" section that "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." There are also additional criteria listed where a Member may request an out-of-network provider. These circumstances 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.

Finding:

The Department requires providers to enroll as providers for fee-for-service providers prior to billing for M/S services, so the requirements for MH/SUD appear substantially similar. It is not clear that both a provider and a member may request authorization for out-of-network services for specified reasons.

Recommendations:	**Complies with Parity Requirements: Yes**
It is not clear that both a provider and a member may request authorization for service. We recommend HCPF consider mandating through contract that both a provider and a member may request authorization for out-of-network services for specified reasons.	

Scenario 3 – RAE 2 & 4

NQTL: Out-of-Network Provider Access Standards (IP, OP, EC, & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Northeast Health Partners Data Request from Health Colorado Interview with Northeast Health Partners, Health Colorado, and Beacon Health Options Beacon Health Options Policy 274L – Request for Out of Network Provider
Goals and Rationale: Policies and protocols are needed to ensure members timely access and medically necessary care, where unavailable through in-network providers.	

Process:

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). The policy gives provision for both a Medicaid recipient and an out-of-network provider may make the request for service. 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.

Finding:
HCPF requires providers to enroll as fee-for-service providers prior to billing for M/S services, so the requirements for MH/SUD are substantially similar.

Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 3 & 5

NQTL: Out-of-Network Provider Access Standards (IP, OP, EC, & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Colorado Access Interview with Colorado Access staff

Goals and Rationale: Policies and protocols are needed to ensure members timely access and medically necessary care, where unavailable through in-network providers.

Process:

Colorado Access in PNS 216 – Provider Reimbursement Rates, discusses non-participating provider rates. For professional services it calls for reimbursement to be the "lesser of billed charges or 100% of the Colorado Access Behavioral Health Non-Participating Provider Rates determined by program executive and loaded into QINXT by the configuration department." For in-state facility charges, it calls for "$700 per diem" and outpatient services to be reimbursed at 20% of billed charges. For out-of-state facility charges, it calls for "$700 per diem" and outpatient services to be reimbursed at 20% of billed charges.

Finding: The Department requires providers to enroll as providers for fee-for-service providers prior to billing for M/S services, so the requirements for MH/SUD are substantially similar.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 3 – RAE 6 & 7

NQTL: Out-of-Network Provider Access Standards (IP, OP, EC, & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Colorado Community Health Alliance Interview with Colorado Community Health Alliance staff
Goals and Rationale: Policies and protocols are needed to ensure members timely access and medically necessary care, where unavailable through in-network providers. **Process:** CCHA allows Medicaid enrolled, 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. **Finding:** The Department requires providers to enroll as providers for fee-for-service providers prior to billing for M/S services, so the requirements for MH/SUD are substantially similar.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 4 -- FFS (MH/SUD) and Rocky Mountain Health Plan Prime MCO (M/S)
FFS (MH/SUD) and Denver Health (M/S)

NQTL: Out-of-Network Provider Access Standards (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**

Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from HCPF Data Request from Denver Health Data Request from Rocky Mountain Health Plans Consultation with HCPF staff Interview with Denver Health staff Interview with Rocky Mountain Health Plans staff
Goals and Rationale: Policies and protocols are needed to ensure members timely access and medically necessary care, where unavailable through in-network providers. **Process:** The Department has an "any willing provider" policy and approach and attempts to have very low barriers to entry for any provider who wants to be a part of the Medicaid network. This policy and approach are used for MH/SUD benefits. Rocky Mountain Health Plans allows members to request providers who are out-of-network. Denver Health allows providers to submit a request for authorization prior to being paid. **Finding:** The Department requires providers to enroll as providers for fee-for-service providers prior to billing for M/S services, so the requirements for MH/SUD are substantially similar.	
Recommendations: None	**Complies with Parity Requirements: Yes**

Scenario 5 – Denver Health PIHP and Denver Health MCO

NQTL: Out-of-Network Provider Access Standards (IP, OP, EC & PD)	**Differences noted between M/S and MH/SUD services:** **No**
Benefits included: **This NQTL applies to all benefit categories.**	**Evidence used for comparison:** Data Request from Denver Health Interview with Denver Health staff
Goals and Rationale: Denver Health should have policies and protocols to ensure members timely access and medically necessary care, where unavailable through in-network providers. **Process:** 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. An out of network provider would be required to submit an	

authorization for services in order to ensure being properly paid for providing services to a DHMC member. Per HCPF 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.	
Recommendations: None	**Complies with Parity Requirements: Yes**

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 UM vendor, eQHealth. The definition for medical necessity is mandated by the state and the criteria are agreed to in contract. The criteria are publicly available 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, 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.*
RAE 1	The process and criteria for medical necessity decision making is delineated in the 2020 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 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	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. *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*

Category	Criteria for Medical Necessity	Reasons for Denial
	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). 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. https://www.healthcoloradorae.com/providers/clinical-tools/ https://www.northeasthealthpartners.org/providers/clinical-tools/ Beacon facilitates discussions with outside senior consultants in the field as well as other practicing professionals. Beacon also 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	*the decision was made, and how to appeal if members disagree.*

Category	Criteria for Medical Necessity	Reasons for Denial
	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. *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.*	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.*