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

June 1, 2022

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

Dear Senator Fields:

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

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

The Department created this year's annual report following a process for determining mental health parity compliance based on the federal parity guidance outlined in the Centers for Medicare & Medicaid Services' Parity Toolkit and in accordance with all state requirements. Based on the review of the Colorado Medicaid benefit, the Department determined:

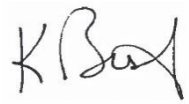
- The written policies and procedures are parity compliant in all Non-Quantitative Treatment Limitations (NQTLs) except in two situations: the fee-for-service inpatient hospital review program's compliance within one NQTL and Denver Health Medicaid Choice's compliance within three NQTLs.

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

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

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

Sincerely,



Kim Bimestefer
Executive Director

KB/STB

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

Cc: Senator Joann Ginal, Vice Chair, Health and Human Services Committee
Senator Janet Buckner, Health and Human Services Committee
Senator Sonya Jaquez Lewis, Health and Human Services Committee
Senator Barbara Kirkmeyer, Health and Human Services Committee
Senator Cleave Simpson, Health and Human Services Committee
Senator Jim Smallwood, Health and Human Services Committee
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Bettina Schneider, Finance Office Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

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

June 1, 2022

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

Dear Representative Michaelson Jenet:

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

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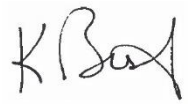

Kim Bimestefer
Executive Director

KB/STB

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

Cc: Representative Emily Sirota, Vice Chair, Public & Behavioral Health & Human Services Committee
Representative Mary Bradfield, Public & Behavioral Health & Human Services Committee
Representative Lisa Cutter, Public & Behavioral Health & Human Services Committee
Representative Serena Gonzales-Gutierrez, Public & Behavioral Health & Human Services Committee
Representative Richard Holtorf, Public & Behavioral Health & Human Services Committee
Representative Iman Jodeh, Public & Behavioral Health & Human Services Committee
Representative Colin Larson, Public & Behavioral Health & Human Services Committee
Representative David Ortiz, Public & Behavioral Health & Human Services Committee
Representative Rod Pelton, Public & Behavioral Health & Human Services Committee
Representative Naquetta Ricks, Public & Behavioral Health & Human Services Committee
Representative Dan Woog, Public & Behavioral Health & Human Services Committee
Representative Mary Young, Public & Behavioral Health & Human Services Committee
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Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Bettina Schneider, Finance Office Director, HCPF
Bonnie Silva, Community Living Interim Office Director, HCPF
Parrish Steinbrecher, Health Information Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Jo Donlin, Legislative Liaison, HCPF

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

June 1, 2022

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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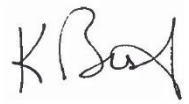

Kim Bimestefer
Executive Director

KB/STB

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

Cc: Representative Yadira Caraveo, Vice Chair, Health & Insurance Committee
Representative Mark Baisley, Health & Insurance Committee
Representative Ron Hanks, Health & Insurance Committee
Representative Dominique Jackson, Health & Insurance Committee
Representative Chris Kennedy, Health & Insurance Committee
Representative Karen McCormick, Health & Insurance Committee
Representative Kyle Mullica, Health & Insurance Committee
Representative David Ortiz, Health & Insurance Committee
Representative Matt Soper, Health & Insurance Committee
Representative Brianna Titone, Health & Insurance Committee
Representative Tonya Van Beber, Health & Insurance Committee
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Jo Donlin, Legislative Liaison, HCPF

June 1, 2022

Mental Health and Substance Use Disorder Parity Report

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

www.hcpf.colorado.gov

COLORADO
Department of Health Care Policy & Financing

Table of Contents

Acronyms

Acronym	Definition
ACC	Accountable Care Collaborative
AL/ADLs	Aggregate Lifetime and Annual Dollar Limits
CCHA	Colorado Community Health Alliance
CCR	Concurrent Review
CFR	Code of Federal Regulations
CM	Clinical Modification
CMS	Centers for Medicare & Medicaid Services
COA	Colorado Access
C.R.S.	Colorado Revised Statutes
DHMC	Denver Health Medicaid Choice
FAQ	Frequently Asked Questions
FFS	Fee-For-Service
FR	Financial Requirement
HSAG	Health Services Advisory Group
ICD	International Classification Of Diseases
IHRP	Inpatient Hospital Review Program
MCE	Managed Care Entity
MCO	Managed Care Organization
MHPAEA	Mental Health Parity and Addiction Equity Act
MH/SUD	Mental Health/Substance Use Disorder
M/S	Medical and Surgical
NABD	Notice Of Adverse Benefit Determination
NQTL	Non-Quantitative Treatment Limitations
PBM	Pharmacy Benefit Manager
PIHP	Prepaid Inpatient Health Plan
PCCM	Primary Care Case Management
QTL	Quantitative Treatment Limitation
RAE	Regional Accountable Entity
RMHP	Rocky Mountain Health Plan
RR	Retrospective Review
SUD	Substance Use Disorder
UM	Utilization Management

Executive Summary

The Colorado Department of Health Care Policy & Financing (Department) created the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for State Fiscal Year 2021 – 2022 in accordance with Colorado Revised Statutes (C.R.S.) 25.5-5-421. The MHPAEA is designed to ensure Medicaid Managed Care Organizations (MCOs) and Medicaid alternative benefit plans providing mental health or substance use disorder (MH/SUD) benefits apply limitations on those benefits that are comparable to and no more stringent than those limitations imposed upon medical and surgical (M/S) benefits in the same classifications. The following comparative analysis was performed across Colorado Medicaid's statewide managed care system, consisting of seven Regional Accountable Entities (RAEs) and two MCOs, and the Department's fee-for-service (FFS) system to determine the status of parity compliance within the Colorado Medicaid delivery system.

The State of Colorado's Medicaid capitated behavioral health benefit is administered through the Accountable Care Collaborative (ACC). The state is divided into seven regions with a single Managed Care Entity (MCE), the RAE, operating the ACC in each region. The ACC is a hybrid managed care program authorized through a Section 1915(b) waiver approved by the Centers for Medicare & Medicaid Services (CMS). The RAEs function as a prepaid inpatient health plan (PIHP) for the administration of all ACC members' capitated MH/SUD services, as well as a Primary Care Case Management (PCCM) entity accountable for the effective and coordinated utilization of FFS M/S Medicaid benefits. The RAEs are responsible for administering Colorado Medicaid's capitated MH/SUD benefit, which includes paying claims and authorizing MH/SUD services. Physical health services are paid FFS by the Department's fiscal agent. In addition, two regions allow members in specific counties to participate in capitated M/S MCOs, Rocky Mountain Health Plan (RMHP) Prime and Denver Health Medicaid Choice (DHMC).

The Department follows a process to determine parity compliance that is based on the federal parity guidance outlined in the CMS parity toolkit, "Parity Compliance in Mental Health and Substance Use Disorder Parity Requirements for Medicaid and Children's Health Insurance Programs," and in accordance with the requirements in C.R.S. § 25.5-5-421. The Department collects public input throughout the year to help assess how processes, strategies, evidentiary standards, and other factors operate in practice. This public input helps inform the comparative analysis. Department research on best practices has also led to improvements for data gathering, reporting, and transparency. The process involves a full analysis of a detailed data request submitted by each RAE, MCO, and the Department's FFS system, along with supporting policy and procedural documentation. The analysis also includes direct interviews with each entity in order to verify, elaborate on, or correct any details.

The Colorado Medicaid service delivery system has multiple components that add complexity to assessing parity. The analysis requires the comparison of a capitated MH/SUD payment structure to a FFS M/S payment structure. The Department chose to design its coverage in this manner to maximize the breadth of MH/SUD services available to its members. The

comparison between MH/SUD and M/S benefits seeks to assess whether the written policies and procedures, in design and applied in practice, affect the ability of Medicaid members to access MH/SUD services.

Summary of Findings

An assessment and comparative analysis of MH/SUD benefit limitations compared to M/S benefit limitations found the written policies and procedures to be parity compliant in all Non-Quantitative Treatment Limitations (NQTLs) except in two situations: the fee-for-service inpatient hospital review program's compliance within one NQTL and Denver Health Medicaid Choice's compliance within three NQTLs. Details are provided in *Non-Quantitative Treatment Limitations* below. Limited situations were also found where MCEs were determined not to have followed their written policies, impacting compliance with Availability of Information parity requirements.

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

Aggregate Lifetime and Annual Dollar Limits

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

Financial Requirements and Quantitative Treatment Limitations

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

Non-Quantitative Treatment Limitations

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

Written policies and procedures were determined to be parity-compliant in all benefit categories for all NQTLs except for the following two instances:

- The Department continues to be out of parity compliance with Concurrent Review NQTL for inpatient hospitalizations as a result of the temporary suspension of the M/S Inpatient Hospital Review Program (IHRP). The Department is still in compliance for the Prior Authorization and Retrospective Review NQTLs. The ongoing public health

emergency placed a great stress upon hospitals and hospital systems, and the Department has responded by taking actions to reduce burden on those hospitals and providers and ensure members have appropriate and timely access to care. This compliance issue was first identified in the 2021 MHPAEA Parity Report.[1] The Department did not pursue a similar suspension to the MH/SUD inpatient authorization review process because it was not at risk of system capacity breach in the same way the hospitals were. The Department also required real-time SUD review insights from tracking the use of the newly effective (January 1, 2021) SUD inpatient and residential benefit. These insights needed to be incorporated into the July 1, 2021 inpatient and residential SUD rate adjustments and were important to the Department's efforts to analyze network access, pinpoint areas needing technical assistance, monitor utilization against projections, identify variations in utilizations by RAE region, and confirm that members were being connected to the most effective treatment options. The Department determined that continuing the MH/SUD inpatient authorization review process was the best course of action to ensure the health and effectiveness of the new SUD residential benefit and the MH/SUD system, as a whole.

The Department is currently working to finalize improvements to the program prior to IHRP reinstitution, with redesign efforts underway. As part of the redesign, the Department will ensure the new IHRP concurrent review process is compliant with parity. To ensure parity compliance, the Department is also taking this opportunity to assess the MCEs' concurrent review policies and procedures for MH/SUD inpatient hospitalizations. Reinstituting the IHRP with the program improvements will not start before January 1, 2023. This date has been delayed from initial estimates due to the ongoing COVID-19 public health emergency to help with hospital overwhelm, and to ensure the full system redesign is completed with extensive planning and receives stakeholder input prior to implementation. The Department is working diligently to complete the work earlier if possible.

- This year's analysis identified a parity compliance issue in the policies used by Denver Health Medicaid Choice (DHMC). DMHC is a staff-model MCO, meaning its medical/health providers are employees rather than independent providers who contract with the health plan. Through their efforts to reduce administrative hurdles for providers in their preferred provider network, they inadvertently created a situation where their M/S services authorization policies were less stringent than comparable MH/SUD policies specific to the Denver Health hospital system. These authorization policies impacted the parity compliance for M/S inpatient and outpatient services regarding Prior Authorization, Concurrent Review, and Retrospective Review. DHMC engages in a risk-based sub-capitation arrangement with Denver Health Hospital Authority. As part of the risk-based arrangement, Denver Health Hospital Authority M/S providers do not need to submit any services for authorization. In contrast, nearly all inpatient MH/SUD services and a select set of

[1] 2021 MHPAEA Parity Report: https://hcpf.colorado.gov/sites/hcpf/files/2021%20MHPAEA%20Parity%20Report.pdf.

outpatient MH/SUD services require authorization. While all out-of-network M/S care requires authorization, a significant majority of M/S and MH/SUD services are provided in the Denver Health hospital system. Upon discovery of this finding, the Department immediately began work with DHMC to address the issues and bring their policies back into compliance. DHMC is currently finalizing the policy changes which should be implemented by July 1, 2022. These changes will be evaluated by the Department to ensure the policies meet parity compliance prior to implementation.

The Department remains compliant with all other aspects of mental health parity.

Availability of Information

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

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

Health Services Advisory Group (HSAG) performed the external quality review audit of the RAEs' and MCOs' policies and procedures in operation. In this year's audit, they determined the MCEs combined to successfully meet 1,221 applicable elements out of a total of 1,316, for a 93 percent compliance score.

Their audit found a few limited situations where confusing member notices were sent out, and inappropriate denials were made to out-of-network providers. In one situation, an MCE was identified to have not sent any members letters with appeals information, rather, they copied the members on letters sent to the providers. The Department determined these instances were not compliant with the Availability of Information parity requirements. The Department notified the specific MCEs of the issues, which then established plans to address these issues. Additionally, HSAG identified situations where service decisions were not well-documented internally. While they are not parity concerns, HSAG notified the specific MCE about the issue for process improvement.

Introduction

The Colorado Department of Health Care Policy & Financing (Department) created the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for state fiscal year 2021 – 2022 in accordance with C.R.S. § 25.5-5-421. The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and related regulations require state Medicaid agencies that have implemented an Alternative Benefit Plan and/or that deliver services through Managed Care Organization (MCO)s to ensure mental health and substance use disorder (MH/SUD) benefits are not managed more stringently than medical/surgical (M/S) benefits.

The Department follows a process to determine parity compliance that is based on the federal parity guidance outlined in the Centers for Medicare and Medicaid Services (CMS) parity toolkit, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs,"[2] and in following with the requirements in C.R.S. § 25.5-5-421.

The final Medicaid/Children's Health Insurance Program parity rule requires analysis of:

- Aggregate lifetime and annual dollar limits (AL/ADLs); and
- Financial requirements and treatment limitations, which include:
  - ✓ Financial requirements (FRs), such as copayments, coinsurance, deductibles, and out-of-pocket maximums.
  - ✓ 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.
  - ✓ 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
- Availability of information.

Definition of M/S and MH/SUD Services

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

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

For the purposes of the parity analysis, the Department has adopted the current version (10) of the International Classification of Diseases, Clinical Modification (ICD-10-CM) as the standard for defining MH/SUD services and M/S services. The Department defines MH/SUD benefits as benefits specifically designed to treat a MH/SUD 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.
- Substance use disorder benefits are defined as benefits used in the treatment of SUD conditions listed in ICD-10 Chapter 5 (F), subchapter 2 (mental and behavioral disorders due to psychoactive substance use).
- Benefits used to treat all other ICD-10 diagnoses are considered M/S.

Benefit Classifications

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

Inpatient

Treatment as a registered bed patient in a hospital or facility and for whom room and board charges are made, excluding nursing facilities.

Outpatient

All covered services or supplies not included in inpatient, emergency care, or prescription drug categories.

Prescription Drugs

Medications that have been approved or regulated by the Food and Drug Administration that can, under federal and state law, be dispensed only pursuant to a prescription drug order from a licensed, certified, or otherwise legally authorized prescriber.

Emergency Care

All covered emergency services or items (including medications) provided in an emergency department 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 MH/SUD services, as well as a Primary Care Case Management (PCCM) entity accountable for the effective and coordinated utilization of fee-for-service (FFS) 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 FFS by the Department's fiscal agent. The Department contracts with a third-party vendor to administer Colorado Medicaid's Utilization Management Program for FFS, referred to as the Colorado Prior Authorization Review.

In two regions covering specific counties, members participate in capitated M/S MCOs. In Region 1, the MCO is operated by the RAE, Rocky Mountain Health Plans (RMHP). In Region 5, the Department contracts directly with the MCO operated by Denver Health Medicaid Choice (DHMC), which is also contracted to function as the MH/SUD PIHP for all members enrolled in the MCO. DHMC subcontracts administration of their MH/SUD PIHP to Colorado Access (COA), including utilization management and network and provider interactions. As of March 2022, there were 156,797 members in MCOs whose M/S and MH/SUD services are covered through capitation payments.

As authorized by the Affordable Care Act of 2010, Colorado expanded Medicaid benefits to individuals ages 19 through 64 at or below 133 percent federal poverty level through an Alternative Benefit Plan that closely aligns, but does not exactly match, the Medicaid state plan adult benefit package. Approximately 513,944 members in the Alternative Benefit Plan receive capitated MH/SUD services, but their M/S services are provided FFS.

MHPAEA and related regulations require state Medicaid agencies that have implemented an Alternative Benefit Plan and/or that deliver services through MCOs to ensure MH/SUD benefits are not managed more stringently than M/S benefits. This analysis complies with 42 Code of Federal Regulations (CFR) § 438.910 and 42 CFR § 440.395.

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

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

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

Methodology

Defining Member Scenarios for Analysis

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

The potential member scenarios are listed in *Table 1*. The colors used for the scenarios in the table are applied to the corresponding scenarios in the appendices.

Table 1. Potential Member Scenarios

Scenario 1	Scenario 2	Scenario 3	Scenario 4
Member gets their inpatient and outpatient MH/SUD services, emergency MH services, and M/S benefits through FFS (this is a service-by-service situation). <1% of all Medicaid members are in this scenario.	Member gets their inpatient and outpatient MH/SUD services, emergency MH services through a RAE (RMHP RAE) under a capitated rate and M/S benefits through an MCO (RMHP Prime MCO). 3% of all Medicaid members are in this scenario.	Member gets their inpatient and outpatient MH/SUD services, emergency MH services through a RAE under a capitated rate and M/S benefits through FFS. 89% of all Medicaid members are in this scenario.	Member gets their inpatient and outpatient MH/SUD services, emergency MH services through Denver Health PIHP under a capitated rate and M/S benefits through an MCO (DHMC). 7% of all Medicaid members are in this scenario.

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	Pharmacy Benefit Manager (PBM)
Scenario 2	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	Med/Surg = MCO MH/SUD = RAE	MCO Managed PBM
Scenario 3	Med/Surg = FFS MH/SUD = RAE	Med/Surg = FFS MH/SUD = RAE	Med/Surg = FFS MH/SUD = RAE	PBM
Scenario 4	Med/Surg = MCO MH/SUD =PIHP	Med/Surg = MCO MH/SUD = PIHP	Med/Surg = MCO MH/SUD = PIHP	MCO Managed PBM

Tools and Resources to Collect and Analyze Required Data

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

Additionally, a set of NQTLs were identified by comparing each benefit plan, along with stakeholder feedback, to a list of NQTLs outlined in the final Medicaid/parity rule, the parity toolkit, written guidance from CMS, and the Department of Labor regarding the commercial parity rule (including frequently asked questions and related guidance). The Department utilizes tools and resources based on federal guidance to collect and analyze the required NQTL data. The tools and resources have been improved from input from stakeholders, industry best practices, and contractor guidance to better capture the policies and procedures that are key to a robust analysis.

A data request was sent to the RAEs, MCOs, and the Department's Utilization Management (UM) team to collect policy and procedural detail for key areas, including:

1. Medical Management Standards.
    a. Prior Authorization – Identify services by name and service code.
    b. Concurrent Review.
    c. Retrospective Review.
    d. Medical Necessity Criteria.
    e. Medical Appropriateness Review.
    f. Fail First/Step Therapy Protocols.
    g. Conditioning Benefits on Completion of a Course of Treatment.
    h. Outlier Management.
    i. Coding Limitations.
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.

For the 2022 report, the Department significantly updated the data request to provide for an improved communication of policy and procedures. This improved format increased the ability for the MCEs to provide greater clarity, while allowing the Department a more straightforward method to collect detail on policies of particular interest to the parity analysis. Stakeholder feedback was instrumental to identifying additional policies of interest.

Completed data requests were required by March 1. The MHPAEA report is accurate and complete through March 1, 2022. Any policy or procedural changes made after that date will be reviewed on an ongoing basis and noted in the following year's MHPAEA Report. There are a few exceptions to the inclusion of policies updated after the March 1 timeframe, which have been noted in the appropriate section. These specific policies were not found to have negatively impacted parity compliance and are being included for informational purposes.

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

Review Process for Medical Necessity Criteria

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

Review Process for NQTLs

The Department prepared a list of common NQTLs that may be in use by the RAEs and the Department for MH/SUD services from the illustrative list of NQTLs in the final Medicaid/parity rule, the parity toolkit, and written guidance from CMS and the Department of Labor regarding the commercial parity rule (including FAQs and related guidance). The Department also gathered feedback through stakeholder written comments, which the Department used to inform the analysis by either affirming previously identified NQTLs or highlighting other areas that may require analysis. The final list included NQTLs applicable to categories such as medical management standards, network admission standards, and provider access. As mentioned previously, the list of NQTLs was reordered for the 2022 report to more logically group them and increase the readability of the appendixes. The appendix for the NQTL Penalties for Noncompliance was removed from this year's report as no health plan applies penalties for non-compliance in any benefit categories. Failure of a provider or participant to follow required procedures may result in an administrative denial, but no additional penalties are levied. The Department will continue to monitor the health plans for this and any other NQTL not listed in the report and will address them specifically when found to be utilized.

The data request for the RAEs, MCOs, and Department's UM included the list of NQTLs identified and asked them to identify any additional NQTLs they apply to MH/SUD services. The request addressed processes, strategies, evidentiary standards, and other factors for

each of the NQTLs that apply to MH/SUD and M/S services, broken down by benefit classification. The request included prompts to help identify the type of information relevant to the parity analysis.

Review Process for Availability of Information

The requirements for availability of information are as follows:

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

These requirements apply to all Colorado Medicaid members receiving MH/SUD benefits, whether through FFS, RAEs, or MCOs. The MCEs were required to provide evidence that they are compliant with this parity requirement, as part of the Health Services Advisory Group (HSAG) audit.

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

Based on the information collected during the analysis, the Colorado Medicaid benefit packages impose no FRs, QTLs, or AL/ADLs on MH/SUD benefits. Should future financial, unit, or dollar limits be imposed, these limitations would be reviewed to ensure parity compliance.

Factors Used to Determine if an NQTL Will Apply

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

The CMS Parity Toolkit divides this analysis into two parts:

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

Following the process outlined in the CMS Parity Toolkit, the Department used the information provided in the data request and interviews with the RAEs, MCOs, and the Department's FFS UM to determine if an NQTL applies and requires analysis. Any identified NQTL is tested for comparability and stringency to ensure it meets parity guidelines. During this analysis, multiple reference points are explored to determine compliance with parity guidelines including: policy follows standard industry practice, is little to no exception or

variation when operationalizing procedures, policy and practice follows established state definitions and guidelines, the staff operationalizing the policy are qualified to make the decisions and complete the tasks assigned, and appropriate supervision and oversight is in place to ensure the policy is operationalized as documented.

Evaluation of Parity Compliance in Operation

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

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

Health Services Advisory Group (HSAG) was the contractor selected to perform this year's annual review of the RAEs' and MCOs' policies and procedures in operation. A summary of HSAG's review can be found below in *Findings, External Quality Review Analysis*. The full report can be found on the Department's parity webpage.[3]

Updates to the MHPAEA Report

The Department has made many improvements to the MHPAEA Report for SFY 2021 - 2022 to improve the readability and clarity of the document, but more importantly, to increase the accuracy and thoroughness of the analysis.

- The Department significantly updated the data request to provide for an improved communication of policy and procedures. This improved format increased the ability for the MCEs to provide greater clarity, while allowing the Department a more straightforward method to collect detail on policies of particular interest to the parity analysis. Stakeholder feedback was instrumental to identifying additional policies of interest.
- The appendices have been updated to provide a side-by-side comparison of MH/SUD and M/S policies and procedures to improve readability. The change also reflects the update to the data request and the additional information acquired. The appendix for the NQTL Penalties for Noncompliance was removed from this year's report as no health plan applies penalties for non-compliance in any benefit categories. Failure of a provider or participant to follow required procedures may result in an administrative denial, but no additional penalties are levied. The Department will continue to monitor the health plans for this and any other NQTL not listed in the report and will address them specifically when found to be utilized.

[3] The Department of Health Care Policy & Financing Mental Health Parity webpage: https://hcpf.colorado.gov/parity.

Stakeholder Engagement and Feedback

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

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

The Department received a total of 16 written comments submitted through the electronic form created specifically for this report. The majority of submissions were received from providers, with some feedback also received from advocates, community members, a Community Centered Board, and a Medicaid member.

Stakeholders shared concerns about prior authorization, reimbursement rates, network adequacy, administrative burden, access to behavioral health services, and the Department writing its own parity report. Concerns that touched on parity-related topics were analyzed for compliance. In regard to the comment about the Department writing its own parity report, CMS holds the Department accountable for parity compliance, the Colorado state statute[4] requires the Department to submit a yearly report, and the Department contracts with Myers and Stauffer to perform an independent review of these reports and the analysis process followed by the Department (see the Mental Health Parity Report External Assessment report.[5])

Provider reimbursement rate concerns are commonly raised by stakeholders, including specific concerns about reimbursement based on clinical licensure, and lower provider reimbursement rates for MH/SUD services in comparison to other states or M/S services. First, it was determined that the processes used by the RAEs to establish charges/reimbursement rates for MH/SUD benefits is comparable and no more stringent than that used for M/S benefits in the same classification in writing and in operation. Further, reimbursement was analyzed for its impact on network adequacy, and it was determined that the processes used

[4] Colorado Revised Statutes 25.5-5-421 (4).
[5] Mental Health Parity External Assessment Report: https://hcpf.colorado.gov/sites/hcpf/files/Mental%20Health%20Parity%20Report%20External%20Assessment%202021.pdf.

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. Details can be found in *Appendix K: Establishing Charges/Reimbursement Rates*. The Department continually monitors the provider networks and requires the RAEs and MCOs to submit network adequacy plans annually and network adequacy reports quarterly.

Parity Monitoring During Reporting Year

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

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

- As of April 1, 2022, Northeast Health Partners and Health Colorado, Inc. eliminated their policy that applied a prior authorization requirement after 25 sessions to the following services: 90832 (30-minute psychotherapy), 90834 (45-minute psychotherapy), 90837 (60-minute psychotherapy), 90846 (family psychotherapy without patient), and 90847 (family psychotherapy with patient).
  - ✓ This change is compliant with parity requirements as it reduces the limitations applied to MH/SUD services.
- As of September 1, 2021, the Colorado Community Health Alliance (CCHA) eliminated their policy that applied a prior authorization requirement after 20 sessions to the following services: 90832 (30-minute psychotherapy), 90834 (45-minute psychotherapy), 90837 (60-minute psychotherapy), 90846 (family psychotherapy without patient), and 90847 family psychotherapy with patient).
  - ✓ This change is compliant with parity requirements as it reduces the limitations applied to MH/SUD services.
- As of January 1, 2022, RMHP eliminated their policy that applied a prior authorization requirement after 12 sessions to 60-minute psychotherapy (90837).
  - ✓ This change is compliant with parity requirements as it reduces the limitations applied to a MH/SUD service.
- In January 2022, the Department temporarily paused prior authorizations requests for Pediatric long-term home health Certified Nursing Assistant services, and home health therapies: occupational therapy, physical therapy, and speech-language pathology therapy services. The pause was extended through at least March 2024 and now

includes pediatric long-term home health intermittent skilled nursing. The two-year pause allows the Department and partners time to robustly engage with stakeholders, train providers on operational changes, evaluate benefit policy, and notify Health First Colorado members before the pause is lifted. This also gives the Department time to ensure full compliance with federal and state policy while keeping Health First Colorado members and their needs front and center.

- ✓ There were no prior authorization requirements on these services during the 2021 MHPAEA Parity Report comparative analysis where compliance with parity was determined. The removal of the prior authorization of the services returns us to that level, and, therefore, continues to be in parity compliance on this aspect.

During the 2022 Legislative Session, the Department supported SB22-156 Medicaid Prior Authorization & Recovery of Payment[6], which removes prior authorizations for Medicaid outpatient psychotherapy and limits when a PIHP (RAE) can retroactively recover provider payments.

Findings

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

Written policies and procedures were determined to be parity-compliant in all benefit categories for all NQTLs except for the following two instances:

- The Department continues to be out of parity compliance with Concurrent Review NQTL for inpatient hospitalizations, as a result of the temporary suspension of the M/S Inpatient Hospital Review Program (IHRP). The Department is still in compliance for the Prior Authorization and Retrospective Review NQTLs. The ongoing public health emergency placed a great stress upon hospitals and hospital systems, and the Department has responded by taking actions to reduce burden on those hospitals and providers and ensure members have appropriate and timely access to care. This compliance issue was first identified in the 2021 MHPAEA Parity Report.[7] The Department did not pursue a similar suspension to the MH/SUD inpatient authorization review process because it was not at risk of system capacity breach in the same way that the hospitals were. The Department also required real-time SUD review insights from tracking the use of the newly effective (January 1, 2021) SUD inpatient and residential benefit. These insights needed to be incorporated into the July 1, 2021 inpatient and residential SUD rate adjustments and were important to the

[6] Colorado State Senate Bill 22-156: https://leg.colorado.gov/bills/sb22-156
[7] 2021 MHPAEA Parity Report: https://hcpf.colorado.gov/sites/hcpf/files/2021%20MHPAEA%20Parity%20Report.pdf.

Department's efforts to analyze network access, pinpoint areas needing technical assistance, monitor utilization against projections, identify variations in utilizations by RAE region, and confirm that members were being connected to the most effective treatment options. It was determined that continuing the MH/SUD inpatient authorization review process was the best course of action to ensure the health and effectiveness of the new SUD residential benefit and the MH/SUD system as a whole. The Department is currently working to finalize improvements to the program prior to IHRP reinstitution, with redesign efforts underway. As part of the redesign, the Department will ensure the new IHRP concurrent review process is compliant with parity. To ensure parity compliance, the Department is also taking this opportunity to assess the MCEs' concurrent review policies and procedures for MH/SUD inpatient hospitalizations. Reinstituting the IHRP with the program improvements will not start before January 1, 2023. This date has been delayed from initial estimates due to the ongoing COVID-19 public health emergency to help with hospital overwhelm, and to ensure the full system redesign is completed with extensive planning and receives stakeholder input prior to implementation. The Department is working diligently to complete the work earlier if possible.

- This year's analysis identified a parity compliance issue in the policies used by Denver Health Medicaid Choice (DHMC). DMHC is a staff model MCO, meaning that its medical/health providers are employees rather than independent providers who contract with the health plan. Through their efforts to reduce administrative hurdles for providers in their preferred provider network, they inadvertently created a situation where their M/S services authorization policies were less stringent than comparable MH/SUD policies specific to the Denver Health hospital system. These authorization policies impacted the parity compliance for M/S inpatient and outpatient services regarding Prior Authorization, Concurrent Review, and Retrospective Review. DHMC engages in a risk-based sub-capitation arrangement with Denver Health Hospital Authority. As part of the risk-based arrangement, Denver Health Hospital Authority M/S providers do not need to submit any services for authorization. In contrast, nearly all inpatient MH/SUD services and a select set of outpatient MH/SUD services require authorization, and while all out-of-network M/S care requires authorization, a significant majority of M/S and MH/SUD services are provided in the Denver Health hospital system. The Department immediately began work with DHMC to address the issues and bring their policies back into compliance. DHMC is currently finalizing the policy changes which should be implemented by July 1, 2022. These changes will be evaluated by the Department to ensure the policies meet parity compliance prior to implementation.

External Quality Review Analysis

Health Services Advisory Group (HSAG) completed their annual review of the RAEs and MCOs' policies and procedures in operation on April 2022. In their review, they perform a detailed record review of a random sample of denial letters in order to provide a score for each MCE that indicates the level at which each one followed their internal policies related to prior authorization and the reason for denial, notification of determination, timeframes for the sending of notices, notice of adverse benefit determinations including required content, use

of qualified clinicians when making denial decisions, peer-to-peer review, and use of established authorization criteria. **For the 2022 report, HSAG determined the MCEs combined for a 93 percent compliance score.** This is a three percent decrease from last year's 96 percent compliance score, but still indicates a strong adherence to policies: out of 1,316 combined applicable elements, they satisfied 1,221 elements.

All MCEs use nationally-recognized utilization review criteria, and all followed their policies and procedures regarding consistency and quality of UM decisions. Three of nine MCEs were in full compliance with the timeframes for sending Notice of Adverse Benefit Determinations (NABDs). The Department launched new benefits for inpatient and residential SUD services on January 1, 2021, and all MCEs met the 72-hour timeliness requirement for these determinations in the first quarter, as inpatient and residential SUD benefits were initiated, and each MCE implemented the new programs. All MCEs used a Department-approved NABD template letter that included the required information and notified members of their right to an appeal.

However, in a few limited situations, confusing member notices were sent out, and inappropriate denials were made due to out-of-network providers. In one situation, an MCE was identified to have not sent any members letters with appeals information, rather, they copied the members on letters sent to the providers. HSAG also found variability in prior authorization requirements for alternative services (i.e., vocational services, intensive case management, residential, respite care, and recovery services). The Department notified the specific MCEs of the issues, who then established plans to address their issues. Additionally, HSAG found that all health plans' policies and procedures described an appropriate level of expertise required for UM staff members making denial determinations; however, record reviews demonstrated that only seven of nine health plans had consistent documentation in the files regarding the individual who made the determination. These situations are not parity concerns, but HSAG notified the specific MCEs about the issues for process improvement.

The full HSAG annual review can be found on the Department's Parity webpage.[8]

[8] The Department of Health Care Policy & Financing Mental Health Parity webpage: https://hcpf.colorado.gov/parity

Appendices

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

Appendix A – Prior Authorization

Description: Prior authorization review (PAR) requires a provider submit a request before performing a service and may only render it after receiving approval. *Note that no emergency services require prior authorization.*

Tools for Analysis: Data request, interviews with health plan staff, and policies/procedures documents referencing utilization management policies, timelines for the processing of authorizations, documentation requirements, methods of document submission, and reviewer qualifications.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Prior Authorization

PRIOR AUTHORIZATION SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
Inpatient Services		
Process		
Are services in this classification subject to prior authorization?	No IP MH/SUD services are subject to PAR.	IP PAR is used for select M/S procedures or services to establish medical necessity.[9] Excluded from PAR requirement are long term rehab facilities and maternity related services.
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	1 business day.	1 business day.
Strategy		
Are prior authorization policies the same for both in-network and out-of-network providers?	Yes[10]	Yes[11]
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize inpatient services?	The FFS UM Vendor uses InterQual and MCG	The FFS UM Vendor uses InterQual and MCG
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change.	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change.

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

[10] The term in-network and out-of-network is not used by FFS UM since the ColoradoPAR program serves the entire state of Colorado and look at in-state and out-of-state (OOS) providers. Some border facilities are considered in-state. Both OOS and in-state providers need to be enrolled with Medicaid to bill for services and the authorization policies are the same.

[11] Ibid.

Prior Authorization

Findings: Scenario 1 – Inpatient Services

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

The inpatient prior authorization policies and procedures regarding exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice. Furthermore, no inpatient MH/SUD services are subject to PAR so the policies for MH/SUD are much less stringent than those for inpatient M/S.

It is determined that these policies and procedures are parity compliant.

PRIOR AUTHORIZATION

SCENARIO 1: DEPARTMENT FFS

QUESTION	MH/SUD	M/S
Outpatient Services		
Process		
Are services in this classification subject to prior authorization?	PAR is only required for OP pediatric behavioral therapy (PBT) services.	There are thousands of codes that require PAR, including conditional PAR requirements.[12] Some conditional PAR requirements exist where in certain circumstances a PAR would not be needed (ie: diapers under unit limit 250) but these are all listed on the fee schedule.
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	10 business days	10 business days
Strategy		

[12] The utilization management vendor for the Department's fee-for-service benefit is responsible for reviewing the majority of codes in the following benefit categories: Durable Medical Equipment (DME), Physical Therapy, Occupational Therapy, Pediatric Behavioral Therapy, Speech Therapy, Synagis, select medical surgeries, transgender services, bariatric surgeries, EPSDT Exceptions, Audiology, Vision, Diagnostic Imaging, Molecular Testing, Out of State Inpatient Admissions, Private Duty Nursing, Pediatric Long Term Home Health, Pediatric Personal Care Services. To view the PAR requirements for each code, see the Fee Schedule(s).

PRIOR AUTHORIZATION SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
Are prior authorization policies the same for both in-network and out-of-network providers?	Yes[13]	Yes[14]
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize outpatient services?	The FFS UM Vendor uses InterQual and MCG	The FFS UM Vendor uses InterQual and MCG
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change. PBT is the only OP MH/SUD service subject to internally developed criteria	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change. 1328 REV codes and CPT codes that utilize in whole or in part internally developed, state developed criteria.

Prior Authorization

Findings: Scenario 1 – Outpatient Services

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

The outpatient prior authorization policies and procedures regarding determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice. Furthermore, only 1 outpatient MH/SUD service is subject to PAR so the policies for MH/SUD are much less stringent than those for outpatient M/S.

It is determined that these policies and procedures are parity compliant.

[13] The term in-network and out-of-network is not used by FFS UM since the ColoradoPAR program serves the entire state of Colorado and look at in-state and out-of-state (OOS) providers. Some border facilities are considered in-state. Both OOS and in-state providers need to be enrolled with Medicaid to bill for services and the authorization policies are the same.
[14] Ibid.

PRIOR AUTHORIZATION SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
Pharmacy Services		
Process		
Are services in this classification subject to prior authorization?	Medications that are listed as non-preferred agents on the preferred drug list require PAR. Drug products requiring a prior authorization for the Health First Colorado pharmacy benefit are listed in Appendix P - Pharmacy Benefit Prior Authorization Procedures and Criteria[15]. Exceptions exist within drug category and can be found in Appendix P. Some physician administered drugs (PADs) are subject to PAR as of 2021. Exceptions exist within drug category and can be found in Appendix P.	Medications that are listed as non-preferred agents on the preferred drug list require PAR. Drug products requiring a prior authorization for the Health First Colorado pharmacy benefit are listed in Appendix P - Pharmacy Benefit Prior Authorization Procedures and Criteria[16]. Exceptions exist within drug category and can be found in Appendix P. Some physician administered drugs (PADs) are subject to PAR as of 2021. Exceptions exist within drug category and can be found in Appendix P.
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	24 hours	24 hours
Does the plan impose any prior authorization requirements or step therapy requirements as a prerequisite to authorizing coverage for any prescription medication approved by the Food and Drug Administration for the treatment of substance use disorders? If so, please explain.	No	No
Strategy		
Are prior authorization policies the same for both in-network and out-of-network providers?	Yes	Yes
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine	Internally developed guidelines are used.	Internally developed guidelines are used.

[15] The Department of Health Care Policy & Financing Pharmacy Resources webpage: https://hcpf.colorado.gov/pharmacy-resources
[16] Ibid.

PRIOR AUTHORIZATION SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
whether to prior authorize pharmacy services?		
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?	Yes. Criteria are based on FDA product labeling, CMS approved compendia, clinical practice guidelines, and peer-reviewed medical literature. All reviews go to the Drug Utilization Review Board who review and act as an advisory council. Criteria are updated as new best practices are established.	Yes. Criteria are based on FDA product labeling, CMS approved compendia, clinical practice guidelines, and peer-reviewed medical literature. All reviews go to the Drug Utilization Review Board who review and act as an advisory council. Criteria are updated as new best practices are established.

Prior Authorization

Findings: Scenario 1 – Pharmacy Services

Colorado Medicaid requires prior authorization for all drugs not listed on the preferred drug list (PDL). The PDL is developed based on safety, effectiveness, and clinical outcomes from classes of medications where there are multiple drug alternatives available and supplemental rebates from drug companies, allowing Colorado the ability to provide medications at the lowest possible costs. The goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting.

The pharmacy services prior authorization policies and procedures regarding exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Prior Authorization

PRIOR AUTHORIZATION SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
Inpatient Services		
Process		

PRIOR AUTHORIZATION SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
Are services in this classification subject to prior authorization?	All IP MH/SUD services except two require PAR	Yes, most IP M/S services require PAR.[17]
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	10 days standard, 72 hours expedited	10 days
Strategy		
Are prior authorization policies the same for both in-network and out-of-network providers?	No, all OON IP services require PAR except emergency services.	No, all OON IP services require PAR except emergency services.
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize inpatient services?	MCG for MH and ASAM for SUD	MCG for M/S
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?	No	Yes, in some situations to supplement MCG criteria as needed. Updated annually at minimum.

Prior Authorization

Findings: Scenario 2 – Inpatient Services

Rocky Mountain Health Plan uses PAR for both their RAE 1 and Prime MCO lines of business to monitor and prevent potential overutilization and underutilization; manage high-cost and prolonged-duration services; ensure enrollee safety; determine the appropriate level of care; and determine whether the service or item is medically necessary. This rationale is applied to both MH/SUD services and M/S services.

The inpatient prior authorization policies and procedures regarding exception policies, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services and in a few situations they are less restrictive or more favorable for MH/SUD services than M/S services, and follow standard industry practice. MH/SUD services and M/S services both require authorization for inpatient services that follow current best practices. The authorization determination timeframes used for MH/SUD and M/S services are based upon timeframes set by state and

[17] RMHP Prime policy document "RMHP_Clinical_Preauth_List_20220101 V3" provides a full list of service codes that do require prior authorization. Any service code that is not on this list does not require prior authorization.

federal, as well as nationally-recognized industry standards of practice. So while the timeframes for determination may be different, these policies and procedures applied to MH/SUD and M/S services have not been found to be more stringent nor create a barrier to access to care for members.

It is determined that these policies and procedures are parity compliant.

PRIOR AUTHORIZATION

SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO

QUESTION	MH/SUD	M/S
Outpatient Services		
Process		
Are services in this classification subject to prior authorization?	Most services do not require PAR. Some specialized, longer term, non-routine services do require PAR.[18]	Most services do not require PAR. Some specialized, longer term, non-routine services do require PAR.[19]
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	10 days standard, 72 hours expedited	10 days standard, 72 hours expedited
Strategy		
Are prior authorization policies the same for both in-network and out-of-network providers?	No, all OON OP services require PAR except emergency services.	No, all OON OP services require PAR except emergency services.
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize outpatient services?	MCG for MH and ASAM for SUD	MCG for M/S
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?	No	Yes, in some situations to supplement MCG criteria as needed. Updated annually at minimum.

[18] RAE 1 outpatient services that require prior authorization: Intensive Outpatient Programing (IOP), Partial Hospitalization Programming (PHP), Psychiatric testing, and Electroconvulsive therapy.

[19] A full list of Rocky Prime MCO outpatient services that require prior authorization can be found on the document "RMHP_Clinical_Preauth_List_20220101 V3". Any service code that is not on this list does not require prior authorization.

Prior Authorization

Findings: Scenario 2 – Outpatient Services

Rocky Mountain Health Plan uses PAR for both their RAE 1 and Prime MCO lines of business to monitor and prevent potential overutilization and underutilization; manage high-cost and prolonged-duration services; ensure enrollee safety; determine the appropriate level of care; and determine whether the service or item is medically necessary. This rationale is applied to both MH/SUD services and M/S services.

As of Jan 1, 2022, the RAE is no longer requiring prior authorization for 60 min psychotherapy (90837). The remaining services that do require prior authorization (Intensive Outpatient Programming, Partial Hospitalization Programming, Psychiatric testing, and Electroconvulsive therapy) are longer term or specialized types of services that few members would need or benefit from and therefore PAR is in place to ensure proper member care.

The outpatient prior authorization policies and procedures regarding exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. MH/SUD services and M/S services both require authorization for a select set of outpatient services that follow current best practices. The outpatient prior authorization timeframes for determination are 10 days for standard and 72 hours for expedited. These timeframes are industry standard, are the same or faster than federal requirements (14 days standard/72 hours expedited) and are consistent with Colorado State Rule (10 days standard/72 hours expedited).

It is determined that these policies and procedures are parity compliant.

PRIOR AUTHORIZATION

SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO

QUESTION	MH/SUD	M/S
Pharmacy Services		
Process		
Are services in this classification subject to prior authorization?	Only a select set of pharmacy services are subject to PAR Any drug that has limits on coverage is eligible for an exception request.	Only a select set of pharmacy services are subject to PAR Any drug that has limits on coverage is eligible for an exception request.
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	24 hours	24 hours
Does the plan impose any prior authorization requirements or step therapy requirements as a prerequisite to authorizing coverage for any prescription medication approved by the	No	No

PRIOR AUTHORIZATION SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
Food and Drug Administration for the treatment of substance use disorders? If so, please explain.		
Strategy		
Are prior authorization policies the same for both in-network and out-of-network providers?	Yes	Yes
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize pharmacy services?	No	No
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?	Yes. All drugs that require PAR are subject to internally developed guidelines. Updated on an ad hoc basis.	Yes. All drugs that require PAR are subject to internally developed guidelines. Updated on an ad hoc basis.

Prior Authorization

Findings: Scenario 2 – Pharmacy Services

Drugs that are determined to need extra safety monitoring, are FDA indicated as 2nd/3rd/4th line or are high cost low utilization/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. This policy is applied equally to both MH/SUD and M/S.

The pharmacy services prior authorization policies and procedures regarding exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 3: Prior Authorization

PRIOR AUTHORIZATION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
Inpatient Services					
Process					
Are services in this classification subject to prior authorization?	All IP services except 3.2WM (H0010) and 3.7WM (H0011) require PAR	All IP services except 3.2WM (H0010) and 3.7WM (H0011) require PAR	All IP services except ASAM 3.2 and 3.7WM require PAR[20]	All IP services except ASAM 3.2WM and 3.7WM require PAR	IP PAR is used for select M/S procedures or services to establish medical necessity.[21] Excluded from PAR requirement are long term rehab facilities and maternity related services.
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	72 hours	72 hours	72 hours	72 hours	1 business day

[20] Inpatient WM (3.7WM) does not require prior authorization (per contract), but requires concurrent review after day five (5). COA does not require prior authorization or concurrent review on 3.2WM services (considered an outpatient service). COA monitors utilization patterns for these services and can perform retrospective review as needed.

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

PRIOR AUTHORIZATION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
Strategy					
Are prior authorization policies the same for both in-network and out-of-network providers?	No, all OON inpatient services require prior authorization with the exception of emergency services.	Yes	Yes	No, all OON inpatient services require prior authorization with the exception of emergency services.	Yes
Evidentiary Services					
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize inpatient services?	MCG for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	MCG for MH and ASAM for SUD	InterQual and MCG for M/S
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?	No	No	No	No	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change.

Prior Authorization

Findings: Scenario 3 – Inpatient Services

Prior authorization policies and procedures seek to ensure that members are receiving the safe and appropriate level of care that is necessary for their condition.

The inpatient prior authorization policies and procedures regarding exception policies, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. The authorization determination timeframes used for MH/SUD and M/S services are based upon timeframes set by state and federal, as well as nationally-recognized industry standards of practice. So while the timeframes for determination may be different, these policies and procedures applied to MH/SUD and M/S services have not been found to be more stringent nor create a barrier to access to care for members. M/S requires prior authorization on select procedures to make sure the procedures and services are medically necessary. MH/SUD does not have procedures, but they do also require prior authorization for services to ensure medical necessity. Both M/S and MH/SUD, most often do not require prior authorization for services that are deemed to be always medically necessary. Additionally, while both look at medical necessity, M/S also looks at less costly options (i.e. does the procedure need to be done in the hospital, convenience of member/caregiver, duplication, timeliness, experimental/investigational/FDA approved). MH/SUD looks to avoid overly invasive services or institutionalizing a member. So, while differences in the policies and procedures exist, the requirements, processes, and rationale for requiring prior authorization review are comparable and applied no more stringently.

It is determined that these policies and procedures are parity compliant.

PRIOR AUTHORIZATION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
Outpatient Services					
Process					
Are services in this classification subject to prior authorization?	Most services do not require PAR. Some specialized, longer term, non-routine services do require PAR.[22]	Most services do not require PAR. Some specialized, longer term, non-routine services do require PAR.[23]	Most services do not require PAR. Some specialized, longer term, non-routine services do require PAR.[24]	Most services do not require PAR. Some specialized, longer term, non-routine services do require PAR.[25]	There are thousands of codes that require PAR, including conditional PAR requirements.[26] Some conditional PAR requirements exist in certain circumstances where a PAR would not be needed (ie: diapers under unit limit 250)

[22] RAE 1 outpatient services that require prior authorization: MH services include Intensive Outpatient Programing (IOP), Partial Hospitalization Programming (PHP), Psychiatric testing, Electroconvulsive therapy, IOP and PHP are PA because they are longer term services. They naturally need to be concurrently reviewed to ensure members are still meeting medical necessity. Psych testing and electroconvulsive therapy are specialized types of services that not everyone needs or would benefit from so need to make sure that providers asking for these services are asking for them so that it is going to benefit the member and their diagnosis.

[23] RAE 2 & 4 routine services that do not require prior authorization: 0510, 0513, 90791, 90792, 90832, 90834, 90837, 90839, 90846, 90847, 90849, 90853, 96372, H0001, H0002, H0004, H0005, H0006, H0018, H0020, H0023, H0025, H0031-34, H0036-38, H2000, H2014-18, H2021, H2022, H2027, H2030, H2031, S9445, S9453, S9454, T1017, T1023 and all E&M codes.

[24] RAE 3 & 5 outpatient services that require prior authorization: Acute Treatment unit, Mental health residential treatment, SUD residential treatment, Intensive Outpatient, Partial hospitalization, Psychological testing, Electroconvulsive therapy, Day treatment.

[25] RAE 6 & 7 outpatient services that do not require prior authorization: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90875, 90876, 96116, 96121, 96130-96138, 96372, 97535, h0001-h0006, h0010 (No PAR for first five days of treatment), h0020, h0033, h0034, h0035, h0045, h2014, h2023-h2037, s9445, s9485, t1005, t1017, 90791, 90792, 90839, 98966-98968,h0001-h0005, h0023, h0025, h0031, t1016, h0032, h0033, h0034, h2000, h2011, s9453, s9454, 99241-99245, 99201-99443, 90833-90838.

[26] The utilization management vendor for the Department's fee-for-service benefit is responsible for reviewing the majority of codes in the following benefit categories: Durable Medical Equipment (DME), Physical Therapy, Occupational Therapy, Pediatric Behavioral Therapy, Speech Therapy, Synagis, select medical surgeries, transgender services, bariatric surgeries, EPSDT Exceptions, Audiology, Vision, Diagnostic Imaging, Molecular Testing, Out of State Inpatient Admissions, Private Duty Nursing, Pediatric Long Term Home Health, Pediatric Personal Care Services.
To view the PAR requirements for each code, see the Fee Schedule(s).

PRIOR AUTHORIZATION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
					but these are all listed on the fee schedule. If a service is being provided emergently then a PAR requirement would be overridden.
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	10 days for standard, 72 hours for expedited	10 days for standard, 72 hours for expedited	10 days for standard, 72 hours for expedited	10 days for standard, 72 hours for expedited	10 days
Strategy					
Are prior authorization policies the same for both in-network and out-of-network providers?	All OON OP services require PAR	All OON OP services require PAR	All OON OP services require PAR	All OON OP services require PAR	Yes.[27]
Evidentiary Services					
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize outpatient services?	MCG for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	MCG for MH and ASAM for SUD	InterQual and MCG for M/S

[27] The term in-network and out-of-network is not used by FFS UM since the ColoradoPAR program serves the entire state of Colorado and look at in-state and out-of-state (OOS) providers. Some border facilities are considered in-state. Both OOS and in-state providers need to be enrolled with Medicaid to bill for services and the authorization policies are the same.

PRIOR AUTHORIZATION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?	No	No	No	No	Yes. 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. 1328 REV codes and CPT codes that utilize in whole or in part internally developed, state developed criteria.

Prior Authorization

Findings: Scenario 3 – Outpatient Services

The outpatient prior authorization policies and procedures regarding exception policies, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. MH/SUD services and M/S services both require authorization for a select set of outpatient services that follow current best practices. The authorization determination timeframes used for MH/SUD and M/S services are based upon timeframes set by state and federal, as well as nationally-recognized industry standards of practice. So while the timeframes for

determination may be different, these policies and procedures applied to MH/SUD and M/S services have not been found to be more stringent nor create a barrier to access to care for members.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Prior Authorization

PRIOR AUTHORIZATION SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
Inpatient Services		
Process		
Are services in this classification subject to prior authorization?	All IP services except ASAM 3.7WM require PAR	No PAR is required in-network All out-of-network care requires PAR
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	72 hours	24 hours for admission notification
Strategy		
Are prior authorization policies the same for both in-network and out-of-network providers?	Yes	No, authorizations are not required in-network, all out-of-network care requires authorization.
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize inpatient services?	InterQual for MH and ASAM for SUD	MCG for M/S
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?	No	No

Prior Authorization

Findings: Scenario 4 – Inpatient Services

Prior authorization used to assure the member is being treated in the least restrictive environment appropriate for their condition.

The inpatient prior authorization policies and procedures regarding exception policies, determination timeframes, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. The authorization determination timeframes used for MH/SUD and M/S services are based upon timeframes set by state and federal, as well as nationally-recognized industry standards of practice. So while the timeframes for determination may be different, these policies and procedures applied to MH/SUD and M/S services have not been found to be more stringent nor create a barrier to access to care for members.

However, no M/S in-network services are subject to authorization, while all MH/SUD in-network services are subject to prior authorization. Therefore, the policies applied to MH/SUD are more stringent than those applied to M/S.

Through their efforts to reduce administrative hurdles for providers in their preferred provider network, they inadvertently created a situation where their M/S services authorization policies were less stringent than comparable MH/SUD policies specific to the Denver Health hospital system. DHMC engages in a risk based sub-capitation arrangement with Denver Health Hospital Authority. DMHC is a staff-model MCO, where it's medical/health providers are employees rather than independent providers who contract with the health plan. As part of the risk based arrangement, Denver Health Hospital Authority providers do not need to submit any services for authorization. All out-of-network M/S care requires authorization.

It is determined that these policies and procedures are out of compliance with parity requirements.

The Department immediately began work with DHMC to address the issues and bring their policies back into compliance. DHMC is currently finalizing the policy changes which should be implemented by July 1, 2022. These changes will be evaluated by the Department to ensure the policies meet parity compliance prior to implementation.

PRIOR AUTHORIZATION

SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO

QUESTION	MH/SUD	M/S
Outpatient Services		
Process		
Are services in this classification subject to prior authorization?	Only the following OP services require PAR: Acute Treatment unit, Mental health residential treatment, SUD residential treatment, Intensive Outpatient, Partial hospitalization, Psychological testing, Electroconvulsive therapy, Day treatment	In-network services subject to PAR: DME rental and purchase if greater than $500, Home health care greater than day 31-59, Autism evaluation, Respiratory equipment (cpap and bipap), Early intervention services. All out-of-network services require PAR.
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	10 days for standard, 72 hours for expedited	10 calendar days

PRIOR AUTHORIZATION SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
Strategy		
Are prior authorization policies the same for both in-network and out-of-network providers?	No, all OP out-of-network services require PAR.	No authorization is required for in-network care. Authorizations are required for all out-of-network care.
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize outpatient services?	InterQual for MH and ASAM for SUD	MCG, Hayes Knowledge Center, and Uptodate
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?		Yes. Oral nutrition and CPAP bipap have internal criteria. All other types of care DHMC uses MCG. Reviewed annually.

Prior Authorization

Findings: Scenario 4 – Outpatient Services

Routine MH/SUD outpatient services do not require prior authorization. Some specialty and/or higher acuity outpatient services do require prior authorization, consistent with industry standards, to ensure that the member cannot be treated in a less restrictive environment.

The outpatient prior authorization policies and procedures regarding exception policies, determination timeframes, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

However, while there are a few M/S in-network services subject to authorization including rental services, there are not comparable MH/SUD in-network services subject to prior authorization making the policies applied to MH/SUD more stringent than those applied to M/S.

Through their efforts to reduce administrative hurdles for providers in their preferred provider network, they inadvertently created a situation where their M/S services authorization policies were less stringent than comparable MH/SUD policies specific to the Denver Health hospital system. DHMC engages in a risk based sub-capitation arrangement with Denver Health Hospital Authority. DMHC is a staff-model MCO, where it's medical/health providers are employees rather than independent providers who contract with the health plan. As part of the risk based arrangement, Denver Health Hospital Authority providers do not need to submit any services for authorization. All out-of-network M/S care requires authorization.

It is determined that these policies and procedures are out of compliance with parity requirements.

The Department immediately began work with DHMC to address the issues and bring their policies back into compliance. DHMC is currently finalizing the policy changes which should be implemented by July 1, 2022. These changes will be evaluated by the Department to ensure the policies meet parity compliance prior to implementation.

PRIOR AUTHORIZATION

SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO

QUESTION	MH/SUD	M/S
Pharmacy Services		
Process		
Are services in this classification subject to prior authorization?	Few MH drugs are subject to prior authorization[28]. No SUD drugs are. Treatments that are supported by CMS approved compendia can be approved without meeting specific criteria. If a member has contraindications to required medications, then exceptions can be made.	DHMC reviews for injectable or IV medications that are non-formulary. An exception exists where a 72 hour emergency supply can be obtained if necessary.
What is the maximum amount of time allowed to issue a determination on a prior authorization request?	24 hours	48 hours
Does the plan impose any prior authorization requirements or step therapy requirements as a prerequisite to authorizing coverage for any prescription medication approved by the Food and Drug Administration for the treatment of substance use disorders? If so, please explain.	No	No
Strategy		
Are prior authorization policies the same for both in-network and out-of-network providers?	Yes	Yes
Evidentiary Services		

[28] DHMC only requires prior authorization for the following mental health drugs: Abilify Maintena, Daytrana, Fanapt, Invega Sustenna, Kapvay, Saphris, Zyprexa Relprevv. No substance use disorder drugs are subject to prior authorization.

PRIOR AUTHORIZATION SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize pharmacy services?	No. Internally developed guidelines are used for the pharmacy benefit.	No. Internally developed guidelines are used for the pharmacy benefit.
Does the plan use internally developed guidelines to determine whether to prior authorize services? IF YES: How frequently are those guidelines updated?	Yes. The development of these internal guidelines use clinical evidence from many sources, such as Micromedex, package labeling information, UptoDate or maybe even MCG. They are updated annually.	Yes. The development of these internal guidelines use clinical evidence from many sources, such as Micromedex, package labeling information, UptoDate or maybe even MCG. They are updated annually.

Prior Authorization

Findings: Scenario 4 – Pharmacy Services

Prior authorization review policies for Prescription Drug services are used for member safety and cost containment.

The pharmacy services prior authorization policies and procedures regarding exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Appendix B – Concurrent Review

Description: Concurrent review (CCR) requires services be periodically reviewed as they are being provided in order to continue the authorization for the service. *Note that no emergency services require prior authorization.*

Tools for Analysis: Data request, interviews with health plan staff, and policies/procedures documents referencing CCR utilization management policies, frequency of review, and reviewer qualifications.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	IP, OP	No	✓Yes
Scenario 2	RMHP and Prime MCO	IP, OP	Yes. Frequency of review is different.	✓Yes
Scenario 3	RAE 1	IP, OP	Yes. See tables below.	No, for IP
	RAE 2 and 4	IP, OP	Yes. See tables below.	No, for IP
	RAE 3 and 5	IP, OP	Yes. See tables below.	No, for IP
	RAE 6 and 7	IP, OP	Yes. See tables below.	No, for IP
Scenario 4	Denver PIHP and Denver Health MCO	IP, OP	Yes. See tables below.	No, for IP & OP

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Concurrent Review

CONCURRENT REVIEW SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
Inpatient Services		
Process		
Are services in this classification subject to concurrent review?	No IP MH/SUD services are subject to CCR.	While IHRP is on hold, no IP M/S services are subject to CCR.
How frequently is concurrent review required for services in this classification?	N/A	N/A
Are concurrent reviews performed by the direct treatment provider, or does the plan require secondary assessment to complete the authorization?	N/A	N/A
What is the maximum amount of time allowed to issue a determination on a concurrent review request?	N/A	N/A
Strategy		
Are concurrent review policies the same for both in-network and out-of-network providers?	N/A	N/A
Evidentiary Services		
Does the plan use nationally recognized evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding concurrent review for inpatient services?	N/A	N/A
"Does the plan use internally developed guidelines to determine whether to concurrently review services? Does the plan use internally developed guidelines to determine whether to concurrently review services? IF YES: How frequently are those guidelines updated?	N/A	N/A

Concurrent Review

Findings: Scenario 1 – Inpatient Services

Concurrent review is not currently used for inpatient fee-for-service MH/SUD or M/S services. Therefore, requirements for inpatient MH/SUD services are comparable to and not more stringent than for M/S services.

It is determined that these policies and procedures are parity compliant.

CONCURRENT REVIEW SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
Outpatient Services		
Process		
Are services in this classification subject to concurrent review?	Services that are subject to PAR are subject to CCR. For MH/SUD, the only service subject to PAR is PBT.[29]	Services that are subject to PAR are subject to CCR.[30]
How frequently is concurrent review required for services in this classification?	Frequency of CCR is established based on the type of service, intensity of the service, and member acuity, and verified against clinical decision support product recommendations.	Frequency of CCR is established based on the type of service, intensity of the service, and member acuity, and verified against clinical decision support product recommendations.
What is the maximum amount of time allowed to issue a determination on a concurrent review request?	The UM Vendor has 10 days business days to complete the review, upon receipt of all necessary documentation from the provider or facility.	The UM Vendor has 10 days business days to complete the review, upon receipt of all necessary documentation from the provider or facility.
Strategy		
Are concurrent review policies the same for both in-network and out-of-network providers?	Yes	Yes
Evidentiary Services		
Does the plan use nationally recognized evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding concurrent review for outpatient services?	The FFS UM Vendor uses InterQual and MCG	The FFS UM Vendor uses InterQual and MCG
Does the plan use internally developed guidelines to determine whether to concurrently review services? IF YES: How frequently are those guidelines updated?	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change.	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change. 1328 REV codes and CPT codes that utilize in whole

[29] The Department does not refer to the authorization as a "concurrent review" authorization, but as a new "prior authorization". The process followed by provider submitting the request, and the UM Vendor internally, for an ongoing OP service resembles a PAR process. For example, if a member is authorized for 6 months of physical therapy, and they need 6 months more, then the process is considered internally as a new PAR but is a continued service as far as the member is concerned.
[30] Ibid.

CONCURRENT REVIEW SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
	PBT is the only OP MH/SUD service subject to internally developed criteria	or in part internally developed, state developed criteria.

Concurrent Review

Findings: Scenario 1 – Outpatient Services

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

The outpatient concurrent review policies and procedures regarding frequency of review, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Concurrent Review

CONCURRENT REVIEW SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
Inpatient Services		
Process		
Are services in this classification subject to concurrent review?	All services that require PAR are subject to CCR.	All services that require PAR are subject to CCR.
How frequently is concurrent review required for services in this classification?	Frequency of CCR is established based on the type of service, intensity of the service, and member acuity, and verified against clinical decision support product recommendations. 3-7 days generally	Frequency of CCR is established based on the type of service, intensity of the service, and member acuity, and verified against clinical decision support product recommendations. Daily or less frequently, depending on clinical presentation and discharge planning need.

CONCURRENT REVIEW SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
What is the maximum amount of time allowed to issue a determination on a concurrent review request?	24 hours	24 hours
Strategy		
Are concurrent review policies the same for both in-network and out-of-network providers?	No, OON providers need CCR for ANY ongoing service. In-network providers only CCR for services on PAR list.	No, OON providers need CCR for ANY ongoing service. In-network providers only CCR for services on PAR list.
Evidentiary Services		
Does the plan use nationally recognized evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding concurrent review for inpatient services?	MCG for MH and ASAM for SUD	MCG
Does the plan use internally developed guidelines to determine whether to concurrently review services? IF YES: How frequently are those guidelines updated?	No.	Yes, for some IP M/S services. Updated annually at a minimum.

Concurrent Review

Findings: Scenario 2 – Inpatient Services

The health plan uses concurrent review to monitor and prevent potential overutilization and underutilization, manage high-cost and prolonged-duration services, ensure enrollee safety, determine the appropriate level of care, and determine whether the service or item continues to be medically necessary.

The inpatient concurrent review policies and procedures regarding exception policies, frequency of review, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services and in a few situations they are less restrictive or more favorable for MH/SUD services than M/S services, and follow standard industry practice. The estimated timeframes for frequency of concurrent review are different, but they are both established based on the type of service, intensity of the service, and member acuity, and verified against clinical decision support product recommendations.

It is determined that these policies and procedures are parity compliant.

CONCURRENT REVIEW

SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO

QUESTION	MH/SUD	M/S
Outpatient Services		
Process		
Are services in this classification subject to concurrent review?	All services that require PAR are subject to CCR.	All services that require PAR are subject to CCR.
How frequently is concurrent review required for services in this classification?	Frequency of CCR is established based on the type of service, intensity of the service, and member acuity, and verified against clinical decision support product recommendations. ~5-10 days	Frequency of CCR is established based on the type of service, intensity of the service, and member acuity, and verified against clinical decision support product recommendations. ~Every 1-2 months
What is the maximum amount of time allowed to issue a determination on a concurrent review request?	24 hours	24 hours
Strategy		
Are concurrent review policies the same for both in-network and out-of-network providers?	No, OON providers need CCR for ANY ongoing service. In-network providers only CCR for services on PAR list.	No, OON providers need CCR for ANY ongoing service. In-network providers only CCR for services on PAR list.
Evidentiary Services		
Does the plan use nationally recognized evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding concurrent review for outpatient services?	MCG for MH and ASAM SUD	MCG
Does the plan use internally developed guidelines to determine whether to concurrently review services? IF YES: How frequently are those guidelines updated?	No	No

Concurrent Review

Findings: Scenario 2 – Outpatient Services

The health plan uses concurrent review to monitor and prevent potential overutilization and underutilization, manage high-cost and prolonged-duration services, ensure enrollee safety, determine the appropriate level of care, and determine whether the service or item continues to be medically necessary.

The outpatient concurrent review policies and procedures regarding exception policies, frequency of review, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. The estimated timeframes for frequency of concurrent review are different, but they are both established based on the type of service, intensity of the service, and member acuity, and verified against clinical decision support product recommendations.

It is determined that these policies and procedures are parity compliant.

Scenario 3: Concurrent Review

CONCURRENT REVIEW SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
Inpatient Services					
Process					
Are services in this classification subject to concurrent review?	All IP services that require PAR are subject to CCR	All IP services that require PAR are subject to CCR[31]	All IP services that require PAR are subject to CCR (this also includes 3.7 WM).	All IP services that require PAR are subject to CCR (this also includes 3.2 and 3.7 WM[32])	While IHRP is on hold, no IP M/S services are subject to CCR.
How frequently is concurrent review required for services in this classification?	~3-7 days	~3-5 days	~3-7 days	~2-3 days[33]	N/A
What is the maximum amount of time allowed to issue a determination on a concurrent review request?	24 hours	72 hours	72 hours	72 hours	N/A
Strategy					

[31] In extremely rare situations (only 2 inpatient facilities currently), RAE 2 & 4 contract with case rate agreements where concurrent reviews are conducted less frequently. These case rate agreements have not been found to improve quality of care and are being phased out. Under this arrangement, authorizations are typically longer and require concurrent review approximately every 14 days rather than the general 3-5 day timeframe.

[32] For 3.2 and 3.7 WM CCR is required if admissions are longer than 5 days for 3.2 WM and 4 days for 3.7 WM per the 1115 waiver

[33] Frequency varies by the member's clinical presentation, but typically reviews are required every 2-3 days. Withdrawal management (3.2 WM and 3.7 WM) occurs at Day 5 +. CCHA doesn't have any facilities on a DRG model, therefore they utilize MCG criteria. If a course of treatment is recommended for 5 days, and 3 days is received then they will review the course of treatment on the 2nd day. CCR time periods are based off the MCG recommendations for the course of care to ensure the member is receiving the right level of care and they are seeing improvement.

CONCURRENT REVIEW SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
Are concurrent review policies the same for both in-network and out-of-network providers?	No, all out-of-network ongoing services are subject to CCR and in-network services only CCR ongoing services from PAR list.	Yes	Yes	Yes	N/A
Evidentiary Services					
Does the plan use nationally recognized evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding concurrent review for inpatient services?	MCG for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	MCG for MH and ASAM for SUD	N/A
Does the plan use internally developed guidelines to determine whether to concurrently review services? IF YES: How frequently are those guidelines updated?	No	No	No	No	N/A

Concurrent Review

Findings: Scenario 3 – Inpatient Services

The Department suspended the physical health fee-for-service Inpatient Hospital Review Program (IHRP) requirement for medical/surgical hospital admissions, initially to support hospitals to focus on COVID-19 care and then to enable the Department to redesign the IHRP process. This suspension pertains to admission reviews, admission notifications, concurrent review, and complex case concurrent review. IHRP is currently suspended, but when it is in operation, Inpatient FFS M/S Concurrent/Continued Stay Reviews are required under IHRP.

The inpatient concurrent review policies and procedures regarding frequency of review, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services all follow standard industry practice. There are some differences seen between the RAEs on typical frequency of concurrent reviews. However, all plans base timeframes upon a member's clinical presentation and the requested service, and follow timeframes set by their clinical decision support systems which are industry standard.

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

It is determined that these policies and procedures are out of compliance with parity requirements.

CONCURRENT REVIEW SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
Outpatient Services					
Process					
Are services in this classification subject to concurrent review?	Only OP services subject to PAR are subject to CCR.[34]	Only OP services subject to PAR are subject to CCR.[35]	Only OP services subject to PAR are subject to CCR.[36]	Only OP services subject to PAR are subject to CCR.[37]	Only OP services subject to PAR are subject to CCR.[38]
How frequently is concurrent review required for services in this classification?	~5-10 days	~3-5 days	Depends on the service. 3-5 days for acute / short-term services, 7-30 days	~1 week-6 months	The frequency of CCR depends on member presentation and progress made, and depending on the service.

[34] RAE 1 outpatient services that require prior authorization: MH services include Intensive Outpatient Programing (IOP), Partial Hospitalization Programming (PHP), Psychiatric testing, Electroconvulsive therapy, IOP and PHP are PA because they are longer term services. They naturally need to be concurrently reviewed to ensure members are still meeting medical necessity. Psych testing and electroconvulsive therapy are specialized types of services that not everyone needs or would benefit from so need to make sure that providers asking for these services are asking for them so that it is going to benefit the member and their diagnosis.

[35] RAE 2 & 4 routine services that do not require prior authorization: 0510, 0513, 90791, 90792, 90832, 90834, 90837, 90839, 90846, 90847, 90849, 90853, 96372, H0001, H0002, H0004, H0005, H0006, H0018, H0020, H0023, H0025, H0031-34, H0036-38, H2000, H2014-18, H2021, H2022, H2027, H2030, H2031, S9445, S9453, S9454, T1017, T1023 and all E&M codes. The outpatient services that do require authorization are generally considered non-routine or more complex interventions such as IOP, in-home services, respite, ECT or psych testing.

[36] RAE 3 & 5 outpatient services that require prior authorization: Acute Treatment unit, Mental health residential treatment, SUD residential treatment, Intensive Outpatient, Partial hospitalization, Psychological testing, Electroconvulsive therapy, Day treatment.

[37] RAE 6 & 7 outpatient services that do not require prior authorization: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90875, 90876, 96116, 96121, 96130-96138, 96372, 97535, h0001-h0006, h0010 (No PAR for first five days of treatment), h0020, h0033, h0034, h0035, h0045, h2014, h2023-h2037, s9445, s9485, t1005, t1017, 90791, 90792, 90839, 98966-98968,h0001-h0005, h0023, h0025, h0031, t1016, h0032, h0033, h0034, h2000, h2011, s9453, s9454, 99241-99245, 99201-99443, 90833-90838.

[38] The Department does not refer to the authorization as a "concurrent review" authorization, but as a new "prior authorization". The process followed by provider submitting the request, and the UM Vendor internally, for an ongoing OP service resembles a PAR process. For example, if a member is authorized for 6 months of physical therapy, and they need 6 months more, then the process is considered internally as a new PAR but is a continued service as far as the member is concerned.

CONCURRENT REVIEW SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION					
			for long-term / intensive services[39]		
What is the maximum amount of time allowed to issue a determination on a concurrent review request?	24 hours internal goal (10 days standard / 72 hours urgent required)	10 days for standard / 72 hours urgent	10 days for standard / 72 hours urgent	10 days for standard / 72 hours urgent	10 business days
Strategy					
Are concurrent review policies the same for both in-network and out-of-network providers?	No, any OON ongoing service is subject to CCR. In-network services only CCR services on PAR list.	Yes, once OON providers have secured a single case agreement for services.	Yes	No, any OON ongoing service is subject to CCR. In-network services only CCR services on PAR list.	Yes[40]
Evidentiary Services					
Does the plan use nationally recognized evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding concurrent	MCG for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	MCG for MH and ASAM for SUD	InterQual and MCG for M/S

[39] RAE 3 & 5 standard concurrent review periods vary depending on the services being rendered: Acute Treatment unit: review every 3-5 days, Short-term Mental health residential treatment: 3-5 days, Long-term Mental health residential treatment: 14-30 days, SUD residential treatment: 7-30 days, Intensive Outpatient: 14-30 days, Partial hospitalization: 7 days, Electroconvulsive therapy: 14-60 days, Day treatment: 30 days

[40] The term in-network and out-of-network is not used by FFS UM since the ColoradoPAR program serves the entire state of Colorado and look at in-state and out-of-state (OOS) providers. Some border facilities are considered in-state. Both OOS and in-state providers need to be enrolled with Medicaid to bill for services and the authorization policies are the same.

CONCURRENT REVIEW SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
review for outpatient services?					
Does the plan use internally developed guidelines to determine whether to concurrently review services? IF YES: How frequently are those guidelines updated?	No	No	No	No	Yes. 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. 1328 REV codes and CPT codes that utilize in whole or in part internally developed, state developed criteria.

Concurrent Review

Findings: Scenario 3 – Outpatient Services

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

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

The outpatient concurrent review policies and procedures regarding frequency of review, required determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services all follow standard industry practice. There are some differences seen between the RAEs on typical frequency of concurrent reviews. However, all plans base timeframes upon a member's clinical presentation and the requested service, and follow timeframes set by their clinical decision support systems which are industry standard. Additionally, RMHP RAE 1 has set an internal requirement for determination timeframes at 24 hours, while it is required in Colorado State Rule that RAEs complete determinations within 10 days for standard requests and 72 hours for urgent requests.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Concurrent Review

CONCURRENT REVIEW SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
Inpatient Services		
Process		
Are services in this classification subject to concurrent review?	All IP services are subject to CCR	No authorizations required in-network, all out-of-network care requires authorization.
How frequently is concurrent review required for services in this classification?	3-7 days generally, dependent on member's presentation, progress made, and care needed	CCR occurs prior to lapse of previously approved timeframe if continued length of stay is required. Timeframe is dependent on member's presentation, progress made, and care needed
What is the maximum amount of time allowed to issue a determination on a concurrent review request?	10 days for standard, 72 hours for urgent	10 days for standard. 72 hours for urgent
Strategy		
Are concurrent review policies the same for both in-network and out-of-network providers?	Yes	No authorizations required in-network, all out-of-network care requires authorization.
Evidentiary Services		
Does the plan use nationally recognized evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding concurrent review for inpatient services?	InterQual for MH and ASAM for SUD	MCG for M/S
Does the plan use internally developed guidelines to determine whether to concurrently review services? IF YES: How frequently are those guidelines updated?	No	No

Concurrent Review

Findings: Scenario 4 – Inpatient Services

Text

The inpatient concurrent review policies and procedures regarding exception policies and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. The authorization determination timeframes used for MH/SUD and M/S services are based upon timeframes set

by state and federal, as well as nationally-recognized industry standards of practice. So while the timeframes for determination may be different, these policies and procedures applied to MH/SUD and M/S services have not been found to be more stringent nor create a barrier to access to care for members. The estimated timeframes for frequency of concurrent review are different, but they are both established based on the type of service, intensity of the service, and member acuity, and verified against clinical decision support product recommendations.

However, no M/S in-network services are subject to authorization, while MH/SUD in-network services that are subject to prior authorization are subject to concurrent review. Therefore, the policies applied to MH/SUD are more stringent than those applied to M/S.

Through their efforts to reduce administrative hurdles for providers in their preferred provider network, they inadvertently created a situation where their M/S services authorization policies were less stringent than comparable MH/SUD policies specific to the Denver Health hospital system. DHMC engages in a risk based sub-capitation arrangement with Denver Health Hospital Authority. DMHC is a staff-model MCO, where it's medical/health providers are employees rather than independent providers who contract with the health plan. As part of the risk based arrangement, Denver Health Hospital Authority providers do not need to submit any services for authorization. All out-of-network M/S care requires authorization.

It is determined that these policies and procedures are out of compliance with parity requirements.

The Department immediately began work with DHMC to address the issues and bring their policies back into compliance. DHMC is currently finalizing the policy changes which should be implemented by July 1, 2022. These changes will be evaluated by the Department to ensure the policies meet parity compliance prior to implementation.

CONCURRENT REVIEW

SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO

QUESTION	MH/SUD	M/S
Outpatient Services		
Process		
Are services in this classification subject to concurrent review?	Only the following OP services require ongoing review for continued need of services: Acute Treatment unit, Mental health residential treatment, SUD residential treatment, Intensive Outpatient, Partial hospitalization,	In-network services subject to authorization: DME rental and purchase if greater than $500, Home health care greater than day 31-59, Autism evaluation, Respiratory equipment (cpap and bipap), Early intervention services. All out-of-network services require authorization.

CONCURRENT REVIEW SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
	Electroconvulsive therapy, Day treatment	
How frequently is concurrent review required for services in this classification?	Depends on the service. 3-5 days for acute / short-term services, 7-30 days for long-term / intensive services	OP M/S services are approved for the initial requested time period. If additional services are needed after that time period, an additional authorization request would need to be submitted. Timeframe is dependent on member's presentation, progress made, and service needed.
What is the maximum amount of time allowed to issue a determination on a concurrent review request?	10 days for standard, 72 hours for urgent	10 days for standard, 72 hours for urgent
Strategy		
Are concurrent review policies the same for both in-network and out-of-network providers?	Yes	No authorizations required in-network, all out-of-network care requires authorization.
Evidentiary Services		
Does the plan use nationally recognized evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding concurrent review for outpatient services?	InterQual for MH and ASAM for SUD	MCG, Hayes Knowledge Center, and Uptodate
Does the plan use internally developed guidelines to determine whether to concurrently review services? IF YES: How frequently are those guidelines updated?	No	Oral nutrition and CPAP bipap have internal criteria. All other types of care DHMC uses MCG. Reviewed annually.

Concurrent Review

Findings: Scenario 4 – Outpatient Services

Routine MH/SUD outpatient services do not require authorization. Some specialty and/or higher acuity outpatient services do require authorization, consistent with industry standards, to assure that the member cannot be treated in a less restrictive environment. The health plan subjects certain M/S services to concurrent review to ensure a member continues to meet the criteria for medical necessity.

The outpatient concurrent review policies and procedures regarding exception policies, determination timeframes, and evidentiary standards for MH/SUD services are substantially

similar to the policies and procedures of M/S services, and follow standard industry practice. The estimated timeframes for frequency of concurrent review are different, but they are both established based on the type of service, intensity of the service, and member acuity, and verified against clinical decision support product recommendations.

However, there are very few M/S in-network services subject to authorization including rental services, while a larger number of MH/SUD in-network services are subject to concurrent review. Therefore, the policies applied to MH/SUD are more stringent than those applied to M/S.

Through their efforts to reduce administrative hurdles for providers in their preferred provider network, they inadvertently created a situation where their M/S services authorization policies were less stringent than comparable MH/SUD policies specific to the Denver Health hospital system. DHMC engages in a risk based sub-capitation arrangement with Denver Health Hospital Authority. DMHC is a staff-model MCO, where it's medical/health providers are employees rather than independent providers who contract with the health plan. As part of the risk based arrangement, Denver Health Hospital Authority providers do not need to submit any services for authorization. All out-of-network M/S care requires authorization.

It is determined that these policies and procedures are out of compliance with parity requirements.

The Department immediately began work with DHMC to address the issues and bring their policies back into compliance. DHMC is currently finalizing the policy changes which should be implemented by July 1, 2022. These changes will be evaluated by the Department to ensure the policies meet parity compliance prior to implementation.

Appendix C – Retrospective Review

Description: Retrospective review (RR) is a protocol for approving a service after it has been delivered. *Note that no emergency services require prior authorization.*

Tools for Analysis: Data request, interviews with health plan staff, and policies/procedures documents referencing services/conditions that trigger RR, utilization management policies, reviewer qualifications.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Retrospective Review

RETROSPECTIVE REVIEW SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
Inpatient Services		
Process		
Is there a time limit on how far in the past services can be retrospectively reviewed? If so, what is that limit?	Time limits for RR are currently waived.	Time limits for RR are currently waived.
Are services in this classification subject to retrospective review?	All benefits that require a PAR may be considered for RR on a case by case basis	All benefits that require a PAR may be considered for RR on a case by case basis
What is the maximum amount of time allowed to issue a determination on a retrospective review request?	10 business days	10 business days
Strategy		
Are retrospective review policies the same for both in-network and out-of-network providers?	Yes[41]	Yes[42]
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding retrospective review for inpatient services?	The FFS UM Vendor uses InterQual and MCG.	The FFS UM Vendor uses InterQual and MCG.
Does the plan use internally developed guidelines to determine whether to prior retrospectively review services? IF YES: How frequently are those guidelines updated?	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change.	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change.

Retrospective Review

Findings: Scenario 1 – Inpatient Services

The goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting. In some situations, the Department's guidance overrides and allows a retrospective review. And in some cases, a member may not be eligible for

[41] The term in-network and out-of-network is not used by FFS UM since the ColoradoPAR program serves the entire state of Colorado and look at in-state and out-of-state (OOS) providers. Some border facilities are considered in-state. Both OOS and in-state providers need to be enrolled with Medicaid to bill for services and the authorization policies are the same.
[42] Ibid.

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.

The inpatient retrospective review policies and procedures regarding time limits, exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

RETROSPECTIVE REVIEW **SCENARIO 1: DEPARTMENT FFS**		
QUESTION	**MH/SUD**	**M/S**
Outpatient Services		
Process		
Is there a time limit on how far in the past services can be retrospectively reviewed? If so, what is that limit?	Time limits for RR are currently waived. Two exceptions to this policy is that, by rule, DME has 90 days and long term health has 10 days.	Time limits for RR are currently waived. Two exceptions to this policy is that, by rule, DME has 90 days and long term health has 10 days.
Are services in this classification subject to retrospective review?	All benefits that require a PAR may be considered for an exception to establishes timeliness rules to allow for a retrospective review on a case by case basis.	All benefits that require a PAR may be considered for an exception to establishes timeliness rules to allow for a retrospective review on a case by case basis.
What is the maximum amount of time allowed to issue a determination on a retrospective review request?	There is no established maximum	There is no established maximum
Strategy		
Are retrospective review policies the same for both in-network and out-of-network providers?	Yes	Yes
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding retrospective review for outpatient services?	The FFS UM Vendor uses InterQual and MCG.	The FFS UM Vendor uses InterQual and MCG.
Does the plan use internally developed guidelines to determine whether to retrospectively review services? IF YES: How frequently are those guidelines updated?	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change.	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change.

Retrospective Review

Findings: Scenario 1 – Outpatient Services

The goals of Colorado Medicaid's Utilization Management Program are to improve members' quality of care and ensure members are receiving the right service at the right time for the right duration in the right setting. In some situations, the Department's guidance overrides and allows a retrospective review. And in some cases, a member may not be eligible for Colorado Medicaid at the time of admission, but retroactive eligibility is obtained while the member is hospitalized or post discharge. A retrospective authorization will be required as soon as the inpatient facility becomes aware of the member's eligibility.

The outpatient retrospective review policies and procedures regarding time limits, exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Retrospective Review

RETROSPECTIVE REVIEW

SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO

QUESTION	MH/SUD	M/S
Inpatient Services		
Process		
Is there a time limit on how far in the past services can be retrospectively reviewed? If so, what is that limit?	No, but claims must be submitted within 120 days	No, but claims must be submitted within 120 days
Are services in this classification subject to retrospective review?	Only services that require PAR would need RR.	Only services that require PAR would need RR.
What is the maximum amount of time allowed to issue a determination on a retrospective review request?	30 days	30 days
Strategy		
Are retrospective review policies the same for both in-network and out-of-network providers?	No, in-network providers only RR services that require PAR if PAR was not obtained. OON providers must RR for any service not PAR'd.	No, in-network providers only RR services that require PAR if PAR was not obtained. OON providers must RR for any service not PAR'd.
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions	MCG for MH and ASAM for SUD.	MCG for M/S

RETROSPECTIVE REVIEW SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
regarding retrospective review for inpatient services?		
Does the plan use internally developed guidelines to determine whether to prior retrospectively review services? IF YES: How frequently are those guidelines updated?	No	Yes, for some IP M/S services. Updated annually at minimum.

Retrospective Review

Findings: Scenario 2 – Inpatient Services

The health plan uses retrospective review to monitor and prevent potential overutilization and underutilization, manage high-cost and prolonged-duration services, ensure enrollee safety, determine the appropriate level of care was utilized, and determine whether the service or item was medically necessary.

The inpatient retrospective review policies and procedures regarding time limits, exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

RETROSPECTIVE REVIEW SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
Outpatient Services		
Process		
Is there a time limit on how far in the past services can be retrospectively reviewed? If so, what is that limit?	No, but claims must be submitted within 120 days of services being rendered.	No, but claims must be submitted within 120 days of services being rendered.
Are services in this classification subject to retrospective review?	Only services that require PAR would need RR.	Only services that require PAR would need RR.
What is the maximum amount of time allowed to issue a determination on a retrospective review request?	30 days	30 days
Strategy		
Are retrospective review policies the same for both in-network and out-of-network providers?	No, in-network providers only RR services that require PAR if PAR was not obtained. OON providers	No, in-network providers only RR services that require PAR if PAR was not obtained. OON providers

RETROSPECTIVE REVIEW SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
	must RR for any service not PAR'd.	must RR for any service not PAR'd.
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding retrospective review for outpatient services?	MCG for MH and ASAM for SUD	MCG for M/S
Does the plan use internally developed guidelines to determine whether to retrospectively review services? IF YES: How frequently are those guidelines updated?	No	Yes, for some OP M/S services. Updated annually at minimum.

Retrospective Review

Findings: Scenario 2 – Outpatient Services

The health plan uses retrospective review to monitor and prevent potential overutilization and underutilization, manage high-cost and prolonged-duration services, ensure enrollee safety, determine the appropriate level of care was utilized, and determine whether the service or item was medically necessary.

The outpatient retrospective review policies and procedures regarding time limits, exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 3: Retrospective Review

RETROSPECTIVE REVIEW SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
Inpatient Services					
Process					
Is there a time limit on how far in the past services can be retrospectively reviewed? If so, what is that limit?	120 days[43]	120 days	120 days	120 days	Time limits for RR are currently waived.
Are services in this classification subject to retrospective review?	All services subject to PAR may be considered for RR if PAR was not obtained.	All IP services may be considered for RR	All IP services may be considered for RR[44] Occasionally the IMD retro enrollment process requires COA to waive RR timeframes	All IP services may be considered for RR There are extensions when members become retroactively eligible for Medicaid	All services subject to PAR may be considered for RR if PAR was not obtained. These are considered on a case by case basis
What is the maximum amount of time allowed to issue a determination on a	30 days	30 days	30 days	30 days	10 days

[43] There is not a specific time limit on retrospective review. However, there is a time limit on claims submission for payment. Claims must be submitted within 120 days of services being rendered, so a provider submitting the review after 120 days wouldn't result in RMHP being able to pay for that review.

[44] COA can retrospectively review any service to determine if medical necessity was met. However, this is fairly uncommon and would be initiated by COA based on utilization patterns or outliers, not requested by the provider or member. Typically, the only retrospective requests initiated by the provider are situations in which prior authorization was not requested, either by provider error or due to confusion around the member's eligibility.

RETROSPECTIVE REVIEW SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
retrospective review request?					
Strategy					
Are retrospective review policies the same for both in-network and out-of-network providers?	No, for in-network providers only those services that require PAR would need RR if PAR was not obtained. OON providers must submit RR for any service not PAR'd.	Yes	Yes	Yes	Yes[45]
Evidentiary Services					
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding retrospective review for inpatient services?	MCG for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	MCG for MH and ASAM for SUD	InterQual and MCG for M/S
Does the plan use internally developed guidelines to determine whether to prior	No	No	No	No	Yes, when no InterQual or MCG criteria is available.

[45] The term in-network and out-of-network is not used by FFS UM since the ColoradoPAR program serves the entire state of Colorado and look at in-state and out-of-state (OOS) providers. Some border facilities are considered in-state. Both OOS and in-state providers need to be enrolled with Medicaid to bill for services and the authorization policies are the same.

RETROSPECTIVE REVIEW SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
retrospectively review services? IF YES: How frequently are those guidelines updated?					Reviewed regularly and updated as evidence/best practices change.

Retrospective Review

Findings: Scenario 3 – Inpatient Services

The inpatient retrospective review policies and procedures regarding exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. The time limit policies on how far in the past services can be retrospectively reviewed are different, but are industry standard with appropriate lengths for providers to receive payment.

It is determined that these policies and procedures are parity compliant.

RETROSPECTIVE REVIEW SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
Outpatient Services					
Process					
Is there a time limit on how far in the past services can be retrospectively reviewed? If so, what is that limit?	No, but claims must be submitted within 120 days of services being rendered.	30 days	120 days	30 days	Time limits for RR are currently waived. Two exceptions to this policy is that, by rule, DME has 90 days and long term health has 10 days.
Are services in this classification subject to retrospective review?	All services subject to PAR may be considered for RR if PAR was not obtained.	All services subject to PAR may be considered for RR if PAR was not obtained. Exceptions are reviewed by the UM Director, Provider Relations Director and VP of Ops for extenuating circumstances.	All services subject to PAR may be considered for RR if PAR was not obtained.	Yes. There are extensions when members become retro actively eligible for Medicaid. The provider has 30 days from the date that they learn of the eligibility to submit a retrospective review request.	All benefits that require a PAR may be considered for an exception to establishes timeliness rules to allow for a retrospective review on a case by case basis.
What is the maximum amount of time allowed to issue a determination on a retrospective review request?	30 days	30 days	30 days	30 days	There is no established maximum
Strategy					
Are retrospective review policies the same for both	No, for in-network providers only	Yes	Yes	Yes	Yes

RETROSPECTIVE REVIEW SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
in-network and out-of-network providers?	those services that require PAR would need RR if PAR was not obtained. OON providers must submit RR for any service not PAR'd.				
Evidentiary Services					
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding retrospective review for outpatient services?	MCG for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	InterQual for MH and ASAM for SUD	MCG for MH and ASAM for SUD	InterQual and MCG for M/S
Does the plan use internally developed guidelines to determine whether to retrospectively review services? IF YES: How frequently are those guidelines updated?	No	No	No	No	Yes, when no InterQual or MCG criteria is available. Reviewed regularly and updated as evidence/best practices change.

Retrospective Review

Findings: Scenario 3 – Outpatient Services

The outpatient retrospective review policies and procedures regarding exception policies, determination timeframes, in-network vs out-of-network policies, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures

of M/S services, and follow standard industry practice. The time limit policies on how far in the past services can be retrospectively reviewed are different, but are industry standard with appropriate lengths for providers to receive payment.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Retrospective Review

RETROSPECTIVE REVIEW SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
Inpatient Services		
Process		
Is there a time limit on how far in the past services can be retrospectively reviewed? If so, what is that limit?	120 days	12 calendar months
Are services in this classification subject to retrospective review?	All IP services may be considered for RR Occasionally the IMD retro enrollment process requires waiving of RR timeframes.	All IP services may be considered for RR
What is the maximum amount of time allowed to issue a determination on a retrospective review request?	30 calendar days	30 calendar days
Strategy		
Are retrospective review policies the same for both in-network and out-of-network providers?	Yes	No authorizations required in-network, all out-of-network care requires authorization.
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding retrospective review for inpatient services?	InterQual for MH and ASAM for SUD	MCG for M/S
Does the plan use internally developed guidelines to determine whether to prior retrospectively review services? IF YES: How frequently are those guidelines updated?	No	No

Retrospective Review

Findings: Scenario 4 – Inpatient Services

Consistent with industry standards, the health plan performs reviews of MH/SUD to assure the member is being treated in the least restrictive environment appropriate for their condition. Typical M/S retrospective reviews allow for extenuating circumstances such as unconscious at arrival, no identification at time of admission, or the facility being unable to determine correct payer.

The inpatient retrospective review policies and procedures regarding exception policies, determination timeframes, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

The time limit policies on how far in the past services can be retrospectively reviewed are different, but are appropriate lengths for providers to receive payment.

However, no M/S in-network services are subject to authorization, while MH/SUD in-network services that are subject to prior authorization are subject to retrospective review. Therefore, the policies applied to MH/SUD are more stringent than those applied to M/S.

Through their efforts to reduce administrative hurdles for providers in their preferred provider network, they inadvertently created a situation where their M/S services authorization policies were less stringent than comparable MH/SUD policies specific to the Denver Health hospital system. DHMC engages in a risk based sub-capitation arrangement with Denver Health Hospital Authority. DMHC is a staff-model MCO, where it's medical/health providers are employees rather than independent providers who contract with the health plan. As part of the risk based arrangement, Denver Health Hospital Authority providers do not need to submit any services for authorization. All out-of-network M/S care requires authorization.

It is determined that these policies and procedures are out of compliance with parity requirements.

The Department immediately began work with DHMC to address the issues and bring their policies back into compliance. DHMC is currently finalizing the policy changes which should be implemented by July 1, 2022. These changes will be evaluated by the Department to ensure the policies meet parity compliance prior to implementation.

RETROSPECTIVE REVIEW

SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO

QUESTION	MH/SUD	M/S
Outpatient Services		
Process		
Is there a time limit on how far in the past services can be retrospectively reviewed? If so, what is that limit?	120 days	12 calendar months
Are services in this classification subject to retrospective review?	Only services subject to PAR are subject to RR	Yes, services provided by out-of-network providers may be considered for RR
What is the maximum amount of time allowed to issue a determination on a retrospective review request?	30 calendar days	30 calendar days
Strategy		
Are retrospective review policies the same for both in-network and out-of-network providers?	Yes	No authorizations required in-network, all out-of-network care requires authorization.

RETROSPECTIVE REVIEW SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
Evidentiary Services		
Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to make decisions regarding retrospective review for outpatient services?	InterQual for MH and ASAM for SUD	MCG, Hayes Knowledge Center, Uptodate
Does the plan use internally developed guidelines to determine whether to retrospectively review services? IF YES: How frequently are those guidelines updated?	No	No

Retrospective Review

Findings: Scenario 4 – Outpatient Services

Routine MH/SUD outpatient services do not require authorization. Some specialty and/or higher acuity outpatient services do require authorization, consistent with industry standards, to assure that the member cannot be treated in a less restrictive environment. Typical M/S retrospective reviews allow for extenuating circumstances such as unconscious at arrival, no identification at time of admission, or the facility being unable to determine correct payer.

The outpatient retrospective review policies and procedures regarding exception policies, determination timeframes, and evidentiary standards for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. The time limit policies on how far in the past services can be retrospectively reviewed are different, but are industry standard with appropriate lengths for providers to receive payment.

However, no M/S in-network services are subject to authorization, while MH/SUD in-network services that are subject to prior authorization are subject to retrospective review. Therefore, the policies applied to MH/SUD are more stringent than those applied to M/S.

Through their efforts to reduce administrative hurdles for providers in their preferred provider network, they inadvertently created a situation where their M/S services authorization policies were less stringent than comparable MH/SUD policies specific to the Denver Health hospital system. DHMC engages in a risk based sub-capitation arrangement with Denver Health Hospital Authority. DMHC is a staff-model MCO, where it's medical/health providers are employees rather than independent providers who contract with the health plan. As part of the risk based arrangement, Denver Health Hospital Authority providers do not need to submit any services for authorization. All out-of-network M/S care requires authorization.

It is determined that these policies and procedures are out of compliance with parity requirements.

The Department immediately began work with DHMC to address the issues and bring their policies back into compliance. DHMC is currently finalizing the policy changes which should be implemented by July 1, 2022. These changes will be evaluated by the Department to ensure the policies meet parity compliance prior to implementation.

Appendix D – Medical Necessity Criteria

Description: Use and applicability of health plan standards and review policies that determines enrollment and authorization for benefits/services. *Note that emergency care is not subject to review for authorization.*

Tools for Analysis: Data request, interviews with health plan staff, and policies/procedures documents referencing protocols for selection of criteria (i.e., utilization of industry-standard criteria) to assess medical necessity for M/S and MH/SUD benefits. Review of compliance with Department-defined medical necessity criteria and directives.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Medical Necessity Criteria

MEDICAL NECESSITY CRITERIA **SCENARIO 1: DEPARTMENT FFS**		
QUESTION	**MH/SUD**	**M/S**
Which evidence-based clinical decision support products (InterQual, Milliman, etc.) does the plan use to determine the medical necessity of services and to which benefit classifications do these criteria apply? (inpatient, outpatient, emergency care, prescription drugs)	IP and OP MH/SUD: InterQual and MCG	IP and OP M/S: InterQual, MCG, and internal guidelines. If there is not existing criteria available in MCG, InterQual or state specific criteria developed, the medical necessity review is completed at the Physician Review Level (in most instances by a physician specialized in that area of the benefit being requested).
Does the plan's definition for medical necessity for individuals age 21 and over follow the state's definition for medical necessity?	Yes	Yes
Does the plan's definition for medical necessity for individuals UNDER the age of 21 follow the state's definition for medical necessity?	Yes	Yes

Medical Necessity Criteria

Findings: Scenario 1

The medical necessity criteria policies and procedures regarding evidentiary standards and medical necessity definitions for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Medical Necessity Criteria

MEDICAL NECESSITY CRITERIA **SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO**		
QUESTION	**MH/SUD**	**M/S**
Which evidence-based clinical decision support products (InterQual, Milliman, etc.) does the plan use to determine the medical necessity of services and to which benefit classifications do these criteria apply?	IP and OP MH: MCG All SUD: ASAM	IP and OP M/S: MCG and internal guidelines

MEDICAL NECESSITY CRITERIA

SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO

QUESTION	MH/SUD	M/S
(inpatient, outpatient, emergency care, prescription drugs)	Pharmacy: Criteria is based on internally developed guidelines.[46]	Pharmacy: Criteria is based on internally developed guidelines.[47]
Does the plan's definition for medical necessity for individuals age 21 and over follow the state's definition for medical necessity?	Yes	Yes
Does the plan's definition for medical necessity for individuals UNDER the age of 21 follow the state's definition for medical necessity?	Yes	Yes

Medical Necessity Criteria

Findings: Scenario 2

The health plan's process to evaluate medical necessity criteria drugs does not consider if the drug is a behavior health or medical indication. All drugs are evaluated based on the same criteria which includes clinical information of the specific drug, tertiary sources (e.g. National guidelines, FDA), expert opinion, pharmacoeconomic evaluations/health outcomes, and quality of life studies.

The medical necessity criteria policies and procedures regarding evidentiary standards and medical necessity definitions for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant

[46] Pharmacy for both MH/SUD and M/S: Criteria for medical necessity is determined during P&T (pharmacy & therapeutics committee) review of the drug. Utilization management (UM) strategies include PA (prior authorization, ST (step therapy/fail first), QL (quantity limit), Age, etc. Criteria is developed from various sources including but not limited to FDA approved PI, clinical guidelines (e.g. ADA, NCCN, ACIP, 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 a UM or FE is submitted, review of the case occurs to decide if coverage is supported. 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. Pharmacy guidelines are internally developed within RMHP.

[47] Ibid.

Scenario 3: Medical Necessity Criteria

MEDICAL NECESSITY CRITERIA **SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS**					
QUESTION	**RAE 1 MH/SUD**	**RAE 2&4 MH/SUD**	**RAE 3&5 MH/SUD**	**RAE 6&7 MH/SUD**	**DEPARTMENT M/S**
Which evidence-based clinical decision support products (InterQual, Milliman, etc.) does the plan use to determine the medical necessity of services and to which benefit classifications do these criteria apply? (inpatient, outpatient, emergency care, prescription drugs)	IP & OP MH: MCG IP & OP SUD: ASAM Criteria Emergency care is not reviewed	IP & OP MH: InterQual IP & OP SUD: ASAM Emergency care is not reviewed	IP & OP MH: InterQual IP & OP SUD: ASAM Emergency care is not reviewed	IP & OP MH: MCG IP & OP SUD: ASAM Criteria Emergency care is not reviewed	IP and OP M/S: InterQual, MCG, and internal guidelines. If there is not existing criteria available in MCG, InterQual or state specific criteria developed, the medical necessity review is completed at the Physician Review Level (in most instances by a physician specialized in that area of the benefit being requested).
Does the plan's definition for medical necessity for individuals age 21 and over follow the state's definition for medical necessity?	Yes	Yes	Yes	Yes[48]	Yes
Does the plan's definition for medical necessity for	Yes	Yes	Yes	Yes	Yes

[48] RAE 6 & 7 use the state's EPSDT definition for medical necessity for both under and over 21 years of age, as the language is appropriate for both populations.

MEDICAL NECESSITY CRITERIA SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
individuals UNDER the age of 21 follow the state's definition for medical necessity?					

Medical Necessity Criteria

Findings: Scenario 3

The medical necessity criteria policies and procedures regarding evidentiary standards and medical necessity definitions for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. RAE 6 & 7 use the state's EPSDT definition for medical necessity for both adults and individuals under 21 years of age. This difference in policy was not found to apply greater stringency for MH/SUD services nor create a barrier to access to care for members.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Medical Necessity Criteria

MEDICAL NECESSITY CRITERIA **SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO**		
QUESTION	**MH/SUD**	**M/S**
Which evidence-based clinical decision support products (InterQual, Milliman, etc.) does the plan use to determine the medical necessity of services and to which benefit classifications do these criteria apply? (inpatient, outpatient, emergency care, prescription drugs)	IP/OP MH: InterQual IP/OP SUD: ASAM	IP/OP/PD: MCG
Does the plan's definition for medical necessity for individuals age 21 and over follow the state's definition for medical necessity?	Yes	Yes
Does the plan's definition for medical necessity for individuals UNDER the age of 21 follow the state's definition for medical necessity?	Yes	Yes

Medical Necessity Criteria

Findings: Scenario 4

The medical necessity criteria policies and procedures regarding evidentiary standards and medical necessity definitions for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Appendix E – Medical Appropriateness Review

Description: The policy and process the health plan utilizes to determine participant services and benefits. *Note that emergency care is not subject to review for authorization*.

Tools for Analysis: Data request, interviews with health plan staff, and policies/procedures documents referencing utilization of clinically-validated medical necessity criteria, reviewer qualifications, and availability of medical necessity criteria.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Medical Appropriateness Review

MEDICAL APPROPRIATENESS REVIEW **SCENARIO 1: DEPARTMENT FFS**		
QUESTION	**MH/SUD**	**M/S**
Which benefit classifications does the plan have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP, OP	IP, OP
What is the process for determining medical appropriateness for individuals OVER the age of 21?	Review submitted information for completeness, compliance and medical appropriateness utilizing specific Department inpatient policy, guidelines, and the appropriate criteria by the first and second level reviewers.[49]	Review submitted information for completeness, compliance and medical appropriateness utilizing specific Department inpatient policy, guidelines, and the appropriate criteria by the first and second level reviewers.[50]
What is the process for determining medical appropriateness for individuals UNDER the age of 21?	Same as above, but also follows EPSDT guidance in any review for a member under 21. This process is built into every PAR review for a member 20 and under automatically.	Same as above, but also follows EPSDT guidance in any review for a member under 21. This process is built into every PAR review for a member 20 and under automatically.
Do you use a two-level review process?	Yes	Yes
Who performs the medical appropriateness reviews? Please include who can approve/deny and the qualifications of the reviewers.	1st level: BCBA can pend, approve, technically deny, refer to 2nd level. 2nd level- BCBA-D can deny for medical necessity or technical, can approve or pend.	1st level: RN or other appropriately licensed personnel for certain benefits can pend, approve, technically deny, refer to 2nd level.

[49] First Level Reviewers for PBT consist of a Board-Certified Behavioral Analyst (BCBA) who may: Approve the service as requested based Department approved criteria, and compliance to policies and federal guidelines, Request additional information from the Provider to support the request, Refer the request to a physician reviewer-If the nurse reviewer believes that the request may not meet medical necessity, should be denied for medical necessity, or would like further input from a physician reviewer, they will refer it for further review and determination (2nd level Review), Deny the request for technical reasons, including failing to provide the necessary documentation, not submitting the request timely, and/or if the request is a duplicate, etc. First Level Reviewers cannot deny for lack of medical necessity. Second Level Reviewers for PBT consist of Board-Certified Behavior Analyst-Doctoral (BCBA-Doctoral) who may: Approve the service as requested based on Department approved Criteria, and compliance to policies and federal guidelines, Request additional information from the Provider to support the request, Render either a full or partial denial for lack of medical necessity.

[50] 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.

MEDICAL APPROPRIATENESS REVIEW SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
		2nd level- physician can deny for medical necessity or technical, can approve or pend.

Medical Appropriateness

Findings: Scenario 1

The medical appropriateness review policies and procedures regarding classifications, processes for determination, two-level review, and reviewer qualifications for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Medical Appropriateness

MEDICAL APPROPRIATENESS REVIEW SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
Which benefit classifications does the plan have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP, OP, PD	IP, OP, PD
What is the process for determining medical appropriateness for individuals OVER the age of 21?	IP/OP: Clinical Coordinators (CC) receive and review clinical documentation from the provider or facility requesting services for the member and compares it to the appropriate medical necessity guidelines (MCG or ASAM Criteria) and the Colorado Medicaid medical necessity criteria to determine if the request is medically appropriate. CCs cannot deny cases for medical necessity. The process is the same for MH/SUD and M/S. Pharmacy: Medical necessity reviews are completed at a variety of medical professional levels. The initial case review	IP/OP: Clinical Coordinators (CC) receive and review clinical documentation from the provider or facility requesting services for the member and compares it to the appropriate medical necessity guidelines (MCG or ASAM Criteria) and the Colorado Medicaid medical necessity criteria to determine if the request is medically appropriate. CCs cannot deny cases for medical necessity. The process is the same for MH/SUD and M/S. Pharmacy: Medical necessity reviews are completed at a variety of medical professional levels. The initial case review

MEDICAL APPROPRIATENESS REVIEW SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
	is completed by a certified pharmacy tech (CPhT) that identifies applicable information from what the prescriber provided. If the CPhT is able to approve, the pharmacy tech will approve. If the CPhT cannot approve based on the guideline criteria, the case is forwarded to a Pharmacist for further review. The initial review is completed by the pharmacist. CPhTs cannot deny cases for medical necessity.	is completed by a certified pharmacy tech (CPhT) that identifies applicable information from what the prescriber provided. If the CPhT is able to approve, the pharmacy tech will approve. If the CPhT cannot approve based on the guideline criteria, the case is forwarded to a Pharmacist for further review. The initial review is completed by the pharmacist. CPhTs cannot deny cases for medical necessity.
What is the process for determining medical appropriateness for individuals UNDER the age of 21?	IP/OP: Clinical Coordinators (CC) receive and review clinical documentation from the provider or facility requesting services for the member and compares it to the appropriate medical necessity guidelines (MCG or ASAM Criteria) and the Colorado Medicaid medical necessity criteria for youth under 20 to determine if the request is medically appropriate. CCs cannot deny cases for medical necessity. The process is the same for MH/SUD and M/S. Pharmacy: Medical necessity reviews are completed at a variety of medical professional levels. The initial case review is completed by a certified pharmacy tech (CPhT) that identifies applicable information from what the prescriber provided. If the CPhT is able to approve, the pharmacy tech will approve. If the CPhT cannot approve based on the guideline criteria, the case is forwarded to a Pharmacist for further review. The initial review is completed by the pharmacist. CPhTs	IP/OP: Clinical Coordinators (CC) receive and review clinical documentation from the provider or facility requesting services for the member and compares it to the appropriate medical necessity guidelines (MCG or ASAM Criteria) and the Colorado Medicaid medical necessity criteria for youth under 20 to determine if the request is medically appropriate. CCs cannot deny cases for medical necessity. The process is the same for MH/SUD and M/S. Pharmacy: Medical necessity reviews are completed at a variety of medical professional levels. The initial case review is completed by a certified pharmacy tech (CPhT) that identifies applicable information from what the prescriber provided. If the CPhT is able to approve, the pharmacy tech will approve. If the CPhT cannot approve based on the guideline criteria, the case is forwarded to a Pharmacist for further review. The initial review is completed by the pharmacist. CPhTs

MEDICAL APPROPRIATENESS REVIEW SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
	cannot deny cases for medical necessity.	cannot deny cases for medical necessity.
Do you use a two-level review process?	Yes, RMHP uses a two level review process. CCs or CPhTs complete the first review and if it appears a request is not meeting medical necessity, it is sent to a medical director or pharmacist for a second level review.	Yes, RMHP uses a two level review process. CCs or CPhTs complete the first review and if it appears a request is not meeting medical necessity, it is sent to a medical director or pharmacist for a second level review.
Who performs the medical appropriateness reviews? Please include who can approve/deny and the qualifications of the reviewers.	Clinical Coordinators can approve authorizations but cannot deny authorizations for medical necessity. All Clinical Coordinators that work on the Prime line of business are licensed behavioral health clinicians (LPC, LMFT, LCSW) or RNs with psychiatric experience. All Clinical Coordinators are licensed in Colorado. Medical directors can approve or deny authorizations. Both Medical Directors that work on the Prime line of business are licensed physicians who hold an unrestricted license to practice in the state of Colorado and are board certified in psychiatry. One of the medical directors is also board certified in addiction medicine. Pharmacy: Medical necessity reviews are completed at a variety of medical professional levels. The initial case review is completed by a certified pharmacy tech (CPhT) that identifies applicable information from what the prescriber provided. If the CPhT is able to approve, the pharmacy tech will approve. If the CPhT cannot approve based on the guideline criteria, the case is forwarded to a	Clinical Coordinators can approve authorizations but cannot deny authorizations for medical necessity. All Clinical Coordinator that work on the Prime line of business are licensed RNs with licensure in Colorado. Medical directors can approve or deny authorizations. The Medical Directors that work on the Prime line of business are licensed physicians who hold an unrestricted license to practice in the state of Colorado. Pharmacy: Medical necessity reviews are completed at a variety of medical professional levels. The initial case review is completed by a certified pharmacy tech (CPhT) that identifies applicable information from what the prescriber provided. If the CPhT is able to approve, the pharmacy tech will approve. If the CPhT cannot approve based on the guideline criteria, the case is forwarded to a Pharmacist for further review. The initial review is completed by the pharmacist.

MEDICAL APPROPRIATENESS REVIEW SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
	Pharmacist for further review. The initial review is completed by the pharmacist.	

Medical Appropriateness Review

Findings: Scenario 2

The medical appropriateness review policies and procedures regarding classifications, processes for determination, two-level review, and reviewer qualifications for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 3: Medical Appropriateness Review

MEDICAL APPROPRIATENESS REVIEW **SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS**					
QUESTION	**RAE 1 MH/SUD**	**RAE 2&4 MH/SUD**	**RAE 3&5 MH/SUD**	**RAE 6&7 MH/SUD**	**DEPARTMENT M/S**
Which benefit classifications does the plan have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP and OP	IP and OP	IP and OP	IP and OP	IP and OP
What is the process for determining medical appropriateness for individuals OVER the age of 21?	Clinical Coordinators review the submitted clinical documentation and compare it to the appropriate medical necessity guidelines and the Colorado Medicaid medical necessity criteria to determine if the request is	Review of clinical information, records, and lab work submitted by the treating provider.	Clinical info is first reviewed by licensed behavioral health clinician for medical appropriateness per medical necessity criteria and InterQual; a physician is consulted as needed.	Follows established procedures for applying clinical criteria based on the individual member's needs and the local delivery system for medical and behavioral health services. Reviewers collect and review relevant clinical information to determine if the	Review submitted information for completeness, compliance and medical appropriateness utilizing specific Department inpatient policy, guidelines, and the appropriate criteria by the first and second level reviewers.[51]

[51] 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.

MEDICAL APPROPRIATENESS REVIEW **SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS**					
QUESTION	**RAE 1 MH/SUD**	**RAE 2&4 MH/SUD**	**RAE 3&5 MH/SUD**	**RAE 6&7 MH/SUD**	**DEPARTMENT M/S**
	medically appropriate.			level-of-care /service requested meets medical necessity, considering the member circumstances.	
What is the process for determining medical appropriateness for individuals UNDER the age of 21?	Same as above. The process followed is the same regardless of the age of the individual.	Same as above. The process followed is the same regardless of the age of the individual.	Same as above. The process followed is the same regardless of the age of the individual.	Same as above. The process followed is the same regardless of the age of the individual.	Same as above, but also follows EPSDT guidance in any review for a member under 21. This process is built into every PAR review for a member 20 and under automatically.
Do you use a two-level review process?	Yes	Yes	Yes	Yes	Yes
Who performs the medical appropriateness reviews? Please include who can approve/deny and the qualifications of the reviewers.	Clinical Coordinators can approve authorizations but cannot deny authorizations for medical necessity. All Clinical Coordinators are licensed behavioral health clinicians (LPC, LMFT, LCSW) or RNs with psychiatric experience. All	Clinical care managers are licensed behavioral health staff can approve services, but can't deny care. Licensed, doctoral-level staff with appropriate education and experience related to the requested services. PhD or PsyD staff are	Licensed behavioral health clinicians may approve authorization requests. Board-certified psychiatrists are the only reviewers who may issue an adverse benefit determinations.	Behavioral Health Care Managers possess an active unrestricted license as an RN, LCSW, LMSW, LMHC, LPC, LBA (as allowed by applicable state laws), LMFT, or Clinical Psychologist, to practice as a health professional within the scope of licensure in	1st level: RN or other appropriately licensed personnel for certain benefits can pend, approve, technically deny, refer to 2nd level. 2nd level-physician/BCBA-D can deny for medical necessity or technical, can approve or pend.

MEDICAL APPROPRIATENESS REVIEW **SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS**					
QUESTION	**RAE 1 MH/SUD**	**RAE 2&4 MH/SUD**	**RAE 3&5 MH/SUD**	**RAE 6&7 MH/SUD**	**DEPARTMENT M/S**
	Clinical Coordinators are licensed in Colorado. Medical directors can approve/deny authorizations. RAE Medical Directors are licensed physicians; hold an unrestricted license to practice in CO; board certified in psychiatry. One medical director is also board certified in addiction medicine.	permitted to deny/approve outpatient services, but not inpatient or residential services. MD or DO staff are permitted to deny/approve all levels of care.		applicable states or territory of the U.S. Medical Directors possess M.D. or D.O.; Board certification; active unrestricted medical license; minimum 5 years clinical experience in BH and UM. Medical Director can approve/deny requested services based on medical necessity.	

Medical Appropriateness Review

Findings: Scenario 3

The medical appropriateness review policies and procedures regarding classifications, processes for determination, two-level review, and reviewer qualifications for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Medical Appropriateness Review

MEDICAL APPROPRIATENESS REVIEW SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
Which benefit classifications does the plan have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP, OP	IP, OP
What is the process for determining medical appropriateness for individuals OVER the age of 21?	When a request for authorization is received, the clinical information is first reviewed by a licensed behavioral health clinician, who reviews for medical appropriateness per medical necessity criteria and InterQual; a physician is consulted as needed.	Care within network does not require review or authorization and without benefit limit. Care outside of network requires medical necessity review and authorization. Outside requests are initially reviewed by licensed registered nurse, who validates medical necessity criteria based on MCG, if criteria is met the request is approved without secondary review. If criteria is not met, then physician review is mandatory
What is the process for determining medical appropriateness for individuals UNDER the age of 21?	When a request for authorization is received, the clinical information is first reviewed by a licensed behavioral health clinician, who reviews for medical appropriateness per medical necessity criteria and InterQual; a physician is consulted as needed. EPSDT requirements are followed when making determinations.	Care within network does not require review or authorization and without benefit limit. Care outside of network requires medical necessity review and authorization. Outside requests are initially reviewed by licensed registered nurse, who validates medical necessity criteria based on MCG, if criteria is met the request is approved without secondary review. If criteria is not met, then physician review is mandatory EPSDT requirements are followed when making determinations.
Do you use a two-level review process?	Yes	Yes
Who performs the medical appropriateness reviews? Please include who can approve/deny and the qualifications of the reviewers.	Licensed behavioral health clinicians may approval authorization requests. Board-certified psychiatrists are the	Licensed registered nurse can review and approve all requests that meet criteria, they can also deny all administrative denials: not a benefit and no prior

MEDICAL APPROPRIATENESS REVIEW SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
	only reviewers who may issue an adverse benefit determinations.	authorization. Any denial not meeting criteria must have second level physician reviewer.

Medical Appropriateness Review

Findings: Scenario 4

The medical appropriateness review policies and procedures regarding classifications, processes for determination, two-level review, and reviewer qualifications for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Appendix F – 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: Data request, interviews with health plan staff, and policies/procedures documents referencing protocols used to determine fail first or step therapy protocols, including which services require these protocols.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 2: Fail First / Step Therapy Protocols

FAIL FIRST / STEP THERAPY PROTOCOLS SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
Does the plan have any policies or processes that require steps or failure on a less costly treatment before authorizing a more costly treatment? If so, please list the benefit classifications of the services and detail the policies or procedures.	MH/SUD: No.[52] Pharmacy: Drugs that guideline 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 on it if there are other options that are considered as safe and effective at a lower cost to ensure effective use of healthcare dollars. There is an exception process that will allow for the target drug to be used without first fail if the provider makes a case that alternatives would not be appropriate for the patient either tried and failed in a timeframe outside what the health plans records show or alternatives would be contraindicated.	M/S: No.[53] Pharmacy: Drugs that guideline 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 on it if there are other options that are considered as safe and effective at a lower cost to ensure effective use of healthcare dollars. There is an exception process that will allow for the target drug to be used without first fail if the provider makes a case that alternatives would not be appropriate for the patient either tried and failed in a timeframe outside what the health plans records show or alternatives would be contraindicated.
Does the plan have any policies or processes that apply steps or failure on a less costly treatment to medication-assisted treatment?	MH/SUD: No. Pharmacy: The process to evaluate drugs that require Fail First/Step Therapy does not consider if the drug is a behavior health or medical indication. All drugs are evaluated based on the same	M/S: No. Pharmacy: The process to evaluate drugs that require Fail First/Step Therapy does not consider if the drug is a behavior health or medical indication. All drugs are evaluated based on the same

[52] RMHP does not have any specific policy or process regarding fail first or step therapy protocols for MH, SUD, or M/S services. However, for some services, MCG's guidelines do indicate that other services should be tried before a more invasive procedure is tried and it is something that is clinically considered when making UM decisions. This is unrelated to the cost of the treatments and is good clinical practice to consider. Instead, the consideration is given to ensure that members are placed in a level of care that meets their specific needs in the least intensive and restrictive way possible. It is also in line with the state's Medicaid medical necessity definition of providing the clinically appropriate treatment in the right place, time, frequency and type.

[53] Ibid.

FAIL FIRST / STEP THERAPY PROTOCOLS **SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO**		
QUESTION	**MH/SUD**	**M/S**
	criteria which includes clinical information of the specific drug, tertiary sources (e.g. National guidelines, FDA), expert opinion, pharmacoeconomic evaluations/health outcomes, and quality of life studies.	criteria which includes clinical information of the specific drug, tertiary sources (e.g. National guidelines, FDA), expert opinion, pharmacoeconomic evaluations/health outcomes, and quality of life studies.

Fail First / Step Therapy Protocols

Findings: Scenario 2

The fail first / step therapy policies and procedures regarding any requirements of steps or failure before authorization MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Fail First / Step Therapy Protocols

FAIL FIRST / STEP THERAPY PROTOCOLS **SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO**		
QUESTION	**MH/SUD**	**M/S**
Does the plan have any policies or processes that require steps or failure on a less costly treatment before authorizing a more costly treatment? If so, please list the benefit classifications of the services and detail the policies or procedures.	9 of 56 drugs on Step Therapy protocols are MH drugs. No SUD drugs are on Step Therapy protocols.	For the required J codes, IV and injectable medications if there is a lower cost alternate or approved formulary drug, the DHMC pharmacy must review clinical justification/documentation from the provider verifying a failed response to the lower cost medication before a higher level drug will be approved.
Does the plan have any policies or processes that apply steps or failure on a less costly treatment to medication-assisted treatment?	No	For the required J codes, IV and injectable medications if there is a lower cost alternate or approved formulary drug, the DHMC pharmacy must review clinical justification/documentation from the provider verifying a failed response to the lower cost medication before a higher level drug will be approved.

Fail First / Step Therapy Protocols

Findings: Scenario 4

Of the 56 drugs DHMC has on Step Therapy protocols, only 9 of those are MH drugs and none of them are SUD drugs. The fail first / step therapy policies and procedures regarding any requirements of steps or failure before authorization of MH/SUD services are less stringent than the policies and procedures applied to M/S services, and they follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Appendix G – Conditioning Benefits on Completion of a Course of Treatment

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

Tools for Analysis: Data request, interviews with health plan staff, and policies/procedures documents referencing presence of utilization and quality management policies that condition benefits on treatment completion and policy applicability to MH/SUD and M/S benefits.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

	Used by	Benefit Categories	Differences between M/S and MH/SUD	Compliance Determined
Scenario 1	Department	*N/A*	*N/A*	*N/A*
Scenario 2	RMHP and Prime MCO	*N/A*	*N/A*	*N/A*
Scenario 3	RAE 1	*N/A*	*N/A*	*N/A*
	RAE 2 and 4	*N/A*	*N/A*	*N/A*
	RAE 3 and 5	*N/A*	*N/A*	*N/A*
	RAE 6 and 7	*N/A*	*N/A*	*N/A*
Scenario 4	Denver PIHP and Denver Health MCO	*N/A*	*N/A*	*N/A*

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

Analysis/Findings: No benefit category was shown to contain policies or procedures conditioning benefits on a completion of a course of treatment.

Appendix H – 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: Data request, interviews with health plan staff, and policies/procedures documents referencing outlier review and quality management policies and processes.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Outlier Management

OUTLIER MANAGEMENT SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
How does the plan monitor over- and under-utilization of services?	The Department's outlier management program for FFS behavioral health has multiple components. These include utilizing a recovery audits contractor (RAC) to review certain claims for the medical appropriateness and billed services. Additionally, the FFS UM Vendor will notify the Department of any concerns regarding waste, fraud, abuse that are identified as a part of the normal review process. And finally, the Department reviews claims for use in future policy setting.	The Department's outlier management program for FFS physical health has multiple components. These include utilizing a recovery audits contractor (RAC) to review certain claims for the medical appropriateness and billed services. Additionally, the FFS UM Vendor will notify the Department of any concerns regarding waste, fraud, abuse that are identified as a part of the normal review process. And finally, the Department reviews claims for use in future policy setting.
Are all services subject to outlier monitoring? IF NO, list all services by benefit classification subject to monitoring.	Outliers are brought to the attention of the Department by the UM Vendor across all benefits.	Outliers are brought to the attention of the Department by the UM Vendor across all benefits.
Are there any exceptions to these policies for reviews of services for members under the age of 21?	EPSDT requirements are followed when making determinations.	EPSDT requirements are followed when making determinations.
What actions are taken based on information from outlier reports? (policy change, payment recovery, additional analysis, etc)	In reviewing outliers, there may be a necessary change in clinical criteria, or policy, additional analysis or referrals to Program Integrity.	In reviewing outliers, there may be a necessary change in clinical criteria, or policy, additional analysis or referrals to Program Integrity.

Outlier Management

Findings: Scenario 1

Outlier management is the health plan's utilization management policies and processes for determining when a participant's benefits requires additional clinical review and potentially service changes.

The outlier management policies and procedures regarding monitoring over- and under-utilization, monitored services, exceptions, and actions taken for MH/SUD services are the same as the policies and procedures for M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Outlier Management

OUTLIER MANAGEMENT SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
How does the plan monitor over- and under-utilization of services?	RMHP monitors over and underutilization of services to ensure that Members receive necessary and appropriate care. Data are collected from multiple sources including HEDIS® results and Member surveys, appeals and grievance data, quality of care reports, utilization management reports and pharmacy utilization reports. Data are reviewed, trended, analyzed and interventions are developed and implemented based on outcomes of the analysis.[54]	RMHP monitors over and underutilization of services to ensure that Members receive necessary and appropriate care. Data are collected from multiple sources including HEDIS® results and Member surveys, appeals and grievance data, quality of care reports, utilization management reports and pharmacy utilization reports. Data are reviewed, trended, analyzed and interventions are developed and implemented based on outcomes of the analysis.[55]
Are all services subject to outlier monitoring? IF NO, list all services by benefit classification subject to monitoring.	MH/SUD: Yes	M/S: Yes
Are there any exceptions to these policies for reviews of services for members under the age of 21?	No	No
What actions are taken based on information from outlier reports? (policy change, payment recovery, additional analysis, etc)	Creation of new programs, change in processes, change in policies, payment recovery in the event of inappropriate billing, and further specific analysis to look at cause and effects. Pharmacy: Programs work with member and prescribers to bring outliers into more standard of care.	Creation of new programs, change in processes, change in policies, payment recovery in the event of inappropriate billing, and further specific analysis to look at cause and effects. Pharmacy: Programs work with member and prescribers to bring outliers into more standard of care.

Outlier Management

[54] Areas of focus include: MONITORING OF OVERUTILIZATION: Concurrent reviews, Pre-authorizations, High ER utilization for non-emergent conditions, Hospitalization for preventable conditions, Hospital readmission within 30 days of discharge, Pharmacy overutilization (Opioids), Colorado Overutilization Project (COUP)- Medicaid; MONITORING OF UNDERUTILIZATION: Members identified with Preventative Care and Screening Gaps, Gaps in Care Reporting (providers), Member Education and Incentives, Encourage annual Wellness Visit, Provider Attribution Reports, Pharmacy Underutilization/Medication Management Program, Disease Management Program(s)

[55] Ibid.

Findings: Scenario 2

The purpose of the health plan's outlier management is to ensure members have access to appropriate care and are receiving services they need while managing healthcare quality, efficiency, and cost.

For pharmacy, the goal of Drug Safety Program is to support prescribers who provide controlled medications to Members by decreasing the risk of duplicate therapy and/or other prescribers of these higher risk medications. In addition, Members enrolled received additional support with medical and social determinants of health issues. The goal of MAP is to increase adherence to chronic medications that have evidence of improving long term outcomes. The goal of MRP is to improve treatment for higher risk and complex members to improve long term outcomes. These programs aim to provide value for our Members/prescribers and the community. These are not intended to limit services but rather for RMHP to facilitate improved communication between the Member, prescriber, and pharmacy.

The outlier management policies and procedures regarding monitoring over- and under-utilization, monitored services, exceptions, and actions taken for MH/SUD services are substantially similar to the policies and procedures for M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 3: Outlier Management

OUTLIER MANAGEMENT SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
How does the plan monitor over- and under-utilization of services?	RMHP monitors over and underutilization of services to ensure that Members receive necessary and appropriate care. Data are collected from multiple sources including HEDIS® results and Member surveys, appeals and grievance data, quality of care reports, utilization management reports and pharmacy utilization reports. Data are reviewed, trended, analyzed and interventions are developed and implemented based	NHP/HCI monitors utilization trends and identifies outliers related to high service volume, high cost, unusual lengths of stay, and 7- and 30-day readmissions.	COA monitors for outliers with frequent utilization of IP/OP services. COA considers frequent utilization on a case-by-case basis when evaluating whether continued or additional services will (or is reasonably expected to) benefit the member in the treatment of their MH/SUD condition(s). Per the definition of medical necessity, this is only one of many factors to consider when medical necessity is being evaluated. COA may recommend a different course of treatment if the services being	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 (i.e. LOS, Readmissions, etc.) made available to Behavioral Health Management and Quality Management (QM)) Departments by the Performance Management Analysts/ Finance Analysts. CCHA participates in the Colorado Client Over-Utilization Program(COUP).	The Department's outlier management program for physical health has multiple components. These include utilizing a recovery audits contractor (RAC) to review certain claims for the medical appropriateness and billed services. Additionally, the FFS UM Vendor will notify the Department of any concerns regarding waste, fraud, abuse that are identified as a part of the normal review process. And finally, the Department reviews claims for use in future policy setting.

OUTLIER MANAGEMENT SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
	on outcomes of the analysis.[56]		requested are not effective in treating the member's MH/SUD condition(s).		
Are all services subject to outlier monitoring? IF NO, list all services by benefit classification subject to monitoring.	Yes	Yes	Yes	Yes	Yes
Are there any exceptions to these policies for reviews of services for members under the age of 21?	No	No	No	No	EPSDT requirements are followed when making determinations.
What actions are taken based on information from outlier reports? (policy change, payment recovery, additional analysis, etc)	Many actions have been taken as a result of reviewing outlier reports including the creation of new programs, change in processes, change in policies, payment recovery	Additional information may be requested to authorize continuing services. For example, the provider may be asked to provide a treatment plan and/or attest that	Interventions/ follow up measures could including (but not limited to): patient education on appropriate service utilization via the COA care management program, provider	The results of the reviews are used to help implement strategies to achieve utilization targets consistent with clinical and quality indicators and	In reviewing outliers, there may be a necessary change in clinical criteria, or policy, additional analysis or referrals to Program Integrity.

[56] Areas of focus include: MONITORING OF OVERUTILIZATION: Concurrent reviews, Pre-authorizations, High ER utilization for non-emergent conditions, Hospitalization for preventable conditions, Hospital readmission within 30 days of discharge, Pharmacy overutilization (Opioids), Colorado Overutilization Project (COUP)- Medicaid, MONITORING OF UNDERUTILIZATION: Members identified with Preventative Care and Screening Gaps, Gaps in Care Reporting (providers), Member Education and Incentives, Encourage annual Wellness Visit, Provider Attribution Reports, Pharmacy Underutilization/Medication Management Program, Disease Management Program(s)

OUTLIER MANAGEMENT SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
	in the event of inappropriate billing, and further specific analysis to look at cause and effects.	they are following the RAE's clinical guidelines. Outlier reports or other data mining may also initiate focused audit processes and/or investigations related to fraud, waste, and abuse.	education on medical necessity, documentation requirements, and/or billing practices, referral to the COA compliance team for auditing and/or recoupment, referral to the COA Quality team for assessment and treatment plan reviews, and/or further analysis and record reviews.	identify fraud and abuse.	

Outlier Management

Findings: Scenario 3

The purpose of the Department's FFS utilization management outlier management policies and processes is for determining when a participant's benefits requires additional clinical review and potentially service changes. RAE 1's goal of outlier management is to ensure members have access to appropriate care and are receiving services they need while managing healthcare quality, efficiency, and cost. RAEs 2 and 4 look to identify utilization trends over time and across facilities or providers. This information can be helpful in educating providers about medical necessity and the application of clinical best practices. Additionally, outlier review is used to identify over-utilization of services that are not medically necessary and to prevent unnecessary costs. RAEs 3 and 5 use these policies to ensure the member is receiving the appropriate and effective level of care for their clinical

presentation. RAEs 6 and 7 use the results of the reviews to help implement strategies to achieve utilization targets consistent with clinical and quality indicators and identify fraud and abuse.

The outlier management policies and procedures regarding monitoring over- and under- utilization, monitored services, exceptions, and actions taken for MH/SUD services are substantially similar to the policies and procedures for M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Outlier Management

OUTLIER MANAGEMENT SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
How does the plan monitor over- and under-utilization of services?	COA monitors for outliers with frequent utilization of inpatient/outpatient services. COA considers frequent utilization on a case-by-case basis when evaluating whether continued or additional services will (or is reasonably expected to) benefit the member in the treatment of their behavioral health condition(s). Per the definition of medical necessity, this is only one of many factors to consider when medical necessity is being evaluated. COA may recommend a different course of treatment if the services being requested are not effective in treating the member's behavioral health condition(s).	The DHMC QI team tracks and monitors over and underutilization (e.g., emergency department readmission, etc.) and reports findings quarterly to the Medical Management Committee.
Are all services subject to outlier monitoring? IF NO, list all services by benefit classification subject to monitoring.	Yes	Yes
Are there any exceptions to these policies for reviews of services for members under the age of 21?	No	No
What actions are taken based on information from outlier reports? (policy change, payment recovery, additional analysis, etc)	If an outlier is identified, any number of interventions/follow up measures could occur, including (but not limited to): patient education on appropriate service utilization via the COA care management program, provider education on medical necessity, documentation requirements, and/or billing practices, referral to the	If an over/under utilizing member is identified the care management team is notified. The care management team will outreach directly to the member to provider education, resources, support and when appropriate advocate for the member to join an intervention program.

OUTLIER MANAGEMENT SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
	COA compliance team for auditing and/or recoupment, referral to the COA Quality team for assessment and treatment plan reviews, and/or further analysis and record reviews.	

Outlier Management

Findings: Scenario 4

The health plan's outlier management policies work to ensure the member is receiving the appropriate and effective level of care for their clinical presentation – that they receive the right care at the right time with the right provider. The purpose is not to limit the accessibility of services, but to identify over- or under-utilization on a case-by-case, member-specific basis to ensure the member is receiving clinically appropriate, clinically effective care for their needs.

The outlier management policies and procedures regarding monitoring over- and under-utilization, monitored services, exceptions, and actions taken for MH/SUD services are substantially similar to the policies and procedures for M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

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: Data request, interviews with health plan staff, and policies/procedures documents referencing 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).

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Coding Limitations

CODING LIMITATIONS SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
What coding set do you use for determining what services are eligible for reimbursement?	Coding limitations are used for IP and OP, in accordance with the CO Medicaid provider billing manual from the Department for FFS MH/SUD and M/S services and guidance from CMS, such as Medically Unlikely Edits (MUE). 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 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 OP 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. FFS 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	Coding limitations are used for IP and OP, in accordance with the CO Medicaid provider billing manual from the Department for FFS MH/SUD and M/S services and guidance from CMS, such as Medically Unlikely Edits (MUE). 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 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 OP 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. FFS 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

CODING LIMITATIONS SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
	Physician's Current Procedural Terminology (CPT) and codes developed by CMS. Updates and revisions to HCPCS listings are documented in the Provider Bulletins. Uniform Services Coding Standards Manual is also used for MH/SUD.	Physician's Current Procedural Terminology (CPT) and codes developed by CMS. Updates and revisions to HCPCS listings are documented in the Provider Bulletins.

Coding Limitations

Findings: Scenario 1

The coding sets used by the health plans establish what services are eligible for reimbursement. The sets utilized for MH/SUD services are substantially similar to those used for M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Coding Limitations

CODING LIMITATIONS SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
What coding set do you use for determining what services are eligible for reimbursement?	RAE/Prime Contract with HCPF, Covered Services HFC Fee Schedule Uniform Services Coding Standards Manual CPT/ICD-10 Standard Code Sets	RAE/Prime Contract with HCPF, Covered Services HFC Fee Schedule Uniform Services Coding Standards Manual CPT/ICD-10 Standard Code Sets

Coding Limitations

Findings: Scenario 2

The coding sets used by the health plans establish what services are eligible for reimbursement. The sets utilized for MH/SUD services are the same to those used for M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 3: Coding Limitations

CODING LIMITATIONS SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
What coding set do you use for determining what services are eligible for reimbursement?	RAE/Prime Contract with HCPF, Exhibit I Uniform Services Coding Standards Manual CPT/ICD-10 Standard Code Sets	RAE Contract with HCPF Uniform Services Coding Standards Manual CPT/ICD-10 Standard Code Sets	RAE Contract with HCPF Uniform Services Coding Standards Manual CPT/ICD-10 Standard Code Sets	RAE Contract with HCPF Uniform Services Coding Standards Manual CPT/ICD-10 Standard Code Sets	Coding limitations are used for IP and OP, in accordance with the Colorado Medicaid provider billing manual from the Department for FFS MH/SUD and M/S services and guidance from CMS, such as Medically Unlikely Edits (MUE). 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

CODING LIMITATIONS SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
					applicable under EPSDT. 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 CPT and codes developed by CMS.

Coding Limitations

Findings: Scenario 3

The coding sets used by the health plans establish what services are eligible for reimbursement. The sets utilized for MH/SUD services are substantially similar to those used for M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Coding Limitations

CODING LIMITATIONS SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
What coding set do you use for determining what services are eligible for reimbursement?	Contract with HCPF and the Uniform Services Coding Standards Manual Includes CPT, HCPC, and revenue codes outlined contract. CPT/ICD-10 Standard Code Sets	Contract with HCPF and the Uniform Services Coding Standards Manual

Coding Limitations

Findings: Scenario 4

The coding sets used by the health plans establish what services are eligible for reimbursement. The sets utilized for MH/SUD services are substantially similar to those used for M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Appendix J - 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: Data request, interviews with health plan staff, and policies/procedures documents referencing provider network selection criteria for network admission, credentialing, and recredentialing of MH/SUD and M/S providers, provider appeals process, utilization of national accrediting standards.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Network Provider Admission

NETWORK PROVIDER ADMISSION SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
What process is followed for recruiting and accepting providers into the plan's network of care professionals?	The Department is responsible for enrolling Providers, and the UM Vendor receives the enrollment feeds, and so as long as the provider is enrolled and the appropriate provider type for the benefit they may request a PAR. The Department will accept any willing provider that meets the enrollment requirements, but will specifically recruit by need. Typically will use the provider bulletin to announce specific needs.	The Department is responsible for enrolling Providers, and the UM Vendor receives the enrollment feeds, and so as long as the provider is enrolled and the appropriate provider type for the benefit they may request a PAR. The Department will accept any willing provider that meets the enrollment requirements, but will specifically recruit by need. Typically will use the provider bulletin to announce specific needs.
What national accrediting standards are used to determine admission into the plan's network of care professionals?	Providers wishing to enroll with Medicaid must the specific requirements of provider type and services to be provided.	Providers wishing to enroll with Medicaid must the specific requirements of provider type and services to be provided.
What process does a provider follow to become credentialed and recredentialed with the plan?	The FFS Medicaid provider enrollment process uses a validation process based on federal requirements (i.e. practitioner must be licensed to enroll, etc.) for all providers.	The FFS Medicaid provider enrollment process uses a validation process based on federal requirements (i.e. practitioner must be licensed to enroll, etc.) for all providers.
How often do providers need to revalidate/recredential?	Providers must revalidate at least every 5 years.	Providers must revalidate at least every 5 years.
How often do providers need to recontract?	Providers do not contract with the Department. Providers enroll with Medicaid and that enrollment does not have a timeframe.	Providers do not contract with the Department. Providers enroll with Medicaid and that enrollment does not have a timeframe.
What process does the plan have in place for a provider to appeal a denial into the plan's network?	If a provider is denied enrolling with Medicaid, they are provided an opportunity to submit updated documentation if they believe it will change the outcome.	If a provider is denied enrolling with Medicaid, they are provided an opportunity to submit updated documentation if they believe it will change the outcome.
Does the plan accept any willing provider into its network of care providers (assuming the provider is Medicaid enrolled, meets credentialing and quality standards, and accepts reasonable reimbursement for services)?	Yes. The FFS health plan does not limit provider participation beyond basic enrollment requirements (i.e. practitioner must be licensed to enroll, etc.) There is not a cap on the	Yes. The FFS health plan does not limit provider participation beyond basic enrollment requirements (i.e. practitioner must be licensed to enroll, etc.) There is not a cap on the

NETWORK PROVIDER ADMISSION SCENARIO 1: DEPARTMENT FFS		
QUESTION	MH/SUD	M/S
	number of providers allowed to enroll and provide services.	number of providers allowed to enroll and provide services.

Network Provider Admission

Findings: Scenario 1

The network provider admission policies and procedures include recruitment, accrediting standards, credentialing/recredentialing, contracting timeframes, appealing a denial, and accepting any willing provider into the network. These policies and procedures for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice. Other than the different licensure, the process is the same for MH/SUD and M/S.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Network Provider Admission

NETWORK PROVIDER ADMISSION SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	MH/SUD	M/S
What process is followed for recruiting and accepting providers into the plan's network of care professionals?	RMHP accepts any willing provider who meets our credentialing standards and is willing to accept and negotiate reasonable reimbursement for services.	RMHP accepts any willing provider who meets our credentialing standards and is willing to accept and negotiate reasonable reimbursement for services.
What national accrediting standards are used to determine admission into the plan's network of care professionals?	NCQA	NCQA
What process does a provider follow to become credentialed and recredentialed with the plan?	Submit complete credentialing packet to RMHP for review. The packet must include a W9, current practice demographics, proof of enrollment with HCPF, and email address. Providers must have a current CAQH application. Providers are recredentialed every 36 months. Re-credentialing focus on verifying that CAQH and	Submit complete credentialing packet to RMHP for review. The packet must include a W9, current practice demographics, proof of enrollment with HCPF, and email address. Providers must have a current CAQH application. Providers are recredentialed every 36 months.

NETWORK PROVIDER ADMISSION SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
	attestation is up-to-date and verifying licensure. If up to date, process is more streamlined.	Re-credentialing focus on verifying that CAQH and attestation is up-to-date and verifying licensure. If up to date, process is more streamlined.
How often do providers need to revalidate/recredential?	Every 36 months.	Every 36 months.
How often do providers need to recontract?	Most Provider contracts are evergreen, so they are in effect unless either party decides to terminate.	Most Provider contracts are evergreen, so they are in effect unless either party decides to terminate.
What process does the plan have in place for a provider to appeal a denial into the plan's network?	If a provider was denied due to credentialing reasons, they can appeal to a Medical Director. The MPRC has oversight of credentialing including the regulatorily required appeal process.	If a provider was denied due to credentialing reasons, they can appeal to a Medical Director. The MPRC has oversight of credentialing including the regulatorily required appeal process.
Does the plan accept any willing provider into its network of care providers (assuming the provider is Medicaid enrolled, meets credentialing and quality standards, and accepts reasonable reimbursement for services)?	Yes	Yes

Network Provider Admission

Findings: Scenario 2

The network provider admission policies and procedures include recruitment, accrediting standards, credentialing/recredentialing, contracting timeframes, appealing a denial, and accepting any willing provider into the network. These policies and procedures for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. Other than the different licensure, the process is the same for MH/SUD and M/S.

It is determined that these policies and procedures are parity compliant.

Scenario 3: Network Provider Admission

NETWORK PROVIDER ADMISSION **SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS**					
QUESTION	**RAE 1 MH/SUD**	**RAE 2&4 MH/SUD**	**RAE 3&5 MH/SUD**	**RAE 6&7 MH/SUD**	**DEPARTMENT M/S**
What process is followed for recruiting and accepting providers into the plan's network of care professionals?	RMHP accepts any willing provider who meets our credentialing standards and is willing to accept and negotiate reasonable reimbursement for services.	The RAE engages specialty provider groups and facilities based on the [57]	The provider recruitment process is a collaborative effort between the Contracting team, Provider Network Services, and clinical program staff: verify provider meets quality standards and conditions for contracting. Provider Network Services contacts provider to schedule a meeting to discuss the contracting process and	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.	The Department is responsible for enrolling Providers, and the UM Vendor receives the enrollment feeds, and so as long as the provider is enrolled and the appropriate provider type for the benefit they may request a PAR. The Department will accept any willing provider that meets the enrollment requirements, but will specifically recruit by need. Typically will

[57] Example specialty provider groups and facilities include 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 substance use disorder providers, dental and other ancillary providers; or Behavioral health providers that span inpatient, outpatient, and all other covered mental health and substance use disorder services.

NETWORK PROVIDER ADMISSION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
			operational requirements of contracted network providers. Assistance in completing required documents is provided, if needed. For some providers, a clinical site visit may also be warranted.[58]		use the provider bulletin to announce specific needs.
What national accrediting standards are used to determine admission into the plan's network of care professionals?	National Committee for Quality Assurance (NCQA)	Council for Affordable Quality Healthcare (CAQH). Optionally a provider can complete a NHP/HCI application which is NCQA accredited and follows NCQA standards for credentialing.	National Committee for Quality Assurance (NCQA)	Council for Affordable Quality Healthcare (CAQH)	Providers wishing to enroll with Medicaid must the specific requirements of provider type and services to be provided.
What process does a provider follow to become credentialed and	Submit complete credentialing packet to RMHP for	Submission of completed and signed applications,	Provider completes paper application or	To become credentialed CCHA uses the CAQH	The Fee-For-Service Medicaid provider enrollment process

[58] Provider recruitment can be initiated as follows: Identified need through provider network adequacy assessment; Internal request from Care Management, Utilization Management, other; External request/referral from providers, members, other

NETWORK PROVIDER ADMISSION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
recredentialed with the plan?	review. The packet must include a W9, current practice demographics, proof of enrollment with HCPF, and email address. Providers must have a current CAQH application. Providers are recredentialed every 36 months. Re-credentialing focus on verifying that CAQH and attestation is up-to-date and verifying licensure. If up to date,	along with all required supporting documentation using CAQH process or NHP/HCI process. The provider is notified about recredentialing up to 6 months ahead of time and if the provider's documents are current with CAQH, then the process is very streamlined.	electronic app through CAQH. To recredential, provider must update (or keep up to date in CAQH) their documentation. If up to date, we are able to recredential practitioners without ever having to notify them.	Universal Provider Data Source. Providers must complete the online credentialing application, authorize access to their information, verify and attest their data is accurate and complete, submit supporting documents.[59] Recredentialing is less administratively burdensome than the initial credentialing process – primarily just ensuring the CAQH information is up to date.	uses a validation process based on federal requirements (i.e. practitioner must be licensed to enroll, etc.) for all providers.

[59] CAQH Universal Provider Data Source credentialing process supporting documents: State license(s) applicable to your provider type, Board certification or highest level of medical training or education, Work history, Admitting privileges at a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Integrated Accreditation for Healthcare Organizations (NIAHO), American Osteopathic Association (AOA) or a network hospital previously approved by the committee, Current DEA certificate or plan to prescribe if no DEA certificate, if applicable, Current Controlled and Dangerous Substances certificate, if applicable, Copy of the professional liability insurance face sheet is required. Organizational providers are required to maintain professional liability insurance in the amounts specified in the Network Provider Agreement consistent with State law requirements and CCHA policy. Summary of all pending or settled malpractice case(s) within the past 10 years, Curriculum vitae, Current signed attestation, Written protocol (advanced nurse practitioners only), Supervision form (physician assistants only), Hospital Coverage letter, required by CCHA from providers who do not have admitting privileges at a participating network hospital, State or federal license sanctions or limitations, Medicare, Medicaid or Federal Employees Health Benefits Program (FEHBP) sanctions, Disclosure of Ownership

NETWORK PROVIDER ADMISSION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
	process is more streamlined.				
How often do providers need to revalidate/recredential?	Providers must revalidate with Health First Colorado every 5 years. Providers must recredential every 36 months.	Providers must revalidate with Health First Colorado every 5 years. Providers must recredential every 36 months.	Providers must revalidate with Health First Colorado every 5 years. Providers must recredential every 36 months.	Providers must revalidate with Health First Colorado every 5 years. Providers must recredential every 36 months.	Providers must revalidate with Health First Colorado at least every 5 years.
How often do providers need to recontract?	Most Provider contracts are evergreen, so they are in effect unless either party decides to terminate.	Contracts with providers are evergreen, automatically renewing each year. Providers are not required to recontract as long as they meet credentialing and recredentialing requirements.	Most provider contracts auto-renew annually unless they are renegotiated or terminated.	CCHA Contracts are Evergreen. CCHA does not require providers to recontract once an agreement is dually executed.	Providers do not contract with the Department. Providers enroll with Medicaid and that enrollment does not have a timeframe.
What process does the plan have in place for a provider to appeal a denial into the plan's network?	If a provider was denied due to credentialing reasons, they can appeal to a Medical Director. The MPRC has oversight of credentialing including the regulatorily	A provider is able to submit appeal to National Credentialing Committee within thirty (30) days of notification.	If the COA Credentialing Committee denies a new provider from joining our network, there is no appeals process. If the Credentialing Committee recommends that a	If an initial application is rejected the Practitioner has the opportunity for an Informal Review/ Reconsideration of the decision and the right to submit additional	If a provider is denied enrolling with Medicaid, they are provided an opportunity to submit updated documentation if they believe it will change the outcome.

NETWORK PROVIDER ADMISSION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
	required appeal process.		provider is terminated from our network, then the provider is offered an appeal process to include a hearing.	information to the Company to correct any errors in the factual information which led to the determination or provide other relevant information. This information must be submitted within the 30 calendar day period immediately following the date of receipt of the letter.	
Does the plan accept any willing provider into its network of care providers (assuming the provider is Medicaid enrolled, meets credentialing and quality standards, and accepts reasonable reimbursement for services)?	Yes	Yes	Yes	Yes	Yes

Network Provider Admission

Findings: Scenario 3

The network provider admission policies and procedures include recruitment, accrediting standards, credentialing/recredentialing, contracting timeframes, appealing a denial, and accepting any willing provider into the network. These policies and procedures for

MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. Other than the different licensure, the process is the same for MH/SUD and M/S.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Network Provider Admission

NETWORK PROVIDER ADMISSION **SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO**		
QUESTION	**MH/SUD**	**M/S**
What process is followed for recruiting and accepting providers into the plan's network of care professionals?	Actively recruit providers based on need identified through care management, utilization management, requests from providers and members. Contact the providers to discuss contracting process and requirements, assist in completing application and credentialing process.	Identify potential gaps or network concerns through network adequacy reporting, utilization team requests, care management programs, grievance and appeals, CAPHS, etc., then outreach to providers.
What national accrediting standards are used to determine admission into the plan's network of care professionals?	NCQA	NCQA
What process does a provider follow to become credentialed and recredentialed with the plan?	Provider completes paper application or electronic app through CAQH. To recredential, provider must update (or keep up to date in CAQH) their documentation. If up to date, we are able to recredential practitioners without ever having to notify them.	Complete Application provided on the CAQH website so that the Credentialing Department may obtain and validate information attested to by the practitioner. The CAQH Credentialing Application must be currently signed or attested with the most recent information. Providers recredential at least every 36 months. DHMC notifies applicant of recredential process in a timely manner to meet 36-month timeframe.
How often do providers need to revalidate/recredential?	Revalidation with Health First CO: Every 5 years Recredentialing for COA: Every 3 years.	Revalidation with Health First CO: Every 5 years Recredentialing for DHMC: Every 3 years.
How often do providers need to recontract?	Most provider contracts auto-renew annually unless they are renegotiated or terminated.	Re-contracting is not required unless either party expresses a need to renegotiate.
What process does the plan have in place for a provider to appeal a denial into the plan's network?	If the COA Credentialing Committee denies a new provider from joining our network, there is no appeals process. If the Credentialing	Practitioners may appeal a credentialing or recredentialing decision using the practitioner appeal process

NETWORK PROVIDER ADMISSION SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
	Committee recommends that a provider is terminated from our network, then the provider is offered an appeal process to include a hearing.	as defined in the DHMC Provider Manual
Does the plan accept any willing provider into its network of care providers (assuming the provider is Medicaid enrolled, meets credentialing and quality standards, and accepts reasonable reimbursement for services)?	Yes	DHMC encourages providers to apply to join the network; however, as a closed network DHMC does not contract with all providers and focuses on areas of identified need.

Network Provider Admission

Findings: Scenario 4

The network provider admission policies and procedures include recruitment, accrediting standards, credentialing/recredentialing, contracting timeframes, appealing a denial, and accepting any willing provider into the network. These policies and procedures for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. Other than the different licensure, the process is the same for MH/SUD and M/S.

It is determined that these policies and procedures are parity compliant.

Appendix K - 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: Data request, interviews with health plan staff, and policies/procedures documents referencing charge establishment standards to ensure timely access to care and sufficient network adequacy; alignment of charges based on provider type and specialty.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Establishing Charges/Reimbursement Rates

ESTABLISHING CHARGES/REIMBURSEMENT RATES SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
What process is used to establish charges and reimbursement rates of payments for participant services rendered by providers? Please separate by benefit classifications as appropriate (inpatient, outpatient, emergency care, prescription drugs).	For Inpatient 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. For Outpatient 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. For Emergency MH/SUD, the Department uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted. Each hospital has a base rate calculated from their Medicare base rates. The average cost of service at a hospital is multiplied by other factors. For MH/SUD 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 physician administered pharmaceuticals, the rate is based off Medicare data. Fees are updated quarterly. If data is not available, the Department uses the Medicare Average Sales Price (ASP) minus 4.5%.	For Inpatient 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. For Outpatient 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. For Emergency 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. 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.

ESTABLISHING CHARGES/REIMBURSEMENT RATES SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
		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 Average Sales Price (ASP) minus 4.5%.
Are there any differences that may exist based on provider type or specialty and separate by benefit classifications as appropriate (inpatient, outpatient, emergency care, prescription drugs).	If it's within the scope of their practice, a provider would get the same rate regardless of provider type or specialty.	If it's within the scope of their practice, a provider would get the same rate regardless of provider type or specialty.
How often is the current provider fee scheduled reviewed ?	At least annually. Labs are updated quarterly.	At least annually. Labs are updated quarterly.
How are providers notified of changes to reimbursement rates?	Any changes are communicated to providers including direct emails, provider bulletin, the ColoradoPAR program website and direct communication with providers.	Any changes are communicated to providers including direct emails, provider bulletin, the ColoradoPAR program website and direct communication with providers.
Is there a process for providers to negotiate reimbursement rates?	Currently, there is not a process for providers to negotiate reimbursement rates. However, provider and stakeholder outreach is performed when rates are being reviewed for sufficiency in order to gather additional reimbursement information that may be lacking in the rate methodology. Single case agreements are used for very limited situations where out of state hospital services are needed for services that the state doesn't have the ability to provide.	Currently, there is not a process for providers to negotiate reimbursement rates. However, provider and stakeholder outreach is performed when rates are being reviewed for sufficiency in order to gather additional reimbursement information that may be lacking in the rate methodology. Single case agreements are used for very limited situations where out of state hospital services are needed for services that the state doesn't have the ability to provide.

Establishing Charges/Reimbursement Rates

Findings: Scenario 1

The policies and procedures regarding establishing charges / reimbursement rates include process used, differences based on provider type or specialty, timeframes for reviewing fees, notifying providers, and negotiating rates. The policies and procedures for establishing charges and reimbursement rates for MH/SUD services are identical in every benefit category

except inpatient services. For inpatient services, while different, the MH/SUD policies and procedures are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Establishing Charges/Reimbursement Rates

ESTABLISHING CHARGES/REIMBURSEMENT RATES

SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO

QUESTION	MH/SUD	M/S
What process is used to establish charges and reimbursement rates of payments for participant services rendered by providers? Please separate by benefit classifications as appropriate (inpatient, outpatient, emergency care, prescription drugs).	Pharmacy: 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, OptumRx. Reimbursement rates are based on brand and generic designation from MediSpan. Brand drugs negotiated at AWP minus % for any branded drug. Generics are set at a MAC price without regard for BH or medical indications IP/OP/EC: RMHP may determine reimbursement rates on the basis of State funding levels and/or fee schedules. Scarce services may receive special consideration for higher rates. This is true for all services.	Pharmacy: 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, OptumRx. Reimbursement rates are based on brand and generic designation from MediSpan. Brand drugs negotiated at AWP minus % for any branded drug. Generics are set at a MAC price without regard for BH or medical indications IP/OP/EC: RMHP may determine reimbursement rates on the basis of State funding levels and/or fee schedules. Scarce services may receive special consideration for higher rates. This is true for all services.
Are there any differences that may exist based on provider type or specialty and separate by benefit classifications as appropriate (inpatient, outpatient, emergency care, prescription drugs).	Pharmacy: No IP/OP/EC: RMHP has different reimbursement levels based upon level of licensure. Scarce services may receive special consideration if needed to fill a network need.	Pharmacy: No IP/OP/EC: RMHP has different reimbursement levels based upon level of licensure. Scarce services may receive special consideration if needed to fill a network need.
How often is the current provider fee scheduled reviewed ?	Pharmacy: Ad Hoc IP/OP/EC: Annually	Pharmacy: Ad Hoc IP/OP/EC: Annually
How are providers notified of changes to reimbursement rates?	Contract amendment	Contract amendment
Is there a process for providers to negotiate reimbursement rates?	Pharmacy: No	Pharmacy: No

ESTABLISHING CHARGES/REIMBURSEMENT RATES **SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO**		
QUESTION	**MH/SUD**	**M/S**
	IP/OP/EC: Providers can submit rates for RMHP review and consideration.	IP/OP/EC: Providers can submit rates for RMHP review and consideration.

Establishing Charges/Reimbursement Rates

Findings: Scenario 2

The policies and procedures regarding establishing charges / reimbursement rates include process used, differences based on provider type or specialty, timeframes for reviewing fees, notifying providers, and negotiating rates. These policies and procedures for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 3: Establishing Charges/Reimbursement Rates

ESTABLISHING CHARGES/REIMBURSEMENT RATES **SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS**					
QUESTION	**RAE 1 MH/SUD**	**RAE 2&4 MH/SUD**	**RAE 3&5 MH/SUD**	**RAE 6&7 MH/SUD**	**DEPARTMENT M/S**
What process is used to establish charges and reimbursement rates of payments for participant services rendered by providers? Please separate by benefit classifications as appropriate (inpatient, outpatient, emergency care, prescription drugs).	IP/OP/EC - RMHP may determine reimbursement rates on the basis of State funding levels and/or fee schedules. Scarce services may receive special consideration for higher rates.	IP/OP/EC – NHP/HCI creates and maintains a fee schedule with Medicaid appropriate rates, uses available tools to determine usual and customary rates including, but not limited to, Colorado Fee For Services Medicaid Rates and standards, CMS Reimbursement Rates, or market standards.	IP/OP/EC - COA utilizes established reimbursement methods such as: DRG for inpatient; RBRVS, EAPG, and Colorado Medicaid fee schedule for outpatient. In addition, provider contracts may also include value based arrangements that provide incentives for meeting quality of care KPI's.	IP/OP/EC - The factors that CCHA uses to determine provider reimbursement rates include: (a) provider location – urban vs. rural; (b) provider setting – office or facility; (c) competitiveness of our rates; (d) CPT/HCPCS code being billed; (e) Medicare reimbursement and tables illustrating office expenses; (f) education level of provider; (g) frequency with which a provider type specific codes; (h) for new CPT/HCPCS codes, evaluation of whether it is a replacement of a prior code, which we would crosswalk to the prior	IP/EC - 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. OP - The Department uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense

ESTABLISHING CHARGES/REIMBURSEMENT RATES SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
				reimbursement amount, or a new code, where fees will be set based on relativity to surrounding codes; (i) Health First Colorado fee schedule; and (j) any legislative actions or requirements to our payment model. Emergency-CCHA will cover and pay for Emergency Services and Care, regardless of whether the entity furnishing the services is a participating provider. Prescription Drugs-N/A	expectations, and capital overhead expense expectations. 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. M/S physician administered pharmaceuticals - The rate is based off Medicare data. Fees are updated quarterly. If data is not available, the Department uses the Medicare Average Sales Price (ASP) minus 4.5%.
Are there any differences that may exist based on provider type or specialty and separate by benefit classifications as appropriate (inpatient,	RMHP has different reimbursement levels based upon level of licensure. Scarce services may receive	NHP/HCI updates reimbursement rates of payments based on provider types. Community Mental Health	The following include, but are not limited to, provider specialties/ expertise that could	Yes, fee schedules vary depending on the provider type.	If it's within the scope of their practice, a provider would get the same rate regardless of provider type or specialty.

ESTABLISHING CHARGES/REIMBURSEMENT RATES **SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS**					
QUESTION	**RAE 1 MH/SUD**	**RAE 2&4 MH/SUD**	**RAE 3&5 MH/SUD**	**RAE 6&7 MH/SUD**	**DEPARTMENT M/S**
outpatient, emergency care, prescription drugs).	special consideration if needed to fill a network need.	Centers are updated annually based on their updated Based Unit Cost and States updated RVU rates. Federally Qualified Health Centers and Rural Health Centers encounter rates are updated ad hoc based on rate updates conducted by the Department. Independent Provider Network OP providers receive standard FFS fee schedule which is reviewed and updated on a periodic basis. IPN IP and residential facilities rates are determined based on usual and customary rates. Additionally, NHP/HCI may negotiate rates, where appropriate, to ensure Members	warrant additional compensation: •Advanced degrees such as an MD, PhD, NP •Providers that serve populations who face barriers to access to care such as, deaf/hard of hearing, foreign language spoken, refugees, BIPOC, LGBTQ •Subspecialties		

ESTABLISHING CHARGES/REIMBURSEMENT RATES SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
		have access to covered services.			
How often is the current provider fee scheduled reviewed ?	Annually	There is no established timeframe for reviewing the IPN OP provider fee schedule, but it is done at minimum annually. It can be done more often if the review deems it appropriate.	At least annually and as indicated by factors such as inflation and market competitiveness.	CCHA continually monitors provider reimbursement using the criteria outlined above.	At least annually. Labs are updated quarterly.
How are providers notified of changes to reimbursement rates?	Contract amendment	Contract amendment, but may be contacted through direct written notice.	Providers are notified of reimbursement changes in formal notices, through the COA Provider Portal, and Provider Newsletters.	Unilateral amendment via email and mailing to primary location on file.	Any changes are communicated to providers including direct emails, provider bulletin, the ColoradoPAR program website and direct communication with providers.
Is there a process for providers to negotiate reimbursement rates?	Providers can submit rates for RMHP review and consideration.	Providers may request review of their reimbursements in writing for consideration.	Each contract with a provider has the potential to be negotiated and/or customized for each provider relationship.	Providers can reach out to their designated contract manager. Fee schedules are negotiated with appropriate rationale.	Single case agreements are used for very limited situations where out of state hospital services are needed for services that the state doesn't have the ability to provide.

Establishing Charges/Reimbursement Rates

Findings: Scenario 3

The policies and procedures regarding establishing charges / reimbursement rates include process used, differences based on provider type or specialty, timeframes for reviewing fees, notifying providers, and negotiating rates. While differences exist in how the charges / reimbursement rates are determined, the processes are industry standard and are applied in a substantially similar and no more stringent method.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Establishing Charges/Reimbursement Rates

ESTABLISHING CHARGES/REIMBURSEMENT RATES SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
What process is used to establish charges and reimbursement rates of payments for participant services rendered by providers? Please separate by benefit classifications as appropriate (inpatient, outpatient, emergency care, prescription drugs).	COA utilizes established reimbursement methods such as: DRG for inpatient; RBRVS, EAPG, and Colorado Medicaid fee schedule for outpatient. In addition, provider contracts may also include value based arrangements that provide incentives for meeting quality of care KPI's.	DHMC utilizes established reimbursement methods such as: DRG for inpatient; EAPG, and the Colorado Medicaid fee schedule for outpatient.
Are there any differences that may exist based on provider type or specialty and separate by benefit classifications as appropriate (inpatient, outpatient, emergency care, prescription drugs).	The following include, but are not limited to, provider specialties/ expertise that could warrant additional compensation: • Advanced degrees such as an MD, PhD, NP • Providers that serve populations who face barriers to access to care such as, deaf/hard of hearing, foreign language spoken, refugees, BIPOC, LGBTQ • Subspecialties	No
How often is the current provider fee scheduled reviewed ?	At least annually	As updates are received
How are providers notified of changes to reimbursement rates?	Formal notices, COA Provider Portal, and Provider Newsletters	Provider website, provider newsletters, and direct communication if appropriate.
Is there a process for providers to negotiate reimbursement rates?	Each contract with a provider has the potential to be negotiated and/or customized for each provider relationship.	DHMC negotiates rate with each provider directly during the contracting process.

Establishing Charges/Reimbursement Rates

Findings: Scenario 4

The policies and procedures regarding establishing charges / reimbursement rates include process used, timeframes for reviewing fees, notifying providers, and negotiating rates. While differences exist in how the charges / reimbursement rates are determined, the processes are industry standard and are applied in a substantially similar and no more stringent method. There are differences in how provider type or specialty are handled, but the MH/SUD providers have the ability to negotiate their payment for care due to managed care and are

not limited to the what fee-for-service pays, and therefore this comparison is more lenient for MH/SUD.

It is determined that these policies and procedures are parity compliant.

Appendix L - Restrictions Based on Geographic Location/Facility Type, Provider Specialty

Description: Health plan policies on recruitment, credentialing, and enrollment of network providers to include any exclusionary criteria.

Tools for Analysis: Data request, interviews with health plan staff, and policies/procedures documents referencing provider network selection criteria for network admission, credentialing and recredentialing of MH/SUD and M/S providers, provider appeals process, and utilization of national accrediting standards.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Analysis: No health plans currently place restrictions based on geographic location, facility type, or provider specialty.

Appendix M - 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: Data request, interviews with health plan staff, and policies/procedures documents referencing 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.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Network Adequacy Determination

NETWORK ADEQUACY DETERMINATION SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
Which benefit classifications do you have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP, OP, EC, PD	IP, OP, EC, PD
How does the plan determine an adequate number of providers in the network? Are there differences by specialty?	Regional comparisons by county, year-over-year comparisons, multiple metrics as a whole, and stakeholder feedback. The process also looks to ensure adequate specialty providers.	Regional comparisons by county, year-over-year comparisons, multiple metrics as a whole, and stakeholder feedback. The process also looks to ensure adequate specialty providers.
What process does the plan follow for maintaining network adequacy?	Consistent evaluation, engagement, and intervention when necessary	Consistent evaluation, engagement, and intervention when necessary
How frequently does the plan report on network adequacy?	Reporting is required at least quarterly.	Reporting is required at least quarterly.
What strategies does the plan use to address identified deficiencies in the network?	The strategies used depend on the data and conclusions.	The strategies used depend on the data and conclusions.

Network Adequacy Determination

Findings: Scenario 1

The policies and procedures regarding network adequacy determination include determining adequacy, maintaining adequacy, reporting, and strategies to address deficiencies. These policies and procedures for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice. As required in contract, all plans report on network adequacy to the Department quarterly.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Network Adequacy Determination

NETWORK ADEQUACY DETERMINATION SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
Which benefit classifications do you have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP, OP, EC, PD	IP, OP, EC, PD

NETWORK ADEQUACY DETERMINATION **SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO**		
QUESTION	**MH/SUD**	**M/S**
How does the plan determine an adequate number of providers in the network? Are there differences by specialty?	Pharmacy: 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: A member would have to pay out of pocket and request coverage via a DMR or manual claim. IP/OP/EC: RMHP Contracts with all willing inpatient facilities and regularly measure adequacy against State benchmarks and reports those results to the State quarterly.	Pharmacy: 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: A member would have to pay out of pocket and request coverage via a DMR or manual claim. IP/OP/EC: RMHP Contracts with all willing inpatient facilities and regularly measure adequacy against State benchmarks and reports those results to the State quarterly.
What process does the plan follow for maintaining network adequacy?	Pharmacy: Creating a broad and inclusive network is important to ensure access to our Members. Optum Specialty and Optum Home Delivery add value and streamlines the process for our Members to access specialty drugs and delivery services. Having more than one vendor for Specialty (with the exception of limited distribution drugs) and Home Delivery can cause some confusion for both the Members and prescribers attempting to utilize these services IP/OP/EC: RMHP Contracts with all willing providers and regularly measures adequacy against State benchmarks	Pharmacy: Creating a broad and inclusive network is important to ensure access to our Members. Optum Specialty and Optum Home Delivery add value and streamlines the process for our Members to access specialty drugs and delivery services. Having more than one vendor for Specialty (with the exception of limited distribution drugs) and Home Delivery can cause some confusion for both the Members and prescribers attempting to utilize these services IP/OP/EC: RMHP Contracts with all willing providers and regularly measures adequacy against State benchmarks and reports those results to the State quarterly. Network adequacy is measured and

NETWORK ADEQUACY DETERMINATION SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
	and reports those results to the State quarterly. Network adequacy is measured and reported annually to our Network Advisory Committee.	reported annually to our Network Advisory Committee.
How frequently does the plan report on network adequacy?	Pharmacy: Quarterly IP/OP/EC: Network reports are supplied to the State on a quarterly basis.	Pharmacy: Quarterly IP/OP/EC: Network reports are supplied to the State on a quarterly basis.
What strategies does the plan use to address identified deficiencies in the network?	Pharmacy: Attempt to contract any pharmacy in the area that is determined to be inadequate. If there are no pharmacies available, make the Members aware of mail order opportunity. IP/OP/EC: RMHP Contracts with all willing inpatient facilities and regularly measure adequacy against State benchmarks. RMHP works with various community stakeholders in an effort to expand services where needed.	Pharmacy: Attempt to contract any pharmacy in the area that is determined to be inadequate. If there are no pharmacies available, make the Members aware of mail order opportunity. IP/OP/EC: RMHP Contracts with all willing inpatient facilities and regularly measure adequacy against State benchmarks. RMHP works with various community stakeholders in an effort to expand services where needed.

Network Adequacy Determination

Findings: Scenario 2

The policies and procedures regarding network adequacy determination include determining adequacy, maintaining adequacy, reporting, and strategies to address deficiencies. These policies and procedures for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice. As required in contract, all plans report on network adequacy to the Department quarterly.

It is determined that these policies and procedures are parity compliant.

Scenario 3: Network Adequacy Determination

NETWORK ADEQUACY DETERMINATION **SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS**					
QUESTION	**RAE 1 MH/SUD**	**RAE 2&4 MH/SUD**	**RAE 3&5 MH/SUD**	**RAE 6&7 MH/SUD**	**DEPARTMENT M/S**
Which benefit classifications do you have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP, OP, EC	IP, OP, EC	IP, OP, EC	IP, OP, EC	IP, OP, EC
How does the plan determine an adequate number of providers in the network? Are there differences by specialty?	RMHP Contracts with all willing inpatient facilities and regularly measure adequacy against State benchmarks and reports those results to the State quarterly.	The plan monitors the network to ensure there is sufficient providers in the network to meet the requirements of the members for access to care to serve all behavioral health needs and allow for member freedom of choice.[60]	Within the comprehensive Network Adequacy report is the Geoaccess report that calls out specialties that are not meeting member to provider time and distance standards and member to provider ratio standards. This is a baseline to our recruitment	CCHA conducts quarterly Network Adequacy reviews as required by HCPF to ensure we have a robust behavioral health network. If our network is deficient in any geographic area or deficient in a provider type, CCHA works to ensure members are able to receive medically	Regional comparisons by county, year-over-year comparisons, multiple metrics as a whole, and stakeholder feedback. The process also looks to ensure adequate specialty providers.

[60] The following network adequacy factors are considered: Anticipated Medicaid enrollment; Expected utilization of services, characteristics and health needs of specific Medicaid populations in the region; Numbers, types, and specialties of network providers required to furnish the contracted Medicaid services; Number of network providers accepting new Medicaid members; Geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members; Ability of providers to communicate with limited-English-proficient members in their preferred language; Ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities; Availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions.

NETWORK ADEQUACY DETERMINATION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
			activity. There are differences in specialties. SUD providers continue to be unmet according to standards and there is an ongoing effort to recruit more providers and add levels of care with current providers.	necessary services as no cost to them, whether through an out-of-network provider, telemedicine, etc. Contractual network deficiency requirement- if our network is deficient in any way we have to alert the state with a notice and a remediation plan. If gaps in the existing network are identified, the Behavioral Health Provider Recruitment Strategy (policy) would be leveraged to bridge gaps.	
What process does the plan follow for maintaining network adequacy?	RMHP Contracts with all willing providers and regularly measures adequacy against State benchmarks and reports those results to the State quarterly. Network adequacy	NHP/HCI creates and maintains fee schedules with Medicaid appropriate rates, uses available tools to determine usual and customary rates including, but not limited to, Colorado	Two workgroups established to address network adequacy. The provider maintenance and retention workgroup work on keeping current contracted providers up-to-	CCHA monitors and tracks changes in the network that could affect sufficiency of service delivery, availability, or provider capacity on an ongoing basis. CCHA notifies HCPF when network	Consistent evaluation, engagement, and intervention when necessary

NETWORK ADEQUACY DETERMINATION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
	is measured and reported annually to our Network Advisory Committee.	Fee For Services Medicaid Rates, CMS Reimbursement Rates, or market standards. NHP/HCI may negotiate rates, where appropriate, to ensure Members have access to covered services. NHP/HCI monitors compliance to access standards by conducting outbound calls to practices to audit appointment availability.	date. The provider recruitment workgroup works specifically on recruiting providers identified as needed through the provider network adequacy assessment, internal request from Care Management, Utilization Management, or external request/referral from providers, members, etc	changes are significant and result in a deficiency within the network.	
How frequently does the plan report on network adequacy?	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly
What strategies does the plan use to address identified deficiencies in the network?	RMHP Contracts with all willing inpatient facilities and regularly measure adequacy against State benchmarks. RMHP works with various community stakeholders in an	NHP/HCI reviews network adequacy to ensure the availability of behavioral health care providers	Direct outreach to providers in specialties identified as deficient.	If gaps in the existing network are identified, the Behavioral Health Provider Recruitment Strategy (policy) would be leveraged to bridge gaps.	The strategies used depend on the data and conclusions.

NETWORK ADEQUACY DETERMINATION SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
	effort to expand services where needed.	within its delivery system.[61]			

Network Adequacy Determination

Findings: Scenario 3

The policies and procedures regarding network adequacy determination include determining adequacy, maintaining adequacy, reporting, and strategies to address deficiencies. These policies and procedures for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. As required in contract, all plans report on network adequacy to the Department quarterly.

It is determined that these policies and procedures are parity compliant.

[61] NHP/HCI: Defines the types of behavioral health care practitioners and providers in its delivery system; Uses an updated and accurate list, in assessing the number of providers with expertise in key culturally based populations; Uses quantifiable and measurable standards for the number of members, by county, through the enrollment file, within the key population groups; Has quantifiable and measurable standards for the geographic distribution of providers. Analyzes performance against the standards annually; Determining any existing gap by a comparison of availability of providers as well as reviewing findings in Member and Family Affairs surveys or through contacts/surveys with advocacy organization of key populations (for examples children in foster care)

Scenario 4: Network Adequacy Determination

NETWORK ADEQUACY DETERMINATION **SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO**		
QUESTION	**MH/SUD**	**M/S**
Which benefit classifications do you have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP, OP, EC, PD	IP, OP, EC, PD
How does the plan determine an adequate number of providers in the network? Are there differences by specialty?	Within the comprehensive Network Adequacy report is the Geoaccess report that calls out specialties that are not meeting member to provider time and distance standards and member to provider ratio standards. This is a baseline to our recruitment activity. There are differences in specialties. SUD providers continue to be unmet according to standards and there is an ongoing effort to recruit more providers and add levels of care with current providers.	DHMC is compliant with the HCPF the quarterly network adequacy reporting requirements. The comprehensive report includes Geoaccess to review time and distance standards to provider offices as well as provider to member ratios. The report includes a variety of different provider types.
What process does the plan follow for maintaining network adequacy?	Two workgroups established to address network adequacy. The provider maintenance and retention workgroup work on keeping current contracted providers up-to-date. The provider recruitment workgroup works specifically on recruiting providers identified as needed through the provider network adequacy assessment, internal request from Care Management, Utilization Management, or external request/referral from providers, members, etc	The quarterly network adequacy reports are discussed during the bi-monthly Network Management Committee (NMC) meeting. The NMC reviews all aspects of network adequacy that includes requests to the utilization management team, care management team, health plan services team, and the grievances and appeals team. DHMC utilizes CAHPS surveys to understand the perception of members regarding network adequacy. Based on the committee review, if an area is determined to be deficient, the Provider Relations team will identify and outreach to providers that provide the service of the deficiency.
How frequently does the plan report on network adequacy?	Quarterly	Quarterly

NETWORK ADEQUACY DETERMINATION **SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO**		
QUESTION	**MH/SUD**	**M/S**
What strategies does the plan use to address identified deficiencies in the network?	Direct outreach to providers in specialties identified as deficient.	The Provider Relations team will identify and outreach to providers that provide the service of the deficiency.

Network Adequacy Determination

Findings: Scenario 4

The policies and procedures regarding network adequacy determination include determining adequacy, maintaining adequacy, reporting, and strategies to address deficiencies. These policies and procedures for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice. As required in contract, all plans report on network adequacy to the Department quarterly.

It is determined that these policies and procedures are parity compliant.

Appendix N - Out-Of-Network Provider Access Standards

Description: Policies and protocols that health plans utilize to ensure participant timely access and medically-necessary care when unavailable through in-network providers.

Tools for Analysis: Data request, interviews with health plan staff, and policies/procedures documents referencing out-of-network provider policies and procedures to include timely access to medically-necessary services, and utilization and frequency of single case agreements.

Summary of Results: The following table illustrates the characteristics of each scenario including health plans being compared, applicable benefit categories, whether differences were found in the analysis, and compliance finding.

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

Results by Scenario: On the following pages, each scenario is expanded into an overview of primary policies that impact this NQTL.

Scenario 1: Out-Of-Network Provider Access Standards

OUT-OF-NETWORK PROVIDER ACCESS STANDARDS SCENARIO 1: DEPARTMENT FFS		
QUESTION	**MH/SUD**	**M/S**
Which benefit classifications do you have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP, OP, EC	IP, OP, EC
Can both a Member and a provider make the request for out-of-network services?	Yes	Yes
What criteria are necessary for the plan to allow out-of-network providers to bill for services?	For non-emergent IP hospital services in out-of-network hospitals to be allowed, the services must not be available in Colorado.[62]	For non-emergent IP hospital services in out-of-network hospitals to be allowed, the services must not be available in Colorado.[63]
What process does the plan have for out-of-network providers to bill for services?	Enrollment. Providers must be enrolled for payment. The Department can walk them through enrollment if it's urgent.	Enrollment. Providers must be enrolled for payment. The Department can walk them through enrollment if it's urgent.

Out-Of-Network Provider Access Standards

Findings: Scenario 1

The policies and procedures regarding out-of-network provider access standards include requesting services, criteria for allowing out-of-network services, and process for billing services. These policies and procedures for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 2: Out-Of-Network Provider Access Standards

OUT-OF-NETWORK PROVIDER ACCESS STANDARDS SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
Which benefit classifications do you have services subject to this NQTL? (inpatient,	IP, OP, EC, PD. Benefit levels for out of network services are the same for all	IP, OP, EC, PD. Benefit levels for out of network services are the same for all services

[62] The term in-network and out-of-network is not used by FFS UM since the ColoradoPAR program serves the entire state of Colorado and look at in-state and out-of-state (OOS) providers. Some border facilities are considered in-state. Both OOS and in-state providers need to be enrolled with Medicaid to bill for services and the authorization policies are the same.
[63] Ibid.

OUT-OF-NETWORK PROVIDER ACCESS STANDARDS SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO		
QUESTION	**MH/SUD**	**M/S**
outpatient, emergency care, prescription drugs)	services with the exception of urgent/emergent care which is always covered.	with the exception of urgent/emergent care which is always covered.
Can both a Member and a provider make the request for out-of-network services?	Pharmacy: No, only Members IP/OP/EC: Yes	Pharmacy: No, only Members IP/OP/EC: Yes
What criteria are necessary for the plan to allow out-of-network providers to bill for services?	Pharmacy: N/A Urgent and Emergent Care is always allowed Out of Network. Additionally, if a service is not available within network, out of network services will be allowed and also in situations of continuity of care.	Pharmacy: N/A Urgent and Emergent Care is always allowed Out of Network. Additionally, if a service is not available within network, out of network services will be allowed and also in situations of continuity of care.
What process does the plan have for out-of-network providers to bill for services?	Pharmacy: N/A Urgent and Emergent Care can be billed in all cases. Out of Network care must be prior authorized. In some cases, a Single Case Agreement will be negotiated.	Pharmacy: N/A Urgent and Emergent Care can be billed in all cases. Out of Network care must be prior authorized. In some cases, a Single Case Agreement will be negotiated.

Out-Of-Network Provider Access Standards

Findings: Scenario 2

The policies and procedures regarding out-of-network provider access standards include requesting services, criteria for allowing out-of-network services, and process for billing services. These policies and procedures for MH/SUD services are the same as the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 3: Out-Of-Network Provider Access Standards

OUT-OF-NETWORK PROVIDER ACCESS STANDARDS SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
Which benefit classifications do you have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP, OP, EC	IP, OP, EC	IP, OP, EC	IP, OP, EC	IP, OP, EC
Can both a Member and a provider make the request for out-of-network services?	Yes	Yes	Yes	Yes	Yes
What criteria are necessary for the plan to allow out-of-network providers to bill for services?	Urgent and Emergent Care is always allowed Out of Network. Additionally, if a service is not available within network, out of network services will be allowed and also in situations of continuity of care.	The provider must meet criteria to serve a member as an out-of-network provide: Medicaid enrolled, meets credentialing and quality standards, and accepts reasonable reimbursement for services. The behavioral health provider must sign a Single Case Agreement with	If COA is unable to accommodate the request for services with a network provider (e.g., due to geography, provider specialty, or continuity of care), then the services are authorized for the out-of-network provider. This is consistent with industry standards.	CCHA allows out-of-network providers to bill for services if a member requires a medically necessary service that is not available from an in-network provider.	For non-emergent inpatient hospital services in out-of-network hospitals to be allowed, the services must not be available in Colorado.[64]

[64] The term in-network and out-of-network is not used by FFS UM since the ColoradoPAR program serves the entire state of Colorado and look at in-state and out-of-state (OOS) providers. Some border facilities are considered in-state. Both OOS and in-state providers need to be enrolled with Medicaid to bill for services and the authorization policies are the same.

OUT-OF-NETWORK PROVIDER ACCESS STANDARDS SCENARIO 3: RAE 1-7 AND DEPARTMENT FFS					
QUESTION	RAE 1 MH/SUD	RAE 2&4 MH/SUD	RAE 3&5 MH/SUD	RAE 6&7 MH/SUD	DEPARTMENT M/S
		agreed upon reimbursement rates and services for execution.			
What process does the plan have for out-of-network providers to bill for services?	Urgent and Emergent Care can be billed in all cases. Out-of-network care must be prior authorized. In some cases, a Single Case Agreement will be negotiated.	Out-of-network providers are required to follow standard billing process including timely filing timeframes and claims submission process for all providers. The provider is required to follow the Department's Uniform Services Coding Standards.	COA requires PAR for all services rendered with an out-of-network provider. If the COA is unable to accommodate the request for services with a network provider (e.g., due to geography, provider specialty, or continuity of care), then the services are authorized for the out-of-network provider. This is consistent with industry standards.	Out-of-network providers are issued an OON agreement if they agree to CCHA's rate schedule. If they do not agree, CCHA will issue a Single Case Agreement for the negotiated rate.	Enrollment. Providers must be enrolled for payment. The Department can walk them through enrollment if it's urgent.

Out-Of-Network Provider Access Standards

Findings: Scenario 3

The policies and procedures regarding out-of-network provider access standards include requesting services, criteria for allowing out-of-network services, and process for billing services. These policies and procedures for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Scenario 4: Out-Of-Network Provider Access Standards

OUT-OF-NETWORK PROVIDER ACCESS STANDARDS SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO		
QUESTION	**MH/SUD**	**M/S**
Which benefit classifications do you have services subject to this NQTL? (inpatient, outpatient, emergency care, prescription drugs)	IP, OP, EC, PD	IP, OP, EC, PD
Can both a Member and a provider make the request for out-of-network services?	Yes	Yes
What criteria are necessary for the plan to allow out-of-network providers to bill for services?	If COA is unable to accommodate the request for services with a network provider (e.g., due to geography, provider specialty, or continuity of care), then the services are authorized for the out-of-network provider. This is consistent with industry standards.	There are instances in which a member may retain their out of network provider (e.g., pregnant women with established care already in their second or third trimester). Additionally, if DHMC is unable to accommodate the request for services with a network provider (e.g., due to geography, provider specialty), then the services are authorized for the out-of-network provider.
What process does the plan have for out-of-network providers to bill for services?	COA requires PAR for all services rendered with an out-of-network provider. If the COA is unable to accommodate the request for services with a network provider (e.g., due to geography, provider specialty, or continuity of care), then the services are authorized for the out-of-network provider. This is consistent with industry standards.	DHMC requires PAR for all services rendered with an out-of-network provider.

Out-Of-Network Provider Access Standards

Findings: Scenario 4

The policies and procedures regarding out-of-network provider access standards include requesting services, criteria for allowing out-of-network services, and process for billing services. These policies and procedures for MH/SUD services are substantially similar to the policies and procedures of M/S services, and follow standard industry practice.

It is determined that these policies and procedures are parity compliant.

Appendix O - 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
FFS	Established by contract with the FFS UM vendor. The definition for medical necessity is mandated by the State and the criteria are agreed to in contract. Specifics of InterQual's proprietary medical necessity criteria is not publicly available. But for MH/SUD, PBT criteria is accessible on the Department's website and made available to enrollees, potential enrollees, and contracting providers upon request.	The Colorado Medicaid member handbook delineates the policy and process for notifying members of the reason for denial of payment. *For any decision that affects Colorado Medicaid coverage or services, providers and members receive a letter. The letter is called a* ***Notice of Action*** *or a* ***Notice of Adverse Benefit Determination****. It tells members what the decision is, why the decision was made, and how to appeal if members disagree.* *For members under age 21, any medical necessity denial states how the member did not meet any requirements under EPSDT.*
RAE 1	The process and criteria for medical necessity decision-making is delineated in the RMHP Provider Manual – Care Management Decision Making section.	
RAE 2 & 4	The Beacon Health Options manual states: *"Beacon's clinical criteria, also known as medically necessary criteria, are based on nationally recognized resources, including but not limited to, those publicly*	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*

CATEGORY	CRITERIA FOR MEDICAL NECESSITY	REASONS FOR DENIAL
	disseminated by the American Medical Association (AMA), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), MCG (formerly known as Milliman Care Guidelines), and the Centers for Medicare and Medicaid Services (CMS). For management of substance use services, Beacon uses ASAM criteria. Beacon's medically necessary criteria are reviewed at least annually, and during the review process, Beacon will leverage its Scientific Review Committee to provide input on new scientific evidence when needed. Medical necessity criteria is reviewed and approved by Beacon's Corporate Medical Management Committee (CMMC) and the Executive Oversite Committee (EOC). *Beacon Provider Clinical Tools* *Network providers are given an opportunity to comment or give advice on development or adoption of UM criteria and on instructions for applying the criteria. These comments and opinions are solicited through practitioner participation on committees and through provider requests for review.* *Beacon facilitates discussions with outside senior consultants in the field as well as other practicing professionals. Beacon also leverages various criteria sets from other utilization management organizations and third-party*	*receive a letter. The letter is called a* ***Notice of Action*** *or a* ***Notice of Adverse Benefit Determination****. It tells members what the decision is, why the decision was made, and how to appeal if members disagree.*

CATEGORY	CRITERIA FOR MEDICAL NECESSITY	REASONS FOR DENIAL
	payers. In addition, Beacon disseminates criteria sets via the website, provider manual, provider forums, newsletters, and individual training sessions. Upon request, members are provided copies of Beacon's medical necessity criteria free of charge. *Medically necessary criteria may vary according to individual state and/or contractual requirements and member benefit coverage. Use of other substance use criteria other than ASAM is required in some jurisdictions.* *Access to the Beacon's medical necessity criteria is available on the website. Visit the ASAM website to order a copy of the ASAM criteria."*	
RAE 3 & 5	COA policy CCS302 outlines the procedures for making medical necessity criteria readily available to beneficiaries and providers. *A. All Utilization Review criteria are available to members, potential members, and affected practitioners upon request.* *New or revised criteria are published and disseminated in the applicable provider manuals and on the company web page.*	COA policy CCS302 outlines the procedures for notifying members of denial of reimbursement or payment, as well as the reason for denial. *All adverse benefit determination notifications sent to members and providers include instructions on how to obtain a copy of the criteria used in the review.*
RAE 6 & 7	CCHA adopts federal and State of Colorado laws and regulations that pertain to the rights of members and ensure 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. *A. All Utilization Review criteria are available to*	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*

CATEGORY	CRITERIA FOR MEDICAL NECESSITY	REASONS FOR DENIAL
	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.	*providers include instructions on how to obtain a copy of the criteria used in the review.*