# Mental Health and Substance Use Disorder Parity Report

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

**June 1, 2025**

**Submitted to: Colorado State Senate Health and Human Services Committee and House Health and Human Services Committee**

COLORADO
Department of Health Care Policy & Financing

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# Acronyms

| Acronym | Definition |
|---|---|
| ACC | Accountable Care Collaborative |
| AL/ADLs | Aggregate Lifetime and Annual Dollar Limits |
| APR-DRG | All-Patient Refined Diagnosis Related Group |
| 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 |
| DRG | Diagnosis Related Group |
| FAQ | Frequently Asked Questions |
| FFS | Fee-For-Service |
| FR | Financial Requirement |
| HCI | Health Colorado, Inc |
| HSAG | Health Services Advisory Group |
| ICD | International Classification of Diseases |
| IHRP | Inpatient Hospital Review Program |
| IHT | Inpatient Hospital Transitions |
| IOP | Intensive Outpatient Programming |
| 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 |
| NHP | Northeast Health Partners |
| NQTL | Non-Quantitative Treatment Limitations |
| PHP | Partial Hospitalization Programming |
| PBM | Pharmacy Benefit Manager |
| PIHP | Prepaid Inpatient Health Plan |
| PCCM | Primary Care Case Management |
| QTL | Quantitative Treatment Limitation |
| RAC | Recovery Audit Contractor |
| RAE | Regional Accountable Entity |
| RMHP | Rocky Mountain Health Plans |
| RR | Retrospective Review |
| SUD | Substance Use Disorder |
| UM | Utilization Management |

# Executive Summary

The goal of parity is to make it no more difficult for people to access behavioral health benefits than to access physical health benefits. Behavioral health includes mental health and substance use disorder care (MH/SUD) and physical health includes medical and surgical care (M/S). Specifically, parity laws require that limitations applied to behavioral health within a benefit classification, such as inpatient, outpatient, emergency care, and pharmacy, should be comparable to and applied no more stringently than those used in the same physical health benefit classification. Differences are allowed at the individual service level if they are not more burdensome overall. The following report describes the annual analysis performed by the Colorado Department of Health Care Policy & Financing (HCPF) to ensure that parity standards are maintained statewide for all Health First Colorado (Colorado's Medicaid program) members.

HCPF created the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for State Fiscal Year 2024 – 2025 in accordance with Colorado Revised Statutes (C.R.S.) 25.5-5-421. MHPAEA is designed to ensure Medicaid Managed Care Organizations (MCOs) and Medicaid alternative benefit plans providing MH/SUD benefits apply limitations on those benefits that are comparable to and no more stringent than those limitations imposed upon 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 HCPF'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 when applicable. M/S services are paid FFS by HCPF'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).

HCPF follows a process to determine parity compliance that is based on the federal parity guidance outlined in the CMS parity toolkit, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs," and in accordance with the requirements in C.R.S. § 25.5-5-421. HCPF 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. HCPF's research on best practices has also led to improvements in data

gathering, reporting, and transparency. The process involves a full analysis of a detailed data request submitted by each RAE, MCO, and HCPF'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 an FFS M/S payment structure. HCPF 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 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. This includes a review of all changes to RAE, MCO, and FFS Utilization Management (UM) policies over the past year, which were all found to be in compliance.

HCPF'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 HCPF 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

HCPF 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, HCPF 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.**

Policy changes made by the MCEs since the 2024 Parity Report were minor in scope and did not impact the Medicaid system's compliance with federal and state parity requirements. Details are listed in the Parity Monitoring During Reporting Year section below.

### Availability of Information

Based on the information collected during HCPF's comparative analysis and the External Quality Review Audit, explained below, **the written policies of the RAEs and MCOs are verified to be 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.

## External Quality Review Audit

Health Services Advisory Group, Inc. (HSAG) performed the annual assessment of Colorado's seven RAEs' and two MCOs' policies and procedures in operation, through a review of inpatient and outpatient adverse benefit determination records. **Overall, six of the nine MCEs scored above 95 percent in calendar year (CY) 2024 record reviews, demonstrating the MCEs' strong adherence to prior authorization policies and procedures. Of the 9 MCEs:**

- Five MCEs either improved or remained consistent, with scores between 96 and 99 percent.
- The remaining four MCEs demonstrated a decline in performance from the previous year:
    - One MCE continued to show high compliance with a decline of 3 percentage points, resulting in an overall score of 97 percent.
    - The other three MCEs showed a significant decline with a decrease in overall score ranging between 9 and 15 percentage points.
- The average score decreased from 95 percent in the CY 2023 record reviews to 92 percent compliance score in CY 2024 record reviews.
- Out of 1446 applicable elements, the MCEs combined to successfully meet 1334.

HCPF shared the findings of the report with all MCEs and is working with the MCEs to improve compliance. See the following HCPF Addendum to EQR Audit Finding section for an overview of those goals and follow up actions.

### HCPF Addendum to EQR Audit Findings

HCPF met with the vendor who administers utilization management for the three regions that saw significant declines in performance. The primary reasons for their missing elements were connected to not sending a notice of adverse benefit determination (NABD) to the member when the denial was labeled as an administrative denial and not including the clinical

determination. In each situation where a NABD was not sent, the MCEs lost multiple points for failing related elements: NABD was not sent to member within the required timeframe, NABD did not include the required content, and the reason for denial in the utilization management system was not consistent with the reason the member was provided in the NABD.

**In each situation identified, services had already been rendered to the member, so this did not prevent a member from getting care**. A notice was not sent to the member to avoid any unnecessary confusion for that member. The interactions were between the RAE and provider related to payment. Regulation and CMS guidance related to the proper notification sent to members is unclear and has historically been a point of discussion between HCPF, MCEs, and HSAG.

The following information was shared by HSAG with the UM vendor and HCPF regarding procedures around administrative denials:

- Definition of NABD – Written notice to the member and notification to the requesting provider is required per 42 CFR 438.210.c. for any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- In 2020, CMS clarified that the only exception to sending the member a NABD is for a clean claim issue. This update is present in 42 CFR 438.400.b.3. "The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) of this chapter is not an adverse benefit determination."
- 2018 discussion of the proposed rule change – examples of purely administrative clean claim issues: "missing the NPI, missing the enrollee's sex, or because the claim is a duplicate".

**Action Plan:** HCPF met with the MCE to discuss the findings and to understand more about the processes followed that resulted in missed scoring elements. HCPF also met with HSAG to understand more about the regulation and CMS guidance that had led to the confusion. HCPF determined that existing state guidance could be contributing to inconsistent reporting. From these conversations, HCPF made the decision to perform thorough review of federal regulation, CMS guidance, and any other source of requirements and best practices in order to create a clear statewide policy to be followed by all MCEs. From this review, HCPF will establish clear requirements and processes related to administrative, technical, and medical denials, and will create guidance documentation to ensure MCEs have full understanding of expectations. The MCE has agreed to update their policies to reflect HCPFs requirements and processes and will fully train all involved staff on the new policies. HCPF has made clear that once in place, the MCE is expected to demonstrate compliance with these new written policies. All policy documents and resources will be shared with HSAG for alignment with future external quality review mental health parity audits and to be reflected in the resulting reports.

The full HSAG External Quality Review Analysis can be found on HCPF's Parity webpage.

# Introduction

The Colorado Department of Health Care Policy & Financing (HCPF) created the annual Mental Health Parity and Addiction Equity Act (MHPAEA) Report for state fiscal year 2024 – 2025 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 Organizations (MCOs) to ensure mental health and substance use disorder (MH/SUD or behavioral health) benefits are not managed more stringently than medical/surgical (M/S or physical health) benefits.

HCPF 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,"[1] 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.

For the purposes of the parity analysis, HCPF has adopted the current version (10) of the International Classification of Diseases, Clinical Modification (ICD-10-CM) as the standard for

[1] CMS Parity Toolkit.

defining MH/SUD services and M/S services. HCPF 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 is a registered bed patient in a hospital or facility and for whom the service duration is 24 hours or greater, 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 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 when applicable. M/S services are paid FFS by HCPF's fiscal agent. HCPF 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, HCPF 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 2025, there were 119,175 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 320,883 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, HCPF'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, HCPF compares managed care policies and procedures for a MH/SUD program against an M/S FFS program.

HCPF 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 of the 1915(b) waiver that HCPF can offer reimbursement for short-term inpatient mental health stays in Institutions for Mental Diseases, peer recovery services, clubhouse and drop-in centers, vocational services, and other alternative services. Substance use disorder stays in Institutions for Mental Diseases, authorized under an 1115 SUD Demonstration Waiver, are provided through the managed care program.

HCPF goes beyond federal requirements by conducting the MHPAEA comparative analyses across all members enrolled with the seven RAEs and the two MCOs. HCPF 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 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/SUD services, and M/S benefits through FFS (this is a service-by-service situation).<br><br><1% of all Medicaid members are in this scenario. | Member gets their inpatient and outpatient MH/SUD services, emergency MH/SUD services through a RAE (RMHP RAE) under a capitated rate and M/S benefits through an MCO (RMHP Prime MCO).<br><br>3% of all Medicaid members are in this scenario. | Member gets their inpatient and outpatient MH/SUD services, emergency MH/SUD services through a RAE under a capitated rate and M/S benefits through FFS.<br><br>89% of all Medicaid members are in this scenario. | Member gets their inpatient and outpatient MH/SUD services, emergency MH/SUD services through Denver Health PIHP under a capitated rate and M/S benefits through an MCO (DHMC).<br><br>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<br>MH/SUD = FFS | Med/Surg = FFS<br>MH/SUD = FFS | Med/Surg = FFS<br>MH/SUD = FFS | Pharmacy Benefit Manager (PBM) |
| **Scenario 2** | Med/Surg = MCO<br>MH/SUD = RAE | Med/Surg = MCO<br>MH/SUD = RAE | Med/Surg = MCO<br>MH/SUD = RAE | MCO Managed PBM |
| **Scenario 3** | Med/Surg = FFS<br>MH/SUD = RAE | Med/Surg = FFS<br>MH/SUD = RAE | Med/Surg = FFS<br>MH/SUD = RAE | PBM |
| **Scenario 4** | Med/Surg = MCO<br>MH/SUD = RAE | Med/Surg = MCO<br>MH/SUD = RAE | Med/Surg = MCO<br>MH/SUD = RAE | MCO Managed PBM |

## Tools and Resources to Collect and Analyze Required Data

HCPF 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). HCPF 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 HCPF's Utilization Management (UM) team to collect policy and procedural details 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.

The MHPAEA report is accurate and complete through March 1, 2025, and the policies and procedures detailed in the data requests received by HCPF were required to be accurate as of that date. 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.

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 HCPF 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

HCPF 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. HCPF analyzed differences in MH/SUD and M/S medical necessity determinations within the care delivery system. The full analysis can be found in the Medical Necessity Criteria Appendix below.

## Review Process for NQTLs

HCPF prepared a list of common NQTLs that may be in use by the RAEs and HCPF 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). HCPF also gathered feedback through stakeholder written comments, which HCPF used to inform the analysis by either affirming previously identified NQTLs or highlighting other areas that may require analysis. The final list included NQTLs applicable to categories such as medical management standards, network admission standards, and provider access. The list of NQTLs is unchanged from the previous year. HCPF will continue to monitor the health plans for any NQTLs, including those not listed in the report, and will address them specifically when they are found to be utilized.

The data request for the RAEs, MCOs, and HCPF's UM included the list of NQTLs identified and asked them to disclose 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 parity rule includes two requirements regarding the availability of information related to MH/SUD benefits:

- Criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries and affected contracting providers upon request.

- The reasons for any denial of reimbursement or payment for MH/SUD benefits must be made available to the beneficiary.

HCPF applies these requirements to all Colorado Medicaid members receiving MH/SUD benefits, whether through FFS, RAEs, or MCOs.

The criteria for medical necessity determinations are evaluated as part of HCPF's comparative analysis and each MCEs' criteria are detailed in the Medical Necessity Criteria Appendix below. The medical necessity criteria used by each MCE is identifiable publicly on their webpages.

The second part of these two parity requirements is monitored as part of the External Quality Review Audit performed annually by HSAG, where the MCEs are required to provide evidence of compliance. HSAG's five-phase assessment includes Document Request, Desk Review, Web-Based Interviews, Analysis, and Reporting to determine compliance. The full External Quality Review Audit can be found on HCPF's Parity webpage.

## 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**. If future financial, unit, or dollar limits are imposed, these limitations will 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, HCPF used the information provided in the data request and interviews with the RAEs, MCOs, and HCPF'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, there 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 C.R.S. § 25.5-5-421(4) by requiring HCPF 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 HCPF's Parity webpage.

# Stakeholder Engagement and Feedback

HCPF considers stakeholder feedback vital to the monitoring of MH/SUD parity. HCPF 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.

## Ongoing Opportunities for Engagement and Reporting Issues

HCPF provides various opportunities for the public to share information, including the following:

- A quarterly behavioral health policy hospital forum attended by the Colorado Hospital Association, urban and rural hospitals, and the RAEs.
- A monthly Institutes for Mental Disease (IMD) forum attended by free-standing psychiatric hospitals, facilities offering crisis stabilization, and the RAEs. As of February 2025, this narrowly focused forum has been merged with the broader behavioral health hospital forum.
- An annual SUD stakeholder forum, a part of Colorado's Expanding the Substance Use Disorder Continuum of Care Section 1115 Demonstration Waiver requirement to present the progress of the SUD benefit.
- Ongoing provider focused forums: quarterly SUD Provider Forum, monthly Safety Net Provider Forum (as of October 2024, this forum continued as monthly office hours), bi-monthly Crisis Services Forum (as of October 2024, this forum continued as office hours), monthly Independent Provider Network (IPN) Collaboration Webinar, and monthly IPN Office Hours.
- Communications and complaints received by the Office of Behavioral Health Ombudsman of Colorado.
- Provider and stakeholder outreach to HCPF staff directly.
- Grievances filed by members that have been escalated to HCPF.
- Managed care grievances filed by providers that have been escalated to HCPF.
- An electronic communication form for the independent provider network to provide written comments.

HCPF's behavioral health policy forum for the hospitals and the RAEs discusses behavioral health issues in hospital settings. Topics discussed in the last year have included a discussion on behavioral health crisis services in hospitals, behavioral health assessments in a hospital setting, integrating support professionals (i.e., Community Health Workers, Qualified Behavioral Health Assistants and Peer Support Professionals), and strategies and supports for successful dispositions. The last SUD stakeholder forum was held on October 16, 2024, and

had an attendance of 17.[2] The SUD Provider Forum discusses policies, changes and expectations of service delivery and billing in the SUD continuum of care, to ask questions, and to raise concerns. The IMD Forum was used to discuss access and reimbursement challenges providers face when providing care to members in need of intensive mental health support and psychiatric care while also meeting the requirements of the federal IMD exclusion. Topics discussed over the last year include care transitions and patient housing instability, barriers to care work review, authorization denials to lower levels of care, and patient acuity. Lastly, the communication form for the independent provider network allows providers to report to HCPF any outstanding issues or concerns they have with the MCEs. More information can be found in the HCPF behavioral health legislative request for information.[3]

## Annual Request for Written Public Comment

In addition to the ongoing communication routes to provide information, HCPF makes an electronic form available annually for stakeholders to share their concerns. HCPF received a total of five written comments submitted through the electronic form created specifically for this report. Two of the responses received were from providers, an additional two responses were from advocates, and the last response was from a representative of a hospital. All submissions that were received included comments that were relevant to Medicaid parity compliance. Most submissions included multiple comments on various topics.

Comments were shared about reimbursement rates, reimbursement for a member with dual diagnoses, network adequacy, prior authorization, NQTLs creating barriers to care, MH treatment for a specific population, SUD treatment in an emergency room, the suggestion for RAEs to have staff with psychiatric expertise, and administrative burden. Concerns that touched on parity-related topics were analyzed for compliance.

A comment shared that the “needs of older Colorado Adults are different than teens most often for mental health services” which did not raise to the level of a parity concern. There was a comment about SUD treatment in an emergency room shared that they’ve seen an “M1 hold lifted and then left without medical advice designation” in which patients will often walk out did not raise to the level of a parity concern. The comment suggesting that “the new RAE format needs a psych team with background in community and behavior disorders” did not raise to the level of a parity concern. The RAEs are required to have utilization management personnel that include behavioral health professionals. To learn more about the ACC Phase III program and RAE contracts, see the ACC Phase III webpage. Comments on the administrative burden of “enormous data reporting requirements for behavioral health providers (required by statute and BHA regulation)” did not raise to the level of a parity concern; however, HCPF continuously engages in efforts to reduce burden for providers. For example, HCPF participated in an Administrative Burden workgroup led by the Behavioral Health Administration. One of the meetings focused on reducing the administrative burden caused by Colorado Client Assessment Record, and Drug and Alcohol Coordinated Data System reports.[4] A comment was shared on the billing of a covered diagnosis for “children who have

[2] Colorado Fourth Annual Substance Use Disorder Stakeholder Forum

[3] 2024 Response to a Request from the Colorado General Assembly

[4] October 2023 BHA Administrative Burden: CCAR/DACODS Modernization presentation

more than one condition;" for example, "if a child comes to the emergency room to be treated for an attempted suicide, that primary condition is related to behavioral health and even if the patient is treated for complex medical needs because of the attempted suicide, providers are only reimbursed for the mental health services." This comment did not escalate to the level of a parity concern.

The comment on prior authorization shared that the RAEs "vary on requirements, forms, processes, and contacts for prior authorization" for inpatient and partial hospitalization behavioral health services. An example was provided where "one RAE requires authorization from the community mental health center in addition to the RAE". HCPF developed a process to assist providers with concerns or issues they may be experiencing with an MCE through a provider escalation form.[5] Prior authorization has been reviewed and it was determined that the prior authorization processes used by the RAEs 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. Details can be found in Appendix A - Prior Authorization. Comments on network adequacy shared that "agencies like Well Power and Aurora Mental Health are overloaded and unable to keep up with the demanding need especially for [adults with chronic mental health]", and that there is a "serious behavioral health crisis on the Western slope of Colorado" due to the closure of an inpatient behavioral health facility. A shortage of behavioral health providers does not constitute a violation of parity unless the shortage is due to a financial or non-quantitative treatment limitation on MH/SUD services that are disproportionately applied or facially disproportionate as compared with those applied to M/S services. Network provider admission and network adequacy determination were reviewed and it was determined that the RAE for this area of Colorado (RAE 1) maintains policies and protocols for admitting providers into their network and determining the sufficiency of the provider network for MH/SUD benefits are comparable and no more stringent than that used for M/S benefits in the same classification in writing and in operation. HCPF will continue efforts to improve our provider networks and improve member access to services.

Three comments were shared on reimbursement rates for MH/SUD providers being "insufficient to cover the cost of care". It has been reviewed and determined that the processes used by the RAEs to establish charges/reimbursement rates for MH/SUD benefits are comparable and no more stringent than that used for M/S benefits in the same classification in writing and in operation. Details can be found in Appendix K - Establishing Charges/Reimbursement Rates. Though HCPF has determined that the process to establish charges/reimbursement rates for MH/SUD benefits is in compliance with parity, HCPF continues to monitor changes in reimbursement rates, especially regarding the IPN. Comparison tables of average reimbursement rates for the limited set of behavioral health services reviewed for Commercial and Medicaid IPN providers can be found in the Action Plan Update.[6] Two comments shared that NQTLs "create barriers to care for patients, as well as administrative burden and expense to providers." The goal of NQTLs such as prior authorizations, concurrent review, medical necessity criteria, and medical appropriateness review are to ensure member access to medically necessary treatment, utilizing the least restrictive setting possible for care and avoiding unnecessary institutionalization, and

[5] Provider Escalation Request Form

[6] Action Plan Update on Medicaid Behavioral Health Reimbursement Rates

maintaining cost control savings for Colorado. Additionally, the goal is to ensure the delivery of efficient and effective health care, to reduce the misuse of inpatient services, and to promote high quality and safe patient care during the inpatient component of the care. Lastly, the purpose of UM programs is to prevent and identify fraud, waste and abuse. HCPF is directly involved with efforts to minimize obstructions to members accessing necessary care.

# Parity Monitoring During Reporting Year

In addition to the review and analysis of policies and procedures performed for the comprehensive annual MHPAEA Report, HCPF 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.

**This report reviewed all changes to RAE, MCO, and FFS UM policies and procedures over the past year and found them all to be in compliance.**

The following are some of the changes made over the reporting year that warranted a review for parity compliance.

- As of March 1, 2025, Rocky Mountain Health Plans transitioned from MCG to InterQual for utilization management[7]. The change applies to both RMHP RAE 1 and PRIME. The change aligns the plans with UnitedHealthcare medical prior authorization and notification requirements. No changes were made to behavioral health prior authorization and notification requirements.

  ✓ InterQual is a nationally recognized and industry standard UM system that is currently used by other RAEs. This change is compliant with parity rules and regulations.

During the 2025 Legislative Session, HCPF supported behavioral health bills in an effort to increase access to services and treatment. HCPF participated in the drafting of House Bill 25-1124 Universal Contracting Provision Requirements which changes the current requirements for contracts used by state agencies contracting for behavioral health services. HCPF supported Senate Bill 25-042 Behavioral Health Crisis Response Recommendations to create several new measures related to behavioral health, including a stakeholder group, new reporting requirements, and updated mental health care practices in the state.

[7] Rocky Mountain Health Plans to align with UnitedHealthcare clinical requirements. December 1, 2024.

# 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. This includes a review of all changes to RAE, MCO, and FFS UM policies over the past year which were all determined to be in compliance.

HCPF'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 HCPF 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

HCPF 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.**

Policy changes made by the MCEs since the 2024 Parity Report were minor in scope and did not impact the Medicaid system's compliance with federal and state parity requirements. Details are listed in the Parity Monitoring During Reporting Year section above.

## External Quality Review Analysis

HCPF contracts with Health Services Advisory Group, Inc. (HSAG) to perform an annual assessment of Colorado's seven RAEs and two MCOs, collectively referred to as "managed care entities (MCEs)" to determine whether each MCE has implemented and followed its own written policies, procedures, and organizational processes related to utilization management (UM) regulations. HSAG's FY 2024-2025 report contains findings from their audit of calendar year (CY) 2024 denial letter records for each MCE. The findings include 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 (NABDs) including required content, use of qualified clinicians when making denial decisions, peer-to-peer review, and use of established authorization criteria.

**Overall, six of the nine MCEs scored above 95 percent in calendar year (CY) 2024 record reviews, demonstrating the MCEs' strong adherence to prior authorization policies and procedures. Of the 9 MCEs:**

- Five MCEs either improved or remained consistent, with scores between 96 and 99 percent.
- The remaining four MCEs demonstrated a decline in performance from the previous year:
    - One MCE continued to show high compliance with a decline of 3 percentage points, resulting in an overall score of 97 percent.
    - The other three MCEs showed a significant decline with a decrease in overall score ranging between 9 and 15 percentage points.
- The average score decreased from 95 percent in the CY 2023 record reviews to 92 percent compliance score in CY 2024 record reviews.
- Out of 1446 applicable elements, the MCEs combined to successfully meet 1334.

For strengths, when additional clinical information was necessary to make a determination, five MCEs documented multiple attempts to outreach the provider for additional information. In some of these instances, the MCEs processed an extension to provide additional time for the provider to respond to the MCE's outreach attempts. In an effort to increase timely access to services, RAE 2 staff members reported assisting in building internet hubs with local libraries to provide members in rural areas with the ability to access telehealth services. CCHA staff members described how they collaborated with the HCPF to update policies ensuring that members admitted to inpatient levels of care in crisis but are later determined to have a non-covered diagnosis will continue to have their stay covered until they are stabilized and safe to discharge to a lower level of care. RMHP RAE 1 and Prime increased the passing interrater reliability (IRR) test score from 80 percent to 90 percent. RMHP staff members noted that this change occurred in preparation for transitioning from using Milliman Clinical Guidelines (MCG) to InterQual utilization review criteria for all MH determinations. Six MCEs documented proactive and/or timely referrals to care coordination to assist members with access to the right care, at the right time, in the right place.

However, three MCEs did not include the clinical criteria used when making a determination within the member letters. Additionally, the same three MCEs did not send an NABD to the member when the denial was labeled as an administrative denial. MCEs showed inconsistency in documenting denials for lack of information. Some MCEs document an administrative denial when there is a lack of adequate information to make a determination, other MCEs document lack of information as medical necessity denials. In some instances, MCEs were inconsistent in this categorization, documenting some lack of information denials as administrative and others as not medically necessary. Four MCEs did not consistently adhere to internal peer-to-peer review procedures by issuing a medical necessity denial determination to the member before the peer-to-peer review was completed. Eight of the MCEs did not consistently send the NABD to the member within the required time frame, despite having accurate policies

and procedures. Three MCEs did not consistently demonstrate outreach to the requesting provider to obtain additional information before issuing a denial related to a lack of adequate documentation to determine medical necessity. HSAG noted a trend of denials for outpatient psychological testing throughout multiple MCEs. MCE staff members reported that providers often raised questions regarding the process required by HCPF and MCE regarding this benefit, resulting in a high percentage of overall denials related to the psychological testing benefit.

HCPF shared the findings of the report with all MCEs and is working with the MCEs to improve compliance. See the following HCPF Addendum to EQR Audit Finding section for an overview of those goals and follow up actions.

## HCPF Addendum to EQR Audit Findings

HCPF met with the vendor who administers utilization management for the three regions that saw significant declines in performance. The primary reasons for their missing elements were connected to not sending a NABD to the member when the denial was labeled as an administrative denial and not including the clinical determination. In each situation where a NABD was not sent, the MCEs lost multiple points for failing related elements: NABD was not sent to member within the required timeframe, NABD did not include the required content, and the reason for denial in the utilization management system was not consistent with the reason the member was provided in the NABD.

**In each situation identified, services had already been rendered to the member, so this did not prevent a member from getting care.** A notice was not sent to the member to avoid any unnecessary confusion for that member. The interactions were between the RAE and provider related to payment. Regulation and CMS guidance related to the proper notification sent to members is unclear and has historically been a point of discussion between HCPF, MCEs, and HSAG.

The following information was shared by HSAG with the UM vendor and HCPF regarding procedures around administrative denials:

- Definition of NABD – Written notice to the member and notification to the requesting provider is required per 42 CFR 438.210.c. for any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- In 2020, CMS clarified that the only exception to sending the member a NABD is for a clean claim issue. This update is present in 42 CFR 438.400.b.3. “The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at § 447.45(b) of this chapter is not an adverse benefit determination.”
- 2018 discussion of the proposed rule change – examples of purely administrative clean claim issues: “missing the NPI, missing the enrollee’s sex, or because the claim is a duplicate”.

**Action Plan:** HCPF met with the MCE to discuss the findings and to understand more about the processes followed that resulted in missed scoring elements. HCPF also met with HSAG to

understand more about the regulation and CMS guidance that had led to the confusion. HCPF determined that existing state guidance could be contributing to inconsistent reporting. From these conversations, HCPF made the decision to perform thorough review of federal regulation, CMS guidance, and any other source of requirements and best practices in order to create a clear statewide policy to be followed by all MCEs. From this review, HCPF will establish clear requirements and processes related to administrative, technical, and medical denials, and will create guidance documentation to ensure MCEs have full understanding of expectations. The MCE has agreed to update their policies to reflect HCPFs requirements and processes and will fully train all involved staff on the new policies. HCPF has made clear that once in place, the MCE is expected to demonstrate compliance with these new written policies. All policy documents and resources will be shared with HSAG for alignment with future external quality review mental health parity audits and to be reflected in the resulting reports.

The full HSAG External Quality Review Analysis can be found on HCPF's Parity webpage.

# Appendices

Appendices A through O 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 to 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** | HCPF | 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. | ✓ Yes |

**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<br>SCENARIO 1: HCPF 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 for admission or medical necessity. IP PAR is focused on facilitating hospital notification of RAEs to facilitate complex discharges. The procedure codes selected are related to codes HCPF has specific coverage criteria for.<br>The APR-DRG and RAC systems function as a disincentive limiting inefficient services.[8] | No IP M/S services are subject to PAR for admission or medical necessity. IP PAR is focused on facilitating hospital notification of RAEs to facilitate complex discharges. The procedure codes selected are related to codes HCPF has specific coverage criteria for.<br>The APR-DRG and RAC systems function as a disincentive limiting inefficient services.[9] |
| **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?** | Yes, when no InterQual or MCG criteria is available. | Yes, when no InterQual or MCG criteria is available. |

[8] HCPF's FFS does not utilize PARs for admissions due to the framework of an inpatient All-Patient Diagnosis Related Group (APR-DRG) based reimbursement system. Conducting PARs interferes with the existing Recovery Audit Contractor (RAC) system that systematically audits claims. The RAC system retrospectively identifies potential payment errors in areas such as duplicate payments, fiscal intermediaries' mistakes, medical necessity, and coding and determines if documentation supports the inpatient versus observation status. The RAC system replaces the function of an admission or medical necessity PAR through the retrospective audit creating a potential of non-payment to a provider. Furthermore, the APR-DRG's payment based upon an average length of stay creates a disincentive for inefficiency of services. For MH/SUD services, an authorization process that occurs at both admission to an inpatient setting, and on a concurrent basis to determine the need for continued length of stay, is necessary to ensure efficiency of services due to claims being paid on a per diem basis.

[9] Ibid

[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<br>SCENARIO 1: HCPF FFS | | |
|---|---|---|
| QUESTION | MH/SUD | M/S |
| **Inpatient Services** | | |
| **IF YES: How frequently are those guidelines updated?** | Reviewed regularly and updated as evidence/best practices change. | Reviewed regularly and updated as evidence/best practices change. |

*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. IP PAR for both MH/SUD and M/S is the same and is focused on facilitating hospital notification of the RAEs to facilitate complex discharges.

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

| PRIOR AUTHORIZATION<br>SCENARIO 1: HCPF 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]<br><br>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 HCPF'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, gender affirming care 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<br>SCENARIO 1: HCPF 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?**<br>**IF YES: How frequently are those guidelines updated?** | Yes, when no InterQual or MCG criteria is available.<br>Reviewed regularly and updated as evidence/best practices change.<br>PBT is the only OP MH/SUD service subject to internally developed criteria | Yes, when no InterQual or MCG criteria is available.<br>Reviewed regularly and updated as evidence/best practices change.<br>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<br>SCENARIO 1: HCPF 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.<br><br>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.<br><br>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 whether to prior authorize pharmacy services?** | Internally developed guidelines are used. | Internally developed guidelines are used. |

[15] The Department of Health Care Policy & Financing Pharmacy Resources webpage.

[16] Ibid.

| PRIOR AUTHORIZATION<br>SCENARIO 1: HCPF FFS | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **Does the plan use internally developed guidelines to determine whether to prior authorize services?**<br>**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<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **Inpatient Services** | | |
| **Process** | | |

| PRIOR AUTHORIZATION<br>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 3.2WM and 3.7WM require PAR | All IP M/S services require PAR.[17] |
| **What is the maximum amount of time allowed to issue a determination on a prior authorization request?** | - IP MH or IP SUD (3.7) if member has not been placed: 72 hours<br>- IP MH or IP SUD (3.7) if the member has already been placed: 72 hours<br>- Special Connections 3.7 services whether the member has been placed or not: 24 hours[18] | All IP services: 72 hours |
| **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?** | InterQual for MH<br>ASAM for SUD | InterQual for M/S |
| **Does the plan use internally developed guidelines to determine whether to prior authorize services?**<br>**IF YES: How frequently are those guidelines updated?** | Yes. RMHP uses internally developed guidelines for some services.[19] | Yes. RMHP uses internally developed guidelines for some services. 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.

[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.

[18] If there is missing clinical information needed to make a medical necessity decision, an extension can be taken extending the turnaround time by 14 days. In most cases, an extension is not needed.

[19] There is an internally developed guideline for Eating Disorder Treatment, created in collaboration with HCPF. The policy was developed in response to Colorado Senate Bill 23-176.

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 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.<br>Some specialized, longer term, non-routine services do require PAR.[20] | Most services do not require PAR.<br>Some specialized, longer term, non-routine services do require PAR.[21] |
| **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?** | InterQual for MH<br>ASAM for SUD | InterQual for M/S |

[20] RAE 1 outpatient services that require prior authorization: ASAM 2.5, MH Partial Hospitalization Programming (PHP), and Electroconvulsive therapy (ECT). They are subject to PAR because some of them are longer term services and lend to being concurrently reviewed to ensure members are still meeting medical necessity.

[21] 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<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **Does the plan use internally developed guidelines to determine whether to prior authorize services?**<br>**IF YES: How frequently are those guidelines updated?** | No | Yes, in some situations to supplement InterQual criteria as needed. Updated annually at minimum. |

*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.

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<br>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<br>Any drug that has limits on coverage is eligible for an exception request. | Only a select set of pharmacy services are subject to PAR<br>Any drug that has limits on coverage is eligible for an exception request. |

| PRIOR AUTHORIZATION<br>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 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 whether to prior authorize pharmacy services?** | No | No |
| **Does the plan use internally developed guidelines to determine whether to prior authorize services?**<br>**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. There are substantially more M/S drugs impacted by limitations than MH/SUD drugs.

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

## Scenario 3: Prior Authorization

| PRIOR AUTHORIZATION<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **Inpatient Services** | | | | | |
| **Process** | | | | | |
| **Are services in this classification subject to prior authorization?** | All IP services except ASAM 3.2WM (H0010) and 3.7WM (H0011) require PAR | All IP services except ASAM 3.2WM (H0010) and 3.7WM (H0011) require PAR | All IP services except ASAM 3.2WM and 3.7WM require PAR[22] | All IP services except ASAM 3.2WM and 3.7WM require PAR | No IP M/S services are subject to PAR for admission or medical necessity. IP PAR is focused on facilitating hospital notification of RAEs to facilitate complex discharges. The procedure codes selected are related to codes HCPF has specific coverage criteria for.<br>The APR-DRG and RAC systems function as a disincentive limiting inefficient services.[23] |

[22] Inpatient WM (3.7WM) does not require prior authorization (per contract), but requires concurrent review after day four (4). 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.

[23] HCPF's FFS does not utilize PARs for admissions or CCRs for continued stays due to the framework of an inpatient All-Patient Diagnosis Related Group (APR-DRG) based reimbursement system. Conducting PARs and CCRs interferes with the existing Recovery Audit Contractor (RAC) system that systematically audits claims. The RAC system retrospectively identifies potential payment errors in areas such as duplicate payments, fiscal intermediaries' mistakes, medical necessity, and coding and determines if documentation supports the inpatient versus observation status. The RAC system

| PRIOR AUTHORIZATION<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **What is the maximum amount of time allowed to issue a determination on a prior authorization request?** | - IP MH or IP SUD (3.7) if member has not been placed: 72 hours<br>- IP MH or IP SUD (3.7) if the member has already been placed: 24 hours<br>- Special Connections 3.7 services whether the member has been placed or not: 24 hours[24] | 72 hours | 72 hours | 72 hours | 1 business day |
| **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** | | | | | |

replaces the function of an admission or medical necessity PAR through the retrospective audit creating a potential of non-payment to a provider. Furthermore, the APR-DRG's payment based upon an average length of stay creates a disincentive for inefficiency of services. For MH/SUD services, an authorization process that occurs at both admission to an inpatient setting, and on a concurrent basis to determine the need for continued length of stay, is necessary to ensure efficiency of services due to claims being paid on a per diem basis.

[24] If there is missing clinical information needed to make a medical necessity decision, an extension can be taken extending the turnaround time by 14 days. In most cases, an extension is not needed.

| PRIOR AUTHORIZATION<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize inpatient services?** | InterQual for MH<br>ASAM for SUD | InterQual for MH<br>ASAM for SUD | InterQual for MH<br>ASAM for SUD | MCG for MH<br>ASAM for SUD | InterQual and MCG for M/S |
| **Does the plan use internally developed guidelines to determine whether to prior authorize services?**<br>**IF YES: How frequently are those guidelines updated?** | Yes. RMHP uses internally developed guidelines for some services.[25]<br>Updated annually, at a minimum. | No | No | No | Yes, when no InterQual or MCG criteria is available.<br>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

[25] There is an internally developed guideline for Eating Disorder Treatment, created in collaboration with HCPF. The policy was developed in response to Colorado Senate Bill 23-176.

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.

While the APR-DRG + RAC system utilized for M/S services and the per diem + authorization system utilized for MH/SUD services are not the same, they both accomplish the same goals of ensuring member access to medically necessary treatment, utilizing the least restrictive setting possible for care and avoiding unnecessary institutionalization, and maintaining cost control savings for Colorado. They are both nationally recognized industry standards of practice. The requirements, processes, and rationale are comparable and applied no more stringently.

Therefore, it is determined that while these policies and procedures are not the same, they are compliant with parity regulations.

| PRIOR AUTHORIZATION<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **Outpatient Services** | | | | | |
| **Process** | | | | | |
| **Are services in this classification subject to prior authorization?** | Most services do not require PAR.<br>Some specialized, longer term, non-routine services do require PAR.[26] | Most services do not require PAR.<br>Some specialized, longer term, non-routine services do require PAR.[27] | Most services do not require PAR.<br>Some specialized, longer term, non-routine services do require PAR.[28] | Most services do not require PAR.<br>Some specialized, longer term, non-routine services do require PAR.[29] | Thousands of codes require PAR, including conditional PAR requirements.[30]<br>Some conditional PAR requirements exist in certain circumstances where a PAR would not be needed (ie: diapers under unit limit 250) - all are listed on the fee schedule. Services provided emergently would override a PAR requirement. |

[26] RAE 1 outpatient services that require prior authorization: ASAM 2.5, MH Partial Hospitalization Programming (PHP), and Electroconvulsive therapy (ECT). They are subject to PAR because some of them are longer term services and lend to being concurrently reviewed to ensure members are still meeting medical necessity.

[27] 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, psychological testing, and all E&M codes.

[28] 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.

[29] RAE 6 & 7 outpatient services that require prior authorization: RAE 6 & 7 outpatient services that require prior authorization: 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 97537, G0176, H0015, H0035, H0037, H0039, H0040, H0043, H0043, H2001, H2012, H2015, H2016, H2017, H2018, H2021, H2022, H2033, S5150, S5151, S9480.

[30] The utilization management vendor for HCPF'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, gender affirming care 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **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[31] | Yes.[32] |
| **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<br>ASAM for SUD | InterQual for MH<br>ASAM for SUD | InterQual for MH<br>ASAM for SUD | MCG for MH<br>ASAM for SUD | InterQual and MCG for M/S |
| **Does the plan use internally developed guidelines to determine whether to prior authorize services?**<br>**IF YES: How frequently are those guidelines updated?** | No | No | No | No | Yes. If no InterQual or MCG criteria is available, state-specific criteria, based on industry best practice and evidenced based research, is utilized. For any members aged 20 and |

[31] Standard request is 10 days for OP level so care. If it is a step-down from IP, 72 hours. An extension up to 14 days if the member or provider requests extension, or CCHA justifies a need for additional information and shows the extension is in the member's best interest. Note that Special Connections ASAM 3.1, 3.5, 3.7 have a 24 hour TAT.

[32] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | | | | | under, EPSDT guidelines and definition are utilized when determining a review outcome. 1328 REV codes and CPT codes utilize in whole or in part internal 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<br>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?** | No PAR is required for in-network[33] IP services.<br>All out-of-network care requires PAR except ASAM 3.2WM and 3.7WM | No PAR is required for in-network[34] IP care unless it is for Acute rehabilitation, bariatric surgery; blepharoplasty, breast procedures, chemical peels dermabrasion, electrolysis, intersex surgical remediation, penile implants and varicose veins.<br>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 | 72 hours for urgent admission. Elective surgery admissions/procedures is 10 days. |
| **Strategy** | | |
| **Are prior authorization policies the same for both in-network and out-of-network providers?** | Yes. However, IP services for DHMP members admitting to Denver Health Hospital do not require PAR. | No. Care at any out-of-network provider/facility requires PAR.<br>Surgical procedures provided at Denver Health Facility do not require PAR. Services provided at facilities outside of Denver Health Hospital require PAR. In or out-of-network providers must request PAR for Acute rehabilitation, bariatric surgery; blepharoplasty, breast procedures, chemical peels dermabrasion, electrolysis, intersex surgical remediation, penile implants and varicose veins. |
| **Evidentiary Services** | | |

[33] "In-network" refers to services provided at Denver Health facilities.

[34] Ibid

| PRIOR AUTHORIZATION<br>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 inpatient services?** | InterQual for MH<br>ASAM for SUD | MCG for M/S |
| **Does the plan use internally developed guidelines to determine whether to prior authorize services?**<br>**IF YES: How frequently are those guidelines updated?** | No | No |

*Prior Authorization*

## Findings: Scenario 4 – Inpatient Services

Prior authorization is used to ensure 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. Additionally, M/S requires PAR for a select set of in-network IP services. 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.

Authorization requirement policies for MH/SUD and M/S, as they apply to in-network and out-of-network services are the same.

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

| PRIOR AUTHORIZATION<br>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:<br>Acute Treatment unit, | In-network services subject to PAR:<br>DME rental and purchase if greater than $500, |

| PRIOR AUTHORIZATION<br>SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| | Mental health residential treatment,<br>SUD residential treatment,<br>Intensive Outpatient,<br>Partial hospitalization,<br>Psychological testing,<br>Electroconvulsive therapy,<br>Day treatment | Home health care days 31 until discharge,<br>Autism evaluation,<br>Early intervention services,<br>Enteral and oral nutrition supplements,<br>Genetic testing,<br>Outpatient therapy - days 31+ until discharge<br>Transplant evaluations and follow up care.<br>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 days for standard, 72 hours for urgent requests. |
| **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. Out-of-network refers to non-contracted providers. | No authorization is required for care at a Denver Health Facility. Care outside of Denver Health Facility requires authorization. |
| **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<br>ASAM for SUD | MCG, Hayes Knowledge Center, and Uptodate |
| **Does the plan use internally developed guidelines to determine whether to prior authorize services?**<br>**IF YES: How frequently are those guidelines updated?** | No | Yes. Oral/enteral nutrition; sleep apnea eval and treatment; hair prosthesis; Dental & anesthesia facility charges. 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.

Policies for MH/SUD and M/S, as they apply to in-network and out-of-network services, are substantially similar.

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

**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[35]. No PAR required for SUD/OUD medications. Exceptions are reviewed on a case by case basis. Medical exceptions are allowed to the PA when the requestor (provider) gives clinical rationale for why the medication is medically necessary | DHMC reviews for injectable or IV medications that are non-formulary.<br>OP M/S drugs: Not all are subject to PAR. See formulary. |
| **What is the maximum amount of time allowed to issue a determination on a prior authorization request?** | IP: 72 hours for urgent requests; 10 days for standard requests<br>OP: 24 hours | IP: 72 hours for urgent requests; 10 days for standard requests<br>OP: 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 | In-network requires review if medication is listed on the Specialty Infusion Grid. All |

[35] 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<br>SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| | | out of network always requires authorization. For OP pharmacy, policies are the same. |
| **Evidentiary Services** | | |
| **Does the plan use evidence-based clinical decision support products (InterQual, Milliman, etc.) to determine whether to prior authorize pharmacy services?** | Peer-reviewed medical literature, Accepted national treatment guidelines, Drug compendia in common use, Other authoritative medical sources, Expert opinion has been obtained where necessary. | Peer-reviewed medical literature, Accepted national treatment guidelines, Drug compendia in common use, Other authoritative medical sources, Expert opinion has been obtained where necessary. |
| **Does the plan use internally developed guidelines to determine whether to prior authorize services?**<br>**IF YES: How frequently are those guidelines updated?** | No | No |

*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** | HCPF | 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. | ✓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 | Yes. See tables below. | ✓ Yes |

**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<br>SCENARIO 1: HCPF 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 for continued stays. IP CCR is focused on facilitating hospital notification of RAEs to facilitate complex discharges. The procedure codes selected are related to codes HCPF has specific coverage criteria for.<br><br>The APR-DRG and RAC system functions as a disincentive limiting inefficient services.[36] | No IP M/S services are subject to CCR for continued stays. IP CCR is focused on facilitating hospital notification of RAEs to facilitate complex discharges. The procedure codes selected are related to codes HCPF has specific coverage criteria for.<br><br>The APR-DRG and RAC system functions as a disincentive limiting inefficient services.[37] |
| **How frequently is concurrent review required for services in this classification?** | 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?** | Yes[38] | Yes[39] |
| **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?** | 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? Does the** | Yes, when no InterQual or MCG criteria is available. | Yes, when no InterQual or MCG criteria is available. |

[36] HCPF's FFS does not utilize CCRs for continued stays due to the framework of an inpatient All-Patient Diagnosis Related Group (APR-DRG) based reimbursement system. Conducting CCRs interferes with the existing Recovery Audit Contractor (RAC) system that systematically audits claims. The RAC system retrospectively identifies potential payment errors in areas such as duplicate payments, fiscal intermediaries' mistakes, medical necessity, and coding and determines if documentation supports the inpatient versus observation status. The RAC system replaces the function of medical necessity through the retrospective audit creating a potential of non-payment to a provider. Furthermore, the APR-DRG's payment based upon an average length of stay creates a disincentive for inefficiency of services.

[37] Ibid

[38] 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.

[39] Ibid

| CONCURRENT REVIEW<br>SCENARIO 1: HCPF FFS | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **plan use internally developed guidelines to determine whether to concurrently review services?**<br>**IF YES: How frequently are those guidelines updated?** | Reviewed regularly and updated as evidence/best practices change. | Reviewed regularly and updated as evidence/best practices change. |

*Concurrent Review*

## Findings: Scenario 1 – Inpatient Services

Concurrent review is not used for inpatient fee-for-service MH/SUD or M/S services. Instead of CCR for continued stays, claims are paid based upon an average length of stay. A cost outlier payment may be added to reimbursement for exceptionally expensive cases, however the RAC system's retroactive audit functions to ensure appropriate services are utilized through the potential of non-payment. The policies and procedures applied to MH/SUD 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.

| CONCURRENT REVIEW<br>SCENARIO 1: HCPF 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.[40] | Services that are subject to PAR are subject to CCR.[41] |
| **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. |

[40] HCPF 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.

[41] Ibid.

| CONCURRENT REVIEW<br>SCENARIO 1: HCPF FFS | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **What is the maximum amount of time allowed to issue a determination on a concurrent review request?** | The UM Vendor has 10 business days to complete the review, upon receipt of all necessary documentation from the provider or facility. | The UM Vendor has 10 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?**<br>**IF YES: How frequently are those guidelines updated?** | Yes, when no InterQual or MCG criteria is available.<br>Reviewed regularly and updated as evidence/best practices change.<br>PBT is the only OP MH/SUD service subject to internally developed criteria | Yes, when no InterQual or MCG criteria is available.<br>Reviewed regularly and updated as evidence/best practices change.<br>1328 REV codes and CPT codes that utilize in whole 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. Furthermore, only one outpatient MH/SUD service is subject to CCR 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.

## Scenario 2: Concurrent Review

| CONCURRENT REVIEW<br>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. 3.7WM is CCR if member is in facility for > 5 days. | 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.<br>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.<br>Daily or less frequently, depending on clinical presentation and discharge planning need. |
| **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?** | InterQual for MH and ASAM for SUD | InterQual |
| **Does the plan use internally developed guidelines to determine whether to concurrently review services?**<br>**IF YES: How frequently are those guidelines updated?** | Yes, for some IP MH/SUD services. Updated annually at a minimum. | 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.[42]<br>ASAM 2.1, ASAM 2.5, MH IOP, MH PHP, ECT | All services that require PAR are subject to CCR.[43]<br>See PAR list for codes requiring PAR. |
| **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.<br>~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.<br>~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. |

[42] RMHP considers all OP CCR as new authorizations (PARs).

[43] Ibid

| CONCURRENT REVIEW<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **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<br>ASAM for SUD | InterQual |
| **Does the plan use internally developed guidelines to determine whether to concurrently review services?**<br>**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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **Inpatient Services** | | | | | |
| **Process** | | | | | |
| **Are services in this classification subject to concurrent review?** | All IP services that require PAR are subject to CCR.<br>2.1, MH IOP, MH PHP | All IP services that require PAR are subject to CCR[44] | 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[45])[46] | No IP M/S services are subject to CCR for continued stays. IP CCR is focused on facilitating hospital notification of RAEs to facilitate complex discharges. The procedure codes selected are related to codes HCPF has specific coverage criteria for.<br>The APR-DRG and RAC system functions as a disincentive limiting inefficient services.[47] |

[44] 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.

[45] 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

[46] CCHA considers all CCR as new authorizations (PAR), outside of the high intensity services.

[47] HCPF's FFS does not utilize CCRs for continued stays due to the framework of an inpatient All-Patient Diagnosis Related Group (APR-DRG) based reimbursement system. Conducting CCRs interferes with the existing Recovery Audit Contractor (RAC) system that systematically audits claims. The RAC system retrospectively identifies potential payment errors in areas such as duplicate payments,

| CONCURRENT REVIEW<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **How frequently is concurrent review required for services in this classification?** | ~3-7 days | ~3-5 days | ~3-7 days | ~2-3 days[48] | 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[49] | N/A |
| **Strategy** | | | | | |
| **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 | Yes[50] |
| **Evidentiary Services** | | | | | |

fiscal intermediaries' mistakes, medical necessity, and coding and determines if documentation supports the inpatient versus observation status. The RAC system replaces the function of medical necessity through the retrospective audit creating a potential of non-payment to a provider. Furthermore, the APR-DRG's payment based upon an average length of stay creates a disincentive for inefficiency of services.

[48] Frequency varies by the member's clinical presentation, but typically reviews are required every 2-3 days. CCHA medical necessity guidelines recommend courses of treatment based on diagnoses alongside outlier course of treatment that is monitored to ensure quality member treatment. Withdrawal management (3.2 WM and 3.7 WM) occurs at day 5 via statute. CCHA doesn't have any facilities on a DRG model, therefore they utilize MCG criteria. 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.

[49] 72 hours, or extended up to 14 days if the member or provider requests extension, or CCHA justifies a need for additional information and shows the extension is in the member's best interest.

[50] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **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<br>ASAM for SUD | InterQual for MH<br>ASAM for SUD | InterQual for MH<br>ASAM for SUD | MCG for MH<br>ASAM for SUD | The FFS UM Vendor uses InterQual and MCG |
| **Does the plan use internally developed guidelines to determine whether to concurrently review services?**<br>**IF YES: How frequently are those guidelines updated?** | Yes. RMHP uses internally developed guidelines for some services.[51] | No | No | No | Yes, when no InterQual or MCG criteria is available.<br>Reviewed regularly and updated as evidence/best practices change. |

*Concurrent Review*

## Findings: Scenario 3 – Inpatient Services

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

[51] There is an internally developed guideline for Eating Disorder Treatment, created in collaboration with HCPF. The policy was developed in response to Colorado Senate Bill 23-176.

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.

While the APR-DRG + RAC system utilized for M/S services and the per diem + authorization system utilized for MH/SUD services are not the same, they both accomplish the same goals of ensuring member access to medically necessary treatment, utilizing the least restrictive setting possible for care and avoiding unnecessary institutionalization, and maintaining cost control savings for Colorado. Instead of concurrent review for continued stays that is used for MH/SUD services, M/S claims are paid based upon an average length of stay. A cost outlier payment may be added to reimbursement for exceptionally expensive cases, however the RAC system's retroactive audit functions to ensure appropriate services are utilized through the potential of non-payment.

Both systems are nationally recognized industry standards of practice. The requirements, processes, and rationale are comparable and applied no more stringently.

Therefore, it is determined that while these policies and procedures are not the same, they are compliant with parity regulations.

| CONCURRENT REVIEW<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **Outpatient Services** | | | | | |
| **Process** | | | | | |
| **Are services in this classification subject to concurrent review?** | Only OP services subject to PAR are subject to CCR.[52] | Only OP services subject to PAR are subject to CCR.[53] | Only OP services subject to PAR are subject to CCR.[54] | Only OP services subject to PAR are subject to CCR.[55] | Only OP services subject to PAR are subject to CCR.[56] |
| **How frequently is concurrent review required for services in this classification?** | ~5-10 days | ~3-5 days, or when needed for a single case agreement | Depends on the service. 3-5 days for acute / short-term services, 7-30 days for long-term / intensive services[57] | ~1 week-6 months | The frequency of CCR depends on member presentation and progress made, and depending on the service. |
| **What is the maximum amount of time allowed to issue a determination** | 24 hours internal goal | 10 days for standard / 72 hours urgent | 10 days for standard / 72 hours urgent | 10 days for standard / 72 hours urgent | 10 business days |

[52] RAE 1 outpatient services that require prior authorization: MH services include 2.1, Intensive Outpatient Programing (IOP), Partial Hospitalization Programming (PHP). 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.

[53] 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, psychological testing, 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, or ECT.

[54] 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.

[55] RAE 6 & 7 outpatient services that require concurrent review: H0035 PHP, S9480 MH IOP, H0015 SUD IOP, H0016 SUD PHP, and H2012 BH Day Treatment. CCHA treats all codes listed in the initial PAR tab for outpatient as new incoming PARs rather than CCR.

[56] HCPF 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.

[57] 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: 10-30 days, Intensive Outpatient: 14-30 days, Partial hospitalization: 7-14 days, Electroconvulsive therapy: 14-60 days, Day treatment: 30 days

| CONCURRENT REVIEW<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **on a concurrent review request?** | (10 days standard / 72 hours urgent required) | | | | |
| **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[58] |
| **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 | 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 concurrently review services?**<br>**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, |

[58] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | | | | | 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 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.

Most MH/SUD services are not subject to CCR. Some specialized, longer term, non-routine services do require PAR such as intensive outpatient programming and partial hospitalization programming. They are concurrently reviewed to ensure the most effective level of treatment and medically necessary services are being provided. Thousands of M/S codes require PAR. The UM vendor for HCPF's FFS 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, gender affirming care 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. CCR is also required for M/S services subject to conditional PAR requirements (ie: diapers under unit limit 250).

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<br>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?** | In-Network, no review is performed and authorization is not required for initial or continued stay.<br>Out-of-Network, a CCR occurs if member requires care longer than the initial review period. | In-Network, no review is performed and authorization is not required for initial or continued stay.<br>Out-of-Network, a concurrent review occurs if member requires care longer than the initial review period. |
| **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. However, IP services for DHMP members admitting to Denver Health Hospital do not require authorization. | No authorizations required in-network except for certain procedures (listed in IP M/S PAR), 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?**<br>**IF YES: How frequently are those guidelines updated?** | No | No |

***Concurrent Review***

## Findings: Scenario 4 – Inpatient Services

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.

Authorization requirement policies for MH/SUD and M/S, as they apply to in-network and out-of-network services, are substantially similar and in some cases more restrictive for M/S.

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

**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:<br>Acute Treatment unit,<br>Mental health residential treatment,<br>SUD residential treatment,<br>Intensive Outpatient,<br>Partial hospitalization,<br>Electroconvulsive therapy,<br>Day treatment | In-network services subject to authorization:<br>DME rental and purchase if greater than $500,<br>Home health care greater than day 31-59,<br>Early intervention services.<br>Enteral and Oral Nutrition Supplements,<br>Outpatient Therapy - days 31+ until discharge<br>Transplant follow up care<br>All out-of-network services require authorization. |
| **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 |

| CONCURRENT REVIEW<br>SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| | | 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<br>ASAM for SUD | MCG, Hayes Knowledge Center, and Uptodate |
| **Does the plan use internally developed guidelines to determine whether to concurrently review services?**<br>**IF YES: How frequently are those guidelines updated?** | No | Oral/enteral nutrition and sleep apnea. 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.

Authorization requirement policies for MH/SUD and M/S, as they apply to in-network and out-of-network services are substantially similar.

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

# 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** | HCPF | 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 | ✓ Yes |

**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<br>SCENARIO 1: HCPF 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[59] | Yes[60] |
| **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?**<br>**IF YES: How frequently are those guidelines updated?** | Yes, when no InterQual or MCG criteria is available.<br>Reviewed regularly and updated as evidence/best practices change. | Yes, when no InterQual or MCG criteria is available.<br>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, HCPF'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

[59] 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.

[60] Ibid.

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<br>SCENARIO 1: HCPF 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 established 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 established 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?**<br>**IF YES: How frequently are those guidelines updated?** | Yes, when no InterQual or MCG criteria is available.<br>Reviewed regularly and updated as evidence/best practices change. | Yes, when no InterQual or MCG criteria is available.<br>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, HCPF'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** | InterQual for MH and ASAM for SUD. | InterQual for M/S |

| RETROSPECTIVE REVIEW<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **decisions regarding retrospective review for inpatient services?** | | |
| **Does the plan use internally developed guidelines to determine whether to prior retrospectively review services?**<br>**IF YES: How frequently are those guidelines updated?** | Yes, for some IP MH/SUD services. Updated annually at minimum[61] | 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<br>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** | | |

[61] There is an internally developed guideline for Eating Disorder Treatment, created in collaboration with HCPF. The policy was developed in response to Colorado Senate Bill 23-176.

| RETROSPECTIVE REVIEW<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **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 regarding retrospective review for outpatient services?** | InterQual for MH and ASAM for SUD | InterQual for M/S |
| **Does the plan use internally developed guidelines to determine whether to retrospectively review services?**<br>**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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF 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 to be paid[62] | 120 days | 90 days. Timely filing is 120 days but a provider must submit a RR request within 90 days of the treatment service to allow UM the 30 days to issue a determination. | 120 days for claims for in-network providers. Out-of-network providers have 365 days | Time limits for RR are currently waived. Two exceptions to this policy are 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 IP services may be considered for RR | All IP services may be considered for RR[63] | All IP services may be considered for RR<br>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.<br>These are considered on a case by case basis |
| **What is the maximum amount of time allowed to issue a determination** | 30 days | 30 days | 30 days | 30 days | 10 days |

[62] There is not a specific time limit on retrospective review. RMHP follows NCQA standards in this area which require that they complete a medical necessity review for any authorization request regardless of when it was submitted. However, there is a time limit on claims submission for payment. Claims must be submitted within 120 days of services being rendered in order to be paid.

[63] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **on a 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[64] |
| **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 | 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 retrospectively review services?** | Yes, for some IP MH/SUD services. Updated annually at minimum.[65] | No | No | No | Yes, when no InterQual or MCG criteria is available.<br>Reviewed regularly and updated as |

[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.

[65] There is an internally developed guideline for Eating Disorder Treatment, created in collaboration with HCPF. The policy was developed in response to Colorado Senate Bill 23-176.

| RETROSPECTIVE REVIEW<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **IF YES: How frequently are those guidelines updated?** | | | | | 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF 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 | 90 days. Timely filing is 120 days but a provider must submit a RR request within 90 days of the treatment service to allow UM the 30 days to issue a determination. | 30 days | Time limits for RR are currently waived, except, by rule, DME has 90 days; 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 not obtained. | All services subject to PAR may be considered for RR if PAR not obtained. Exceptions 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 not obtained. | Yes. Extensions exist when members become retroactively eligible for Medicaid. Provider has 30 days from the date they learn of eligibility to submit retrospective review request. | All benefits that require a PAR may be considered for an exception to established 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, services requiring | Yes | Yes | Yes | Yes |

| RETROSPECTIVE REVIEW<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **in-network and out-of-network providers?** | 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?** | InterQual 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?**<br>**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<br>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 for timely filing<br>90 days for submitting retrospective reviews | UM will review if no claims have been submitted up until the regulatory filing deadlines. |
| **Are services in this classification subject to retrospective review?** | Yes | Yes |
| **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. However, inpatient services for DHMP members admitting to Denver Health Hospital do not require authorization. | 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 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?**<br>**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.

Authorization requirement policies for MH/SUD and M/S, as they apply to in-network and out-of-network services, are substantially similar and in some cases more restrictive for M/S.

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

**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 for timely filing<br>90 days for submitting retrospective reviews | 12 calendar months |
| **Are services in this classification subject to retrospective review?** | Only services subject to PAR may be considered for RR | Only services subject to PAR 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 | Authorizations are not required in-network, all services 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 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?**<br>**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.

Authorization requirement policies for MH/SUD and M/S, as they apply to in-network and out-of-network services are substantially similar.

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

# Appendix D – Medical Necessity Criteria

**Description:** Use and applicability of health plan standards and review policies that determine 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 HCPF-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** | HCPF | 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<br>SCENARIO 1: HCPF 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.<br>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<br>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** | IP and OP MH: InterQual<br>All SUD: ASAM | IP and OP M/S: InterQual and internal guidelines |

| MEDICAL NECESSITY CRITERIA<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **apply? (inpatient, outpatient, emergency care, prescription drugs)** | Pharmacy: Criteria is based on internally developed guidelines.[66] | Pharmacy: Criteria is based on internally developed guidelines.[67] |
| **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.

As of March 1, 2025, Rocky Mountain Health Plans transitioned from MCG to InterQual for utilization management. The change applies to both RMHP RAE 1 and PRIME. The change aligns the plans with UnitedHealthcare medical prior authorization and notification requirements. No changes were made to behavioral health prior authorization and notification requirements. InterQual is a nationally recognized and industry standard UM system that is also currently used by other RAEs. This change is compliant with parity rules and regulations.

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

[66] 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 United Healthcare (UHC).

[67] Ibid.

## Scenario 3: Medical Necessity Criteria

| MEDICAL NECESSITY CRITERIA<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF 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<br>IP & OP SUD: ASAM Criteria<br>Emergency care is not reviewed | IP & OP MH: InterQual<br>IP & OP SUD: ASAM<br>Emergency care is not reviewed | IP & OP MH: InterQual<br>IP & OP SUD: ASAM<br>Emergency care is not reviewed | IP & OP MH: MCG<br>IP & OP SUD: ASAM Criteria<br>Emergency care is not reviewed | IP and OP M/S: InterQual, MCG, and internal guidelines.<br>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[68] | Yes |
| **Does the plan's definition for medical necessity for individuals UNDER the age of 21 follow the state's** | Yes | Yes | Yes | Yes | Yes |

[68] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/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<br>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<br>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** | HCPF | 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<br>SCENARIO 1: HCPF 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 HCPF inpatient policy, guidelines, and the appropriate criteria by the first and second level reviewers.[69] | Review submitted information for completeness, compliance and medical appropriateness utilizing specific HCPF inpatient policy, guidelines, and the appropriate criteria by the first and second level reviewers.[70] |
| **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.<br>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.<br>2nd level- physician can deny for medical necessity or |

[69] First Level Reviewers for PBT consist of a Board-Certified Behavioral Analyst (BCBA) who may: Approve the service as requested based HCPF 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 HCPF 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.

[70] First Level Reviewers consist of Registered Nurses who may: Approve the service as requested based on MCG/InterQual or HCPF 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 HCPF 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<br>SCENARIO 1: HCPF FFS | | |
|---|---|---|
| QUESTION | MH/SUD | M/S |
| | | 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 Review

| MEDICAL APPROPRIATENESS REVIEW<br>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 compare it to the appropriate medical necessity guidelines (InterQual 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.<br><br>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 | IP/OP: Clinical Coordinators (CC) receive and review clinical documentation from the provider or facility requesting services for the member and compare it to the appropriate medical necessity guidelines (InterQual 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.<br><br>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 |

| MEDICAL APPROPRIATENESS REVIEW<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| | 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. | 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 (InterQual 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.<br><br>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 cannot deny cases for medical necessity. | 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 (InterQual 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.<br><br>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 cannot deny cases for medical necessity. |

| MEDICAL APPROPRIATENESS REVIEW<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **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 RMHP line of business are licensed behavioral health clinicians (LPC, LMFT, LCSW) or RNs with psychiatric experience. All Clinical Coordinators are licensed in Colorado.<br><br>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.<br><br>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. | 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 RNs with licensure in Colorado.<br><br>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.<br><br>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<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| | 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF 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 medically appropriate. | 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. These procedures apply to PAR, CCR, and RR. Reviewers collect and review relevant clinical information to determine if the | Review submitted information for completeness, compliance and medical appropriateness utilizing specific HCPF inpatient policy, guidelines, and the appropriate criteria by the first and second level reviewers.[71] |

[71] First Level Reviewers consist of Registered Nurses who may: Approve the service as requested based on MCG/InterQual or HCPF 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 HCPF 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | | | | 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.<br>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.<br>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.<br>2nd level-physician/BCBA-D can deny for medical necessity or technical, can approve or pend. |

| MEDICAL APPROPRIATENESS REVIEW<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | Clinical Coordinators are licensed in Colorado.<br><br>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.<br><br>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<br>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. See PAR policy. | IP, OP. Care at a DH facility does not requirement authorization. Care outside of DH requires medical necessity review and authorization. |
| **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. | Requests are reviewed based on medical necessity guidelines, eligibility and benefits. If medical necessity review guidelines are 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.<br>EPSDT requirements are followed when making determinations. | Requests are reviewed based on medical necessity guidelines, eligibility and benefits. If medical necessity review guidelines are not met, then physician review is mandatory.<br>EPSDT requirements are followed when making determinations. |
| **Do you use a two-level review process?** | Yes.<br>Approvals do not require a two-level review (physician consult is optional for approvals). Denials require a two-level review (physician must issue an adverse benefit determination). | Yes.<br>Administrative denials (not a benefit, not a contracted provider) can be denied by licensed registered nurse which is the first level reviewer. Medical necessity denials require secondary level reviews by a physician reviewer. |
| **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 only reviewers who may issue an adverse benefit determinations. | 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 authorization. Any denial not meeting criteria must have |

| MEDICAL APPROPRIATENESS REVIEW<br>SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| | | second level physician reviewer. Physician reviewers are state licensed and Board certified. |

*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 require 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** | HCPF | *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<br>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.[72]<br><br>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.[73]<br><br>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.<br><br>Pharmacy: No step therapy or fail first policies apply to MAT. | M/S: No.<br><br>Pharmacy: No step therapy or fail first policies apply to MAT. |

*Fail First / Step Therapy Protocols*

### Findings: Scenario 2

[72] 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, InterQual 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.

[73] Ibid.

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<br>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** | HCPF | *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** | HCPF | 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<br>SCENARIO 1: HCPF FFS | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **How does the plan monitor over- and under-utilization of services?** | HCPF'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 HCPF of any concerns regarding waste, fraud, abuse that are identified as a part of the normal review process. And finally, HCPF reviews claims for use in future policy setting. | HCPF'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 HCPF of any concerns regarding waste, fraud, abuse that are identified as a part of the normal review process. And finally, HCPF 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 HCPF by the UM Vendor across all benefits. | Outliers are brought to the attention of HCPF 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 require 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<br>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.[74] | 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.[75] |
| **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.<br>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.<br>Pharmacy: Programs work with member and prescribers to bring outliers into more standard of care. |

*Outlier Management*

### Findings: Scenario 2

[74] 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)

[75] Ibid.

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 the 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF 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.<br>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). | HCPF'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 HCPF of any concerns regarding waste, fraud, abuse that are identified as a part of the normal review process. And finally, HCPF reviews claims for use in future policy setting. |

| OUTLIER MANAGEMENT<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | on outcomes of the analysis.[76] | | 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 in the event of inappropriate billing, and further | 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 they are following the RAE's clinical guidelines. Outlier | Interventions/ follow up measures could include (but are not limited to): patient education on appropriate service utilization via the COA care management program, provider education on medical necessity, documentation | The results of the reviews are used to help implement strategies to achieve utilization targets consistent with clinical and quality indicators and identify fraud and abuse. | In reviewing outliers, there may be a necessary change in clinical criteria, or policy, additional analysis or referrals to Program Integrity. |

[76] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | specific analysis to look at cause and effects. | reports or other data mining may also initiate focused audit processes and/or investigations related to fraud, waste, and abuse. | 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. | | |

*Outlier Management*

## Findings: Scenario 3

The purpose of HCPF's FFS utilization management outlier management policies and processes is for determining when a participant's benefits require 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<br>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 provide education, resources, support and when appropriate advocate for the member to join an intervention program. |

| OUTLIER MANAGEMENT<br>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 Service 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** | HCPF | 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<br>SCENARIO 1: HCPF 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 HCPF for FFS MH/SUD and M/S services and guidance from CMS, such as Medically Unlikely Edits (MUE).<br><br>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.<br><br>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.<br><br>For OP services Providers still need to ensure that they are meeting all other requirements for the benefit and PAR process.<br><br>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.<br><br>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 HCPF for FFS MH/SUD and M/S services and guidance from CMS, such as Medically Unlikely Edits (MUE).<br><br>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.<br><br>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.<br><br>For OP services Providers still need to ensure that they are meeting all other requirements for the benefit and PAR process.<br><br>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.<br><br>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<br>SCENARIO 1: HCPF 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.<br><br>Uniform Service 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<br>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<br><br>HFC Fee Schedule<br><br>Uniform Service Coding Standards Manual<br><br>CPT/ICD-10 Standard Code Sets | RAE/Prime Contract with HCPF, Covered Services<br><br>HFC Fee Schedule<br><br>Uniform Service Coding Standards Manual<br><br>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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **What coding set do you use for determining what services are eligible for reimbursement?** | RAE/Prime Contract with HCPF, Exhibit I<br>Uniform Service Coding Standards Manual<br>CPT/ICD-10 Standard Code Sets | RAE Contract with HCPF<br>Uniform Service Coding Standards Manual<br>CPT/ICD-10 Standard Code Sets | RAE Contract with HCPF<br>Uniform Service Coding Standards Manual<br>CPT/ICD-10 Standard Code Sets | RAE Contract with HCPF<br>Uniform Service Coding Standards Manual<br>CPT/ICD-10 Standard Code Sets | Coding limitations are used for IP and OP, in accordance with the Colorado Medicaid provider billing manual from HCPF for FFS MH/SUD and M/S services and guidance from CMS, such as Medically Unlikely Edits (MUE).<br>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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | | | | | applicable under EPSDT.<br><br>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<br>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 Service Coding Standards Manual<br><br>Includes CPT, HCPCS, and revenue codes outlined contract.<br><br>CPT/ICD-10 Standard Code Sets | Contract with HCPF and the Uniform Service 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** | HCPF | 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<br>SCENARIO 1: HCPF FFS | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| **What process is followed for recruiting and accepting providers into the plan's network of care professionals?** | HCPF 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. HCPF 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. | HCPF 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. HCPF 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 meet the specific requirements of provider type and services to be provided. | Providers wishing to enroll with Medicaid must meet 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 HCPF. Providers enroll with Medicaid and that enrollment does not have a timeframe. | Providers do not contract with HCPF. 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<br>SCENARIO 1: HCPF 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<br>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.<br>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<br>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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF 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 [77] | 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 operational requirements of contracted network | 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. | HCPF 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. HCPF 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. |

[77] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | | | providers. Assistance in completing required documents is provided, if needed. For some providers, a clinical site visit may also be warranted.[78] | | |
| **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 meet 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?** | Submit complete credentialing packet for review. Packet includes W9, practice demographics, proof of enrollment with HCPF, and email address. | Submission of completed and signed applications, along with all required supporting documentation using CAQH process or NHP/HCI process. | Provider completes paper application or electronic app through CAQH.<br>To recredential, provider must update (or keep up to date in CAQH) | CAQH Universal Provider Data Source is used. Providers must complete the online credentialing application, authorize access to their information, verify and attest | The Fee-For-Service Medicaid provider enrollment process uses a validation process based on federal requirements (i.e. practitioner must |

[78] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | Providers must have a current CAQH application. Providers are recredentialed every 36 months.<br>Re-credentialing focus on verifying that CAQH and attestation is up-to-date and verifying licensure. If up to date, process is more streamlined. | 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. | their documentation. If up to date, we are able to recredential practitioners without ever having to notify them. | their data is accurate and complete, submit supporting documents.[79]<br>Recredentialing is less administratively burdensome than the initial credentialing process – primarily just ensuring the CAQH information is up to date. | be licensed to enroll, etc.) for all providers. |
| **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. |

[79] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **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 HCPF. 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 required appeal process. | 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 provider is terminated from our network, then the provider is offered an appeal process to include a hearing. | 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 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 | 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | | | | 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<br>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.<br>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.<br>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<br>Recredentialing for COA: Every 3 years. | Revalidation with Health First CO: Every 5 years<br>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 | Practitioners may appeal a credentialing or recredentialing decision using the practitioner appeal process |

| NETWORK PROVIDER ADMISSION<br>SCENARIO 4: DENVER HEALTH PIHP AND DENVER HEALTH MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| | process. If the Credentialing 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** | HCPF | 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<br>SCENARIO 1: HCPF 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, HCPF uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations and capital overhead expense expectations.<br><br>For Outpatient MH/SUD, HCPF uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations.<br><br>For Emergency MH/SUD, HCPF uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted. Each hospital has a base rate calculated from their Medicare base rates. The average cost of service at a hospital is multiplied by other factors.<br><br>For MH/SUD prescribed pharmaceuticals, HCPF bases the payment on an average acquisition cost with a multiplier. If the average acquisition cost is unavailable, HCPF uses the average wholesale cost with a multiplier.<br><br>For MH/SUD physician administered pharmaceuticals, the rate is based off Medicare data. Fees are updated quarterly. If data is not available, HCPF uses the Medicare Average Sales Price (ASP) minus 4.5%. | For Inpatient M/S, HCPF uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted. Each hospital has a base rate calculated from their Medicare base rates. The average cost of service at a hospital is multiplied by other factors.<br><br>For Outpatient M/S services, HCPF uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations, and capital overhead expense expectations.<br><br>For Emergency M/S services, HCPF uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted. Each hospital has a base rate calculated from their Medicare base rates. The average cost of service at a hospital is multiplied by other factors.<br><br>For M/S prescribed pharmaceuticals, HCPF bases the payment on an average acquisition cost with a multiplier. If the average acquisition cost is unavailable, HCPF uses the average wholesale cost with a multiplier. |

| ESTABLISHING CHARGES/REIMBURSEMENT RATES<br>SCENARIO 1: HCPF 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, HCPF 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 does not have copays for Medicaid Members. RMHP reimburses pharmacies based on lesser of logic. Brand drugs negotiated at AWP minus % for any branded drug. Generics are set at a NADAC price or WAC or U&C. Pricing is the same for both Brand or generic (based on MSC from Medispan) without regard for BH or medical indications.<br><br>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 does not have copays for Medicaid Members. RMHP reimburses pharmacies based on lesser of logic. Brand drugs negotiated at AWP minus % for any branded drug. Generics are set at a NADAC price or WAC or U&C. Pricing is the same for both Brand or generic (based on MSC from Medispan) without regard for BH or medical indications.<br><br>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<br><br>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<br><br>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<br><br>IP/OP/EC: Annually | Pharmacy: Ad Hoc<br><br>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<br><br>IP/OP/EC: Providers can submit rates for RMHP review and consideration. | Pharmacy: No<br><br>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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF 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 - Pharmacy: RMHP does not have copays for Medicaid Members. RMHP reimburses pharmacies based on lesser of logic. Brand drugs negotiated at AWP minus % for any branded drug. Generics are set at a NADAC price or WAC or U&C. Pricing is the same for both Brand or generic (based on MSC from Medispan) without regard for BH or medical indications.<br><br>RMHP may determine reimbursement rates on the basis of State funding levels and/or fee | 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 - Factors used to determine provider reimbursement rates: (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 reimbursement amount, or a new | IP/EC - HCPF uses the All Payer Refined Diagnosis Related Group (APR-DRG) payment methodology for provider reimbursement. This model incentivizes using the lowest level of care necessary for a service. The model is weighted. Each hospital has a base rate calculated from their Medicare base rates. The average cost of service at a hospital is multiplied by other factors.<br><br>OP - HCPF uses its standard cost-based rate methodology that factors in indirect and direct care requirements, facility expense expectations, administrative expense expectations, and |

| ESTABLISHING CHARGES/REIMBURSEMENT RATES<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | schedules. Scarce services may receive special consideration for higher rates. This is true for all services. | | | 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 | capital overhead expense expectations.<br>M/S prescribed pharmaceuticals -HCPF bases the payment on an average acquisition cost with a multiplier. If the average acquisition cost is unavailable, HCPF uses the average wholesale cost with a multiplier.<br>M/S physician administered pharmaceuticals - The rate is based off Medicare data. Fees are updated quarterly. If data is not available, HCPF uses the Medicare Average Sales Price (ASP) minus 4.5%. |
| **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).** | RMHP has different reimbursement levels based upon level of licensure. Scarce services may receive special consideration if | Reimbursement rates updated based on provider types. CMHCs are updated annually based on their updated Based Unit Cost and States updated RVU rates. FQHCs and Rural | The following include, but are not limited to, provider specialties/ expertise that could warrant additional compensation: | 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | needed to fill a network need. | Health Centers encounter rates are updated based on rate updates conducted by HCPF. Independent OP providers receive standard FFS fee schedule which is reviewed and updated on periodic basis. Independent IP and residential facilities rates are determined based on usual and customary rates. NHP/HCI may negotiate rates, where appropriate, to ensure Members have access to covered services. | •Advanced degrees such as an MD, PhD, NP<br>•Providers that serve populations who face barriers to access to care such as, deaf/hard of hearing, foreign language spoken, refugees, BIPOC, LGBTQ<br>•Subspecialties | | |
| **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 | 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. |

| ESTABLISHING CHARGES/REIMBURSEMENT RATES<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | | the review deems it appropriate. | | | |
| **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. | Changes are communicated to providers through direct emails, provider bulletin, 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<br>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).** | Utilizes established methods such as: DRG for IP; RBRVS, EAPG, and Colorado Medicaid fee schedule for OP. 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:<br>• Advanced degrees: MD, PhD, NP<br>• Providers that serve populations who face barriers to access to care such as, deaf/hard of hearing, foreign language spoken, refugees, BIPOC, LGBTQ<br>• 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 what FFS 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** | HCPF | *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 HCPF.

**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** | HCPF | 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<br>SCENARIO 1: HCPF 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 HCPF quarterly.

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

## Scenario 2: Network Adequacy Determination

| NETWORK ADEQUACY DETERMINATION<br>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<br>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. Home delivery pharmacy is limited to Optum Home Delivery as the in network pharmacy. Out of network: A member would have to pay out of pocket and request coverage via a DMR or manual claim.<br><br>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. Home delivery pharmacy is limited to Optum Home Delivery as the in network pharmacy. Out of network: A member would have to pay out of pocket and request coverage via a DMR or manual claim.<br><br>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<br><br>IP/OP/EC: RMHP Contracts with all willing providers and regularly measures adequacy against State benchmarks and reports those results to the State quarterly. | 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<br><br>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<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| | 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<br>IP/OP/EC: Network reports are supplied to the State on a quarterly basis. | Pharmacy: Quarterly<br>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.<br>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.<br>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 HCPF quarterly.

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

## Scenario 3: Network Adequacy Determination

| NETWORK ADEQUACY DETERMINATION<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF 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?** | Pharmacy: In network: Our nationwide network allows the Member to have no restrictions on location for retail pharmacy. Home delivery pharmacy is limited to Optum Home Delivery as the in network pharmacy. Out of network: A member would have to pay out of pocket and request | 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.[80] | 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 | 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 necessary services as no cost to them, whether through an | 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. |

[80] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | coverage via a DMR or manual claim.<br>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. | | 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. | 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 is measured and reported annually to our Network | 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 Fee For Services Medicaid Rates, CMS Reimbursement | 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 | 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 changes are significant and result | Consistent evaluation, engagement, and intervention when necessary |

| NETWORK ADEQUACY DETERMINATION<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | Advisory Committee. | 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. | 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 | 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 measures adequacy against State benchmarks. RMHP works with various | NHP/HCI reviews network adequacy to ensure the availability of behavioral health care providers within its delivery system.[81] | 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. |

[81] 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)

| NETWORK ADEQUACY DETERMINATION<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| | community stakeholders in an effort to expand services where needed. | | | | |

*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 HCPF quarterly.

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

## Scenario 4: Network Adequacy Determination

| NETWORK ADEQUACY DETERMINATION<br>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<br>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 HCPF 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** | HCPF | 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<br>SCENARIO 1: HCPF 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.[82] | For non-emergent IP hospital services in out-of-network hospitals to be allowed, the services must not be available in Colorado.[83] |
| **What process does the plan have for out-of-network providers to bill for services?** | Enrollment. Providers must be enrolled for payment. HCPF can walk them through enrollment if it's urgent. | Enrollment. Providers must be enrolled for payment. HCPF 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<br>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. Benefit levels for out of network services are the same for all services with the exception | IP, OP, EC, PD. Benefit levels for out of network services are the same for all services with the exception of |

[82] 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.

[83] Ibid.

| OUT-OF-NETWORK PROVIDER ACCESS STANDARDS<br>SCENARIO 2: RAE 1 AND ROCKY MOUNTAIN HEALTH PLAN PRIME MCO | | |
|---|---|---|
| **QUESTION** | **MH/SUD** | **M/S** |
| | of urgent/emergent care which is always covered. | 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<br>IP/OP/EC: Yes | Pharmacy: No, only members<br>IP/OP/EC: Yes |
| **What criteria are necessary for the plan to allow out-of-network providers to bill for services?** | Pharmacy: N/A<br>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<br>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<br>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<br>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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF 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. | Provider must meet criteria to serve members as out-of-network provider: Medicaid enrolled, meets credentialing / quality standards, accepts reasonable reimbursement for services. The provider must sign a Single Case Agreement with agreed upon reimbursement rates and services for execution. | 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.[84] |

[84] 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<br>SCENARIO 3: RAE 1-7 AND HCPF FFS | | | | | |
|---|---|---|---|---|---|
| QUESTION | RAE 1<br>MH/SUD | RAE 2&4<br>MH/SUD | RAE 3&5<br>MH/SUD | RAE 6&7<br>MH/SUD | HCPF M/S |
| **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 HCPF's Uniform Service Coding Standards. | PAR required 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), 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. HCPF 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<br>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 where a member may retain their out of network provider (e.g., pregnant women with established care already in second or third trimester). 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?** | PAR required 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

The parity rule includes two requirements regarding the availability of information related to MH/SUD benefits:

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

HCPF applies these requirements to all Colorado Medicaid members receiving MH/SUD benefits, whether through FFS, RAEs, or MCOs.

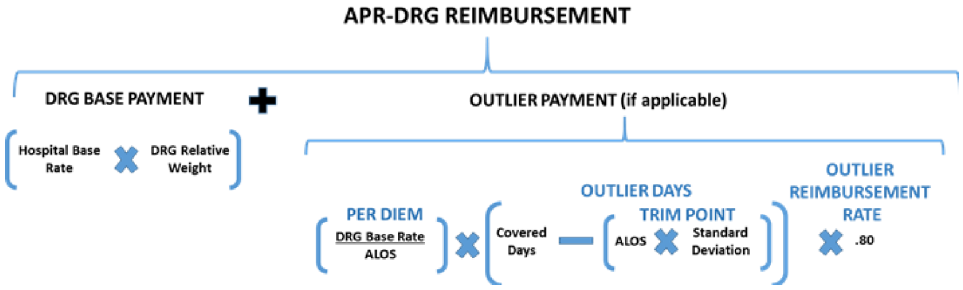
The criteria for medical necessity determinations are evaluated as part of HCPF's comparative analysis and each MCEs' criteria are detailed in the Medical Necessity Criteria Appendix above. The medical necessity criteria used by each MCE is identifiable publicly on their webpages.

The second part of these two parity requirements is monitored as part of the External Quality Review Audit performed annually by HSAG, where the MCEs are required to provide evidence of compliance. HSAG's five-phase assessment includes Document Request, Desk Review, Web-Based Interviews, Analysis, and Reporting to determine compliance. The full External Quality Review Audit can be found on HCPF's Parity webpage.

**All plans reviewed have provided substantial evidence that they are compliant with both parity requirements.**

# Appendix P – Summary of APR-DRG/RAC vs Authorization/Per Diem Systems

## APR-DRG/RAC System




Each claim is assigned a DRG (retrospectively by the claim system/3M after the claim is submitted). That DRG is determined by the diagnoses and services documented on the claim:

- Related outpatient services, including observation, that occur immediately prior to an inpatient admission are included as part of the inpatient claim. This allows services provided during that time to influence the DRG assignment and better represent one episode of care.

Each DRG has an Average Length of Stay (ALOS) and Trim Point (ALOS x Standard Deviation) assigned.

The payment methodology equation is comprised of two main elements: the DRG Base Payment and Outlier Payment for Outlier Days:

**DRG Base Payment**: Hospital-Specific Base Rate multiplied by the Relative Weight of the DRG in which the claim is grouped.

**Outlier Days**: For any days a patient remains in the hospital beyond the Trim Point, the hospital is paid at a rate of 80% of the per diem. Outlier days are calculated as follows: DRG base rate / ALOS = Per Diem * 80% = Outlier Per Diem Rate. **Outlier Payment** = (Covered Days – Trim Point) * .80.

- Covered days are days the client was Medicaid eligible during the inpatient portion of the claim. Days during outpatient/observation are not counted towards covered days.

The Recovery Audit Contractor (RAC) uses proprietary software programs to identify potential payment errors in areas such as duplicate payments, fiscal intermediaries' mistakes, medical necessity, and coding. In addition, the contract includes determining if documentation supports the inpatient versus observation status. These reviews are retrospective. The whole concept of DRGs reimbursement is incompatible with concurrent reviews as the system is based on trim points that drive the same reimbursement level when the length of stay is

within those trim points, and a reduced rate outlier payment is applied when it goes beyond it.

## PAR/CCR/Per Diem System

For mental health and substance use disorder services, an authorization process is in place that occurs both prior to admission to an inpatient setting and on a concurrent basis to determine the need for continued length of stay. This process is conducted by both the RAE's and MCO's. Claims are generally paid by special fee schedules that are paid on a per diem basis.