Nonquantitative Treatment Limit (NQTL) Survey of Regional Accountable Entities (2019)

Background

Under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), Colorado is required to conduct an analysis of the benefits offered to its Medicaid members and people enrolled in the state's Children's Health Insurance Program (CHIP). MHPAEA stipulates that the state and its contracted managed care plans must not limit behavioral health services in a manner that is more restrictive than that by which it limits physical health services. The analysis takes into account both quantitative limits on services, such as visit limits or co-pays, and nonquantitative treatment limits (NQTLs). NQTLs are "soft limits" applied to covered benefits, such as prior authorization requirements, as well as structural approaches to service delivery, such as the development of treatment provider networks.

This survey is designed to collect essential information about how Colorado's seven Regional Accountable Entities (RAE) apply NQTLs to the services they cover for Medicaid members. The Department has identified five NQTLs about which it requires additional information for the purposes of the mandatory parity analysis. These NQTLs may or may not be applied to services across five classifications of covered benefits: inpatient, outpatient, emergency, and pharmacy services. The questions contained in this survey have been developed to help the RAEs describe how they manage the full range of benefits they provide to Medicaid members throughout Colorado.

Format of the Survey

The response section of this survey consists of five worksheets, each one representing an NQTL identified by the Department. Each sheet contains a series of questions about how the NQTLs are applied across four benefit classifications--inpatient, outpatient, emergency, and pharmacy services. Questions about NQTL application in the four classifications are repeated in four sections throughout each sheet. There is also a space for each RAE to identify itself in each section.

Survey Responses

There are cells to the right of survey questions where RAEs can type in their responses. Responses to this survey should be very succinct and limited to the substance of the questions being asked. Many of the survey questions only require "yes" or "no" answers. Please limit the length and complexity of responses accordingly.

Pharmacy Benefits

The Department is aware that the state, not RAEs, set pharmacy benefit policy through its prescription drug formulary and provider guidance. Nonetheless, this survey includes the same questions about NQTL application to benefits in the pharmacy classification as it does for the inpatient, outpatient, and emergency classifications. Wherever possible, RAEs should provide relevant and succinct answers to questions about pharmacy benefits, particularly when they illuminate availability and access for Medicaid members.

MHPAEA or Survey-Related Terms	Definition
Nonquantitative Treatment Limit	Non-numerical limits on the scope of duration of benefits for treatment.
Inpatient Services	Services in which: a) the patient is admitted to an institution, hospital, or facility for greater than 24 hours, or b) the patient receives residential care through a facility for greater than 24 hours, or c) the patient receives the specific benefit in an institutional setting which is not their usual place of residence (such as a licensed hospice facility) for greater than 24 hours, and d) the service is not a respite service
Outpatient Services	Services in which the patient receives treatment a) without being admitted to an institution, per definition of 'Inpatient Services', **and** b) services are not emergent, per definition of 'Emergency Services'. This includes the provision of equipment and supplies, such as DMEPOS, and services delivered in the home, school, and any settings that meet home and community based services characteristics. This excludes services provided by a pharmacy.
Emergency Services	Services which are specifically designated to be rendered on an emergent basis. Examples includes: 'behavioral emergency crisis services', 'hospital emergency room services', and 'emergency transportation'.
Pharmacy Services	Services which can be provided by pharmacies.

Prior Authorization	Requirement that a provider must submit a request before performing a service and may only render it after receiving approval.
Concurrent Review	Requirement that services be periodically reviewed as they are being provided in order to continue authorization.
Retrospective Review	Protocol for approving coverage for a service after it has been delivered.
Network Provider Admission	Process of accepting treatment providers into the health plan's network of care professionals.
Establishing Charges	Methods for determining usual, customary, and reasonable charges for services.

Mental Health Parity and Addiction Equity Act (MHPAEA) Nonquantitative Treatment Limit (NQTL) Analysis		RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	FFS Medical/Surgical
Regional Accountable Entity: All RAEs **Benefit Classification:** INPATIENT SERVICES									
NQTL: Prior Authorization									
Prior Authorization: Requirement that a provider must submit a request before performing a service and may only render it after receiving approval.									
Process									
Are **all services** in this classification prior authorized? List any services (by procedure code) in this classification to which prior authorization does not apply.		Yes	**Yes**	Yes, all inpatient services require prior authorization.	**Yes**	Yes, all inpatient services require prior authorization.	**Yes**	**Yes**	**Yes**
Are there **exceptions** to prior authorization requirements in certain circumstances? List the situations when exceptions are granted.		Yes. Providers who are at financial risk, have been trained on health plan guidelines and have agreed to adhere to them are exempt from prior authorization requirements.	**Yes, for cases where there are questions around eligibility.**	Yes. Occasionally a member's Health First Colorado (Colorado Medicaid) status/eligibility/RAE assignment is unknown at the time of admission. If a provider experiences issues with a member's eligibility that results in the inability to seek authorization prior to admission, Colorado Access will review for authorization in a concurrent or retrospective manner.	**Yes, for cases where there are questions around eligibility.**	Yes. Occasionally a member's Health First Colorado (Colorado Medicaid) status/eligibility/RAE assignment is unknown at the time of admission. If a provider experiences issues with a member's eligibility that results in the inability to seek authorization prior to admission, Colorado Access will review for authorization in a concurrent or retrospective manner.	**Yes; Providers have one business day to request an authorization. If the member enters treatment as a John Doe, the provider is exempt from requesting prior auth until they identify who the member is and verify the member's Medicaid. Members who admit as ineligible for Medicaid also do not require prior authorization. In these cases, retro active requests for authorization are permitted.**	**Yes; Providers have one business day to request an authorization. If the member enters treatment as a John Doe, the provider is exempt from requesting prior auth until they identify who the member is and verify the member's Medicaid. Members who admit as ineligible for Medicaid also do not require prior authorization. In these cases, retro active requests for authorization are permitted.**	**Yes**
Are prior authorizations performed by the **direct treatment provider**, or does the plan require **secondary assessment** to complete the authorization?		Direct treatment providers complete the prior authorization request and submit it to the health plan for those services subject to prior authorization. The health plan reviews the request and approves or denies it.	**The prior approval is completed between the direct treatment provider and NHP, however we do require a secondary assessment to be completed (or waived) by the CMHC prior to authorization.**	Most prior authorizations are performed by the direct treatment provider. Some hospitals/hospital systems contract with an entity that performs evaluations on their behalf (e.g., HCAT for HealthOne, PEPS for Centura). Colorado Access accepts prior authorization requests from any of these entities. Colorado Access does not require any assessments from a secondary provider in order to request prior authorization.	**The prior approval is completed between the direct treatment provider and NHP, however we do require a secondary assessment to be completed (or waived) by the CMHC prior to authorization.**	Most prior authorizations are performed by the direct treatment provider. Some hospitals/hospital systems contract with an entity that performs evaluations on their behalf (e.g., HCAT for HealthOne, PEPS for Centura). Colorado Access accepts prior authorization requests from any of these entities. Colorado Access does not require any assessments from a secondary provider in order to request prior authorization.	**Direct Treatment Provider**	**Direct Treatment Provider**	**Direct Treatment Provider**
What is the maximum amount of **time** allowed to issue a determination on a prior authorization request?		72 hours	**72 hours (generally only takes that long if trying to identify placement)**	Per state and federal regulations, expedited prior authorization decisions must be made in 72 hours or less. COA recognizes that this is typically an unreasonably long amount of time for someone in behavioral health crisis in need of inpatient care. Therefore, Colorado Access has an internal turnaround time requirement of 2 hours or less for inpatient prior authorizations.	**72 hours (generally only takes that long if trying to identify placement)**	Per state and federal regulations, expedited prior authorization decisions must be made in 72 hours or less. COA recognizes that this is typically an unreasonably long amount of time for someone in behavioral health crisis in need of inpatient care. Therefore, Colorado Access has an internal turnaround time requirement of 2 hours or less for inpatient prior authorizations.	**72 Hours**	**72 Hours**	**Variable**
Strategy									
What is the **rationale** for prior authorizing services in this classification?		Those services that are high cost, high risk or for which there is a potential for overutilization are subject to prior authorization.	Inpatient level of care is the most restrictive for members. We conduct Prior Authorization reviews to make sure that Member could not be safely treated at a lower level of care.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member's condition, and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.	Inpatient level of care is the most restrictive for members. We conduct Prior Authorization reviews to make sure that Member could not be safely treated at a lower level of care.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member's condition, and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	**To contain costs, provide only medically necessary care, and ensure criteria are met**
Are prior authorization policies the same for both **in-network and out-of-network** providers?		Yes	**Yes**	Yes.	**Yes**	Yes.	**Yes**	**Yes**	**Yes**
If there is any **change** to prior authorization policies or procedures, does the plan **update providers** about the change? How often do these updates occur?		Yes. The health plan provides updates annually.	Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Procedural changes are rare; minor changes (e.g., an edit to the prior authorization request form) are not uncommon.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Procedural changes are rare; minor changes (e.g., an edit to the prior authorization request form) are not uncommon.	Yes. Thus far, there have not been any changes to these requirements but if changes are made in the future, providers will be updated.	Yes. Thus far, there have not been any changes to these requirements but if changes are made in the future, providers will be updated.	**Yes, Providers notified via website**
Evidentiary Standards									
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to determine whether to prior authorize services?		Yes	No	InterQual. Case-by case review by a Colorado Access Medical Director for any request not meeting InterQual criteria.	No	InterQual. Case-by case review by a Colorado Access Medical Director for any request not meeting InterQual criteria.	Yes	Yes	**Yes**
Does the plan use **internally developed guidelines** to determine whether to prior authorize services? IF YES: How **frequently** are those guidelines updated?		No	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	No	No	**Yes**

Benefit Classification: OUTPATIENT SERVICES	
NQTL: Prior Authorization	
Prior Authorization: Requirement that a provider must submit a request before performing a service and may only render it after receiving approval.	
Process	

Are **all services** in this classification prior authorized? List any services (by procedure code) in this classification to which prior authorization does not apply.		No More intensive outpatient services require prior authorization. These services include: - Psych Testing - ECT - PHP (MH Only) - IOP (Both MH and SUD) - Day Treatment	**No, those services which are considered "routine" outpatient do not require authorization. Those include: 0510, 0521, 0529, 90791, 90792, 90832, 90834, 90837, 90839, 90846, 90847, 90849, 90853, 96372, H0001, H0002, H0004, H0005, H0006, H0018, H0020, H0023, H0025, H0031-34, H0036-38, H2000, H2014-18, H2021, H2022, H2027, H2030, H2031, S3005, S9445, S9453, S9454, T1007, T1017, T1019, T1023 and all E&M codes.**	No. The only services in this classification that require authorization are the following: Acute treatment unit services (ATU), residential services (short and long term), day treatment, respite, intensive outpatient services (IOP, both mental health and substance use disorder), partial hospitalization, electroconvulsive therapy, and psychological testing. All other services are considered routine outpatient services and do not require authorization for in-network providers.	**Many services which are considered "routine" outpatient do not require authorization. Those include: 0510, 0521, 0529, 90792, 90839, 90849, 90853, 96372, H0001, H0002, H0004, H0005, H0006, H0018, H0020, H0023, H0025, H0031-34, H0036-38, H2000, H2014-18, H2021, H2022, H2027, H2030, H2031, S3005, S9445, S9453, S9454, T1007, T1017, T1019, T1023 and all E&M codes. Routine outpatient services covered under the Short Term Behavioral Health Benefit are subject to authorization after the first 6 visits.**	No. The only services in this classification that require authorization are the following: Acute treatment unit services (ATU), residential services (short and long term), day treatment, respite, intensive outpatient services (IOP, both mental health and substance use disorder), partial hospitalization, electroconvulsive therapy, and psychological testing. All other services are considered routine outpatient services and do not require authorization for in-network providers.	**No; 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90875, 90876, 96116, 96121, 96130-96139, 96372, 97535, g1076, h0006, h0020, h0033, h0034, h0035, h0045, h2014, h2023-h2032, s3005, s9445, s9485, t1005, t1017, 90791, 90792, 90839, 90940, 98966-98968,h0001-h0005, h0023, h0025, h0031, h0032, h2000, h2011, s9453, s9454, t1007, t1023, 99241-99245, 99201-99443, 90833-90838**	**No; 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90875, 90876, 96116, 96121, 96130-96139, 96372, 97535, g1076, h0006, h0020, h0033, h0034, h0035, h0045, h2014, h2023-h2032, s3005, s9445, s9485, t1005, t1017, 90791, 90792, 90839, 90940, 98966-98968,h0001-h0005, h0023, h0025, h0031, h0032, h2000, h2011, s9453, s9454, t1007, t1023, 99241-99245, 99201-99443, 90833-90838**	**No**
Are there **exceptions** to prior authorization requirements in certain circumstances? List the situations when exceptions are granted.		Yes. Providers who are at financial risk, have trained on health plan guidelines and agreed to adhere to them are exempt from prior authorization requirements.	**Yes. For cases where there are questions around eligibility.**	Yes. Occasionally a member's Medicaid status/eligibility/RAE assignment is unknown at the time of admission. If a provider experiences issues with a member's eligibility that results in the inability to seek authorization prior to admission, Colorado Access will review for authorization in a concurrent or retrospective manner. Colorado Access has also arranged a waiver of prior authorization requirements for some high-volume/high-performing providers for some of the above services that typically require prior authorization. Arrangements of this nature are managed on a case-by-case basis.	**Yes. For cases where there are questions around eligibility.**	Yes. Occasionally a member's Medicaid status/eligibility/RAE assignment is unknown at the time of admission. If a provider experiences issues with a member's eligibility that results in the inability to seek authorization prior to admission, Colorado Access will review for authorization in a concurrent or retrospective manner. Colorado Access has also arranged a waiver of prior authorization requirements for some high-volume/high-performing providers for some of the above services that typically require prior authorization. Arrangements of this nature are managed on a case-by-case basis.	**Yes; Providers have one business day to request an authorization. If the member enters treatment as a John Doe, the provider is exempt from requesting prior auth until they identify who the member is and verify the member's Medicaid. Members who admit as ineligible for Medicaid also do not require prior authorization. In these cases, retro active requests for authorization are permitted.**	**Yes; Providers have one business day to request an authorization. If the member enters treatment as a John Doe, the provider is exempt from requesting prior auth until they identify who the member is and verify the member's Medicaid. Members who admit as ineligible for Medicaid also do not require prior authorization. In these cases, retro active requests for authorization are permitted.**	**Yes**
Are prior authorizations performed by the **direct treatment provider**, or does the plan require **secondary assessment** to complete the authorization?		Direct treatment providers complete the prior authorization request and submit it to the health plan for those services subject to prior authorization. The health plan reviews the request and approves or denies it. One exception to this process is that labs (direct treatment provider) do not complete prior authorization request. In that instance, the provider ordering the labs completes the prior authorization request.	**By the direct treatment provider**	Most prior authorizations are initiated by the direct treatment provider - either the member's treatment provider at the current level of care, or the intended level of care (e.g., residential services may be requested by the residential provider who has accepted the member into their program or the current inpatient or outpatient provider). Colorado Access would accept a prior authorization request from any of these entities. Colorado Access does not require any kind of assessment by a secondary provider in order to complete the authorization.	**By the direct treatment provider**	Most prior authorizations are initiated by the direct treatment provider - either the member's treatment provider at the current level of care, or the intended level of care (e.g., residential services may be requested by the residential provider who has accepted the member into their program or the current inpatient or outpatient provider). Colorado Access would accept a prior authorization request from any of these entities. Colorado Access does not require any kind of assessment by a secondary provider in order to complete the authorization.	**Direct Treatment Provider**	**Direct Treatment Provider**	**Direct Treatment Provider**
What is the maximum amount of **time** allowed to issue a determination on a prior authorization request?		10 calendar days	**10 calendar days**	Per state and federal regulations, standard prospective prior authorization decisions are made within a maximum of 10 calendar days. Expedited decisions are made within 72 hours. Colorado Access also accounts for the health needs and status of the member when making decisions in a timely manner. For example, ATU decisions are typically made within the 2-hour inpatient required turnaround time, and any step-down care decisions are made prior to the member's discharge from their current level of care.	**10 calendar days**	Per state and federal regulations, standard prospective prior authorization decisions are made within a maximum of 10 calendar days. Expedited decisions are made within 72 hours. Colorado Access also accounts for the health needs and status of the member when making decisions in a timely manner. For example, ATU decisions are typically made within the 2-hour inpatient required turnaround time, and any step-down care decisions are made prior to the member's discharge from their current level of care.	**10 Days**	**10 Days**	**Variable**
Strategy										
What is the **rationale** for prior authorizing services in this classification?		Those services that are high cost, high risk or for which there is a potential for overutilization are subject to prior authorization.	The outpatient services that do require authorization are generally considered non-routine or more complex interventions such as IOP, in-home services, respite, ECT or psych testing where we want to establish medical necessity.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. This means that the care is necessary and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified setting.	The outpatient services that do require authorization are generally considered non-routine or more complex interventions such as IOP, in-home services, respite, ECT or psych testing where we want to establish medical necessity.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. This means that the care is necessary and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified setting.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	**To contain costs, provide only medically necessary care, and ensure criteria are met**
Are prior authorization policies the same for both **in-network and out-of-network** providers?		Yes	**Yes. Out of network providers have to secure a single case agreement for services.**	No. Out-of-network providers are required to seek prior authorization before rendering any outpatient services, even routine outpatient services. Prior authorization for routine outpatient services is not required for in-network providers.	**Yes. Out of network providers have to secure a single case agreement for services.**	No. Out-of-network providers are required to seek prior authorization before rendering any outpatient services, even routine outpatient services. Prior authorization for routine outpatient services is not required for in-network providers.	**No**	**No**	**Yes**
If there is any **change** to prior authorization policies or procedures, does the plan **update providers** about the change? How often do these updates occur?		Yes, The health plan provides updates annually.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Changes to the authorization process for these levels of care would be infrequent, typically only if changes are made to the CPT/HCPC codes themselves (e.g., 2019 changes to the psychological testing codes)	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Changes to the authorization process for these levels of care would be infrequent, typically only if changes are made to the CPT/HCPC codes themselves (e.g., 2019 changes to the psychological testing codes)	Changes are communicated through email blasts to our provider network distribution list, monthly CCHA newsletters, provider open-mic calls, and ad hoc provider bulletins. Updates do not occur at any specific frequency.	Changes are communicated through email blasts to our provider network distribution list, monthly CCHA newsletters, provider open-mic calls, and ad hoc provider bulletins. Updates do not occur at any specific frequency.	**Yes, Providers notified via email**
Evidentiary Standards										
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to determine whether to prior authorize services?		Yes	No	InterQual. Case-by case review by a COA Medical Director for any request not meeting InterQual criteria.	No	InterQual. Case-by case review by a COA Medical Director for any request not meeting InterQual criteria.	Yes	Yes	**Yes**
Does the plan use **internally developed guidelines** to determine whether to prior authorize services? IF YES: How **frequently** are those guidelines updated?		No	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	No.	No.	**Yes, Variable frequency of updates**

Benefit Classification: EMERGENCY SERVICES

NQTL: Prior Authorization

Prior Authorization: Requirement that a provider must submit a request before performing a service and may only render it after receiving approval.

Process									
Are **all services** in this classification prior authorized? List any services (by procedure code) in this classification to which prior authorization does not apply.		No. No emergency services are subject to prior authorization.	**Services billed as emergent (either by the CPT code or modifier) do not require authorization.**	No. Emergency and Crisis services do not require prior authorization.	**Services billed as emergent (either by the CPT code or modifier) do not require authorization.**	No. Emergency and Crisis services do not require prior authorization.	**No emergency services require prior authorization**	**No emergency services require prior authorization**	**No**

Are there **exceptions** to prior authorization requirements in certain circumstances? List the situations when exceptions are granted.		No. No emergency services are subject to prior authorization.	N/A	No. Emergency and Crisis services do not require prior authorization.	**N/A**	No. Emergency and Crisis services do not require prior authorization.	**N/A**	**N/A**	**N/A**
Are prior authorizations performed by the **direct treatment provider**, or does the plan require **secondary assessment** to complete the authorization?		Not applicable. No emergency services are subject to prior authorization.	N/A	N/A. Emergency and Crisis services do not require prior authorization.	**N/A**	N/A. Emergency and Crisis services do not require prior authorization.	**N/A**	**N/A**	**N/A**
What is the maximum amount of **time** allowed to issue a determination on a prior authorization request?		Not applicable. No emergency services are subject to prior authorization.	**N/A**	N/A. Emergency and Crisis services do not require prior authorization.	**N/A**	N/A. Emergency and Crisis services do not require prior authorization.	**N/A**	**N/A**	**N/A**
Strategy									
What is the **rationale** for prior authorizing services in this classification?		Not applicable. No emergency services are subject to prior authorization.	**We do not require PA for emergent services.**	N/A. Emergency and Crisis services do not require prior authorization.	**We do not require PA for emergent services.**	N/A. Emergency and Crisis services do not require prior authorization.	**N/A**	**N/A**	**N/A**
Are prior authorization policies the same for both **in-network and out-of-network** providers?		Not applicable. No emergency services are subject to prior authorization.	**N/A**	Yes - Emergency services can be provided by an in-network or out-of-network provider without authorization.	**N/A**	Yes - Emergency services can be provided by an in-network or out-of-network provider without authorization.	**N/A**	**N/A**	**N/A**
If there is any **change** to prior authorization policies or procedures, does the plan **update providers** about the change? How often do these updates occur?		Not applicable. No emergency services are subject to prior authorization.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Emergency and Crisis services do not require prior authorization. However, should any changes occur, COA would notify providers as necessary.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Emergency and Crisis services do not require prior authorization. However, should any changes occur, COA would notify providers as necessary.	Yes, we would update providers if there were to be changes, but there have not been any changes thus far.	Yes, we would update providers if there were to be changes, but there have not been any changes thus far.	**N/A**
Evidentiary Standards									
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to determine whether to prior authorize services?		Not applicable. No emergency services are subject to prior authorization.	No	N/A. Emergency and Crisis services do not require prior authorization.	No	N/A. Emergency and Crisis services do not require prior authorization.	N/A	N/A	**N/A**
Does the plan use **internally developed guidelines** to determine whether to prior authorize services? IF YES: How **frequently** are those guidelines updated?		Not applicable. No emergency services are subject to prior authorization.	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	N/A. Emergency and Crisis services do not require prior authorization.	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	N/A. Emergency and Crisis services do not require prior authorization.	N/A	N/A	**N/A**

Benefit Classification: PHARMACY SERVICES

NQTL: Prior Authorization

Prior Authorization: Requirement that a provider must submit a request before performing a service and may only render it after receiving approval.

Process									
Are **all services** in this classification prior authorized? List any services (by procedure code) in this classification to which prior authorization does not apply.		Not applicable	**The RAE does not perform PA for pharmacy services.**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**The RAE does not perform PA for pharmacy services.**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A; CCHA does not administer the pharmacy benefit**	**N/A; CCHA does not administer the pharmacy benefit**	**No**
Are there **exceptions** to prior authorization requirements in certain circumstances? List the situations when exceptions are granted.		Not applicable	**N/A**	N/A - Colorado is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	**Yes**
Are prior authorizations performed by the **direct treatment provider**, or does the plan require **secondary assessment** to complete the authorization?		Not applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	**Direct Treatment Provider**
What is the maximum amount of **time** allowed to issue a determination on a prior authorization request?		Not applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	**Variable**
Strategy									
What is the **rationale** for prior authorizing services in this classification?		Not applicable	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A	To contain costs, provide only medicall neccessity care and ensure criteria are met.
Are prior authorization policies the same for both **in-network and out-of-network** providers?		Not applicable	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A	Yes
If there is any **change** to prior authorization policies or procedures, does the plan **update providers** about the change? How often do these updates occur?		Not applicable	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A	Providers notified via website.
Evidentiary Standards									
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to determine whether to prior authorize services?		Not applicable	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A	Yes
Does the plan use **internally developed guidelines** to determine whether to prior authorize services? IF YES: How **frequently** are those guidelines updated?		Not applicable	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A	Yes

Mental Health Parity and Addiction Equity Act (MHPAEA) Nonquantitative Treatment Limit (NQTL) Analysis		RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	FFS Medical/Surgical
Regional Accountable Entity: All RAEs	**Benefit Classification:** INPATIENT SERVICES								
NQTL: Concurrent Review									
Concurrent Review: Requirement that services be periodically reviewed as they are being provided in order to continue authorization.									
Process									
Are **all services** in this classification concurrently reviewed? List any services (by procedure code) in this classification to which concurrent review does not apply.		Yes	Yes	Yes.	Yes	Yes.	Yes	Yes	Concurrent review equivalent to prior authorization for medical surgical. Renewing treatment services is renewing a PAR, or submitting a new PAR to continue treatment.
Are there **exceptions** to concurrent review requirements in certain circumstances? List the situations when exceptions are granted.		No	Yes. For inpatient facilities contracted under a case rate agreement, concurrent reviews are conducted less frequently.	No	Yes. For inpatient facilities contracted under a case rate agreement, concurrent reviews are conducted less frequently.	No	No	No	**Yes**
How **frequently** is concurrent review required for services in this classification?		Upon admission, dependent on length of stay every 2 to 3 days.	**It varies depending on the level of care and the facility in question.**	The reviewer establishes a review period consistent with the member's clinical presentation and the member's anticipated discharge timeline. Most inpatient stays are reviewed every 2-3 days, but could be extended or shortened as needed.	**It varies depending on the level of care and the facility in question.**	The reviewer establishes a review period consistent with the member's clinical presentation and the member's anticipated discharge timeline. Most inpatient stays are reviewed every 2-3 days, but could be extended or shortened as needed.	**Frequency varies by the member's clinical presentation, but typically reviews are required every 3 days.**	**Frequency varies by the member's clinical presentation, but typically reviews are required every 3 days.**	**Variable**
Are concurrent reviews performed by the direct treatment provider, or does the plan require **secondary assessment** to complete the authorization?		Direct Treatment Provider	**Direct treatment provider**	Concurrent reviews occur between the current treatment provider and a Colorado Access reviewer. Colorado Access does not require assessment from any secondary reviewers.	**Direct treatment provider**	Concurrent reviews occur between the current treatment provider and a Colorado Access reviewer. Colorado Access does not require assessment from any secondary reviewers.	**Direct treatment provider**	**Direct treatment provider**	**Both**
What is the **maximum amount of time** allowed to issue a determination on a concurrent review request?		1 business day	**72 hours when reviewing on last covered day**	Per state and federal regulations, 1 business day.	**72 hours when reviewing on last covered day**	Per state and federal regulations, 1 business day.	**72 hours**	**72 hours**	**Variable**
Strategy									
What is the **rationale** for applying concurrent review to services in this classification?		To ensure that appropriate level of care and quality services are provided.	Inpatient level of care is the most restrictive for members. We conduct Concurrent reviews to make sure that Member could not be safely treated at a lower level of care. Concurrent reviews are also critical in succesful discharge coordination.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member's condition, and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.	Inpatient level of care is the most restrictive for members. We conduct Concurrent reviews to make sure that Member could not be safely treated at a lower level of care. Concurrent reviews are also critical in succesful discharge coordination.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member's condition, and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	To contain costs, provide only medical necessity care and ensure criteria are met.
Are concurrent review policies the same for both **in-network and out-of-network** providers?		Yes	**Yes, however a SCA is needed for out-of-network providers**	Yes.	**Yes, however a SCA is needed for out-of-network providers**	Yes.	**Yes**	**Yes**	Yes
If there is any change to concurrent review policies or procedures, does the plan **update providers** about the change?		If RMHP changed its policy about concurrent review, it would update providers.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Procedural changes are rare; minor changes (e.g., an edit to the prior authorization request form) are not uncommon.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Procedural changes are rare; minor changes (e.g., an edit to the prior authorization request form) are not uncommon.	Yes	Yes	Yes, via website.
Evidentiary Standards									
Does the plan use **nationally recognized evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding concurrent review?		Tes	No	InterQual. Case-by case review by a Colorado Access Medical Director for any request not meeting InterQual criteria.	No	InterQual. Case-by case review by a Colorado Access Medical Director for any request not meeting InterQual criteria.	Yes	Yes	No
Does the plan use **internally developed guidelines** to determine whether to concurrently review services? IF YES: How **frequently** are those guidelines updated?		No	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	No	No	Yes

	Benefit Classification: OUTPATIENT SERVICES
NQTL: Concurrent Review	
Concurrent Review: Requirement that services be periodically reviewed as they are being provided in order to continue authorization.	
Process	

Are **all services** in this classification concurrently reviewed? List any services (by procedure code) in this classification to which concurrent review does not apply.		No More intensive outpatient services require concurrent review for authorization. These services include: - Psych Testing - ECT - PhP (MH Only) - IOP (Both MH and SUD) - Day Treatment	**No. Those services which are considered "routine" outpatient do not require authorization. Those include: 0510, 0521, 0529, 90791, 90792, 90832, 90834, 90837, 90839, 90846, 90847, 90849, 90853, 96372, H0001, H0002, H0004, H0005, H0006, H0018, H0020, H0023, H0025, H0031-34, H0036-38, H2000, H2014-18, H2021, H2022, H2027, H2030, H2031, S3005, S9445, S9453, S9454, T1007, T1017, T1019, T1023 and all E&M codes.**	No. Only bed-based services require concurrent review: acute treatment unit services (ATU), and residential services.	**No. Many services which are considered "routine" outpatient do not require authorization. Those include: 0510, 0521, 0529, 90792, 90839, 90849, 90853, 96372, H0001, H0002, H0004, H0005, H0006, H0018, H0020, H0023, H0025, H0031-34, H0036-38, H2000, H2014-18, H2021, H2022, H2027, H2030, H2031, S3005, S9445, S9453, S9454, T1007, T1017, T1019, T1023 and all E&M codes. Routine outpatient services covered under the Short Term Behavioral Health Benefit are subject to authorization after the first 6 visits.**	No. Only bed-based services require concurrent review: acute treatment unit services (ATU), and residential services.	**No; 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90875, 90876, 96116, 96121, 96130-96139, 96372, 97535, g1076, h0006, h0020, h0033, h0034, h0035, h0045, h2014, h2023-h2032, s3005, s9445, s9485, t1005, t1017, 90791, 90792, 90839, 90940, 98966-98968,h0001-h0005, h0023, h0025, h0031, h0032, h2000, h2011, s9453, s9454, t1007, t1023, 99241-99245, 99201-99443, 90833-90838**	**No; 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90875, 90876, 96116, 96121, 96130-96139, 96372, 97535, g1076, h0006, h0020, h0033, h0034, h0035, h0045, h2014, h2023-h2032, s3005, s9445, s9485, t1005, t1017, 90791, 90792, 90839, 90940, 98966-98968,h0001-h0005, h0023, h0025, h0031, h0032, h2000, h2011, s9453, s9454, t1007, t1023, 99241-99245, 99201-99443, 90833-90838**	No
Are there **exceptions** to concurrent review requirements in certain circumstances? List the situations when exceptions are granted.		No	**No**	No.	**No**	No.	**No**	**No**	No
How **frequently** is concurrent review required for services in this classification?		For those outpatient services that require concurrent review, frequency is every 3-5 days based on severity of symptoms	**That varies depending on the particular service and how quickly authorized units are exhausted.**	The reviewer establishes a review period consistent with the member's clinical presentation, the member's anticipated discharge timeline, and the program from which the member is receiving services. For example, ATU services are reviewed every 2-3 days similar to inpatient, short-term residential services are typically reviewed every 3-5 days, and long-term residential services are typically reviewed every 30 days. These timeframes are adjusted on a case-by-case basis.	**That varies depending on the particular service and how quickly authorized units are exhausted.**	The reviewer establishes a review period consistent with the member's clinical presentation, the member's anticipated discharge timeline, and the program from which the member is receiving services. For example, ATU services are reviewed every 2-3 days similar to inpatient, short-term residential services are typically reviewed every 3-5 days, and long-term residential services are typically reviewed every 30 days. These timeframes are adjusted on a case-by-case basis.	**Frequency varies by the member's clinical presentation, but typically reviews are required every one - three weeks.**	**Frequency varies by the member's clinical presentation, but typically reviews are required every one - three weeks.**	Variable
Are concurrent reviews performed by the direct treatment provider, or does the plan require **secondary assessment** to complete the authorization?		Direct Treatment Provider	**Direct treatment provider**	Concurrent reviews occur between the current treatment provider and a Colorado Access reviewer. Colorado Access does not require assessment from any secondary reviewers.	**Direct treatment provider**	Concurrent reviews occur between the current treatment provider and a Colorado Access reviewer. Colorado Access does not require assessment from any secondary reviewers.	**Direct treatment provider**	**Direct treatment provider**	Direct Treatment Provider
What is the **maximum amount of time** allowed to issue a determination on a concurrent review request?		10 days	**10 calendar days**	Per state and federal regulations, 1 business day.	**10 calendar days**	Per state and federal regulations, 1 business day.	**10 days**	**10 days**	Variable
Strategy									
What is the **rationale** for applying concurrent review to services in this classification?		The outpatient services needing concurrent review are considered to be more complex that typical outpatient services. There is also the need to ensure that medical necessity is met for these levels of care.	The outpatient services that do require authorization are generally considered non-routine or more complex interventions such as IOP, in-home services, respite, ECT or psych testing where we want to establish medical necessity.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. This means that the care is necessary and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified setting.	The outpatient services that do require authorization are generally considered non-routine or more complex interventions such as IOP, in-home services, respite, ECT or psych testing where we want to establish medical necessity.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. This means that the care is necessary and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified setting.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	To contain costs, provide only medical necessity care and ensure criteria are met.
Are concurrent review policies the same for both **in-network and out-of-network** providers?		Yes	**Yes, Out of network providers have to secure a single case agreement for services.**	Yes.	**Yes. Out of network providers have to secure a single case agreement for services.**	Yes.	**No**	**No**	Yes
If there is any change to concurrent review policies or procedures, does the plan **update providers** about the change?		If RMHP changed its policy about concurrent review, it would update providers.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Procedural changes are rare; minor changes (e.g., an edit to the prior authorization request form) are not uncommon.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Procedural changes are rare; minor changes (e.g., an edit to the prior authorization request form) are not uncommon.	Yes	Yes	Yes, Providers notified via website
Evidentiary Standards									
Does the plan use **nationally recognized evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding concurrent review?		Yes	No	InterQual. Case-by case review by a Colorado Access Medical Director for any request not meeting InterQual criteria.	No	InterQual. Case-by case review by a Colorado Access Medical Director for any request not meeting InterQual criteria.	Yes	Yes	Yes
Does the plan use **internally developed guidelines** to determine whether to concurrently review services? IF YES: How **frequently** are those guidelines updated?		No	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	No	No	Yes

Benefit Classification: EMERGENCY SERVICES

NQTL: Concurrent Review

Concurrent Review: Requirement that services be periodically reviewed as they are being provided in order to continue authorization.

Process									
Are **all services** in this classification concurrently reviewed? List any services (by procedure code) in this classification to which concurrent review does not apply.		No	No. Concurrent review is conducted for CSU if the stay is over 5 days.	No. Emergency and Crisis services do not require authorization.	No. Concurrent review is conducted for CSU if the stay is over 5 days.	No. Emergency and Crisis services do not require authorization.	No emergency services require prior authorization	No emergency services require prior authorization. We are currently not reviewing CSU's for concurrent review	N/A
Are there **exceptions** to concurrent review requirements in certain circumstances? List the situations when exceptions are granted.		No Exceptions	N/A	No. Emergency and Crisis services do not require authorization.	N/A	No. Emergency and Crisis services do not require authorization.	N/A	N/A	N/A

How **frequently** is concurrent review required for services in this classification?		Not applicable. RMHP does not conduct concurrent review for emergency services.	N/A	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A	N/A
Are concurrent reviews performed by the direct treatment provider, or does the plan require **secondary assessment** to complete the authorization?		Not applicable. RMHP does not conduct concurrent review for emergency services.	N/A	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A	N/A
What is the **maximum amount of time** allowed to issue a determination on a concurrent review request?		Not applicable. No emergency services are subject to prior authorization.	72 hours, if applicable	N/A - Emergency and Crisis services do not require authorization.	72 hours, if applicable	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A	N/A
Strategy									
What is the **rationale** for applying concurrent review to services in this classification?		Not applicable. RMHP does not conduct concurrent review for emergency services.	We do not authorize emergent services.	N/A - Emergency and Crisis services do not require authorization.	We do not authorize emergent services.	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A	N/A
Are concurrent review policies the same for both **in-network and out-of-network** providers?		Yes	N/A	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A	N/A
If there is any change to concurrent review policies or procedures, does the plan **update providers** about the change?		If RMHP changed its policy about concurrent review, it would update providers.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Emergency and Crisis services do not require authorization. However, should any changes occur, COA would notify providers as necessary.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Emergency and Crisis services do not require authorization. However, should any changes occur, COA would notify providers as necessary.	N/A	N/A	N/A
Evidentiary Standards									
Does the plan use **nationally recognized evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding concurrent review?		Not applicable. No emergency services are subject to prior authorization.	No	N/A - Emergency and Crisis services do not require authorization.	No	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A	N/A
Does the plan use **internally developed guidelines** to determine whether to concurrently review services? IF YES: How **frequently** are those guidelines updated?		Not applicable. No emergency services are subject to prior authorization.	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	N/A - Emergency and Crisis services do not require authorization.	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A	N/A

Benefit Classification: PHARMACY

NQTL: Concurrent Review

Concurrent Review: Requirement that services be periodically reviewed as they are being provided in order to continue authorization.

Process									
Are **all services** in this classification concurrently reviewed? List any services (by procedure code) in this classification to which concurrent review does not apply.		Not applicable	**The RAE does not perform UM for pharmacy services.**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**The RAE does not perform UM for pharmacy services.**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A; CCHA does not administer the pharmacy benefit.**	**N/A; CCHA does not administer the pharmacy benefit.**	No
Are there **exceptions** to concurrent review requirements in certain circumstances? List the situations when exceptions are granted.		Not applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes
How **frequently** is concurrent review required for services in this classification?		Not applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Variable
Are concurrent reviews performed by the direct treatment provider, or does the plan require **secondary assessment** to complete the authorization?		Not applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Direct Treatment Provider
What is the **maximum amount of time** allowed to issue a determination on a concurrent review request?		Not applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Variable
Strategy									
What is the **rationale** for applying concurrent review to services in this classification?		Not applicable	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	To contain costs, provide only medical necessity care and ensure criteria are met.
Are concurrent review policies the same for both **in-network and out-of-network** providers?		Not applicable	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes
If there is any change to concurrent review policies or procedures, does the plan **update providers** about the change?		Not applicable	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes, Provider notified via website
Evidentiary Standards									
Does the plan use **nationally recognized evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding concurrent review?		Not applicable	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes
Does the plan use **internally developed guidelines** to determine whether to concurrently review services? IF YES: How **frequently** are those guidelines updated?		Not applicable	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes

Mental Health Parity and Addiction Equity Act (MHPAEA) Nonquantitative Treatment Limit (NQTL) Analysis		RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	FFS Medical/Surgical
Regional Accountable Entity: All RAEs	**Benefit Classification:** INPATIENT SERVICES								
NQTL: Retrospective Review									
Retrospective Review: Protocol for approving coverage for a service after it has been delivered.									
Process									
Is there a **time limit** on how far in the past services can be retrospectively reviewed? If so, what is that limit?		Yes. PAR providers have a timely filing limits of 180 days. Exception: NonPAR is case by case based on when the facility identifies the Member has Medicaid. Exception: Retroenrollment.	**120 days**	120 days	**120 days**	120 days	**Yes; the standard timeline is 30 days but the timeline may be extended on a case-by-case basis**	**Yes; the standard timeline is 30 days but the timeline may be extended on a case-by-case basis**	2 years
Are **all services** in this classification subject to retrospective review? List any services in this classification (by procedure code) to which retrospective review does not apply.		Yes	Yes	Yes.	Yes	Yes.	Yes	Yes	Yes
Are there **exceptions** to retrospective review in certain circumstances, including extension of time limits? List the situations when exceptions are granted.		No	**Yes. An exception was made for the recent "IMD clean-up" project between the RAEs, HCPF and the 7 IMDs.**	Not typically. Any extenuating circumstance would be reviewed on a case-by-case basis.	**Yes. An exception was made for the recent "IMD clean-up" project between the RAEs, HCPF and the 7 IMDs.**	Not typically. Any extenuating circumstance would be reviewed on a case-by-case basis.	**There are extensions when members become retro actively eligible for Medicaid. The provider has 30 days from the date that they learn of the eligibility to submit a retrospective review request.**	**There are extensions when members become retro actively eligible for Medicaid. The provider has 30 days from the date that they learn of the eligibility to submit a retrospective review request.**	Yes
What is the maximum amount of **time** allowed to issue a determination on a retrospective review request?		30 days	**30 calendar days**	Per state and federal regulations, within 30 days of the receipt of the request.	**30 calendar days**	Per state and federal regulations, within 30 days of the receipt of the request.	**30 days**	**30 days**	None
Strategy									
What is the **rationale** for retrospectively reviewing services in this classification?		To ensure that appropriate level of care and quality services are provided.	Inpatient level of care is the most restrictive for members. We conduct retrospective reviews to make sure that Member could not be safely treated at a lower level of care.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member's condition, and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.	Inpatient level of care is the most restrictive for members. We conduct retrospective reviews to make sure that Member could not be safely treated at a lower level of care.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the kind of services the member is receiving or the severity of the member's condition, and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified medical setting.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	Medical Necessity
Are retrospective review policies the same for both **in-network and out-of-network** providers?		No. If PAR provider does not obtain prior authorization we would deny it. If it is an out of network provider we would review.	**Yes**	Yes.	**Yes**	Yes.	**Yes**	**Yes**	Yes
If there is any **change** to retrospective review policies or procedures, does the plan **update providers** about the change?		Yes	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Procedural changes are rare; minor changes (e.g., an edit to the prior authorization request form) are not uncommon.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Procedural changes are rare; minor changes (e.g., an edit to the prior authorization request form) are not uncommon.	Yes	Yes	Yes, updates via website
Evidentiary Standards									

Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding retrospective review?		Yes	No	InterQual. Case-by case review by a Colorado Access Medical Director for any request not meeting InterQual criteria.	No	InterQual. Case-by case review by a Colorado Access Medical Director for any request not meeting InterQual criteria.	Yes	Yes	Yes
Does the plan use **internally developed guidelines** to determine whether to prior retrospectively review services? IF YES: How **frequently** are those guidelines updated?		No	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	No	No	Yes
Benefit Classification: OUTPATIENT SERVICES									
NQTL: Retrospective Review									
Retrospective Review: Protocol for approving coverage for a service after it has been delivered.									
Process									
Is there a **time limit** on how far in the past services can be retrospectively reviewed? If so, what is that limit?		Yes. PAR providers have a timely filing limits of 180 days. Exception: NonPAR is case by case based on when the facility identifies the Member has Medicaid. Exception: Retroenrollment.	**30 days**	120 days	**30 days**	120 days	**Yes; the standard is 30 days but the timeline may be extended on a case-by-case basis**	**Yes; the standard is 30 days but the timeline may be extended on a case-by-case basis**	2 years
Are **all services** in this classification subject to retrospective review? List any services in this classification (by procedure code) to which retrospective review does not apply.		Yes. We review on a case by case basis.	**No. Those services which are considered "routine" outpatient do not require authorization. Those include: 0510, 0521, 0529, 90791, 90792, 90832, 90834, 90837, 90839, 90846, 90847, 90849, 90853, 96372, H0001, H0002, H0004, H0005, H0006, H0018, H0020, H0023, H0025, H0031-34, H0036-38, H2000, H2014-18, H2021, H2022, H2027, H2030, H2031, S3005, S9445, S9453, S9454, T1007, T1017, T1019, T1023 and all E&M codes.**	Yes.	**No. Many services which are considered "routine" outpatient do not require authorization. Those include: 0510, 0521, 0529, 90792, 90839, 90849, 90853, 96372, H0001, H0002, H0004, H0005, H0006, H0018, H0020, H0023, H0025, H0031-34, H0036-38, H2000, H2014-18, H2021, H2022, H2027, H2030, H2031, S3005, S9445, S9453, S9454, T1007, T1017, T1019, T1023 and all E&M codes. Routine outpatient services covered under the Short Term Behavioral Health Benefit are subject to authorization after the first 6 visits.**	Yes.	No; 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90875, 90876, 96116, 96121, 96130-96139, 96372, 97535, g1076, h0006, h0020, h0033, h0034, h0035, h0045, h2014, h2023-h2032, s3005, s9445, s9485, t1005, t1017, 90791, 90792, 90839, 90940, 98966-98968,h0001-h0005, h0023, h0025, h0031, h0032, h2000, h2011, s9453, s9454, t1007, t1023, 99241-99245, 99201-99443, 90833-90838	No; 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90875, 90876, 96116, 96121, 96130-96139, 96372, 97535, g1076, h0006, h0020, h0033, h0034, h0035, h0045, h2014, h2023-h2032, s3005, s9445, s9485, t1005, t1017, 90791, 90792, 90839, 90940, 98966-98968,h0001-h0005, h0023, h0025, h0031, h0032, h2000, h2011, s9453, s9454, t1007, t1023, 99241-99245, 99201-99443, 90833-90838	Yes
Are there **exceptions** to retrospective review in certain circumstances, including extension of time limits? List the situations when exceptions are granted.		Yes. Exception: NonPAR is case by case based on when the facility identifies the Member has Medicaid. Exception: Retroenrollment.	**Yes. Exceptions are reviewed by the Utilization Management Director, Provider Relations Director and VP of Operations for extenuating circumstances.**	Not typically. Any extenuating circumstance would be reviewed on a case-by-case basis.	**Yes. Exceptions are reviewed by the Utilization Management Director, Provider Relations Director and VP of Operations for extenuating circumstances.**	Not typically. Any extenuating circumstance would be reviewed on a case-by-case basis.	**There are extensions when members become retro actively eligible for Medicaid. The provider has 30 days from the date that they learn of the eligibility to submit a retrospective review request.**	**There are extensions when members become retro actively eligible for Medicaid. The provider has 30 days from the date that they learn of the eligibility to submit a retrospective review request.**	Yes
What is the maximum amount of **time** allowed to issue a determination on a retrospective review request?		30 calendar days	**30 calendar days**	Per state and federal regulations, within 30 days of the receipt of the request.	**30 calendar days**	Per state and federal regulations, within 30 days of the receipt of the request.	**30 days**	**30 days**	None
Strategy									
What is the **rationale** for retrospectively reviewing services in this classification?		To ensure that appropriate level of care and quality services are provided.	The outpatient services that do require authorization are generally considered non-routine or more complex interventions such as IOP, in-home services, respite, ECT or psych testing where we want to establish medical necessity.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. This means that the care is necessary and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified setting.	The outpatient services that do require authorization are generally considered non-routine or more complex interventions such as IOP, in-home services, respite, ECT or psych testing where we want to establish medical necessity.	Colorado Access is committed to assuring that members receive the most appropriate and cost-effective service consistent with generally accepted medical standards of care. This means that the care is necessary and that safe, cost-effective and adequate care cannot be received as an outpatient or in a less intensified setting.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	To be able to provide care coordination to members and to help ensure that members are receiving the correct type of care for their clinical presentation.	Medical Necessity

Are retrospective review policies the same for both **in-network and out-of-network** providers?		No. If PAR provider does not obtain prior authorization we would deny it. If it is an out of network provider we would review.	**Yes**	Yes.	**Yes**	Yes.	**No**	**No**	Yes
If there is any **change** to retrospective review policies or procedures, does the plan **update providers** about the change?		Yes	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Procedural changes are rare; minor changes (e.g., an edit to the prior authorization request form) are not uncommon.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Yes, any changes to the authorization process would be communicated to providers via the Colorado Access website, provider manual, and/or the provider newsletter. Procedural changes are rare; minor changes (e.g., an edit to the prior authorization request form) are not uncommon.	Yes	Yes	Yes, updates via website
Evidentiary Standards									
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding retrospective review?		Yes	No	InterQual. Case-by case review by a COA Medical Director for any request not meeting InterQual criteria.	No	InterQual. Case-by case review by a COA Medical Director for any request not meeting InterQual criteria.	Yes	Yes	Yes
Does the plan use **internally developed guidelines** to determine whether to prior retrospectively review services? IF YES: How **frequently** are those guidelines updated?		No	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	Yes We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	No.	No	No	Yes

Benefit Classification: EMERGENCY SERVICES									
NQTL: Retrospective Review									
Retrospective Review: Protocol for approving coverage for a service after it has been delivered.									
Process									
Is there a **time limit** on how far in the past services can be retrospectively reviewed? If so, what is that limit?		Not applicable. Emergency services are not subject to retrospective review**.**	**We do not conduct UM review for emergent services.**	N/A - Emergency and Crisis services do not require authorization.	**We do not conduct UM review for emergent services.**	N/A - Emergency and Crisis services do not require authorization.	**N/A; Emergency services do not require review**	**N/A; Emergency services do not require review**	N/A
Are **all services** in this classification subject to retrospective review? List any services in this classification (by procedure code) to which retrospective review does not apply.		Not applicable. Emergency services are not subject to retrospective review.	**We do not conduct UM review for emergent services.**	N/A - Emergency and Crisis services do not require authorization.	**We do not conduct UM review for emergent services.**	N/A - Emergency and Crisis services do not require authorization.	No; review are not required	No; review are not required	N/A
Are there **exceptions** to retrospective review in certain circumstances, including extension of time limits? List the situations when exceptions are granted.		No	**N/A**	N/A - Emergency and Crisis services do not require authorization.	**N/A**	N/A - Emergency and Crisis services do not require authorization.	**N/A**	**N/A**	N/A
What is the maximum amount of **time** allowed to issue a determination on a retrospective review request?		Not applicable. Emergency services are not subject to retrospective review.	**N/A**	N/A - Emergency and Crisis services do not require authorization.	**N/A**	N/A - Emergency and Crisis services do not require authorization.	**N/A**	**N/A**	N/A
Strategy									
What is the **rationale** for retrospectively reviewing services in this classification?		Not applicable. Emergency services are not subject to retrospective review.	**N/A**	N/A - Emergency and Crisis services do not require authorization.	**N/A**	N/A - Emergency and Crisis services do not require authorization.	**N/A**	**N/A**	N/A
Are retrospective review policies the same for both **in-network and out-of-network** providers?		Not applicable. Emergency services are not subject to retrospective review.	**Yes, as applicable**	N/A - Emergency and Crisis services do not require authorization.	**Yes, as applicable**	N/A - Emergency and Crisis services do not require authorization.	**Yes**	**Yes**	N/A

If there is any **change** to retrospective review policies or procedures, does the plan **update providers** about the change?		If RMHP changed its policy about retrospective review for emergency services, it would update providers.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Emergency and Crisis services do not require authorization. However, should any changes occur, COA would notify providers as necessary.	Yes. Clinical policies are reviewed on an annual basis but may be adjusted more frequently should a change be required. Any changes are communicated to provider through alerts, website updates and Manual updates.	Emergency and Crisis services do not require authorization. However, should any changes occur, COA would notify providers as necessary.	N/A	N/A	N/A
Evidentiary Standards									
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding retrospective review?		Not applicable. Emergency services are not subject to retrospective review.	No	N/A - Emergency and Crisis services do not require authorization.	No	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A	N/A
Does the plan use **internally developed guidelines** to determine whether to prior retrospectively review services? IF YES: How **frequently** are those guidelines updated?		Not applicable. Emergency services are not subject to retrospective review.	We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	N/A - Emergency and Crisis services do not require authorization.	We use proprierary standards which are posted to the website. Those standards are reviewed at least annually.	N/A - Emergency and Crisis services do not require authorization.	N/A	N/A	N/A

Benefit Classification: PHARMACY SERVICES

NQTL: Retrospective Review

Retrospective Review: Protocol for approving coverage for a service after it has been delivered.

Process									
Is there a **time limit** on how far in the past services can be retrospectively reviewed? If so, what is that limit?		Not applicable. Pharmacy services are not subject to retrospective approval review**.**	**The RAE does not perform UM on pharmacy services.**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**The RAE does not perform UM on pharmacy services.**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A; CCHA does not administer the pharmacy benefit.**	**N/A; CCHA does not administer the pharmacy benefit.**	2 years
Are **all services** in this classification subject to retrospective review? List any services in this classification (by procedure code) to which retrospective review does not apply.		Not applicable.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes
Are there **exceptions** to retrospective review in certain circumstances, including extension of time limits? List the situations when exceptions are granted.		Not applicable.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes
What is the maximum amount of **time** allowed to issue a determination on a retrospective review request?		Not applicable.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	None
Strategy									
What is the **rationale** for retrospectively reviewing services in this classification?		Not applicable.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Medical Necessity
Are retrospective review policies the same for both **in-network and out-of-network** providers?		Not applicable.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes
If there is any **change** to retrospective review policies or procedures, does the plan **update providers** about the change?		Not applicable.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes, via the website
Evidentiary Standards									
Does the plan use **evidence-based clinical decision support products** (Interqual, Milliman, etc.) to make decisions regarding retrospective review?		Not applicable.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes
Does the plan use **internally developed guidelines** to determine whether to prior retrospectively review services? IF YES: How **frequently** are those guidelines updated?		Not applicable.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	N/A	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Yes

Mental Health Parity and Addiction Equity Act (MHPAEA) Nonquantitative Treatment Limit (NQTL) Analysis		RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	FFS Medical/Surgical
Regional Accountable Entity: All RAEs **Benefit Classification:** INPATIENT SERVICES									
NQTL: Network Provider Admission									
Network Provider Admission: Process of accepting treatment providers into the health plan's network of care professionals.									
Process									
Does the plan have an **internal credentialing committee** that makes decisions about admitting providers into the network?		RMHP utilizes regional peer review committees that review applications and make recommendations to RMHP Medical Directors.	**Yes**	We follow NCQA Credentialing Standards, and providers that serve members in the inpatient setting are not in the scope of credentialing.	**Yes**	We follow NCQA Credentialing Standards, and providers that serve members in the inpatient setting are not in the scope of credentialing.	**Yes**	**Yes**	**No**
Are there any **exceptions** to the normal provider admission process for the plan for certain types of providers?		Certain providers that are working under the supervision of a credentialed provider do not require credentialing by RMHP.	**No**	N/A	**No**	N/A	**No**	**No**	**No**
Is there an **appeals process** in place for providers who apply for admission into the network and are denied?		Yes	**Yes**	No, there is not an appeals process for providers denied initial credentialing. We do offer an appeals process for providers that are termed from the network during the recredentialing process.	**Yes**	No, there is not an appeals process for providers denied initial credentialing. We do offer an appeals process for providers that are termed from the network during the recredentialing process.	**Yes**	**Yes**	**No**
Strategy									
Does the plan conduct a **needs assessment** for the population you serve and use that as the basis for establishing a network provider admission strategy?		RMHP does an access and availabilitly analysis on an annual basis. Within our service area RMHP rarely will limit admission of qualified providers, but may limit providers who are not located in the service area who are not filling a need.	**We use the Network Adequacy reports**	Yes, periodically.	**We use the Network Adequacy reports**	Yes, periodically.	**Yes**	**Yes**	No
Evidentiary Standards									
Does the plan use **National Committee for Quality Assurance (NCQA)** guidelines for admitting providers into the network?		Yes-We are NCQA accredited.	**Yes**	We follow NCQA Credentialing Standards, and providers that serve members in the inpatient setting are not in the scope of credentialing.	**Yes**	We follow NCQA Credentialing Standards, and providers that serve members in the inpatient setting are not in the scope of credentialing.	**Yes**	**Yes**	Yes
Does the plan use **URAC accreditation** criteria for admitting providers into the network?		No-we are NCQA accredited.	**No**	No.	**No**	No.	**No**	**No**	No
Does the plan use **primary source data** from individuals applying to the network (licensure, certifications, malpractice history, liability insurance, etc.) when making admission decisions?		Yes	**Yes**	N/A	**Yes**	N/A	**Yes**	**Yes**	Yes

Benefit Classification: OUTPATIENT SERVICES	
NQTL: Network Provider Admission	
Network Provider Admission: Process of accepting treatment providers into the health plan's network of care professionals.	
Process	

Does the plan have an **internal credentialing committee** that makes decisions about admitting providers into the network?		RMHP utilizes regional peer review committees that review applications and make recommendations to RMHP Medical Directors.	**Yes**	Yes. The Credentialing Committee meets once a month to review files that do not meet criteria. The Medical Director signs off on clean files.	**Yes**	Yes. The Credentialing Committee meets once a month to review files that do not meet criteria. The Medical Director signs off on clean files.	**Yes**	**Yes**	**No**
Are there any **exceptions** to the normal provider admission process for the plan for certain types of providers?		Certain providers that are working under the supervision of a credentialed provider do not require credentialing by RMHP.	**No**	There are no exceptions in the credentialing process.	**No**	There are no exceptions in the credentialing process.	**No**	**No**	**No**
Is there an **appeals process** in place for providers who apply for admission into the network and are denied?		Yes	**Yes**	No, there is not an appeals process for providers denied initial credentialing. We do offer an appeals process for providers that are termed from the network during the recredentialing process.	**Yes**	No, there is not an appeals process for providers denied initial credentialing. We do offer an appeals process for providers that are termed from the network during the recredentialing process.	**Yes**	**Yes**	**No**
Strategy									
Does the plan conduct a **needs assessment** for the population you serve and use that as the basis for establishing a network provider admission strategy?		RMHP does an access and availabilitly analysis on an annual basis. Within our service area RMHP rarely will limit admission of qualified providers, but may limit providers who are not located in the service area who are not filling a need.	**We use the Network Adequacy reports**	Yes, periodically.	**We use the Network Adequacy reports**	Yes, periodically.	**Yes**	**Yes**	No
Evidentiary Standards									
Does the plan use **National Committee for Quality Assurance (NCQA**) guidelines for admitting providers into the network?		Yes. We are NCQA accredited.	**Yes**	Yes, we follow NCQA Credentialing Standards.	**Yes**	Yes, we follow NCQA Credentialing Standards.	**Yes**	**Yes**	Yes
Does the plan use **URAC accreditation** criteria for admitting providers into the network?		No. We are NCQA accredited.	**No**	No.	**No**	No.	**No**	**No**	No
Does the plan use **primary source data** from individuals applying to the network (licensure, certifications, malpractice history, liability insurance, etc.) when making admission decisions?		Yes	**Yes**	Yes, we follow NCQA Credentialing Standards, and therefore primary source verify these items.	**Yes**	Yes, we follow NCQA Credentialing Standards, and therefore primary source verify these items.	**Yes**	**Yes**	Yes

Benefit Classification: EMERGENCY SERVICES

NQTL: Network Provider Admission

Network Provider Admission: Process of accepting treatment providers into the health plan's network of care professionals.

Process									
Does the plan have an **internal credentialing committee** that makes decisions about admitting providers into the network?		RMHP utilizes regional peer review committees that review applications and make recommendations to RMHP Medical Directors.	**Providers do not have to be credentialed to provide emergent services.**	We follow NCQA Credentialing Standards, and providers that serve members in emergency setting are not in the scope of credentialing.	**Providers do not have to be credentialed to provide emergent services.**	We follow NCQA Credentialing Standards, and providers that serve members in emergency setting are not in the scope of credentialing.	**N/A; CCHA does not credential Emergency Departments**	**N/A; CCHA does not credential Emergency Departments**	No
Are there any **exceptions** to the normal provider admission process for the plan for certain types of providers?		Certain providers that are working under the supervision of a credentialed provider do not require credentialing by RMHP.	**Providers do not have to be credentialed to provide emergent services.**	N/A	**Providers do not have to be credentialed to provide emergent services.**	N/A	**N/A**	**N/A**	No
Is there an **appeals process** in place for providers who apply for admission into the network and are denied?		Yes	**N/A**	N/A	**N/A**	N/A	**N/A**	**N/A**	No

Strategy									
Does the plan conduct a **needs assessment** for the population you serve and use that as the basis for establishing a network provider admission strategy?		RMHP does an access and availabilitly analysis on an annual basis. Within our service area RMHP rarely will limit admission of qualified providers, but may limit providers who are not located in the service area who are not filling a need.	**We use the Network Adequacy reports**	Yes, periodically.	**We use the Network Adequacy reports**	Yes, periodically.	**N/A**	**N/A**	No
Evidentiary Standards									
Does the plan use **National Committee for Quality Assurance (NCQA**) guidelines for admitting providers into the network?		Yes. We are NCQA accredited.	**Yes**	We follow NCQA Credentialing Standards, and providers that serve members in emergency setting are not in the scope of credentialing.	**Yes**	We follow NCQA Credentialing Standards, and providers that serve members in emergency setting are not in the scope of credentialing.	**N/A**	**N/A**	Yes
Does the plan use **URAC accreditation** criteria for admitting providers into the network?		No. We are NCQA accredited.	**No**	No.	**No**	No.	**N/A**	**N/A**	No
Does the plan use **primary source data** from individuals applying to the network (licensure, certifications, malpractice history, liability insurance, etc.) when making admission decisions?		Yes	**Yes**	N/A	**Yes**	N/A	**N/A**	**N/A**	Yes

Benefit Classification: PHARMACY SERVICES

NQTL: Network Provider Admission

Network Provider Admission: Process of accepting treatment providers into the health plan's network of care professionals.

Process									
Does the plan have an **internal credentialing committee** that makes decisions about admitting providers into the network?		Not Applicable	**We do not credential pharmacies.**	We follow NCQA Credentialing Standards, and pharmacy services are not in the scope of credentialing.	**We do not credential pharmacies.**	We follow NCQA Credentialing Standards, and pharmacy services are not in the scope of credentialing.	**N/A; CCHA does not credential pharmacies**	**N/A; CCHA does not credential pharmacies**	No
Are there any **exceptions** to the normal provider admission process for the plan for certain types of providers?		Not Applicable	**N/A**	N/A	**N/A**	N/A	**N/A**	**N/A**	No
Is there an **appeals process** in place for providers who apply for admission into the network and are denied?		Not Applicable	**N/A**	N/A	**N/A**	N/A	**N/A**	**N/A**	No
Strategy									
Does the plan conduct a **needs assessment** for the population you serve and use that as the basis for establishing a network provider admission strategy?		Not Applicable	**N/A**	Yes, periodically.	**N/A**	Yes, periodically.	**N/A**	**N/A**	No
Evidentiary Standards									
Does the plan use **National Committee for Quality Assurance (NCQA**) guidelines for admitting providers into the network?		Not Applicable	**N/A**	We follow NCQA Credentialing Standards, and pharmacy services are not in the scope of credentialing.	**N/A**	We follow NCQA Credentialing Standards, and pharmacy services are not in the scope of credentialing.	**N/A**	**N/A**	No
Does the plan use **URAC accreditation** criteria for admitting providers into the network?		Not Applicable	**N/A**	No.	**N/A**	No.	**N/A**	**N/A**	No
Does the plan use **primary source data** from individuals applying to the network (licensure, certifications, malpractice history, liability insurance, etc.) when making admission decisions?		Not Applicable	**N/A**	N/A	**N/A**	N/A	**N/A**	**N/A**	Yes

Mental Health Parity and Addiction Equity Act (MHPAEA) Nonquantitative Treatment Limit (NQTL) Analysis		RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	FFS Medical/Surgical
Regional Accountable Entity: All RAEs **Benefit Classification:** INPATIENT SERVICES									
NQTL: Establishing Charges									
Establishing Charges: Methods for determining usual, customary, and reasonable charges for services.									
Process									
Does the plan have an **internal process** for establishing charges for services, or is that role delegated to a vendor?		RMHP does this process internally.	**Internal process**	Colorado Access uses an internally developed Standard Rate Guide with reimbursement rates. We do not delegate this service.	**Internal process**	Colorado Access uses an internally developed Standard Rate Guide with reimbursement rates. We do not delegate this service.	**Internal Process**	**Internal Process**	**Yes**
How **frequently** does the plan update its charges for services in this classification?		RMHP reviews this process in accordance with fee schedules changes published by the state and our contractual rate setting process.	**There is no set schedule. Rates are reviewed based on market changes, provider requests, etc.**	Our reimbursement rates are adjusted annually when Medicare and Medicaid adjust their rates, when applicable. We are in the process of developing new IP rates and methodology for this catergory this year.	**There is no set schedule. Rates are reviewed based on market changes, provider requests, etc.**	Our reimbursement rates are adjusted annually when Medicare and Medicaid adjust their rates, when applicable. We are in the process of developing new IP rates and methodology for this catergory this year.	**When necessary due to per diem and DRG updates**	**When necessary due to per diem and DRG updates**	**DRGs are updated and per diems are updated on ad hoc basis**
Strategy									
What is the **rationale** for the plan's approach to establishing charges.		RMHP reimburses providers in a manner that is fair and within the budget requirements of the plan. Our strategy is to benchmark to market standard, reflect available budget, offer value based reimbursment for value-based care.	**Inpatient rates are set based on market trends, utilization and quality review.**	We want to pay our providers a fair rate so that they are encouraged to participate in the Medicaid network and provide services to Colorado Access's Health First Colorado (Colorado Medicaid) Members. We are working on a new value-based reimbursement to ensure that Colorado Access meets the RAE key performance indicators for regions 3 and 5, which in turn will result in improved patient care.	**Inpatient rates are set based on market trends, utilization and quality review.**	We want to pay our providers a fair rate so that they are encouraged to participate in the Medicaid network and provide services to Colorado Access's Health First Colorado (Colorado Medicaid) Members. We are working on a new value-based reimbursement to ensure that Colorado Access meets the RAE key performance indicators for regions 3 and 5, which in turn will result in improved patient care.	Past and present market costs, as well as the Medicaid fee schedule	Past and present market costs, as well as the Medicaid fee schedule	Approved State Plan Amendment
Does the plan consider **attracting an adequate network of providers** when developing its approach to establishing charges?		Yes.	**Yes**	Yes. Establishing fair rates has allowed us to have an expansive network.	**Yes**	Yes. Establishing fair rates has allowed us to have an expansive network.	Yes	Yes	No
Evidentiary Standards									
Does the plan use Colorado's **Medicaid Fee-for-Service (FFS)** rate schedule to determine how much it will charge for services?		RMHP uses the Medicaid Fee for Service rate in accordance with the budget and prior utilization to determine allowed charges.	No	N/A	No	N/A	Yes	Yes	Yes
Does the plan use Colorado's **Relative Value Units (RVU)** table as criteria for establishing charges?		RMHP uses Colorado's RVU table along with the budget and past utlization to determine allowed charges.	No	N/A	No	N/A	No	No	No

Benefit Classification: OUTPATIENT SERVICES	
NQTL: Establishing Charges	

Establishing Charges: Methods for determining usual, customary, and reasonable charges for services.

Process									
Does the plan have an **internal process** for establishing charges for services, or is that role delegated to a vendor?		RMHP does this process internally.	**Internal process**	Internal process.	**Internal process**	Internal process.	**Internal Process**	**Internal Process**	**Yes**
How **frequently** does the plan update its charges for services in this classification?		RMHP reviews this process in accordance with fee schedules changes published by the state and our contractual rate setting process.	**There is no set schedule. Rates are reviewed based on market changes, provider requests, etc.**	They are automatically updated annually when CMS and Health First Colorado (Colorado Medicaid) update. Updates were made in 2018/2019 for Community Mental Health Centers. We are performing a more extensive reimbursement update for non-Community Mental Health Center behavioral health providers in 2019.	**There is no set schedule. Rates are reviewed based on market changes, provider requests, etc.**	They are automatically updated annually when CMS and Health First Colorado (Colorado Medicaid) update. Updates were made in 2018/2019 for Community Mental Health Centers. We are performing a more extensive reimbursement update for non-Community Mental Health Center behavioral health providers in 2019.	**When necessary due to fee schedule updaets**	**When necessary due to fee schedule updaets**	**Annual Review**
Strategy									
What is the **rationale** for the plan's approach to establishing charges.		RMHP reimburses providers in a manner that is fair and within the budget requirements of the plan. Our strategy is to benchmark to market standard, reflect available budget, offer value based reimbursment for value-based care.	Outpatient rates are set based on market trends, utilization and quality review.	To provide fair rates to providers, and encourage providers to meet the RAE key performance indicator measures.	Outpatient rates are set based on market trends, utilization and quality review.	To provide fair rates to providers, and encourage providers to meet the RAE key performance indicator measures.	Past and present market costs, as well as the Medicaid fee schedule	Past and present market costs, as well as the Medicaid fee schedule	Approved State Plan Amendment
Does the plan consider **attracting an adequate network of providers** when developing its approach to establishing charges?		Yes.	Yes	Yes.	Yes	Yes.	Yes	Yes	Yes
Evidentiary Standards									
Does the plan use Colorado's **Medicaid Fee-for-Service (FFS)** rate schedule to determine how much it will charge for services?		RMHP uses the Medicaid Fee for Service rate in accordance with the budget and prior utilization to determine allowed charges.	No	Yes, partially.	No	Yes, partially.	Yes	Yes	Yes
Does the plan use Colorado's **Relative Value Units (RVU)** table as criteria for establishing charges?		RMHP uses Colorado's RVU table along with the budget and past utilzation to determine allowed charges.	Yes. Only for CMHCs outpatient MH serivces not for IPN providers or SUD services.	Yes, partially.	Yes. Only for CMHCs outpatient MH serivces not for IPN providers or SUD services.	Yes, partially.	Yes, taken into consideration for CMHCs	Yes, taken into consideration for CMHCs	Yes

Benefit Classification: EMERGENCY SERVICES

NQTL: Establishing Charges

Establishing Charges: Methods for determining usual, customary, and reasonable charges for services.

Process									
Does the plan have an **internal process** for establishing charges for services, or is that role delegated to a vendor?		RMHP does this process internally.	**Internal process**	Internal process only.	**Internal process**	Internal process only.	**Internal Process**	**Internal Process**	Yes
How **frequently** does the plan update its charges for services in this classification?		RMHP reviews this process in accordance with fee schedules changes published by the state and our contractual rate setting process.	**There is no set schedule. Rates are reviewed based on market changes, provider requests, etc.**	Annually if there are changes to RBRVS or Health First Colorado (Colorado Medicaid).	**There is no set schedule. Rates are reviewed based on market changes, provider requests, etc.**	Annually if there are changes to RBRVS or Health First Colorado (Colorado Medicaid).	**As Needed**	**As Needed**	Rates review annually
Strategy									

What is the **rationale** for the plan's approach to establishing charges.		RMHP reimburses providers in a manner that is fair and within the budget requirements of the plan. Our strategy is to benchmark to market standard, reflect available budget, offer value based reimbursment for value-based care.	Emergency rates are set based on market trends, utlization and quality review.	To attract and maintain providers, and to pay a fair rate.	Emergency rates are set based on market trends, utlization and quality review.	To attract and maintain providers, and to pay a fair rate.	We negotiate emergency rates based on market costs	We negotiate emergency rates based on market costs	Approved State Plan Amendment
Does the plan consider **attracting an adequate network of providers** when developing its approach to establishing charges?		Yes.	Yes	Yes.	Yes	Yes.	N/A	N/A	Yes
Evidentiary Standards									
Does the plan use Colorado's **Medicaid Fee-for-Service (FFS)** rate schedule to determine how much it will charge for services?		RMHP uses the Medicaid Fee for Service rate in accordance with the budget and prior utilization to determine allowed charges.	No	Yes, partially.	No	Yes, partially.	No	No	Yes
Does the plan use Colorado's **Relative Value Units (RVU)** table as criteria for establishing charges?		RMHP uses Colorado's RVU table along with the budget and past utlization to determine allowed charges.	No	Yes, partially.	No	Yes, partially.	No	No	Yes

Benefit Classification: PHARMACY SERVICES

NQTL: Establishing Charges

Establishing Charges: Methods for determining usual, customary, and reasonable charges for services.

Process									
Does the plan have an **internal process** for establishing charges for services, or is that role delegated to a vendor?		Not Applicable	**The RAE does not reimburse pharmacy services so therefor does not contract with pharmacies.**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**The RAE does not reimburse pharmacy services so therefor does not contract with pharmacies.**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A; CCHA does not pay pharmacy claims**	**N/A; CCHA does not pay pharmacy claims**	Yes
How **frequently** does the plan update its charges for services in this classification?		Not Applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Variable
Strategy									
What is the **rationale** for the plan's approach to establishing charges.		Not Applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	Approved State Plan Amendment
Does the plan consider **attracting an adequate network of providers** when developing its approach to establishing charges?		Not Applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	No
Evidentiary Standards									
Does the plan use Colorado's **Medicaid Fee-for-Service (FFS)** rate schedule to determine how much it will charge for services?		Not Applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	No
Does the plan use Colorado's **Relative Value Units (RVU)** table as criteria for establishing charges?		Not Applicable	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	N/A - Colorado Access is not responsible for pharmacy services for the RAE.	**N/A**	**N/A**	No