State of West Virginia

Department of Health and Human Resources

Mountain Health Trust

Mental Health Parity

Compliance Documentation

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State of West Virginia

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Common Terms and Acronyms

Term/Acronym	Definition
ABP	Alternative Benefit Plan
ACA	Affordable Care Act
ACT	Assertive Community Treatment
AHRQ	Agency for Healthcare Research and Quality
AICD	Automatic Implantable Cardioverter-Defibrillator
AIM	American Imaging Management
AL/ADL	Aggregate Lifetime and Annual Dollar Limits
ASAM	American Society of Addiction Medicine
BMS	Bureau for Medical Services, WV's State Medicaid Agency
CAD	Coronary Artery Disease
CALOCUS	Child and Adolescent Utilization System
CHIP	Children's Health Insurance Program
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CSAT	Center for Substance Abuse Treatment
CSU	Community Psychiatric Supportive Treatment
CT	Computed Tomography
CTA	CT Angiography
DHHR, Department	Department of Health and Human Resources
DME	Durable Medical Equipment
DRG	Diagnosis Related Group
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUR	Drug Utilization Review
ECT	Electro-Convulsive Treatment
EEG	Electroencephalogram

Term/Acronym	Definition
E&M	Evaluation and Monitoring
EHB	Essential Health Benefit
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ER	Emergency Room
FDA	Food and Drug Administration
FDB	First Data Bank
FFS	Fee-For-Service
FQHCs	Federally Qualified Health Centers
FR	Financial Requirements
HCERA	Health Care and Education Reconciliation Act of 2010
HEDIS	Healthcare Effectiveness Data and Information Set
HID	Health Information Design
ICD	International Classification of Diseases
IOP	Intensive Outpatient Services
LTSS	Long-Term Services and Supports
LOCUS	Level of Care Utilization System
MCE	Managed Care Entity
MCO	Managed Care Organization
MCG	Industry Evidence-Based Care Guidelines, Part of the Hearst Health Network
MH	Mental Health
MHPAEA	Mental Health Parity and Addiction Equity Act of 2008
MHT	Mountain Health Trust
MPI	Myocardial Perfusion Imaging
MPTAC	Medical Policy and Technology Assessment Committee
MRA	Magnetic Resonance Angiogram
MRI	Magnetic Resonance Imaging
M/S	Medical/Surgical
NCQA	National Committee for Quality Assurance

Term/Acronym	Definition
NQTL	Non-Quantitative Treatment Limit
PA	Prior Authorization
PCP	Primary Care Provider
PDL	Preferred Drug List
P&T	Pharmaceutical and Therapeutics
PET	Positron Emission Tomography
PH	Partial Hospitalization
PHP	Partial Hospitalization Program
PPACA	Patient Protection and Affordable Care Act
PQIC	Physician's Quality Improvement Committee
PRTF	Psychiatric Residential Treatment Facility
QAPI	Quality Assessment Performance Improvement
QI	Quality Improvement
QM/UM	Quality Management/Utilization Management Committee
QTL	Quantitative Treatment Limit
RDTP	Rational Drug Therapy Program
RX	Prescription Drug
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SEMP	Safe & Effective Management Plan of Pain Guidelines
SFY	State Fiscal Year
SIU	Special Investigations Unit
SPA	State Plan Amendment
SUD	Substance Use Disorder
State	West Virginia
THP	The Health Plan
UniCare	UniCare Health Plan of West Virginia
UR	Utilization Review

1.0 Introduction

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The MHPAEA requires insurers and plans to guarantee that all financial requirements (FR) (i.e., deductibles, co-pays), as well as caps and limitations on benefits, be no more restrictive for mental health (MH) services then for medical and surgical counterparts under the same plan.

The Affordable Care Act (ACA) built upon the MHPAEA by including MH services as an essential health benefit (EHB), and mandating that parity rules apply to individual and small-group markets. On March 30, 2016, the Centers for Medicare & Medicaid Services (CMS) finalized the MH and substance use disorder (SUD) parity rule for Medicaid and the Children's Health Insurance Program (CHIP) effective May 31, 2016. This final rule applied parity rules to Medicaid Managed Care Organizations (MCOs), Medicaid benchmark and benchmark-equivalent plans (referred to in this rule as Medicaid Alternative Benefit Plans [ABPs]), and CHIP.

In January 2017, the CMS issued rules, guidance, and a toolkit to assist the states in achieving compliance with the law.

Mountain Health Trust (MHT) is the Medicaid managed care program for WV. This document analyzes and demonstrates MHT's compliance with the MHPAEA. The State administers CHIP in a separate program and is submitting separate parity compliance documentation.

Mountain Health Promise is a Specialized Managed Care Program for Children and Youth and separate parity compliance documentation has been submitted.

2.0 Methodology

2.1 Benefit Package Identification Process

The WV Department of Health and Human Resources (DHHR, Department), Bureau for Medical Services (BMS), is the designated single state agency responsible for the administration of the State's Medicaid program. BMS provides access to appropriate healthcare for Medicaid-eligible individuals.

BMS has entered into contracts with three MCOs to provide risk-based comprehensive services to WV Medicaid/MHT's managed care enrollees: Aetna, The Health Plan (THP), and UniCare Health Plan of WV (UniCare).

2.2 Process to Determine Responsibility for Parity Analysis

WV Medicaid delivers most benefits using managed care; a few services are carved out and provided through fee-for-service (FFS) delivery systems. Pharmacy, school-based health services, and a few specific medical procedures are carved out of the MCO contract and provided on a FFS basis to MCO members. Pharmacy services were carved out of managed care as of July 1, 2017. In State Fiscal Year (SFY) 2016, behavioral health services were transitioned from FFS to managed care so behavioral health services and physical health services would be more integrated.

Because of the mixed delivery system, the State is responsible for conducting the parity analysis.

2.3 Stakeholder Participation

Stakeholders from DHHR BMS and the different delivery systems were involved in the review process, including the Assistant to the Deputy Secretary of Public Health, the Director of Pharmacy Services, the Director of Behavioral Health and Long-Term Care, and key individuals from Aetna, THP, and UniCare. State Medicaid contracted with its project management services vendor to facilitate the workgroups and provide subject matter expertise, project coordination, research, information gathering, and project management support.

3.0 Definitions

3.1 Benefit Groupings

3.1.1 Medical/Surgical (M/S) Benefits

Medical/Surgical (M/S) benefits are benefits for items or services for medical conditions or surgical procedures as defined by the state, and in accordance with applicable federal and state law, that do not include MH or SUD benefits.

3.1.2 MH Benefits

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), was selected as the generally recognized diagnostic standard for identifying MH/SUD services, and distinguishing MH/SUD services for procedure codes that can be used in both an M/S and MH/SUD context. MH services are those billed with a principal diagnosis from the DSM-V, excluding any diagnosis in the SUD range of F10 – F19.99.

3.1.3 SUD Benefits

SUD services are those billed with a principal diagnosis in the range F10 – F19.99 using the DSM-V.

3.2 Benefit Classifications

3.2.1 Inpatient

Inpatient services are services provided to a patient who has been formally admitted to a hospital or long-term care facility on the recommendation of a physician and is receiving room, board, and professional services in the institution on a continuous, 24-hour-a-day basis. Inpatient services include all treatments, pharmaceuticals, equipment, tests, and procedures provided during an inpatient treatment episode.

3.2.2 Outpatient

Outpatient services are services provided to a patient who is evaluated or treated at a hospital emergency department, medical clinic, diagnostic center, or other appropriate medical facility who is not receiving room, board, and professional services on a 24-hour-a-day basis, and who is not receiving Current Procedural Terminology (CPT) services 99281 – 99285 during the treatment episode. Outpatient services include all treatments, equipment, tests, procedures, and clinician-administered pharmaceuticals provided during an outpatient treatment episode.

3.2.3 Emergency Care

Emergency care services are services that are part of a treatment episode that includes CPT codes 99281 – 99285. For MH/SUD, crisis services (S9484, S9485, H0007, and H2011) are included in the emergency care classification because the goals of treatment are to assess and stabilize the patient, after which time the most appropriate disposition is determined.

Table 3.1: Emergency Care CPT Codes

CPT Code	Definition
99281	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem-focused history; a problem-focused examination; and straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
S9484	Crisis intervention mental health services per hour
S9485	Crisis intervention mental health services per diem
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H2011	Crisis intervention services per 15 minutes

3.2.4 Prescription Drug

Prescription drugs are simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that, by law, require a prescription. Prescription drug coverage is not provided by the MCO. BMS provides outpatient prescription drug coverage directly to Medicaid enrollees (source: MCO Contract).

4.0 Grouping and Classification of Benefits

4.1 Methodology

4.1.1 Benefit Grouping Process

Using a Medicaid data claims extract with procedure codes and diagnosis codes, non-pharmacy benefits were grouped as M/S, MH, or SUD, based on primary diagnoses provided in Section 3.1.

To group the pharmacy benefits, the First Databank HIC3 Class Codes were used, which group drugs into therapeutic classes. A subject matter expert manually reviewed covered therapeutic classes to ascertain they were appropriately assigned to MH/SUD, M/S, or both.

The State's internal workgroup reviewed the final benefit groupings for MH/SUD, M/S, and both.

4.1.2 Benefit Classification Process

To map non-pharmacy benefits to the inpatient, outpatient, prescription drug, and emergency care classifications as defined earlier, the MCO benefit package was reviewed against the agreed-upon definitions.

Pharmacy benefits were mapped to the prescription drug classification except drugs administered by a provider as part of an inpatient, outpatient, or emergency care episode of care.

WV's internal workgroup reviewed the final classification of benefits for both pharmacy and non-pharmacy benefits.

4.2 Non-Pharmacy Benefit Grouping and Classification

The following table shows the WV Medicaid non-pharmacy benefits grouped as MH, SUD, and M/S and classified as inpatient, outpatient, and emergency care. WV Medicaid covers MH/SUD benefits in every classification in which there is an M/S benefit. Pharmacy benefits can be found in Section 4.3.

Table 4.1: Non-Pharmacy Benefit Grouping and Classification

	Inpatient	Outpatient	Emergency Care
MH	• Inpatient Hospital Care • Inpatient Psychiatric Hospital • Rehabilitative Psychiatric Treatment (<21) • Prescription Drugs (Physician Administered)	• Clinic Services • Physician Services • Rural Health Clinic Services: Including Federally Qualified Health Centers (FQHCs) • Specialty Care • Behavioral Health Outpatient Services • Psychological Services	• Emergency Room (ER) • Outpatient Hospital Services • Emergency Transportation/ Ambulance • Prescription Drugs

	Inpatient	Outpatient	Emergency Care
	• Laboratory Services and Testing • Psychiatric Residential Treatment Facility (PRTF) (Children <21) • Hospital Services, Inpatient – Behavioral Health and Substance Use Disorder (SUD) Stays • Hospice • Evaluation and Monitoring (E&M) Services	• Outpatient Hospital Services • Outpatient Psychiatric Treatment • Prescription Drugs (Physician administered) • Speech Therapy • Laboratory Services and Testing • Nutritional Counseling • School-Based Services • Primary Care Office Visit • Nurse Practitioners' Services • Tobacco Cessation • Early Periodic Screening, Diagnosis, and Treatment (EPSDT) • Psychological testing/Psychiatric Testing • Developmental Testing: Limited • Developmental Testing: Extended • Neurobehavioral Status Exam • Neuropsychological Testing Battery • Individual Psychophysiological Biofeedback Training • Community Psychiatric Supportive Treatment (CSU) • Day Treatment • Therapeutic Behavioral Services – Development and Implementation • Targeted Case Management, • Comprehensive Community Support Services • Psychiatric Diagnostic Evaluation without Medical Services (Initial) or Medical Services • Multifamily Psychotherapy • Initial Evaluation without Medication Services	(Administered in the ER) • Laboratory Services and Testing • Crisis Residential Unit • Crisis Stabilization Unit • Crisis intervention

	Inpatient	Outpatient	Emergency Care
		• Individual Psychotherapy Services • Psychotherapy Patient & Family with E&M Services • Family Psychotherapy (Conjoint Psychotherapy) Occurs with and without Patient Present • Family Psychotherapy (with Patient Present) by Licensed Therapist. • Intensive Outpatient Services (IOP) • Partial Hospitalization Program (PHP) • Assertive Community Treatment (ACT) • Behavioral Health Home Visits • Psychological/Neuropsychological Testing • Outpatient electro-convulsive Treatment (ECT) • Psychotherapy Visits • Intensive Outpatient Testing • Transcranial Magnetic Stimulation for Depression • Psychiatric Diagnostic Interview • Case Consultation • Behavioral Health Counseling, Professional, Individual and Group • MH Assessment (Non-Physician) • MH Service Plan Development • Screening by Licensed Psychologist • Physician Coordinated Care Oversight Services • Developmental Testing • Nonemergency Medical Transportation	
SUD	• Inpatient Hospital Care	• Clinic Services	• ER

	Inpatient	Outpatient	Emergency Care
	• Inpatient Psychiatric Hospital • Rehabilitative Psychiatric Treatment (<21) • Prescription Drugs (Physician Administered) • Laboratory Services and Testing • PRTF(Children <21) • Hospital Services, Inpatient – Behavioral Health and SA Stays • Inpatient Psychiatric Services for Individuals Under Age 21 • E&M Services • Inpatient Detoxification	• Physician Services • Rural Health Clinic Services: Including FQHCs • Specialty Care • Behavioral Health Outpatient Services • Psychological Services • Outpatient Hospital Services • Outpatient Psychiatric Treatment • Prescription Drugs (Physician Administered) • Laboratory Services and Testing • Tobacco Cessation • School-Based Services • Nutritional Counseling • IOP • Behavioral Health Home Visits • Case Consultation • Behavioral Health Counseling, Professional, Individual, and Group • Targeted Case Management, • Comprehensive Community Support Services	• Emergency Transportation/ Ambulance • Prescription Drugs (Administered in the ER) • Laboratory Services and Testing • Crisis Residential Unit • Crisis Stabilization Unit
M/S	• Diagnostic X-Ray • Inpatient Hospital Care • Hospice • Hospital Inpatient/Maternity • Prescription Drugs (Physician Administered) • Physical Therapy • Occupational Therapy • Orthotics and Prosthetics • Inpatient Rehabilitation Hospital Services (<21)	• Ambulatory Surgical Center Services • Clinic Services • Children with Special Health Care Needs • Physician Services • Private Duty Nursing • Right From the Start Services • Rural Health Clinic Services: Including FQHCs • Vision Services • Dental Services (Children) • Nurse Practitioners' Services • Nurse Midwife Services	• Diagnostic X-Ray • ER • Emergency Transportation/ Ambulance • Laboratory Services and Testing • Prescription Drugs (Administered in the ER) • DME

	Inpatient	Outpatient	Emergency Care
	• Laboratory Services and Testing • EPSDT • Organ Transplant Services • Inpatient Hospice Care • Elective C-sections and All Elective Inductions	• Primary Care Office Visit • Specialty Care • Podiatry • Chiropractic • Diagnostic X-Ray • Outpatient Hospital Services • Hospice • Outpatient/Maternity • Prescription Drugs (Physician administered) • Physical Therapy • Occupational Therapy • Speech Therapy • Cardiac Rehabilitation • Pulmonary Rehabilitation • Durable Medical Equipment (DME) • Orthotics and Prosthetics • Home Health Care Services • Laboratory Services and Testing • Diabetes Education • Diabetes Disease State Management • EPSDT • Family Planning Services and Supplies • Nutritional Counseling • Personal Care Services • Abortion Services • School-Based Services • Organ Transplant Services • Automatic implantable cardioverter-defibrillator (AICD) • Biventricular Pacemaker • Cardiac Catheterization • Chemotherapy • Clinical Trials	• Laboratory Services and Testing • Dental Services (Adult) • Dental Services (Children)

	Inpatient	Outpatient	Emergency Care
		• Computed Tomography (CT) scans • Dental treatment for dental accidents • Genetic Testing • Hyperbaric Oxygen • Injectable and Self-Administered Injectable Drugs if Covered Under M/S Benefit • MRI (Magnetic Resonance Imaging)/Magnetic Resonance Angiogram (MRA)/Positron Emission Tomography (PET) • Molecular diagnostic testing • Non-Implanted Prosthetic Devices • Nuclear Radiology • Nutritional Formulas and supplements • Oral Surgery • Outpatient Polysomnograms • Outpatient Surgery • Pain Management Services/Programs, Including Epidural Steroid Injections • SPECT MPI (Myocardial Perfusion Imaging [MPI]) • Virtual Colonoscopy • Hysterectomy • Tonsillectomy with or without Adenoidectomy • Sleep Studies • Spinal Injections • Video Electroencephalogram (EEG) • Radiation Treatments • Venous Ablation • Septoplasty • Nuclear Cardiology	

4.3 Pharmacy Benefit Grouping and Classification

The embedded Microsoft Excel file below groups and classifies approved prescription drugs according to the definitions provided in Section 3.0.

Copy of Pharmacy Classification.xlsx

5.0 MCO Contract Compliance

WV Medicaid's SFY2021 MCO contract includes the following provisions requiring compliance with federal MH parity regulations, demonstrating compliance with 42 CFR Part 438.6(n). WV's SFY2021 MCO contract is included in this report as Appendix B.

5.1 Article II, Section 4.10 Utilization Review and Control

Page 19: "The MCO may place appropriate limits on the covered services provided under this Contract on the basis of criteria applied under the Medicaid State Plan, such as medical necessity or for the purpose of utilization control, provided the MCO services can reasonably be expected to achieve the purpose for which such services are furnished. The MCO must ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The MCO is prohibited from arbitrarily denying or reducing the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Notwithstanding the above, all covered services must be provided in compliance with the MHPAEA, and with EPSDT requirements, and the respective federal regulations."

5.2 Article II, Section 5.14 Compliance with Applicable Laws, Rules, and Policies

Page 23: "The MCO and its Subcontractors, in performing this contract, must comply with all applicable Federal and State laws, regulations, and written policies, including those pertaining to licensing and including those affecting the rights of enrollees. MCOs must include provisions relating to compliance with such laws in Subcontracts with providers. Assessment of compliance must be included in the MCOs' credentialing procedures to the extent feasible.

Work performed under this Contract must conform to the federal requirements set forth in Title 45, CFR Part 74 and Title 42, Part 434. The MCO must also abide by all applicable Federal and State laws and regulations including but not limited to:

- Section 504 of the Rehabilitation Act of 1973;
- Title IX of the Education Amendments of 1972;
- The Age Discrimination Act of 1975;
- Titles II and III of the Americans with Disabilities Act;
- Section 542 of the Public Health Service Act, pertaining to nondiscrimination against substance users;
- Title 45, Part 46 of the Code of Federal Regulations, pertaining to research involving human subjects;
- Title 45 Parts 160 and 164 Subparts A and E, pertaining to privacy and confidentiality;
- Title 42 Parts 434 and 438 of the Code of Federal Regulations, pertaining to managed care;

- Title 42 Parts 438, 440, and 457 of the Code of Federal Regulations, pertaining to mental health parity and addiction equity;
- Copeland Anti-Kickback Act;
- Davis-Bacon Act;
- Contract Work Hours and Safety Standards;
- Right to Inventions Made Under a Contract or Agreement;
- Clean Air Act and Federal Water Pollution Control Act;
- Byrd Anti-Lobbying Amendment;
- Debarment and Suspension;
- American Disabilities Act of 1990 as amended;
- Assisted Suicide Funding Restriction Act of 1997;
- Patient Protection and Affordable Care Act (PPACA);
- Mental Health Parity and Addiction Equity Act of 2008;
- Health Care and Education Reconciliation Act of 2010 (HCERA); and
- Any other pertinent Federal, State or local laws, regulations, or policies in the performance of this contract."

5.3 Article III, Section 10.1 MCO Behavioral Services Administration

Pages 157-158: "The MCO must provide inpatient and outpatient behavioral services as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished [42 CFR § 438.210]. The benefit must be provided in accordance with 42 CFR part 438 Subpart K, Parity in Mental Health and SUD Benefits. The MCO must develop and maintain an ongoing Mental Health Parity Compliance Plan to be submitted BMS annually by June 30th. The MCO is not subject to implementation of parity requirement associated with quantitative treatment limits of prescription drugs, as this benefit is administered under FFS. (Footnote 15: 42 CFR § 438.210)

The MCO may place appropriate limits on a service on the basis of such criteria as medical necessity or utilization control, consistent with the terms of this Contract and clinical guidelines. The MCO may not impose an aggregate lifetime, annual dollar limits, or other cumulative financial limits on mental health or SUD services.

The MCO must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of any type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees, to maintain compliance with the Bureau's Mental Health Parity Plan.

If an MCO enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care or prescription drugs), mental

health or substance use disorder benefits much be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided.

The MCO may not impose non-quantitative treatment limits (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification."

6.0 FR and QTLs

6.1 Aggregate Lifetime (AL) and Annual Dollar Limits (ADL)

6.1.1 FFS Benefits

WV Medicaid does not impose aggregate lifetime (AL), annual dollar limits (ADL), or other cumulative financial limits on any services provided through the FFS delivery system, including MH or SUD services. Because WV Medicaid does not impose this type of treatment limitation, WV has determined Medicaid to be in compliance with the parity regulations for AL/ADLs.

6.1.2 MCOs

WV Medicaid behavioral health services provided through the managed care delivery system are not subject to AL, ADL, or other cumulative financial limits as evidenced in WV Medicaid's SFY2021 MCO contract, Section 10.1 MCO Behavioral Services Administration (see Appendix B, page 158), which states: "The MCO may not impose an aggregate lifetime, annual dollar limits, or other cumulative financial limits on mental health or SUD services." Because WV Medicaid does not allow MCOs to utilize this type of treatment limitation, WV has determined the Medicaid MCOs to be in compliance with the parity regulations for AL/ADLs.

6.2 FR

6.2.1 FFS Benefits

WV Medicaid does not use coinsurance or deductibles in the FFS delivery system.

WV Medicaid does not charge copayments on non-pharmacy behavioral health services provided through the FFS delivery system.

WV's prescription drug copayment structure applies different levels of FR to different tiers of prescription drug benefits based on the cost of the prescription and is applied in a comparable manner without regard to whether a drug is generally prescribed for M/S benefits or for MH/SUD benefits. This multi-tiered approach satisfies parity requirements as set forth in 42 CFR 438.910(c)(2)(i).

6.2.2 MCOs

WV Medicaid behavioral health services provided through the managed care delivery system are not subject to premiums or deductibles as evidenced in WV Medicaid's SFY2021 MCO contract Definition of Cost-Sharing on page 6, which states: "There are no premiums or deductibles under the WV Medicaid program."

WV Medicaid behavioral health services provided through the managed care delivery system are not subject to copayments as evidenced in WV Medicaid's SFY2021 MCO contract, Section 3.9.1 Services and Members Exempt from Cost-Sharing Obligations of WV Medicaid's SFY2021 MCO contract (see Appendix B, pages 109 – 110), which states:

“The MCO and the MCO’s providers may not charge copays to the following MCO members or on the following services:

- Family planning services;
- Emergency services;
- Behavioral Health services;
- Members under age twenty-one (21);
- Pregnant women (including the sixty (60) day postpartum period following the end of pregnancy);
- American Indians and Alaska Natives;
- Enrollees receiving hospice care;
- Enrollees in nursing homes;
- Any additional enrollees or services excluded under the State Plan authority; and
- Enrollees who have met their household maximum limit for the cost-sharing obligations per calendar quarter.”

Because WV Medicaid prohibits the MCOs from charging copayments for behavioral health services, WV has determined the Medicaid MCOs to meet the parity regulations regarding FR.

6.3 QTLs

6.3.1 FFS Benefits

State Medicaid school-based health services include limitations on both MS and MH services. For MH, there are limitations regarding different types of psychotherapy services (i.e., individual, group, and family), developmental testing, and psychological testing. The State plans a QTL review and analysis which will include carved-out FFS services and MHP waiver services.

6.3.2 MCOs

The MCOs do not have any QTLs for MH/SUD benefits. Any service identified with a QTL, such as number of visits, can be exceeded if meeting medical necessity, as no hard caps are in place.

7.0 NQTLs

7.1 NQTL Identification and Analysis Process

7.1.1 NQTL Identification

To identify NQTLs, WV first reviewed documentation for carved-out FFS benefits, as well as documentation from the MCOs; this included reviewing the WV Medicaid State Plan, WV Medicaid provider manuals, and MCO member and provider handbooks.

To identify additional NQTLs and collect information about how they are applied in operation, WV created a comprehensive NQTL workbook, distributed it to the MCOs, and met with stakeholders from FFS programs. The State held an educational session with key individuals from the MCO to review the workbook and provide additional information about the purpose of the MH parity regulations and the analysis process. School-Based Health Services do not have any NQTLs applied to MH/SUD services that could limit patients' access to care. Pharmacy NQTLs that could potentially limit patients' access to care are analyzed in Section 8.0.

7.1.2 NQTL Evaluation Approach

Once all requested information about NQTLs was received, NQTLs were analyzed for comparability and stringency based on the federal guidance provided in the "Parity Compliance Toolkit." Based on the guidance provided in the August 22, 2017, webinar, for each NQTL in each classification for each MCO, six questions were addressed to make a compliance determination:

1. What benefits is the NQTL assigned to?
2. Strategy: Why is the NQTL assigned to these services?
3. Evidentiary Standard: What evidence supports the rationale for the assignment?
4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the MCO, beneficiary, and provider perspectives).
5. Strategy: How frequently or strictly is the NQTL applied?
6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

WV held additional meetings with the MCOs to explain the importance of understanding how the NQTLs are applied in writing and in operation, and to address follow-up questions in order to complete the analysis.

7.2 NQTL Classification

Table 7.1 below lists all NQTLs applicable to MH/SUD benefits and the benefits to which they apply in a classification. The following sub-sections describe how each NQTL applied to MH/SUD benefits meets the parity requirements of comparability and stringency for associated processes, strategies, evidentiary standards, and other factors.

Table 7.1: NQTLs by MCO and Classification

Section	MH/SUD NQTL	Inpt	Outpt	Emergency Services	Pharmacy	Compliant
8.0	**Utilization Review**					
8.1.1, 8.1.2	PA – Aetna	x	x			x
8.1.3 8.1.4	PA – THP	x	x			x
8.1.5 8.1.6	PA (Outpatient with Continued Review) – UniCare	x	x			See Appendix
8.1.7	Concurrent Review – Aetna	x	x			x
8.1.3, 8.1.8	Concurrent Review – THP	x	x			x
8.1.5	Concurrent Review – UniCare	x				See Appendix
8.1.9	Retrospective Review – Aetna	x	x			x
8.1.10	Retrospective Review – THP	x	x			x
8.1.5	Retrospective Review – UniCare	x	x			x
8.2	**Medical Management**					
8.2.1	Medical necessity criteria – Aetna	x	x	x		x
8.2.2	Medical necessity criteria – THP	x	x	x		x
8.2.3	Medical necessity criteria - UniCare	x	x	x		x
8.2.4	Practice Guidelines – Aetna	x	x			x
8.2.5	Practice Guidelines – THP	x	x			x
8.2.6	Practice Guidelines - UniCare	x	x			x
8.3	**Provider Network**					
8.3.1	Network size (patient-to-provider ratio, location, etc.) – Aetna	x	x	x		x
8.3.2	Network size (patient-to-provider ratio, location, etc.) – THP	x	x	x		x

Section	MH/SUD NQTL	Inpt	Outpt	Emergency Services	Pharmacy	Compliant
8.3.3	Network size (patient-to-provider ratio, location, etc.) – Unicare	x	x	x		x
11.0	**Pharmacy**					
11.1	Use of a Preferred Drug List (PDL)				x	x
11.2	Drugs on PDL must be tried first (step therapy/fail first)				x	x
11.3	Prior authorization				x	x
11.4	Prospective review				x	x
11.5	Higher (initial) dose of Suboxone covered only once				x	x
11.6	Pharmacy lock-in program				x	x

8.0 NQTL Analysis

8.1 Utilization Review NQTLs

8.1.1 Prior Authorization – Inpatient (Aetna)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
• MH/SUD Inpatient services • Psychiatric Residential Treatment Facilities *Medical services for the treatment of an emergency condition, including emergency transportation, crisis intervention/stabilization, and mobile response, are permitted to be delivered in or out of network without obtaining prior authorization.*	• M/S Inpatient hospital care • Inpatient hospice care, out of network *Medical services for the treatment of an emergency condition, including emergency transportation, are permitted to be delivered in or out of network without obtaining prior authorization.*

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
Objectives/Strategies • Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that might be approved, potentially denied, or reduced on the basis of medical necessity • Forward potential denials or reductions to the CMO or designated Medical Director for review • Ensure requests are processed by urgency and provider and/or members are notified of the determination within required time frames • Ensure the services are in the defined benefits and are appropriate, timely, and cost effective • Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished and that the services are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan	Objectives/Strategies • Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that might be approved, potentially denied, or reduced on the basis of medical necessity • Forward potential denials or reductions to the CMO or designated Medical Director for review • Ensure requests are processed by urgency and provider and/or members are notified of the determination within required time frames • Ensure the services are in the defined benefits and are appropriate, timely, and cost effective • Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished and that the services are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan

3. *Evidentiary Standard: What evidence supports the rationale for the assignment?*

MH/SUD	M/S
• The MCO adopts evidenced-based guidelines (e.g., MCG, ASAM Criteria) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives • The following are clinical criteria/guidelines that might be used when making PA decisions: ○ Criteria required by applicable state or federal regulatory agency ○ MCG (physical and behavioral health evidence-based clinical guidelines that are updated annually) ○ American Society of Addiction Criteria (ASAM) Criteria ○ Level of Care Utilization System (LOCUS), Children & Adolescent Service Intensity Instrument (CASII) ○ Aetna Clinical Policy Bulletins (CPBs), which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies ○ Aetna Policy Council Review • The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high-quality, and cost-effective care	• The MCO adopts evidenced-based guidelines (e.g., MCG) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiative • The following are clinical criteria/guidelines that might be used when making prior authorizations decisions: ○ Criteria required by applicable state or federal regulatory agency ○ MCG (physical and behavioral health evidence-based clinical guidelines that are updated annually) ○ Aetna CBPs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies ○ Aetna Policy Council Review • The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high-quality, and cost-effective care

4. *Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO beneficiary, and provider perspectives)*

MH/SUD	M/S
• PAs are performed by telephone or facsimile, and decisions are based on medical necessity	• PAs are performed by telephone or facsimile, and decisions are based on medical necessity

MH/SUD	M/S
• For urgent pre-service approvals, decisions are based on need, but no more than 2 calendar days from receipt of request • For urgent pre-service denials, decisions are based on need, but no more than 2 calendar days from receipt of request • For non-urgent pre-service approvals, based on members need but no more than 7 calendar days from receipt of the request • For non-urgent pre-service approvals, based on members need but no more than 7 calendar days from receipt of the request	• For urgent pre-service approvals, decisions are based on need, but no more than 2 calendar days from receipt of request • For urgent pre-service denials, decisions are based on need, but no more than 2 calendar days from receipt of request • For non-urgent pre-service approvals, based on members need but no more than 7 calendar days from receipt of the request • For non-urgent pre-service approvals, based on members need but no more than 7 calendar days from receipt of the request

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• The MCO annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision-making • A corrective education plan and monitoring of staff members who score below Aetna's interrater reliability target (85%)	• The MCO annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision-making • A corrective education plan and monitoring of staff members who score below Aetna's interrater reliability target (85%)

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld ○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site)	• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld ○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site)

MH/SUD	M/S
• The Service Improvement Committee (SIC) reviews all the above for Parity Rule compliance concerns • If there are any indications of potential noncompliance with the Parity Rule, the underlying data will be comprehensively reviewed, and if necessary, the appropriate actions will be taken	• These indicators are compared to MH/SUD indicators to identify any mental health parity concerns

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.1.2 Prior Authorization – Outpatient (Aetna)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
• Partial hospitalization (PH) • Services from a Non-Participating Provider (except emergency services) • Clinic Services • Physician Services • Rural Health Clinic Services Including FQHCs • Specialty Care • Behavioral Health Outpatient Services • Psychological Services • Outpatient Hospital Services • Outpatient Psychiatric Treatment • Speech Therapy • Laboratory Services and Testing • Nutritional Counseling • Tobacco Cessation • School-Based Services • Primary Care Office Visit • Nurse Practitioners' Services • EPSDT	• Ambulatory Surgical Center Services • Clinic Services • Children with Special Health Care Needs Services • Physician Services • Private Duty Nursing • Right From the Start Services • Rural Health Clinic Services Including FQHCs • Vision Services • Dental Services • Nurse Practitioners' Services • Nurse Midwife Services • Primary Care Office Visit • Specialty Care • Podiatry • Chiropractic Services • Diagnostic X-Ray • Outpatient Hospital Services • Hospice If Out of Network

MH/SUD	M/S
• Psychological Testing/Psychiatric Testing • Development Testing: Limited • Development Testing: Extended • Neurobehavioral Status Exam • Neuropsychological Testing Battery • Individual Psychophysiological Biofeedback Training • CSU • Day Treatment • Therapeutic Behavioral Services-Development and Implementation • Targeted Case Management, Each 15 Minutes • Comprehensive Community Support Services • Psychiatric Diagnostic Evaluation Without Medical Services (Initial) or Medical Services • Multifamily Psychotherapy • Initial Evaluation Without Medication Services • Individual Psychotherapy Services • Psychotherapy Patient and Family with E&M Services • Family Psychotherapy (Conjoint Psychotherapy) Occurs With and Without Patient Present • Family Psychotherapy (With Patient Present) by Licensed Therapist • IOP • PHP • ACT • Behavioral Health Home Visits • Psychological/Neuropsychological testing • Outpatient ECT • Psychotherapy Visits, after 12 visits, for Nonbiologically Based Diagnoses • Intensive Outpatient Testing • Transcranial Magnetic Stimulation for Depression • Psychiatric Diagnostic Interview • Case consultation • Behavioral health counseling, professional, individual and group • MH assessment (non-physician) • MH service plan development	• Outpatient/Maternity • Physical Therapy • Occupational Therapy • Speech Therapy • Cardiac Rehabilitation • DME • Orthotics and Prosthetics • Home Healthcare Services • Laboratory Services and testing • Diabetes Education • Diabetes Management • EPSDT • Family Planning Services and Supplies • Nutritional Counseling • Tobacco Cessation • Personal Care Services • Abortion Services • School-Based Services • Organ Transplant Services • AICD • Biventricular pacemaker • Cardiac catheterization • Chemotherapy • Clinical Trials • CT Scans • Dental Treatment for Dental Accidents (non-emergent) • Genetic Testing • Hyperbaric oxygen • Injectable and self-administered injectable drugs if covered under M/S benefit • MRI/MRA/PET • Molecular diagnostic testing • Non-implanted Prosthetic Devices • Nuclear radiology • Nutritional Formulas and Supplements • Oral Surgery

MH/SUD	M/S
• Crisis intervention • Screening by licensed psychologist • Physician coordinated care oversight services • Developmental testing • Nonemergency medical transportation *Medical services for the treatment of an emergency condition, including emergency transportation, crisis intervention/stabilization, and mobile response, are permitted to be delivered in or out of network without obtaining prior authorization*	• Outpatient Polysomnograms • Outpatient Surgery • Pain Management Services/Programs, Including Epidural Steroid Injections • SPECT MPI • Virtual Colonoscopy • Hysterectomy • Tonsillectomy With or Without Adenoidectomy • Sleep Studies • Spinal Injections • Video EEG • Radiation treatments • Venous ablation • Septoplasty • Nuclear Cardiology *Medical services for the treatment of an emergency condition, including emergency transportation, are permitted to be delivered in or out of network without obtaining prior authorization*

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
Objectives/Strategies • Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that might be approved, potentially denied, or reduced on the basis of medical necessity criteria • Forward potential denials or reductions to the CMO or designated Medical Director for review • Ensure requests are processed by urgency of request and Provider and/or Members are notified of the determination within require time frames	Objectives/Strategies • Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that might be approved, potentially denied, or reduced on the basis of medical necessity • Forward potential denials or reductions to the CMO or designated Medical Director for review • Ensure requests are processed by urgency of request and Provider and/or Members are notified of the determination within require time frames

MH/SUD	M/S
• Ensure the services are in the defined benefits, and are appropriate, timely, and cost effective • Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished at that are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan	• Ensure the services are in the defined benefits, and are appropriate, timely, and cost effective • Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished at that are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S

• The MCO adopts evidenced-based guidelines (e.g., MCG) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives
• The following are clinical criteria/guidelines that might be used when making PA decisions:
  ○ Criteria required by applicable state or federal regulatory agency
  ○ MCG (physical and behavioral health evidence-based clinical guidelines that are updated annually)
  ○ ASAM Criteria
  ○ LOCUS, CASII
  ○ Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies
  ○ Aetna Policy Council Review
• The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of
	• The MCO adopts evidenced-based guidelines (e.g., MCG) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives
	• The following are clinical criteria/guidelines that might be used when making prior authorizations decisions:
	  ○ Criteria required by applicable state or federal regulatory agency
	  ○ MCG (physical and behavioral health evidence-based clinical guidelines that are updated annually)
	  ○ Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organization and government public health agencies
	  ○ Aetna Policy Council Review
	• The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high quality, and cost-effective care

MH/SUD	M/S
service to achieve timely, high quality, and cost-effective care	

4. *Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)*

MH/SUD	M/S
• PAs are performed by telephone or facsimile, and decisions are based on medical necessity • For urgent pre-service approvals, decisions are based on need, but no more than 2 calendar days from receipt of request • For urgent pre-service denials, decisions are based on need, but no more than 2 calendar days from receipt of request • For non-urgent pre-service approvals, based on members need but no more than 7 calendar days from receipt of the request • For non-urgent pre-service approvals, based on members need but no more than 7 calendar days from receipt of the request	• PAs are performed by telephone or facsimile, and decisions are based on medical necessity • For urgent pre-service approvals, decisions are based on need, but no more than 2 calendar days from receipt of request • For urgent pre-service denials, decisions are based on need, but no more than 2 calendar days from receipt of request • For non-urgent pre-service approvals, based on members need but no more than 7 calendar days from receipt of the request • For non-urgent pre-service approvals, based on members need but no more than 7 calendar days from receipt of the request

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
• Aetna annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision-making • A corrective education plan and monitoring of staff member who score below Aetna's inter-rater reliability target (85%)	• Aetna annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision-making • A corrective education plan and monitoring of staff members who score below Aetna's inter-rater reliability target (85%)

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S
• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals, including: ○ Number of service authorizations requested ○ Number of service authorizations denied	• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals, including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal

MH/SUD	M/S
○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld ○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site) • The SIC reviews all the above for Parity Rule compliance concerns • If there are any indications of potential noncompliance with the Parity Rule exists, the underlying data will be comprehensively reviewed, and if necessary, the appropriate actions will be taken	○ Number of denied service authorizations with member appeal upheld ○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site) • These indicators are compared to MH/SUD indicators to identify any MH parity concerns

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.1.3 Prior Authorization and Concurrent Review - Inpatient (THP)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
• Tertiary Care • Out-of-Network Care • Elective Inpatient Care* • Inpatient Psychiatric • SUD Rehabilitation • Residential Adult Services for SUD • Psychiatric Residential Treatment Facilities **Notification for urgent and emergent admissions within 48 hours or as soon as reasonably possible*	• Tertiary Care • Out-of-Network Care • Elective Care in a Facility (Including M/S, Elective Obstetric, Skilled Nursing Facility (SNF), Medical Rehabilitation, and Long-Term Acute Care Hospitals)

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
Objectives/Strategies:	Objectives/Strategies:

MH/SUD	M/S
• Proactive assessment of the member receiving the most appropriate care and treatment at the most appropriate facility • Medical necessity review of the elective service based on the individualized need of the member and coverage supported by the contracted benefit plan utilizing nationally recognized criteria • Pre-authorization of elective admission is performed to confirm eligibility, benefits, and appropriateness of services to be rendered and level of care to be utilized • Reduce occurrences of misuse, over- or underutilization of services • Promote improvement of inpatient care outcomes • Confirm that discharge planning is begun early in the stay and assist with coordination of post-discharge services • Identify and refer members who could benefit from Aetna's Better Health's Integrated Management program or a community health program • Collaborate with members' assigned case managers to support a seamless transition of care between locations of care • Identify other payers (e.g., coordination of benefits, third-party liability, Medicare liability) • Identify and initiate referrals related to high-cost cases for reinsurance notification and potential quality of care issues, if appropriate	• Proactive assessment of the member receiving the most appropriate care and treatment at the most appropriate facility • Medical necessity review of the elective service based on the individualized need of the member and coverage supported by the contracted benefit plan utilizing nationally recognized criteria • Pre-authorization of Elective Admission is performed to confirm eligibility, benefits, and appropriateness of services to be rendered and level of care to be utilized • Reduce occurrences of misuse, over- or underutilization of services • Promote improvement of inpatient care outcomes • Confirm that discharge planning is begun early in the stay and assist with coordination of post-discharge services • Identify and refer members who could benefit from Aetna's Better Health's Integrated Management program or a community health program • Collaborate with members' assigned case managers to support a seamless transition of care between locations of care • Identify other payers (e.g., coordination of benefits, third-party liability, Medicare liability) • Identify and initiate referrals related to high-cost cases for reinsurance notification and potential quality of care issues, if appropriate

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
• Monthly, the chief medical officer (CMO), in conjunction with the director of Medical Management, is responsible for analyzing utilization data and identifying areas of concern. The CMO presents quarterly summaries of this information to the Quality Management/Utilization Management (QM/UM) Committee.	• Monthly, the CMO, in conjunction with the director of Medical Management, is responsible for analyzing utilization data and identifying areas of concern. The CMO presents quarterly summaries of this information to the QM/UM Committee. • This information assists with updating the list of services requiring PA and is updated at

MH/SUD	M/S
• This information assists with updating the list of services requiring PA and is updated at least annually and revised periodically as appropriate • The QM/UM committee is responsible to provide feedback to the CMO and provide action plans, including adjustments to the Quality Assessment Performance Improvement (QAPI) program • Inpatient services are costlier than most outpatient services • Individuals with MH conditions should be treated in the least restrictive environment and in a manner designed to preserve their dignity and autonomy and to maximize the opportunities for recovery. Concurrent review facilitates timely transfer of the member to the most appropriate level of care. • Any facility-based service that requires preauthorization is reviewed through the use of evidence-based criteria (Interqual or ASAM) and/or expert medical review • Review of preauthorization lists, denial rate reports, and out-of-network reports	least annually and revised periodically as appropriate • The QM/UM Committee is responsible to provide feedback to the CMO and provide action plans including adjustments to the QAPI program • Inpatient services are costlier than most outpatient services • Any facility-based service that requires preauthorization is reviewed through the use of evidence-based criteria (Interqual) and/or expert medical review • Review of preauthorization list, denial rates, facility report, out-of-network PA report

4. Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)

MH/SUD	M/S
• Urgent Admission (Preauthorization not required) • Notification is required at the time of, or as soon as practically possible after admission • Reviews are conducted of members' acute care hospitalizations as clinically indicated, either on-site or by telephone or facsimile. • Members of THP are afforded direct access to behavioral healthcare, meaning they have no need to obtain a pre-authorization in times of crisis or to be directed for evaluation of a behavioral health issue	• Urgent Admission • For urgent concurrent approvals/denials, decision must be communicated within 24 hours or one calendar day of request • Reviews are conducted of members' acute care hospitalizations as clinically indicated, either on-site or by telephone or facsimile and decisions are based on medical necessity

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• Evidence-based criteria is the basis of all decisions, however, review decisions are not made solely based on criteria • Members are regarded as individuals with specific care needs. • Only a physician may make an exception or issue a denial related to a preservice determination. • No vendors are utilized for BH/SUD • Each practitioner who makes medical review necessity decisions will have randomly selected cases evaluated quarterly. Individual results will be tabulated and reviewed by the Medical Directors Oversight Committee and reported to the Executive Committee as part their oversight annually. Collected scores will be used as a basis for individual assessment and for continuous quality improvement (CQI) within the group PROCEDURE: ○ The practitioner interrater review will be performed at least quarterly and analyzed annually ○ Reviews will consist of two approvals and two denials per month, with 2 random reviews in the year to total 50 case reviews per medical director (if applicable) ○ The selection of cases will range across all lines of business ○ The cases are randomly selected from the denial and approval files ○ The cases will be randomly selected and reviewed for consistency, rationality and uniformity in applying criteria/guidelines, by the Clinical Service Compliance Manager, Director of Medical Management or the Pre-Authorization Management Coordinator. ○ Compliance of 90 percent or greater is acceptable ○ Ad hoc reviews may be performed at any time as part of a performance evaluation.	• Evidence-based criteria is the basis of all decisions, however, review decisions are not made solely based on criteria • Members are regarded as individuals with specific care needs • Only a physician may make an exception or issue a denial related to a preservice determination • Palladian is the only vendor performing M/S services for Medicaid member elective procedures and their inpatient PA review is limited to spinal surgery. Palladian is NCQA accredited and subject to external audit in that fashion as well as sharing data with THP monthly. • Each practitioner who makes medical review necessity decisions will have randomly selected cases evaluated quarterly. Individual results will be tabulated and reviewed by the Medical Directors Oversight Committee and reported to the Executive Committee as part their oversight annually. Collected scores will be used as a basis for individual assessment and for CQI within the group PROCEDURE: ○ The practitioner interrater review will be performed at least quarterly and analyzed annually ○ Reviews will consist of two approvals and two denials per month, with 2 random reviews in the year to total 50 case reviews per medical director (if applicable) ○ The selection of cases will range across all lines of business ○ The cases are randomly selected from the denial and approval files ○ The cases will be randomly selected and reviewed for consistency, rationality and uniformity in applying criteria/guidelines, by the Clinical Service Compliance Manager, Director of Medical Management or the Pre-Authorization Management Coordinator.

MH/SUD	M/S
○ The cases are reviewed using the monitoring tool application in the HEART system. The cases are reviewed to assess for consistency, correct interpretation and application of criteria/guidelines and member's benefit within the coverage determination. Assessment is made to determine if the clinical decision involved the use of all submitted clinical information and claims history. Documentation to include rationale of the determination and mention of available possible alternatives to non-authorized services; a clear statement of "authorize" or "do not authorize" ○ Once the reviews are completed, the results will be discussed with the individual practitioner; which will include education, if needed ○ The results will be shared with the Director of Medical Management, the Vice President of Clinical Services, and the CMO ○ Annual results will be reported to MDOC and to the CQI committee	○ Compliance of 90 percent or greater is acceptable ○ Ad hoc reviews may be performed at any time as part of a performance evaluation ○ The cases are reviewed using the monitoring tool application in the HEART system. The cases are reviewed to assess for consistency, correct interpretation and application of criteria/guidelines and member's benefit within the coverage determination. Assessment is made to determine if the clinical decision involved the use of all submitted clinical information and claims history Documentation to include rationale of the determination and mention of available possible alternatives to non-authorized services; a clear statement of "authorize" or "do not authorize" ○ Once the reviews are completed, the results will be discussed with the individual practitioner; which will include education, if needed ○ The results will be shared with the Director of Medical Management, the Vice President of Clinical Services, and the CMO ○ Annual results will be reported to MDOC and to the CQI committee

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
• Complaints for MH/SUD enrollees are addressed and reviewed for opportunities for improvement • Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the QM/UM Committee • Annual report of inter-rater reliability assessment results • Monthly monitoring of denials by type (administrative/medical necessity)	• Complaints for MH/SUD enrollees are addressed and reviewed for opportunities for improvement • Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the QM/UM Committee • Annual report of inter-rater reliability assessment results. • Monthly monitoring of denials by type (administrative/medical necessity)

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.1.4 Prior Authorization – Outpatient (THP)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
• Psychotherapy visits, after 12 visits, for nonbiologically based diagnoses (treatment plan must be submitted) • Neuropsychological testing • Outpatient ECT • Transcranial magnetic stimulation for depression • Urine Drug Testing • IOP (after 30 units/days) • ACT • Genetic, pharmacokinetic, pharmacogenomics, and pharmacodynamics testing • Peer Review Recovery Support (H0038) after 400 unites • Out-of-area and out-of-network care • PH (after 30 units/days) • Crisis Stabilization Unit (CSU) (after 144 units) (Emergent Care) • Ambulance/ambulette – non-emergent • Applied Behavioral Analysis for Autism	• All out-of-network care per plan design • All services require pre-authorization per plan design (tertiary care) • CT/MRI/MRA • CT angiography (CTA) for Coronary Artery Disease (CAD) • Cardiac Imaging (CT/MRI/PET) • Virtual colonoscopy • Urine drug testing • CT/CTA • MPI (Nuclear Stress) • Echo/Echo Stress • Medical Procedures (including services related to spine management) • Ambulatory services (including ambulatory blood pressure monitoring) • Ancillary providers and services (including ambulance/ambulette – non-emergent) • New medical technologies (including artificial urinary sphincter)

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
PA is required for the following reasons: • Quality of care • Correct level of care • Coordination of care • Overutilization • Case management	PA is required for the following reasons: • Overutilization • Patient safety • High-cost services • Coordination of care • Care coordination

MH/SUD	M/S
• High-cost services • Determine benefit limits • Confirm most appropriate care, treatment and setting • Perform medical necessity review of the service with consideration of the individualized need of the member • All reviews for medical appropriateness by THP are determined by written criteria that are based on medical evidence	• Determine benefit limits • Potential for fraud • Prevent inappropriate use of technology • Confirm most appropriate care, treatment and setting • Perform medical necessity review of the service with consideration of the individualized need of the member • All reviews for medical appropriateness by THP are determined by written criteria that are based on medical evidence

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S

• Utilization data is monitored monthly and annually to identify potential patterns of underutilization and overutilization
  ○ Established thresholds are used to detect inappropriate utilization
  ○ Contributing causes are identified, and effective interventions are developed.
  ○ A summary report of monthly referrals regarding the authorization of services and denials is reviewed to determine the rate of authorization and any need for continued pre-authorization of the services
• Clinical Analytics program analyzes cost drivers, quality of services, and care delivery to provide support for PA assignment
• Review of reauthorization lists, preservice denial reports
• Any outpatient pre-service that requires preauthorization is reviewed through the use of evidence-based criteria (Interqual, ASAM, CMS/BMS criteria, Transplant and Technology, Hayes, UpToDate) and/or expert medical review
	• Utilization data is monitored monthly and annually to identify potential patterns of underutilization and overutilization
	  ○ Established thresholds are used to detect inappropriate utilization
	  ○ Contributing causes are identified, and effective interventions are developed
	  ○ A summary report of monthly referrals regarding the authorization of services and denials is reviewed to determine the rate of authorization and any need for continued pre-authorization of the services
	• Clinical Analytics program analyzes cost drivers, quality of services, and care delivery to provide support for PA assignment
	• Review of reauthorization lists, preservice denial reports
	• Any outpatient pre-service that requires preauthorization is reviewed through the use of evidence-based criteria (Interqual, ASAM, CMS/BMS criteria, Transplant and Technology, Hayes, UpToDate) and/or expert medical review

4. Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)

MH/SUD	M/S
• The UM program specifies the use of qualified health professionals whose education and experience are commensurate with the UM reviews or member navigation they perform ○ All care/complex case and chronic disease navigation, pre-authorization, and inpatient navigation decisions are made by individuals who have knowledge and skills to evaluate working diagnoses and proposed treatment plans ○ All registered nurses maintain, and show proof of, continued licensing and continuing education, credentialing, and certification, when appropriate ○ All certified complex case navigators maintain continued certification in complex case navigation ○ All registered nurses in the medical and behavioral health units are hired as per the qualifications required in the job description for a nurse navigator. ○ Behavioral health pre-authorization navigators (BA-psychology) will keep current with industry standards ○ A senior-level physician oversees the UM program and a designated behavioral healthcare practitioner oversees the behavioral health aspects of the program ○ Management staff (director, managers, supervisors) have day-to-day involvement in medical department and behavioral health activities and are available on-site daily and by telephone after regular business hours ○ Management staff participate in staff training, conduct staff meetings with responsibility for agendas and minutes, and provide guidance during “grand rounds” ○ Management staff complete interrater reliability review as per the Interrater Review Reliability Monitoring Policy	• The UM program specifies the use of qualified health professionals whose education and experience are commensurate with the UM reviews or member navigation they perform ○ All care/complex case and chronic disease navigation, pre-authorization, and inpatient navigation decisions are made by individuals who have knowledge and skills to evaluate working diagnoses and proposed treatment plans ○ All registered nurses maintain, and show proof of, continued licensing and continuing education, credentialing, and certification, when appropriate ○ All certified complex case navigators maintain continued certification in complex case navigation ○ All registered nurses in the medical and behavioral health units are hired as per the qualifications required in the job description for a nurse navigator ○ A senior-level physician oversees the UM program and a designated behavioral healthcare practitioner oversees the behavioral health aspects of the program. ○ Management staff (director, managers, supervisors) have day-to-day involvement in medical department and behavioral health activities and are available on-site daily and by telephone after regular business hours ○ Management staff participate in staff training, conduct staff meetings with responsibility for agendas and minutes, and provide guidance during “grand rounds” ○ Management staff complete interrater reliability review as per the Interrater Review Reliability Monitoring Policy ○ All non-authorizations of services that result from a determination of medical appropriateness are made by a licensed practitioner. This ensures that appropriate

MH/SUD	M/S
○ All non-authorizations of services that result from a determination of medical appropriateness are made by a licensed practitioner. This ensures that appropriate clinical judgment is used in making the denial determination. The practitioner(s) maintains continued licensing without restriction and board certification if applicable ○ Three years managed care experience in a managed care setting or behavioral health preferred ○ Any non-authorization of care or service based on medical appropriateness is reviewed by a practitioner, dentist, behavioral health practitioner, or pharmacist, as appropriate. The non-authorization rationale is documented in the system with electronic practitioner signature, date, and time ○ All cases that require clinical judgment outside the expertise of the medical directors are reviewed by licensed board-certified specialty practitioners. A list of (PAC) board-certified practitioners by specialty is kept by the UM staff as a resource when needed • The following staff may approve services: ○ Staff who are not qualified healthcare professionals and are under the supervision of an appropriately licensed health professional, when there are explicit UM criteria and no clinical judgment is required ○ Licensed healthcare professionals	clinical judgment is used in making the denial determination. The practitioner(s) maintains continued licensing without restriction and board certification if applicable ○ Three years managed care experience in a managed care setting or behavioral health preferred ○ Any non-authorization of care or service based on medical appropriateness is reviewed by a practitioner, dentist, behavioral health practitioner, or pharmacist, as appropriate. The non-authorization rationale is documented in the system with electronic practitioner signature, date, and time ○ All cases that require clinical judgment outside the expertise of the medical directors are reviewed by licensed board-certified specialty practitioners. A list of (PAC) board-certified practitioners by specialty is kept by the UM staff as a resource when needed • The following staff may approve services: ○ Staff who are not qualified healthcare professionals and are under the supervision of an appropriately licensed health professional, when there are explicit UM criteria and no clinical judgment is required ○ Licensed healthcare professionals

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• Evidence-based criteria is the basis of all decisions, however, review decisions are not made solely based on criteria. Members are regarded as individuals with specific care needs	• Evidence-based criteria is the basis of all decisions, however, review decisions are not made solely based on criteria. Members are regarded as individuals with specific care needs. Only a physician may make an

MH/SUD	M/S
• Only a physician may make an exception or issue a denial related to a preservice determination • No vendors are utilized for BH/SUD • Each practitioner who makes medical review necessity decisions will have randomly selected cases evaluated quarterly. Individual results will be tabulated and reviewed by the Medical Directors Oversight Committee and reported to the Executive Committee as part their oversight annually. Collected scores will be used as a basis for individual assessment and for continuous quality improvement (CQI) within the group PROCEDURE: ○ The practitioner interrater review will be performed at least quarterly and analyzed annually ○ Reviews will consist of two approvals and two denials per month, with 2 random reviews in the year to total 50 case reviews per medical director (if applicable) ○ The selection of cases will range across all lines of business ○ The cases are randomly selected from the denial and approval files ○ The cases will be randomly selected and reviewed for consistency, rationality and uniformity in applying criteria/guidelines, by the Clinical Service Compliance Manager, Director of Medical Management or the Pre-Authorization Management Coordinator ○ Compliance of 90 percent or greater is acceptable ○ Ad hoc reviews may be performed at any time as part of a performance evaluation ○ The cases are reviewed using the monitoring tool application in the HEART system. The cases are reviewed to assess for consistency, correct interpretation and application of criteria/guidelines and member's benefit within the coverage determination. Assessment is made to determine if the	exception or issue a denial related to a preservice determination • Palladian is the only vendor performing M/S services for Medicaid member elective procedures and their inpatient PA review is limited to spinal surgery. Palladian is NCQA accredited and subject to external audit in that fashion as well as sharing data with THP monthly • Each practitioner who makes medical review necessity decisions will have randomly selected cases evaluated quarterly. Individual results will be tabulated and reviewed by the Medical Directors Oversight Committee and reported to the Executive Committee as part their oversight annually. Collected scores will be used as a basis for individual assessment and for CQI within the group PROCEDURE: ○ The practitioner interrater review will be performed at least quarterly and analyzed annually ○ Reviews will consist of two approvals and two denials per month, with 2 random reviews in the year to total 50 case reviews per medical director (if applicable) ○ The selection of cases will range across all lines of business ○ The cases are randomly selected from the denial and approval files ○ The cases will be randomly selected and reviewed for consistency, rationality and uniformity in applying criteria/guidelines, by the Clinical Service Compliance Manager, Director of Medical Management or the Pre-Authorization Management Coordinator ○ Compliance of 90 percent or greater is acceptable ○ Ad hoc reviews may be performed at any time as part of a performance evaluation ○ The cases are reviewed using the monitoring tool application in the HEART system. The cases are reviewed to assess for consistency, correct

MH/SUD	M/S
clinical decision involved the use of all submitted clinical information and claims history. Documentation to include rationale of the determination and mention of available possible alternatives to non-authorized services; a clear statement of "authorize" or "do not authorize" ○ Once the reviews are completed, the results will be discussed with the individual practitioner; which will include education, if needed ○ The results will be shared with the Director of Medical Management, the Vice President of Clinical Services, and the CMO ○ Annual results will be reported to MDOC and to the CQI committee	interpretation and application of criteria/guidelines and member's benefit within the coverage determination. Assessment is made to determine if the clinical decision involved the use of all submitted clinical information and claims history. Documentation to include rationale of the determination and mention of available possible alternatives to non-authorized services; a clear statement of "authorize" or "do not authorize" ○ Once the reviews are completed, the results will be discussed with the individual practitioner; which will include education, if needed ○ The results will be shared with the Director of Medical Management, the Vice President of Clinical Services, and the CMO ○ Annual results will be reported to MDOC and to the CQI committee

6. Evidentiary Standard: What standard supports the frequency or rigor that is applied?

MH/SUD	M/S
• Complaints for MH/SUD enrollees are addressed and reviewed for opportunities for improvement • Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the QM/UM Committee • Annual report of inter-rater reliability assessment results. • Monthly monitoring of denials by type (administrative/medical necessity)	• Complaints for MH/SUD enrollees are addressed and reviewed for opportunities for improvement • Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the QM/UM Committee • Annual report of inter-rater reliability assessment results. • Monthly monitoring of denials by type (administrative/medical necessity)

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose

the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.1.5 Prior Authorization, Concurrent (Continued), Retrospective – Inpatient (UniCare)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S

• All inpatient hospital services require PA including:
  ○ Psychiatric Residential Treatment Facility (PRTF)
  ○ Inpatient Psychiatric
  ○ Inpatient Detoxification
  ○ Inpatient Substance Use Treatment
	• All inpatient hospital services except emergency and obstetrical care require PA including:
	  ○ Long-term acute care facility
	  ○ Rehabilitation facility admissions
	  ○ Inpatient hospice
	• Newborn stays beyond federally mandated timeframes

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S

• Inpatient MH/SUD services are assigned PA because:
  ○ PA assures the least restrictive safe environment to promote dignity and function
  ○ These are high cost services and PA provides an opportunity to reduce unnecessary costs by preventing overutilization through medical necessity review and facilitating discharge planning
  ○ High variability in length of stay
• Only non-emergent inpatient services have PA
	• Non-emergent/elective inpatient admissions are assigned PA because:
	  ○ PA assures the appropriate level of care for the condition, OR
	  ○ These are high cost services and PA provides an opportunity to reduce unnecessary costs by preventing overutilization through medical necessity review and facilitating discharge planning
	  ○ High variability in length of stay
	• Only non-emergent inpatient services have PA

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S

• Evidence of the high cost of inpatient services includes monthly and annual cost and utilization reports
• For these services, high variability in length of stay
• The following data sources may be used in utilization monitoring:
  ○ Claims Reports
	• Evidence of the high cost of inpatient services includes monthly and annual cost and utilization reports
	• For these services, high variability in length of stay
	• The following data sources may be used in utilization monitoring:
	  ○ Claims Reports

MH/SUD	M/S
○ Member Complaints, Denials, Approvals, and Appeals Analysis ○ Authorization/cost reports ○ Audits of appropriateness of appropriate clinical criteria ○ HEDIS findings • Focus Studies that evaluate access to care, use of preventative care services and other services • UniCare Medicaid staff reviewers use the following criteria when making a medical necessity determination: ○ Applicable state and federal guidelines ○ Member benefits ○ Medical policy and clinical guidelines applicable to UniCare ○ Physician Specialty Societies where publicly available for peer-reviewed literature, including Agency For Healthcare Research and Quality (AHRQ) ○ MCG™ Evidence-Based Clinical Guidelines ○ UniCare policies and procedures ○ UniCare behavioral health medical necessity criteria, as applicable ○ American Imaging Management (AIM) Specialty Health Guidelines ○ Member characteristics/factors/ circumstances • Characteristics of the local delivery system that are available for the particular patient	○ Member Complaints, Denials, Approvals, and Appeals Analysis ○ Authorization/cost reports ○ Audits of appropriateness of appropriate clinical criteria ○ HEDIS findings • Focus Studies that evaluate access to care, use of preventative care services and other services • UniCare Medicaid staff reviewers use the following criteria when making a medical necessity determination: ○ Applicable state and federal guidelines ○ Member benefits ○ Medical policy and clinical guidelines applicable to UniCare ○ Physician Specialty Societies where publicly available for peer-reviewed literature, including AHRQ ○ MCG™ Evidence-Based Clinical Guidelines ○ UniCare policies and procedures ○ AIM Specialty Health Guidelines ○ Member characteristics/factors/ circumstances • Characteristics of the local delivery system that are available for the particular patient

4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the MCO, beneficiary, and provider perspectives).

MH/SUD	M/S
• Prior authorization must be obtained prior to admission, except in the case of emergencies, when notification is required within 24 hours of admission • Utilization Management (UM) staff will request clinical information from the hospital on the same day they are notified of the member's admission	• Prior authorization must be obtained prior to admission, except in the case of emergencies, when notification is required within 24 hours of admission. UM staff will request clinical information from the hospital on the same day they are notified of the member's admission • All inpatient and residential services regardless of BH/PH designation must be made via phone, fax or electronic request

MH/SUD	M/S
• All inpatient and residential services regardless of BH/PH designation must be made via phone, fax or electronic request • Decision and screening criteria are designed to assist UM Program associates in assessing the appropriateness of care and length of stay for clinical health situations. Application of criteria is not absolute but based upon the individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems • UniCare applies evidenced-based and consensus driven criteria for UM screening and decisions in accordance with the member's specific benefit plan. Actively practicing physicians are involved in the development and adoption of the review criteria • Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the Medical Policy and Technology Assessment Committee (MPTAC) and the Physician's Quality Improvement Committee (PQIC) • The decision to approve, modify or deny requested non-urgent pre-service request is made within 7 calendar days of receiving the request, within which time the provider will be notified of the decision • Written or electronic confirmation of deferrals, denials, modifications, reductions, suspensions or terminations of covered services will be sent to provider and member within 7 calendar days of the request • The decision and notification to approve, modify or deny requested urgent or expedited services are made as expeditiously as the member's health condition requires, and no later than within two 2-3* calendar days of receipt of request (whichever is the least from the request receipt date) • UniCare makes decisions regarding approval or denial of urgent care continued stay services within 3* calendar days of the receipt of request	• Decision and screening criteria are designed to assist UM Program associates in assessing the appropriateness of care and length of stay for clinical health situations. Application of criteria is not absolute but based upon the individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems • UniCare applies evidenced-based and consensus driven criteria for UM screening and decisions in accordance with the member's specific benefit plan. Actively practicing physicians are involved in the development and adoption of the review criteria • Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the PQIC • The decision to approve, modify or deny requested non-urgent pre-service request is made within 7 calendar days of receiving the request, within which time the provider will be notified of the decision • Written or electronic confirmation of deferrals, denials, modifications, reductions, suspensions or terminations of covered services will be sent to provider and member within 7 calendar days of the request • The decision and notification to approve, modify or deny requested urgent or expedited services are made as expeditiously as the member's health condition requires, and no later than within two 2-3* calendar days of receipt of request (whichever is the least from the request receipt date) • UniCare makes decisions regarding approval or denial of urgent care continued stay services within 3* calendar days of the receipt of request • For Emergency Stabilization and Post-Stabilization, the emergency department's treating physician determines the services needed to stabilize the member's emergency medical condition. After the member is

MH/SUD	M/S
• For Emergency Stabilization and Post-Stabilization, the emergency department's treating physician determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's physician must contact the member's primary care provider (PCP) for authorization of further services. The member's PCP is noted on the ID card. If the PCP does not respond within one hour, all necessary services will be considered authorized • Non-clinical administrative staff gathers information and conducts pre-review screening under the guidance and direction of licensed health professionals. • Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care) • The Clinician Reviewer can approve the requested services after establishing medical necessity. If the clinical information submitted does not allow an approval decision to be made, the nurse will forward the request to a peer clinical reviewer • Only a physician can deny an authorization request. The provider may request a peer to peer to discuss the care, submit a reconsideration and/or can appeal the decision • Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement	stabilized, the emergency department's physician must contact the member's PCP for authorization of further services. The member's PCP is noted on the ID card. If the PCP does not respond within one hour, all necessary services will be considered authorized • Non-clinical administrative staff gathers information and conducts pre-review screening under the guidance and direction of licensed health professionals • Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care) • The Clinician Reviewer can approve the requested services after establishing medical necessity. If the clinical information submitted does not allow an approval decision to be made, the nurse will forward the request to a peer clinical reviewer • Only a physician can deny an authorization request. The provider may request a peer to peer to discuss the care, submit a reconsideration and/or can appeal the decision • Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S

• Initial authorization limits vary based on medical necessity review
• The duration of initial authorizations for acute inpatient care vary based on medical necessity review
• When a member's hospital stay is expected to exceed the number of days authorized during pre-service review, or when the inpatient stay did not have preservice review, the hospital must contact us for continued stay review. UniCare requires clinical reviews on all members admitted as inpatients to:
  ○ Acute care hospitals
  ○ Intermediate facilities
  ○ Inpatient rehabilitation facilities
• The decision to approve, deny or modify post-service requests is made within 30 calendar days of Post Service Clinical Claim Review Unit's (PSCCR) receipt of request. If the decision is a denial or modification, the provide is also notified electronically or in writing within 30 days of the receipt of the request
	• Initial authorization limits vary based on medical necessity review
	• The duration of initial authorizations for acute inpatient care vary based on medical necessity review
	• When a member's hospital stay is expected to exceed the number of days authorized during pre-service review, or when the inpatient stay did not have preservice review, the hospital must contact us for continued stay review. UniCare requires clinical reviews on all members admitted as inpatients to:
	  ○ Acute care hospitals
	  ○ Intermediate facilities
	  ○ Inpatient rehabilitation facilities
	• The decision to approve, deny or modify post-service requests is made within 30 calendar days of Post Service Clinical Claim Review Unit's (PSCCR) receipt of request. If the decision is a denial or modification, the provide is also notified electronically or in writing within 30 days of the receipt of the request

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S
• NQTL Self Compliance Tool for Utilization Management Reviews has been developed • Reviewers are audited annually for interrater reliability and must score 90%	• NQTL Self Compliance Tool for Utilization Management Reviews has been developed • Reviewers are audited annually for interrater reliability and must score 90%

7. *Compliance Determination*

*Based on a review of the materials provided, there are potential areas of noncompliance with the required timeframes required by the FY2021 MCO Contract. A letter will be sent to UniCare to ascertain compliance. The letter will be included in the appendix.

8.1.6 Prior Authorization and Continued Review – Outpatient (Unicare)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S

• Partial Hospitalization Program
• Intensive Outpatient Services
• Psychology and Neuropsychology Testing
• Drug Screenings
• Community Psychiatric Supportive Treatment, after first three days of treatment
• Out-of-Network services
• Behavioral health services do not need a referral/behavioral health screening and assessment do not require prior authorization
• ECT
	• Advanced radiology services
	  ○ CT, MRI, PET scan
	• All out-of-network services
	• Durable medical equipment
	• Genetic testing
	• Home health care services, including hospice care
	• Select outpatient surgeries/procedures including but not limited to:
	  ○ Hysterectomy
	  ○ Bariatric surgery
	• Out-of-network services

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
Selected outpatient MH/SUD services are assigned prior authorization: • Because of their potential for overutilization • For patient safety (i.e., ECT) • To control costs • To avoid waste and abuse of Medicaid funds • To ensure services are meeting their objectives	Selected outpatient M/S services are assigned preservice review: • Because of their potential for overutilization • For patient safety • To control costs • To avoid waste and abuse of Medicaid funds • To ensure services are meeting their objectives • To ensure services are meeting their objectives

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S

• Evidence of the utilization of outpatient services includes monthly and annual cost and utilization reports
  ○ In UniCare's experience, psychological and neuropsychological testing, comprehensive support, inpatient E&M services, ACT, IOP, and CSU are frequently ordered inappropriately
  ○ Medical necessity is based on national guidelines and reviewed annually by the internal medical advisory committee
• The following data sources may be used in utilization monitoring:
  ○ Claims reports
  ○ Member complaints and appeals analysis
  ○ HEDIS findings
  ○ Focus Studies that evaluate access to care, use of preventative care services, and other services
• For ECT, medical research shows patient risk of complications, primarily from anesthesia. National guidelines are used to determine medical necessity and are reviewed annually by a medical advisory committee
• For patient safety, nationally-recognized standards of care and practice from sources including:
  ○ National Committee for Quality Assurance (NCQA)
  ○ American Psychiatric Association
  ○ American Society of Addiction Medicine (ASAM) Treatment
  ○ National Alliance on Mental Illness
  ○ SAMHSA
  ○ Cumulative professional expertise and experience
	• Evidence of the utilization of outpatient services includes monthly and annual cost and utilization reports
	  ○ In Unicare's experience, physical therapy, speech therapy, inpatient E&M services, venous ablation, hysterectomy, DME, orthotics, prosthetics, nuclear cardiology, and septoplasty are frequently ordered inappropriately
	  ○ Medical necessity is based on national guidelines and reviewed annually by the internal medical advisory committee
	• The following data sources may be used in utilization monitoring:
	  ○ Claims reports
	  ○ Member complaints and appeals analysis
	  ○ HEDIS findings
	  ○ Focus Studies that evaluate access to care, use of preventative care services, and other services
	• For advanced radiology services (CT, CTA, MRI, PET), medical research shows patient risks from exposure to radiation and contrast media
	• For spinal injections, medical research shows that spinal injections are frequently used for patients without the appropriate indications and/or for patients for whom they would present a serious risk
	• For advanced radiology services and spinal injections, national guidelines are used to determine medical necessity and are reviewed annually by a medical advisory committee

4. *Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the MCO, beneficiary, and provider perspectives).*

MH/SUD	M/S

• UniCare Medicaid staff reviewers use the following criteria when making a medical necessity determination:
  ○ Applicable State and federal guidelines
  ○ Member benefits
  ○ Medical policy and clinical guidelines applicable to UniCare
  ○ Physician Specialty Societies where publicly available for peer-reviewed literature, including AHRQ
  ○ MCG™ Evidence-Based Clinical Guidelines
  ○ UniCare policies and procedures
  ○ UniCare behavioral health medical necessity criteria, as applicable
  ○ AIM Specialty Health Guidelines
  ○ Member characteristics/factors/ circumstances
  ○ Characteristics of the local delivery system that are available for the particular patient
• Decision and screening criteria are designed to assist Utilization Management (UM) Program associates in assessing the appropriateness of care and length of stay for clinical health situations. Application of criteria is not absolute, but based upon the individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems
• UniCare applies evidenced-based and consensus-driven criteria for UM screening and decisions in accordance with the member's specific benefit plan. Actively practicing physicians are involved in the development and adoption of the review criteria
• Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the PQIC
	• UniCare Medicaid staff reviewers use the following criteria when making a medical necessity determination:
	  ○ Applicable State and federal guidelines
	  ○ Member benefits
	  ○ Medical policy and clinical guidelines applicable to UniCare
	  ○ Physician Specialty Societies where publicly available for peer-reviewed literature, including AHRQ
	  ○ MCG™ Evidence-based Clinical Guidelines
	  ○ UniCare policies and procedures
	  ○ AIM Specialty Health Guidelines
	  ○ Member characteristics/factors/ circumstances
	  ○ Characteristics of the local delivery system that are available for the particular patient
	• Decision and screening criteria are designed to assist UM Program associates in assessing the appropriateness of care and length of stay for clinical health situations. Application of criteria is not absolute, but based upon the individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems
	• UniCare applies evidenced-based and consensus-driven criteria for UM screening and decisions in accordance with the member's specific benefit plan. Actively practicing physicians are involved in the development and adoption of the review criteria
	• Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the PQIC
	• The treating physician or provider initiates a pre-service/urgent pre-service request prior to rendering services to the member

MH/SUD	M/S
• The treating physician or provider initiates a pre-service/urgent pre-service request prior to rendering services to the member • The provider may submit PA requests by fax, telephone, or electronic submission using approved forms • UniCare only collects information necessary to perform utilization review and only requires submission of the section(s) of the medical record necessary for each case reviewed, so not to be overly burdensome for the member, provider, or the healthcare delivery organization's staff • Pre-Review Process: Non-clinical administrative staff gather information and conduct pre-review screening under the guidance and direction of licensed health professionals • Review of Medical Necessity: Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care) • The Clinician Reviewer can approve the requested services after establishing medical necessity. If the clinical information submitted does not allow for an approval decision to be made, the nurse will forward the request to a peer clinical reviewer • Only a UniCare authorized appropriately licensed practitioner can deny a request for services for lack of medical necessity • Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement • The decision to approve, modify or deny requested non-urgent pre-service request is made within 7 calendar days of receiving the request, within which time the provider will be notified of the decision • Written or electronic confirmation of deferrals, denials, modifications, reductions, suspensions or terminations of covered	• The provider may submit PA requests by fax, telephone, or electronic submission • UniCare only collects information necessary to perform utilization review and only requires submission of the section(s) of the medical record necessary for each case reviewed, so not to be overly burdensome for the member, provider, or the healthcare delivery organization's staff • Pre-Review Process: Non-clinical administrative staff gather information and conduct pre-review screening under the guidance and direction of licensed health professionals • Review of Medical Necessity: Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care) • The Clinician Reviewer can approve the requested services after establishing medical necessity. If the clinical information submitted does not allow for an approval decision to be made, the nurse will forward the request to a peer clinical reviewer • Only the medical director or doctorate-level practitioners with an active professional license or certification can deny services for lack of medical necessity • Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement • The decision to approve, modify or deny requested non-urgent pre-service request is made within 7 calendar days of receiving the request, within which time the provider will be notified of the decision • Written or electronic confirmation of deferrals, denials, modifications, reductions, suspensions of covered services will be sent to the provider and member within 7 calendar days of the request. • The decision and notification to approve, modify or deny requested urgent or expedited

MH/SUD	M/S
services will be sent to provider and member within 7 calendar days of the request • The decision and notification to approve, modify or deny requested urgent or expedited services are made as expeditiously as the member's health condition requires, and no later than within two 2-3* calendar days of receipt of request (whichever is the least from the request receipt date) • UniCare makes decisions regarding approval or denial of urgent care continued stay services within 3* calendar days of the receipt of request	services are made as expeditiously as the member's health condition requires, and no later than within two 2-3* calendar days of receipt of request (whichever is the least from the request receipt date) • UniCare makes decisions regarding approval or denial of urgent care continued stay services within 3* calendar days of the receipt of request

5. Strategy: How frequently or strictly is PA applied?

MH/SUD	M/S
• Initial authorization limits vary based on medical necessity review • Some services require continued review after a predetermined visits (e.g., psychological testing is limited to four hours per member per provider per year before further review and authorization) • The Preservice Continued Review Process enables the extension of previously approved, ongoing courses of treatment. It follows the same process as described above • The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability and these results are analyzed and reported to the UM Committee	• Initial authorization limits vary based on medical necessity review • Some services require continued review after a predetermined visits (e.g., physical, occupational, and speech therapy, the "soft limit" is 10 visits before authorization is required) • The Preservice Continued Review Process enables the extension of previously approved, ongoing courses of treatment. It follows the same process as described above • The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability and these results are analyzed and reported to the UM Committee

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
• The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability and	• The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability and

MH/SUD	M/S
these results are analyzed and reported to the UM Committee. • UniCare monitors authorization requests, approvals, denials, and appeals.	these results are analyzed and reported to the UM Committee. • UniCare monitors authorization requests, approvals, denials, and appeals.

7. Compliance Determination

*Based on a review of the materials provided, there are potential areas of noncompliance with the required timeframes required by the FY2021 MCO Contract. A letter will be sent to UniCare to ascertain compliance. The letter will be included in the appendix.

8.1.7 Concurrent Review – Inpatient and Outpatient (Aetna)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
• MH/SUD Inpatient services • Psychiatric Residential Treatment Facilities • Rehabilitative Psychiatric Treatment (<21) • Crisis stabilization unit • Day treatment • IOP	• M/S Inpatient hospital care • Hospice care (inpatient) • Hospice care, outpatient services • Hospital Inpatient/Maternity Services • Organ Transplant Services

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
Objectives/Strategies • Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that may be approved, potentially denied or reduced on the basis of Medical Necessity • Forward potential denials or reductions to the CMO or designated Medical Director for review • Ensure requests are processed by urgency of request and Provider and/or Members are notified of the determination within require timeframes • To ensure the services are in the defined benefits, and are appropriate, timely, and cost-effective	Objectives/Strategies • Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that may be approved, potentially denied or reduced on the basis of Medical Necessity • Forward potential denials or reductions to the CMO or designated Medical Director for review • Ensure requests are processed by urgency of request and Provider and/or Members are notified of the determination within require timeframes • To ensure the services are in the defined benefits, and are appropriate, timely, and cost-effective

MH/SUD	M/S
• To ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished at that are no less than the amount, duration or scope for the same services furnished to members under the Medicaid State Plan	• To ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished at that are no less than the amount, duration or scope for the same services furnished to members under the Medicaid State Plan

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
• Monthly, the CMO, in conjunction with the director of Medical Management, is responsible for analyzing utilization data, identifying areas of concern. The CMO presents quarterly summaries of this information to the QM/UM • This information assists with updating the list of services requiring prior authorization/concurrent review and is updated at least annually and revised periodically as appropriate • The QM/UM committee is responsible to provide feedback to the CMO and provide action plans including adjustments to the QAPI program • The Clinical Review Hierarchy is as follows: ○ Federal and State mandates ○ Member benefits (contract language, including definitions and specific contract provisions/exclusions ○ Anthem Medical Policies ○ AIM Clinical Guidelines (diagnostic imaging, sleep diagnostic and treatment management guidelines, and others developed by AIM Specialty Health [AIM]} approved for use by Medical Policy Technology Assessment Committee (MPTAC) ○ Anthem Clinical UM Guidelines ○ MCG care guidelines ○ Other vendor documents (e.g., Orthonet, ASH, etc.) • Persons with mental health conditions should be treated in the **l**east restrictive	• Monthly, the CMO, in conjunction with the director of Medical Management, is responsible for analyzing utilization data, identifying areas of concern • The CMO presents quarterly summaries of this information to the QM/UM • This information assists with updating the list of services requiring prior authorization/concurrent review and is updated at least annually and revised periodically as appropriate • The QM/UM committee is responsible to provide feedback to the CMO and provide action plans including adjustments to the QAPI program • The Clinical Review Hierarchy is as follows: ○ Federal and State mandates ○ Member benefits (contract language, including definitions and specific contract provisions/exclusions ○ Anthem Medical Policies ○ AIM Clinical Guidelines (diagnostic imaging, sleep diagnostic and treatment management guidelines, and others developed by AIM Specialty Health [AIM]} approved for use by Medical Policy Technology Assessment Committee (MPTAC) ○ Anthem Clinical UM Guidelines ○ MCG care guidelines ○ Other vendor documents (e.g., Orthonet, ASH, etc.)

MH/SUD	M/S
environment and in a manner designed to preserve their dignity and autonomy and to maximize the opportunities for recovery	

4. Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)

MH/SUD	M/S
Reviews are conducted of members' acute care hospitalizations as clinically indicated, either onsite or by telephone or facsimile	Reviews are conducted of members' acute care hospitalizations as clinically indicated, either onsite or by telephone or facsimile and decisions based on medical necessity

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• Aetna annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision making • A corrective education plan and monitoring of staff member who score below Aetna's inter-rater reliability target	• Aetna annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision making • A corrective education plan and monitoring of staff members who score below Aetna's inter-rater reliability target

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld ○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site)	• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld ○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude & service, billing and financial; and quality of office site)

MH/SUD	M/S
• The SIC reviews all the above for Parity Rule compliance concerns • If there are any indications of potential noncompliance with the Parity Rule exists, the underlying data will be comprehensively reviewed, and if necessary, the appropriate actions will be taken	• These indicators are compared to MH/SUD indicators to identify any mental health parity concerns

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.1.8 Concurrent review – Inpatient (THP)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
Concurrent reviews are performed on all hospitalized members	Concurrent reviews are performed on all hospitalized members

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
Concurrent review is performed to assist with discharge planning to ascertain quality of care. It allows for identification of patients with potential discharge planning needs. These patients are referred by the nurse inpatient navigator to care, complex case, chronic disease navigation, or the social worker as appropriate for early intervention	Concurrent review is performed to assist with discharge planning to ascertain quality of care. It allows for identification of patients with potential discharge planning needs. These patients are referred by the nurse inpatient navigator to care, complex case, chronic disease navigation, or the social worker as appropriate for early intervention

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
Nationally recognized criteria are used for admission and continued stay. All criteria cannot be applied to all cases. Factors such as the member's age, living conditions, support systems,	Nationally recognized criteria are used for admission and continued stay. All criteria cannot be applied to all cases. Factors such as the member's age, living conditions, support systems,

MH/SUD	M/S
past medical/surgical history, and network capabilities are considered	past medical/surgical history, and network capabilities are considered

4. Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the managed care organization, beneficiary, and provider perspectives)

MH/SUD	M/S
Concurrent review is performed telephonically or by facsimile and involves communication with practitioners, hospital Utilization Review (UR) and social services staff, and family members as necessary	Concurrent review is performed telephonically or by facsimile and involves communication with practitioners, hospital UR and social services staff, and family members as necessary

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
Concurrent review frequency is determined by InterQual criteria, acuity of member. Frequently occurs every 1 – 2 days	Concurrent review is determined by InterQual criteria, acuity of the member, and input from the medical director. Frequently occurs as often as daily

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
• Concurrent review promotes quality of care and discharge planning • Member complaints and appeals data is collected and analyzed for evidence that NQTLs are applied more stringently to MH/SUD	• Concurrent review allows for the continued reassessment of the medical appropriateness of care and provide for continuity of care and arrangement for needs post discharge • Member complaints and appeals data are collected and analyzed for evidence that NQTLs are applied more stringently to MH/SUD

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.1.9 Retrospective Review – Inpatient and Outpatient (Aetna)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
• MH/SUD Inpatient services • Psychiatric Residential Treatment Facilities • Crisis Stabilization Services • Inpatient Detoxification	• M/S Inpatient hospital care • Inpatient Maternity care

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
Objectives/Strategies • Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that may be approved, potentially denied or reduced on the basis of Medical Necessity • Forward potential denials or reductions to the CMO or designated Medical Director for review • Ensure requests are processed by urgency of request and Provider and/or Members are notified of the determination within require timeframes • To ensure the services are in the defined benefits, and are appropriate, timely, and cost-effective • To ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished at that are no less than the amount, duration or scope for the same services furnished to members under the Medicaid State Plan	Objectives/Strategies • Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that may be approved, potentially denied or reduced on the basis of Medical Necessity • Forward potential denials or reductions to the CMO or designated Medical Director for review • Ensure requests are processed by urgency of request and Provider and/or Members are notified of the determination within require timeframes • To ensure the services are in the defined benefits, and are appropriate, timely, and cost-effective • To ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished at that are no less than the amount, duration or scope for the same services furnished to members under the Medicaid State Plan

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
• The MCO adopts evidenced-based guidelines (e.g., MCG) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care	• The MCO adopts evidenced-based guidelines (e.g., MCG) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care

MH/SUD	M/S
management, discharge planning, patient education, and quality initiatives • The guidelines help assure that utilization review decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high quality, and cost-effective care	management, discharge planning, patient education, and quality initiatives • The guidelines help assure that utilization review decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high quality, and cost-effective care

4. Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)

MH/SUD	M/S
Retrospective reviews are based solely on the medical information available to the attending physician or ordering practitioner/provider at the time the health care services were provided	Retrospective reviews are based solely on the medical information available to the attending physician or ordering practitioner/provider at the time the health care services were provided

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• The MCO annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision making • A corrective education plan and monitoring of staff members who score below Aetna's inter-rater reliability target	• The MCO annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision making • A corrective education plan and monitoring of staff members who score below Aetna's inter-rater reliability target

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld	• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld

MH/SUD	M/S
○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude & service, billing and financial; and quality of office site) • The SIC reviews all the above for Parity Rule compliance concerns • If there are any indications of potential noncompliance with the Parity Rule exists, the underlying data will be comprehensively reviewed, and if necessary, the appropriate actions will be taken	○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude & service, billing and financial; and quality of office site) • These indicators are compared to MH/SUD indicators to identify any mental health parity concerns

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.1.10 Retrospective Review – Inpatient and Outpatient (THP)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
Prior authorization is required for the following: • All elective inpatient care • Out-of-network/out-of-area care • Tertiary admissions	Prior authorization is required for the following: • All elective inpatient care • Out-of-network/out-of-area care • Long-term acute care • All elective C-sections and all elective inductions • Tertiary admissions

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
Retrospective review takes place to determine if a stay, in part or totally, was medically appropriate. See Prior Authorization for strategy	Retrospective review takes place to determine if a stay, in part or totally, was medically appropriate. See Prior Authorization for strategy

3. *Evidentiary Standard: What evidence supports the rationale for the assignment?*

MH/SUD	M/S
See inpatient prior authorization and concurrent review	See inpatient prior authorization and concurrent review

4. *Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)*

MH/SUD	M/S
Retrospective review is conducted only when THP is informed of an admission after the admission has taken place. RN nurse navigators with five years of experience and behavioral medical director help navigate and make case determinations. Any potential quality issues are directed to the Quality Improvement (QI) department. Any potential fraud issues are directed to the Special Investigations Unit (SIU) of the Compliance Department. InterQual criteria are used	Retrospective review is conducted only when THP is informed of an admission after the admission has taken place. RN nurse navigators with five years of experience and behavioral medical director help navigate and make case determinations. Any potential quality issues are directed to the QI department. Any potential fraud issues are directed to the SIU unit of the Compliance Department. InterQual criteria are used

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
All inpatient admissions that are not initially authorized undergo retrospective review	All inpatient admissions that are not initially authorized undergo retrospective review

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S
• Members are held harmless if this retrospective review determines that the admission was medically inappropriate. If a hospital has repeated admissions without prior authorization, the issue is referred to the Provider Relations Department. Policies and procedures are reviewed annually. If an admission is denied, the provider is advised of appeal rights • Member complaints and appeals data is collected and analyzed for evidence that NQTLs are applied more stringently to MH/SUD	• Members are held harmless if this retrospective review determines that the admission was medically inappropriate. If a hospital has repeated admissions without prior authorization, the issue is referred to the Provider Relations Department. Policies and procedures are reviewed annually. If an admission is denied, the provider is advised of appeal rights • Member complaints and appeals data is collected and analyzed for evidence that NQTLs are applied more stringently to MH/SUD

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.2 Medical Management NQTLs

8.2.1 Medical Necessity (Inpatient, Outpatient, Emergency Services) - Aetna

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
Per MCO Contract: For Medicaid-covered medical or other health services to children under 21, "medically necessary" refers to services which: • are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity, or limitation in function, cause illness or infirmity, endanger life, or worsen disability; • are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions; • are consistent with the diagnosis of the conditions; • are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence, and e) will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age	Per MCO Contract: For Medicaid-covered medical or other health services to children under twenty-one (21), "medically necessary" refers to services which: • are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity, or limitation in function, cause illness or infirmity, endanger life, or worsen disability; • are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions; • are consistent with the diagnosis of the conditions; • are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence, and e) will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age

2. *Strategy: Why is the NQTL assigned to these services?*

MH/SUD	M/S
N/A	N/A

3. *Evidentiary Standard: What evidence supports the rationale for the assignment?*

MH/SUD	M/S
The MCO uses the following criteria for physical health and behavioral health consulted in the order listed below; as applicable: • Criteria required by applicable state or federal regulatory agency • ASAM • MCG for physical and behavioral health criteria • LOCUS, CALOCUS (Child and Adolescent Level of Care Utilization System) or CASII (Child and Adolescent Service Intensity Instrument) for behavioral health • Aetna Clinical Policy Bulletins (CPBs) • Aetna Clinical Policy Council Review (7000.30) • Emergency Services	The MCO uses the following criteria for physical health and behavioral health consulted in the order listed below; as applicable: • Criteria required by applicable state or federal regulatory agency • ASAM • MCG for physical and behavioral health criteria • LOCUS, CALOCUS or CASII for behavioral health • Aetna CPBs • Aetna Clinical Policy Council Review. (7000.30) • Emergency Services

4. *Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)*

MH/SUD	M/S
• Aetna Better Health is responsible for review and approval of the utilization management criteria used for medical necessity determinations • Additionally, Aetna Better Health is responsible to confirm that medical necessity criteria are established in accordance with generally accepted standards of medical practice and are objective, based on medical evidence, and clinically appropriate for the	• Aetna Better Health is responsible for review and approval of the utilization management criteria used for medical necessity determinations • Additionally, Aetna Better Health is responsible to confirm that medical necessity criteria are established in accordance with generally accepted standards of medical practice and are objective, based on medical evidence, and clinically appropriate for the

MH/SUD	M/S
member's condition and characteristics of the local delivery system[1] • Service authorization staff who make medical necessity determinations are trained on the criteria and the criteria are accepted and reviewed according to Aetna Better Health policies and procedures • Medical necessity initial and annual review processes consist of an evaluation of existing criteria, determination of any recommendations or changes, and final acknowledgement or acceptance of criteria • The process involves appropriate practitioners in developing adopting, and reviewing criteria, per NCQA standards • Annually the UM Steering Committee reviews national criteria sets and the procedures for applying them against current clinical and medical evidence • The UM Steering Committee is comprised of senior and plan medical directors representing a broad range of specialties such as emergency medicine, behavioral health, pediatrics, surgery, family medicine and internal medicine • The UM Steering Committee review and recommendations of criteria sets are then taken to the QM/UM Committee • The QM/UM Committee membership includes local medical directors and community practitioners who review criteria sets in comparison to state requirements, update, and adopt final criteria sets as appropriate • Adopted criteria are submitted to the Aetna Better Health quality Management Oversight Committee for review and adoption • If primary criteria are not clear enough to make a determination and the requested service is not addressed by the Aetna CPBs, the medical director may submit a request for	member's condition and characteristics of the local delivery system[4] • Service authorization staff who make medical necessity determinations are trained on the criteria and the criteria are accepted and reviewed according to Aetna Better Health policies and procedures • Medical necessity initial and annual review processes consist of an evaluation of existing criteria, determination of any recommendations or changes, and final acknowledgement or acceptance of criteria • The process involves appropriate practitioners in developing adopting, and reviewing criteria, per NCQA standards • Annually the UM Steering Committee reviews national criteria sets and the procedures for applying them against current clinical and medical evidence • The UM Steering Committee is comprised of senior and plan medical directors representing a broad range of specialties such as emergency medicine, behavioral health, pediatrics, surgery, family medicine and internal medicine • The UM Steering Committee review and recommendations of criteria sets are then taken to the QM/UM Committee • The QM/UM Committee membership includes local medical directors and community practitioners who review criteria sets in comparison to state requirements, update, and adopt final criteria sets as appropriate • Adopted criteria are submitted to the Aetna Better Health quality Management Oversight Committee for review and adoption • If primary criteria are not clear enough to make a determination and the requested service is not addressed by the Aetna CPBs, the medical director may submit a request for

[1] NCQA HP 2020 UM2 A1-3
[4] NCQA HP 2020 UM2 A1-3

MH/SUD	M/S
a position determination to the Aetna Clinical Policy Council. • The policy council will research literature applicable to the specific request and, when a determination is reached, will respond to the medical director • When criteria are present but unclear in relation to the situation, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area before making a determination of medical necessity [2] • Practitioners/providers are notified in the denial letter (i.e., Notice of Action) that they may request a peer-to-peer consultation to discuss denied authorizations, including behavioral health decisions with the medical director reviewer by calling Aetna Better Health[3]	a position determination to the Aetna Clinical Policy Council. • The policy council will research literature applicable to the specific request and, when a determination is reached, will respond to the medical director • When criteria are present but unclear in relation to the situation, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area before making a determination of medical necessity [5] • Practitioners/providers are notified in the denial letter (i.e., Notice of Action) that they may request a peer-to-peer consultation to discuss denied authorizations, including behavioral health decisions with the medical director reviewer by calling Aetna Better Health[6]

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• The determination of whether a service is medically necessary is made on a case-by-case basis, taking into account the individual needs of the member and allowing for consultation with requesting practitioners/providers when appropriate • Aetna Better Health considers at least the following individual characteristics when applying criteria: age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable[7]	• The determination of whether a service is medically necessary is made on a case-by-case basis, taking into account the individual needs of the member and allowing for consultation with requesting practitioners/providers when appropriate • Aetna Better Health considers at least the following individual characteristics when applying criteria: age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable[8]

[2] NCQA HP 2020 UM4 F1
[3] NCQA HP 2020 UM7A, D
[5] NCQA HP 2020 UM4 F1
[6] NCQA HP 2020 UM7A, D
[7] NCQA HP 2020 UM2 A2
[8] NCQA HP 2020 UM2 A2

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld ○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site) • The SIC reviews all the above for Parity Rule compliance concerns. • If any indications of potential noncompliance with the Parity Rule exist, the underlying data will be comprehensively reviewed, and if necessary, the appropriate actions will be taken.	• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld ○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site) • These indicators are compared to MH/SUD indicators to identify any mental health parity concerns.

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.2.2 Medical Necessity Criteria – THP

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
Refers to all contractually obligated services	Refers to all contractually obligated services

2. *Strategy: Why is the NQTL assigned to these services?*

MH/SUD	M/S
N/A	N/A

3. *Evidentiary Standard: What evidence supports the rationale for the assignment?*

MH/SUD	M/S
Evidentiary standard: Interqual, ASAM, CMS/BMS, review of medical and scientific sources including peer reviewed studies in medical journals that meet nationally recognized standards including sources such as Hayes Inc, National Institute of Health's National Library of Medicine, Federal Agency for Healthcare Research and Quality, National Comprehensive Cancer Network, and other	Evidentiary standard: Interqual, ASAM, CMS/BMS, review of medical and scientific sources including peer reviewed studies in medical journals that meet nationally recognized standards including sources such as Hayes Inc, National Institute of Health's National Library of Medicine, Federal Agency for Healthcare Research and Quality, National Comprehensive Cancer Network, and other

4. *Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the managed care organization, beneficiary, and provider perspectives)*

MH/SUD	M/S
Any outpatient pre-service that requires preauthorization is reviewed through the use of evidence-based criteria (Interqual, ASAM, CMS/BMS criteria, Transplant and Technology, Hayes, UpToDate) and/or expert medical review	Any outpatient pre-service that requires preauthorization is reviewed through the use of evidence-based criteria (Interqual, ASAM, CMS/BMS criteria, Transplant and Technology, Hayes, UpToDate) and/or expert medical review

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
• The determination of whether a service is medically necessary is made on a case-by-case basis, taking into account the individual needs of the member and allowing for consultation with requesting practitioners/providers when appropriate • Aetna Better Health considers at least the following individual characteristics when applying criteria: age, comorbidities, complications, progress of treatment,	• The determination of whether a service is medically necessary is made on a case-by-case basis, taking into account the individual needs of the member and allowing for consultation with requesting practitioners/providers when appropriate • Aetna Better Health considers at least the following individual characteristics when applying criteria: age, comorbidities, complications, progress of treatment,

MH/SUD	M/S
psychosocial situation, and home environment, when applicable [9]	psychosocial situation, and home environment, when applicable [10]

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld ○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude & service, billing and financial; and quality of office site) • The Service Improvement Committees reviews all the above for Parity Rule compliance concerns • If there are any indications of potential noncompliance with the Parity Rule exists, the underlying data will be comprehensively reviewed, and if necessary, the appropriate actions will be taken	Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including: ○ Number of service authorizations requested ○ Number of service authorizations denied ○ Number of denied service authorizations with member appeal ○ Number of denied service authorizations with member appeal upheld ○ Number of denied service authorizations with member appeal reversed ○ Complaints by NCQA category (quality of care, access, attitude & service, billing and financial; and quality of office site) • These indicators are compared to MH/SUD indicators to identify any mental health parity concerns

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on medical/surgical benefits.

[9] NCQA HP 2020 UM2 A2
[10] NCQA HP 2020 UM2 A2

8.2.3 Medical Necessity Criteria – UniCare

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
Refers to all contractually obligated services	Refers to all contractually obligated services

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
N/A	N/A

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S

• Review of denials/approvals, appeals/overturned appeals, along with authorization volume/cost and the continued presence of appropriate clinical criteria, are done on a semi-annual basis for each service on PA
• Medical necessity criteria based on national guidelines and reviewed annually by the internal medical advisory committee
• The Clinical Review Hierarchy is as follows:
  ○ Federal and State mandates
  ○ Member benefits (contract language, including definitions and specific contract provisions/exclusions
  ○ Anthem Medical Policies
  ○ AIM Clinical Guidelines (diagnostic imaging, sleep diagnostic and treatment management guidelines, and others developed by AIM Specialty Health [AIM]} approved for use by Medical Policy Technology Assessment Committee (MPTAC)
  ○ Anthem Clinical UM Guidelines
  ○ MCG care guidelines
  ○ Other vendor documents (e.g., Orthonet, ASH, etc.)
	• Review of denials/approvals, appeals/overturned appeals, along with authorization volume/cost and the continued presence of appropriate clinical criteria, are done on a semi-annual basis for each service on PA
	• Medical necessity criteria based on national guidelines and reviewed annually by the internal medical advisory committee
	• The Clinical Review Hierarchy is as follows:
	  ○ Federal and State mandates
	  ○ Member benefits (contract language, including definitions and specific contract provisions/exclusions
	  ○ Anthem Medical Policies
	  ○ AIM Clinical Guidelines (diagnostic imaging, sleep diagnostic and treatment management guidelines, and others developed by AIM Specialty Health [AIM]} approved for use by Medical Policy Technology Assessment Committee (MPTAC)
	  ○ Anthem Clinical UM Guidelines
	  ○ MCG care guidelines
	  ○ Other vendor documents (e.g., Orthonet, ASH, etc.)

4. *Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the managed care organization, beneficiary, and provider perspectives)*

MH/SUD	M/S
Prior authorization is performed by a Registered Nurse, LCSW, LICSW, Psychologist or LPC. If the Registered Nurse, LCSW, LICSW, Psychologist or LPC cannot deny the service based on medical necessity criteria review, the case will go to the physician for review. Only a physician can deny an authorization request. PRTF admissions require a mandatory physician review upon admission and as required. Policies and Procedures reflect this process	Prior authorization is performed by a Registered Nurse. If the Registered Nurse cannot approve the service based on medical necessity criteria Prior authorization is performed by a Registered Nurse. If the Registered Nurse cannot approve the service based on medical necessity criteria review, the case will go to the physician for review. Only a physician can deny an authorization request. Acute Inpatient Rehab (AIR) admission and continued stay requires a mandatory physician review. Policies and Procedures reflect this process

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
Medical necessity criteria based on national guidelines and reviewed annually by the internal medical advisory committee	Medical necessity criteria based on national guidelines and reviewed annually by the internal medical advisory committee

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S
NQTL Self Compliance Tool for Utilization Management Reviews has been developed. Reviewers are audited annually for interrater reliability and must score 90%	NQTL Self Compliance Tool for Utilization Management Reviews has been developed. Reviewers are audited annually for interrater reliability and must score 90%

7. *Compliance Determination*

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on medical/surgical benefits.

8.2.4 Practice Guidelines: Inpatient, Outpatient, Emergency Services – Aetna

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
Practice guidelines provide decision-making criteria to practitioners, providers, and members	Practice guidelines provide decision-making criteria to practitioners, providers, and members

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
• To promote consistent application of evidence-based treatment methodologies • Facilitate improvement of healthcare • Reduce unnecessary variations in care.	• To promote consistent application of evidence-based treatment methodologies • Facilitate improvement of healthcare • Reduce unnecessary variations in care.

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
The MCO uses the following criteria for physical health and behavioral health consulted in the order listed below; as applicable: • Criteria required by applicable state or federal regulatory agency • ASAM • MCG for physical and behavioral health criteria • LOCUS, CALOCUS, or CASII for behavioral health • Aetna CPBs • Aetna Clinical Policy Council Review (7000.30), Emergency Services	The MCO uses the following criteria for physical health and behavioral health consulted in the order listed below; as applicable: • Criteria required by applicable state or federal regulatory agency • ASAM • MCG for physical and behavioral health criteria • LOCUS, CALOCUS, or CASII for behavioral health • Aetna CPBs • Aetna Clinical Policy Council Review (7000.30), Emergency Services

4. Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)

MH/SUD	M/S
Practice guidelines are made available to practitioners, providers, or members	Practice guidelines are made available to practitioners, providers, or members

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
Medical necessity decisions are determined by evidenced-based guidelines	Medical necessity decisions are determined by evidenced-based guidelines

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S

• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including:
  ○ Number of service authorizations requested
  ○ Number of service authorizations denied
  ○ Number of denied service authorizations with member appeal
  ○ Number of denied service authorizations with member appeal upheld
  ○ Number of denied service authorizations with member appeal reversed
  ○ Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site)
• The SIC reviews all the above for mental health parity compliance concerns
• If there are any indications of potential noncompliance with the Parity Rule exists, the underlying data will be comprehensively reviewed, and if necessary, the appropriate actions will be taken
	• Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including:
	  ○ Number of service authorizations requested
	  ○ Number of service authorizations denied
	  ○ Number of denied service authorizations with member appeal
	  ○ Number of denied service authorizations with member appeal upheld
	  ○ Number of denied service authorizations with member appeal reversed
	  ○ Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site)
	• These indicators are compared to MH/SUD indicators to identify any mental health parity concerns

7. *Compliance Determination*

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.2.5 Practice Guidelines – THP

1. *What benefits is the NQTL assigned to?*

MH/SUD	M/S
Clinical guidelines topics are related to areas determined to be high risk, high volume, and/or problem prone areas are selected	Clinical guidelines topics are related to areas determined to be high risk, high volume, and/or problem prone areas are selected, and members

2. *Strategy: Why is the NQTL assigned to these services?*

MH/SUD	M/S
• Clinical guidelines measure quality across the organization and ensure content is consistent for each condition managed as well as ensuring appropriate practitioner oversight of programs • Evidence-based clinical guidelines are valuable to The Health Plan in analyzing performance, taking action for quality improvement and demonstrating improvement	• Clinical guidelines measure quality across the organization and ensure content is consistent for each condition managed as well as ensuring appropriate practitioner oversight of programs • Evidence-based clinical guidelines are valuable to The Health Plan in analyzing performance, taking action for quality improvement and demonstrating improvement variations in care

3. *Evidentiary Standard: What evidence supports the rationale for the assignment?*

MH/SUD	M/S
Evidentiary standard: Interqual, ASAM, CMS/BMS, review of medical and scientific sources including peer reviewed studies in medical journals that meet nationally recognized standards including sources such as Hayes Inc, National Institute of Health's National Library of Medicine, Federal Agency for Healthcare Research and Quality, National Comprehensive Cancer Network, and other	Evidentiary standard: Interqual, ASAM, CMS/BMS, review of medical and scientific sources including peer reviewed studies in medical journals that meet nationally recognized standards including sources such as Hayes Inc, National Institute of Health's National Library of Medicine, Federal Agency for Healthcare Research and Quality, National Comprehensive Cancer Network, and other

4. *Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)*

MH/SUD	M/S

• Our practice guidelines require a consistent and uniform approach to their development, accomplished through the following objectives:
  ○ Ensuring the involvement of the medical directors, the Quality Improvement
	• Our practice guidelines require a consistent and uniform approach to their development, accomplished through the following objectives:
	  ○ Ensuring the involvement of the medical directors, the Quality Improvement

MH/SUD	M/S
Committee (QIC), and The Health Plan practitioners ○ Ensuring the distribution of the guidelines to all applicable practitioners. Our guidelines are on our website for practitioners to access. Practitioners are also notified of their availability ○ Ensuring the development of methods for the regular evaluation of the delivery of clinical care consistent with guidelines. Clinical practice guidelines will be researched, adopted, and distributed to appropriate participating practitioners to ensure the most current clinical practices are in place for the treatment of The Health Plan members. All practice guidelines adopted by The Health Plan are coordinated through the Physician Advisory Committee(s)	Committee (QIC), and The Health Plan practitioners ○ Ensuring the distribution of the guidelines to all applicable practitioners. Our guidelines are on our website for practitioners to access. Practitioners are also notified of their availability ○ Ensuring the development of methods for the regular evaluation of the delivery of clinical care consistent with guidelines. Clinical practice guidelines will be researched, adopted, and distributed to appropriate participating practitioners to ensure the most current clinical practices are in place for the treatment of The Health Plan members. All practice guidelines adopted by The Health Plan are coordinated through the Physician Advisory Committee(s)

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• Two non-preventive behavioral health guidelines are maintained at all times • Topics related to areas determined to be high risk, high volume, and/or problem prone areas are selected for additional guideline development • Guidelines are made available to the appropriate practitioners and they are provided with education	• Two non-preventive acute or chronic guidelines are maintained at all times • Topics related to areas determined to be high risk, high volume, and/or problem prone areas are selected for additional guideline development • Guidelines are made available to the appropriate practitioners and they are provided with education

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
Topics related to areas determined to be high risk, high volume, and/or problem prone areas are selected for additional guideline development. This ensures that the topics selected are worthwhile, population-based, and deserving of resource commitment	Topics related to areas determined to be high risk, high volume, and/or problem prone areas are selected for additional guideline development. This ensures that the topics selected are worthwhile, population-based, and deserving of resource commitment

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.2.6 Practice Guidelines – UniCare

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
Practice guidelines are available for a variety of behavioral health disorders commonly seen	Practice guidelines are available for a variety of medical conditions

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
• To base care on evidenced-based medical literature and reduce variation in care • To improve outcomes	• To base care on evidenced-based medical literature and reduce variation in care • To improve outcomes

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
UniCare adopts nationally-recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of members	UniCare adopts nationally-recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of members

4. Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)

MH/SUD	M/S
The guidelines, which UniCare uses for quality and disease management programs, are based on reasonable medical evidence UniCare reviews the guidelines at least every two years, or when changes are made to national guidelines, for content accuracy, current primary sources, new technological advances and recent medical research.	The guidelines, which UniCare uses for quality and disease management programs, are based on reasonable medical evidence UniCare reviews the guidelines at least every two years, or when changes are made to national guidelines, for content accuracy, current primary sources, new technological advances and recent medical research.

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
Physicians are encouraged to utilize available guidelines	Physicians are encouraged to utilize available guidelines

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S
Guidelines are updated when changes are made in national guidelines, new technology advances are made, and/or changes in recent medical resource	Guidelines are updated when changes are made in national guidelines, new technology advances are made, and/or changes in recent medical resource

7. *Compliance Determination*

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.3 Provider Network NQTLs

8.3.1 Network Size – Patient-to-Provider Ratio, Location, etc. (Aetna)

1. *What benefits is the NQTL assigned to?*

MH/SUD	M/S
All benefit services that the MCO is contractually obligated to provide	All benefit services that the MCO is contractually obligated to provide

2. *Strategy: Why is the NQTL assigned to these services?*

MH/SUD	M/S
To develop and maintain a robust provider/practitioner network capable of meeting the healthcare needs of the MCO membership in an accessibly, timely, and convenient manner, and in accordance with plan contract requirements	To develop and maintain a robust provider/practitioner network capable of meeting the healthcare needs of the MCO membership in an accessibly, timely, and convenient manner, and in accordance with plan contract requirements

3. *Evidentiary Standard: What evidence supports the rationale for the assignment?*

MH/SUD	M/S
• The SIC, consisting of the managers of Member Services, Provider Relations, Medical Management, Quality Management, and the Health Plan Administration, meets at least quarterly to receive network data, analyze network data, identify opportunities for improvement, develop action items, and monitor outcomes of the changes for member access to services • SIC tracks the nature of these issues and identifies trends that might be indicative of network need	• The SIC, consisting of the managers of Member Services, Provider Relations, Medical Management, Quality Management, and the Health Plan Administration, meets at least quarterly to receive network data, analyze network data, identify opportunities for improvement, develop action items, and monitor outcome of the changes for member access to services • SIC tracks the nature of these issues and identifies trends that might be indicative of network need

4. *Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)*

MH/SUD	M/S
• The Network manager, with input from the National Medicaid Data and Reporting Team, plan departments, and providers/practitioners, regularly monitors network adequacy parameters on both a scheduled and ad hoc basis • These parameters include: ○ Accessibility of practitioners (telephone and ease of scheduling appointment) ○ Availability of practitioners (extent to which practitioners are geographically distributed, and the presence of the right number and type of providers to meet the needs of its membership) ○ Network adequacy • GeoAccess Reports are analyzed to determine the geographic distribution and cultural background of providers/practitioners in relation to member demographics • To confirm the availability of practitioners who provide primary care practitioner (PCP) services, including general and internal medicine, family practice, nurse practitioners, pediatrics, or other provider/practitioner types designated by government sponsor as a PCP, Aetna Better Health:	• The Network manager, with input from the National Medicaid Data and Reporting Team, plan departments and providers/practitioners, regularly monitors network adequacy parameters on both a scheduled and ad hoc basis • These parameters include: ○ Accessibility of practitioners (telephone and ease of scheduling appointment) ○ Availability of practitioners (extent to which practitioners are geographically distributed, and the presence of the right number and type of providers to meet the needs of its membership) ○ Network adequacy • GeoAccess Reports are analyzed to determine the geographic distribution and cultural background of providers/practitioners in relation to member demographics • To confirm the availability of practitioners who provide PCPs services, including general and internal medicine, family practice, nurse practitioners, pediatrics, or other provider/practitioner types designated by government sponsor as a PCP, Aetna Better Health:

MH/SUD	M/S
○ Establishes measurable standards for the number of each type of practitioner providing primary care ○ Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care ○ Annually analyzes performance against the standards for the number of each type of practitioner providing primary care ○ Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care ○ During the network development process, Aetna Better Health will determine whether practitioners have the capacity in their practice and are accepting new patients ○ If a practitioner is a PCP, the maximum panel size will be two thousand (2,000) patients. Aetna Better Health does review the availability of PCPs with an open panel annually, and the goal is <5% of PCPs having a closed panel • To confirm the availability of high-volume and high-impact specialists within its delivery system, Aetna Better Health: • Defines which practitioners serve as high-volume and high-impact specialists. At minimum:[11] ○ High-volume specialties include obstetrics / gynecology ○ High-impact specialties include oncology • Establishes measurable standards for the number of each type of high-volume[12] and high-impact specialist	○ Establishes measurable standards for the number of each type of practitioner providing primary care ○ Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care ○ Annually analyzes performance against the standards for the number of each type of practitioner providing primary care ○ Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care ○ During the network development process, Aetna Better Health will determine whether practitioners have the capacity in their practice and are accepting new patients ○ If a practitioner is a PCP, the maximum panel size will be two thousand (2,000) patients. Aetna Better Health does review the availability of PCPs with an open panel annually, and the goal is <5% of PCPs having a closed panel • Aetna Better Health's high-volume behavioral health practitioners are defined by BMS • To confirm the availability of high-volume BHPs within its delivery system, Aetna Better Health: • Defines which practitioners serve as high-volume BHPs • Establishes quantifiable and measurable standards for the number of each type of high-volume BHP • Establishes quantifiable and measurable standards for the geographic distribution of each type of high-volume behavioral health provider

[11] NCQA HP 2019/2020NET1 C1
[12] NCQA HP 2019/2020NET1 C1

MH/SUD	M/S
• Establishes measurable standards for the geographic distribution of each type of high-volume and high-impact specialist[13] • Annually analyzes performance against established standards[14]	• Annually analyzes performance against the standards

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
The goal is to meet network adequacy goals 100% of the time	The goal is to meet network adequacy goals 100% of the time

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S

• The SIC, consisting of the managers of Member Services, Provider Relations, Medical Management, Quality Management, and the Health Plan Administration, meets at least quarterly to receive network data, analyze network data, identify opportunities for improvement, develop action items, and monitor outcome of the changes for member access to services
• SIC tracks the nature of these issues and identifies trends that might be indicative of network need
• Networks are monitored for adequacy by several methods:
  ○ Number of services issues
  ○ Number of providers/practitioners by type
  ○ Percent outside acceptable ranges
  ○ Ratio of practitioner/providers required per 1,000 members
  ○ PCP panel status
• Network reporting:
	• The SIC, consisting of the managers of Member Services, Provider Relations, Medical Management, Quality Management, and the Health Plan Administration, meets at least quarterly to receive network data, analyze network data, identify opportunities for improvement, develop action items, and monitor outcome of the changes for member access to services
	• SIC tracks the nature of these issues and identifies trends that might be indicative of network need
	• Networks are monitored for adequacy by several methods:
	  ○ Number of services issues
	  ○ Number of providers/practitioners by type
	  ○ Percent outside acceptable ranges
	  ○ Ratio of practitioner/providers required per 1,000 members
	  ○ PCP panel status
	• Network reporting:

[13] NCQA HP 2019/2020NET1 C3-4
[14] NCQA HP 2019/2020NET1 C5

MH/SUD	M/S
○ Monthly provider/practitioner add/termination report to BMS ○ Annually Adequacy and GeoAccess reporting ○ Quarterly provider/practitioner panel size reporting ○ Annual Assessment of Network Adequacy	○ Monthly provider/practitioner add/termination report to BMS ○ Annually Adequacy and GeoAccess reporting ○ Quarterly provider/practitioner panel size reporting ○ Annual Assessment of Network Adequacy

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.3.2 Network Size – THP

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
All benefit services that THP is contractually obligated to provide	All benefit services that THP is contractually obligated to provide

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
• THP must ensure that all covered services including additional or supplemental services contracted by or on behalf of MHT members, are available and accessible • BMS has set minimum provider network adequacy standards that THP must meet or exceed in all areas in which THP operates. THP must comply with all the network adequacy standards in the MCO Contract • The intent of the standards is to provide for access to services at least as good, if not better, than access to care under the traditional Medicaid program	• THP must ensure that all covered services including additional or supplemental services contracted by or on behalf of MHT members, are available and accessible • BMS has set minimum provider network adequacy standards that THP must meet or exceed in all areas in which THP operates. THP must comply with all the network adequacy standards in the MCO Contract • The intent of the standards is to provide for access to services at least as good, if not better, than access to care under the traditional Medicaid program

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
• To ensure a robust network of providers so enrollees have access to mental health services • The THP provides ongoing care by ensuring availability of high-volume behavioral health practitioners within our delivery system • The behavioral health practitioner network includes psychiatrists, psychologists, counselor/therapists, and social workers, some with sub-specialties • Practitioners are available in all areas of THP network • Services are monitored quarterly related to MH and SUD to help ensure that benefits are not more limited in availability, scope, or duration than medical or surgical services in compliance with the MHPAEA • To ensure THP meets or exceeds all geographic network adequacy standards in the MCO contract	• To ensure a robust network of providers for enrollees to have access to all MCO provided services • To ensure THP meets or exceeds all geographic network adequacy standards in the MCO contract

4. Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)

MH/SUD	M/S
• If THP is unable to provide certain covered services, enrollees may get out-of-network services, and the cost is no greater than in-network services would have been • Enrollees may receive emergency care in- or out- of-network • THP must meet network adequacy standards (adult and pediatric) behavioral health providers and facilities, substance use disorder providers and facilities, and additional providers to promote the objectives of the Medicaid program as determined by CMS • THP is required to comply with updated network standards within 90 calendar days of issuance, unless otherwise agreed to in writing by BMS within 60 calendar days of issuance	• If THP is unable to provide certain covered services, enrollees may get out-of-network services, and the cost is no greater than in-network services would have been • Enrollees may receive emergency care in- or out- of-network • THP, by Contract, must meet network adequacy standards (adult and pediatric) for certain M/S specialists, basic hospital services, and additional providers to promote the objectives of the Medicaid program as determined by CMS • THP is required to comply with updated network standards within 90 calendar days of issuance, unless otherwise agreed to in writing by BMS within 60 calendar days of issuance

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
The goal is to meet or exceed network adequacy goals 100% of the time	The goal is to meet or exceed network adequacy goals 100% of the time

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S
THP should meet network adequacy standards 100% of the time. However, in its sole discretion, BMS allows some exceptions to the provider access standards allowed under limited circumstances (e.g., if no appropriate provider types are located within the mileage standards	THP should meet network adequacy standards 100% of the time. However, in its sole discretion, BMS allows some some exceptions to the provider access standards allowed under limited circumstances (e.g., if no appropriate provider types are located within the mileage standards

7. *Compliance Determination*

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits.

8.3.3 Network Size (Patient-to-Provider Ratio) – UniCare

1. *What benefits is the NQTL assigned to?*

MH/SUD	M/S
UniCare is obligated to meet required patient-to-provider ratios for all services it is contractually obligated to provide	UniCare is obligated to meet required patient-to-provider ratios for all services it is contractually obligated to provide

2. *Strategy: Why is the NQTL assigned to these services?*

MH/SUD	M/S
To develop and maintain an adequate provider/practitioner network capable of meeting the healthcare needs of UniCare MCO membership in an accessible way and in accordance with plan contract requirements	To develop and maintain an adequate provider/practitioner network capable of meeting the healthcare needs of UniCare MCO membership in an accessible way and in accordance with plan contract requirements

3. *Evidentiary Standard: What evidence supports the rationale for the assignment?*

MH/SUD	M/S
• The MCO must establish a sufficient number of providers to maintain sufficient access in accordance with BMS's Medicaid managed care network standards, state regulations, accreditation standards for all enrollees • To be included in the network, a provider must meet all credentialing requirements (in accordance with NCQA and state/Unicare requirements) and sign a contract agreeing to all UniCare policies/regulations and rates	• The MCO must establish a sufficient number of providers to maintain sufficient access in accordance with BMS's Medicaid managed care network standards state regulations, accreditation standards for all enrollees • To be included in the network, a provider must meet all credentialing requirements (in accordance with NCQA and state/Unicare requirements) and sign a contract agreeing to all UniCare policies/regulations and rates

4. *Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements from the MCO, beneficiary, and provider perspectives)*

MH/SUD	M/S
• UniCare allows out-of-state providers to join the network if they are located in states bordering WV • UniCare uses the time/distance requirements in the MCO Contract • If no in-network provider is available to provide the medically appropriate care or the member meets continuity of care criteria, UniCare will authorize out of network care • Members may access emergency care in- or out-of network	• UniCare allows out-of-state providers to join the network if they are located in states bordering WV • UniCare uses the time/distance requirements in the MCO Contract • If no in-network provider is available to provide the medically appropriate care or the member meets continuity of care criteria, UniCare will authorize out of network care • Members may access emergency care in- or out-of-network

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
The MCO is required to meet Medicaid's managed care network standards for all enrollees, exceptions are permitted when travel time to a provider is better than what exists in the community at large	The MCO is required to meet Medicaid's managed care network standards for all enrollees exceptions are permitted when travel time to a provider is better than what exists in the community at large

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S
Annually, UniCare reviews the geographic market, network adequacy for specialties; these are	Annually, UniCare reviews the geographic market, network adequacy for specialties; these are

MH/SUD	M/S
reviewed by the health plan, network relations, and modified as needed	reviewed by the health plan, network relations, and modified as needed

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on M/S benefits

9.0 Prescription Services NQTLs

9.1 Use of a PDL

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
• The PDL only addresses certain drug classes • Some classes of drugs will not be reviewed for preferential agents because of no or limited cost savings • Drugs that have historically been covered by Medicaid and are not listed on the PDL will continue to be covered	• The PDL only addresses certain drug classes • Some classes of drugs will not be reviewed for preferential agents because of no or limited cost savings • Drugs that have historically been covered by Medicaid and are not listed on the PDL will continue to be covered

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
WV uses a formulary, or PDL, to control costs	WV uses a formulary, or PDL, to control costs

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
• The WV Medicaid Pharmaceutical and Therapeutics (P&T) Committee is committed to: • Objectively recommending drugs for inclusion on the WV PDL that are effective and cost efficient, while providing maximum safety--the Institute for Clinical and Economic (ICER) recommendations are researched	• The WV Medicaid P&T Committee is committed to: • Objectively recommending drugs for inclusion on the WV PDL that are effective and cost efficient, while providing maximum safety—the ICER recommendations are researched • Examining the scientific literature (found in labeling, drug compendia, and peer-reviewed

MH/SUD	M/S
• Examining the scientific literature (found in labeling, drug compendia, and peer-reviewed clinical literature) for sound clinical evidence that supports selecting specific drugs to be included on the PDL • Helping to ensure that the PDL provides for medically appropriate drug therapies for use in the general Medicaid population, allowing healthcare providers to care for the majority of their patients without a prior authorization request • A vendor provides clinical monographs to validate equal therapeutic effectiveness of drugs in the class and solicits rebates for drugs that are to be preferred	clinical literature) for sound clinical evidence that supports selecting specific drugs to be included on the PDL • Helping to ensure that the PDL provides for medically appropriate drug therapies for use in the general Medicaid population, allowing healthcare providers to care for the majority of their patients without a prior authorization request • A vendor provides clinical monographs to validate equal therapeutic effectiveness of drugs in the class and solicits rebates for drugs that are to be preferred

4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the MCO, beneficiary, and provider perspectives).

MH/SUD	M/S
• Each drug is reviewed on its clinical merits relative to other medications in the same therapeutic class • Published, peer-reviewed clinical trials are the primary source of information used by the State's PDL vendor for this review • Data regarding efficacy, effectiveness, adverse effects, and tolerability is analyzed and compared to other drugs within the therapeutic class • From this analysis, the clinical staff determines an agent's superiority, equivalency, or inferiority relative to the comparator drugs • After the clinical review, a financial analysis is performed. This analysis incorporates utilization data from the State as well as net drug costs from the manufacturers • With this data, the financial staff determines the fiscal impact of the PDL status (preferred or non-preferred) of each medication • Incorporating all this information, the PDL vendor makes suggestions to the State's Medicaid P&T Committee regarding the PDL status of each medication	• Each drug is reviewed on its clinical merits relative to other medications in the same therapeutic class • Published, peer-reviewed clinical trials are the primary source of information used by the State's PDL vendor for this review • Data regarding efficacy, effectiveness, adverse effects, and tolerability is analyzed and compared to other drugs within the therapeutic class • From this analysis, the clinical staff determines an agent's superiority, equivalency, or inferiority relative to the comparator drugs • After the clinical review, a financial analysis is performed. This analysis incorporates utilization data from the State as well as net drug costs from the manufacturers • With this data, the financial staff determines the fiscal impact of the PDL status (preferred or non-preferred) of each medication • Incorporating all this information, the PDL vendor makes suggestions to the State's Medicaid P&T Committee regarding the PDL status of each medication

MH/SUD	M/S
• After reviewing and discussing these suggestions, the P&T Committee makes recommendations to BMS for final decisions • The Drug Utilization Review (DUR) Board then recommends PA criteria to the State • Some classes are eliminated when there are no longer savings in the class • The P&T Committee meets three times per year and as necessary to review the PDL and new drugs as they become available • New drugs introduced into the marketplace in therapeutic classes that have been reviewed will be considered non-preferred until the annual review of the particular therapeutic class • Exceptions to this policy will be made for drugs that the U.S. Food and Drug Administration (FDA) has given priority status	• After reviewing and discussing these suggestions, the P&T Committee makes recommendations to BMS for final decisions • The DUR Board then recommends PA criteria to the State • Some classes are eliminated when there are no longer savings in the class • The P&T Committee meets three times per year and as necessary to review the PDL and new drugs as they become available • New drugs introduced into the marketplace in therapeutic classes that have been reviewed will be considered non-preferred until the annual review of the particular therapeutic class • Exceptions to this policy will be made for drugs that the FDA has given priority status

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• The trial criteria and exceptions for a PDL drug are established based on clinical evidence and the recommendations of the BMS Department of Pharmacy Services that are reviewed and approved by the WV DUR Board • Therapeutic classes are reviewed annually, at a minimum. Classes may be reviewed more often if new drugs are introduced to the class • The PDL is reviewed in total annually and updated quarterly • If a therapeutic class has been reviewed by the P&T Committee and the Secretary of DHHR has approved the recommended drugs in that category, new chemical entities must be listed in First Data Bank (FDB) for six months prior to the next scheduled P&T Committee meeting to be eligible for review • Until that time, the new drug will be non-preferred and available via the PA process. In addition, the new drug will not be listed on the PDL until officially reviewed • If a new drug is considered unique and has been classified a priority drug by the FDA, the	• The trial criteria and exceptions for a PDL drug are established based on clinical evidence and the recommendations of the BMS Department of Pharmacy Services that are reviewed and approved by the WV DUR Board • Therapeutic classes are reviewed annually, at a minimum. Classes may be reviewed more often if new drugs are introduced to the class • The PDL is reviewed in total annually and updated quarterly • If a therapeutic class has been reviewed by the P&T Committee and the Secretary of DHHR has approved the recommended drugs in that category, new chemical entities must be listed in FDB for six months prior to the next scheduled P&T Committee meeting to be eligible for review • Until that time, the new drug will be non-preferred and available via the PA process. In addition, the new drug will not be listed on the PDL until officially reviewed

MH/SUD	M/S
BMS and the P&T Chair may, based on clinical judgment, exempt the drug from the six-month rule	• If a new drug is considered unique and has been classified a priority drug by the FDA, the BMS and he P&T Chair may, based on clinical judgment, exempt the drug from the six-month rule

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
The PDL compliance rate was approximately 96% for quarter 4 of 2019 as well as quarter 1 of 2020	The PDL compliance rate of all drug classes minus mental health was approximately 90% for quarter 4 of 2019 and 91% for quarter 1 of 2020

9.2 Drugs on the PDL Must Be Tried first (Step Therapy/Fail First)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
Drugs in these therapeutic classes: • Alzheimer's: Cholinesterase Inhibitors • Alzheimer's: N-methyl-d-aspartate (NMDA) • Anticonvulsants: Adjuvants • Anticonvulsants: Barbiturates • Anticonvulsants: Benzodiazepines • Anticonvulsants: Cannabinoid • Anticonvulsants: Hydantoins • Anticonvulsants: Succinimides • Antidepressants: Other • Antidepressants: TCA • Antidepressants: SSRI • Antipsychotics: Atypical • Opiate Dependence Treatments • Sedative Hypnotics • Stimulants: Amphetamines • Stimulants: Non-Amphetamine	Drugs in these therapeutic classes: • Acne Agents, Topical • Analgesics, Narcotic Short-Acting (Non-parenteral) • Androgenic Agents • Anesthetics, Topical • Angiotensin Modulators • Antianginal and Anti-ischemic • Antibiotics, GI & Related Agents • Antibiotics, Inhaled • Antibiotics, Topical • Antibiotics, Vaginal • Anticoagulants • Anticonvulsants • Antiemetics • Antifungals, Oral • Antihypertensives, Sympatholytics • Antihyperuricemics • Antimigraine Agents, Other • Antimigraine Agents, Triptans

MH/SUD	M/S
	• Antiparasitics, Topical • Antiparkinson's Agents • Antipsoriatics, Topical • Antiretrovirals • Antivirals, Oral • Antivirals, Topical • Beta Blockers • Bladder Relaxant Preparations • Bone Resorption Suppression and Related Agents • BPH Treatments • Bronchodilators, Beta Agonist • Calcium Channel Blockers • Cephalosporins and Related Antibiotics • Colony Stimulating Factors • COPD Agents • Cytokine & CAM Antagonists • Epinephrine, Self-injected • Erythropoiesis Stimulating Proteins • Fluoroquinolones (Oral) • Glucocorticoids, Inhaled • Growth Hormone • H. Pylori Treatment • Hepatitis B Treatments • Hepatitis C Treatments • Hyperparathyroid Agents • Hypoglycemics, Biguanides • Hypoglycemics, DPP-4 Inhibitors • Hypoglycemics, GLP-1 Agonists • Hypoglycemics, Insulin and Related Agents • Hypoglycemics, Meglitinides • Hypoglycemics, Bile Acid Sequestrants • Hypoglycemics, SGLT2 Inhibitors • Hypoglycemics, TZD • Immunomodulators, Atopic Dermatitis • Immunomodulators, Genital Warts & Actinic Keratosis Agents

MH/SUD	M/S
	• Immunosuppressives, Oral • Intranasal Rhinitis Agents • Irritable Bowel Syndrome/Short Bowel Syndrome/Selected GI Agents • Laxatives and Cathartics • Leuikotriene Modifiers • Lipotropics, Other (Non-statins) • Lipotropics, Statins • MABS, ANTI-IL/IgE • Macrolides/Ketolides • Multiple Sclerosis Agents • Narcoleptic Agents • Neuropathic Pain • NSAIDS • Ophthalmic Antibiotics • Ophthalmic Antibiotics/Steroid Combinations • Ophthalmics for Allergic Conjunctivitis • Ophthalmics, Anti-inflammatories – Immunomodulators • Ophthalmics, Anti-inflammatories • Ophthalmics, Glaucoma Agents • Otic Antibiotics • PAH Agents – Endothelin Receptor Antagonists • PAH Agents – Guanylate Cyclase Stimulator • PAH Agents – PDE5s • PAH Agents – Prostacyclins • Pancreatic Enzymes • Phosphate Binders • Platelet Aggregation Inhibitors • Progestins for Cachexia • Progestational Agents • Proton Pump Inhibitors • Skeletal Muscle Relaxants • Steroids, Topical • Tetracyclines • Ulcerative Colitis Agents

MH/SUD	M/S
	• Vasodilators, Coronary

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
WV uses a formulary, or PDL, to control costs	WV uses a formulary, or PDL, to control costs

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
Help ensure medically appropriate drug therapies for use in the general Medicaid population that are effective and cost efficient, while providing maximum safety and allowing healthcare providers to care for the majority of their patients without a prior authorization request	Help ensure medically appropriate drug therapies for use in the general Medicaid population that are effective and cost efficient, while providing maximum safety and allowing healthcare providers to care for the majority of their patients without a prior authorization request

4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the MCO, beneficiary, and provider perspectives).

MH/SUD	M/S
• Processes for applying the NQTL are the same for all covered prescription drugs; edits are applied at the point of sale when the prescription is adjudicated • Non-PDL prescriptions are denied at the point of sale if no trials of preferred drugs are in the patient's history	• Processes for applying the NQTL are the same for all covered prescription drugs; edits are applied at the point of sale when the prescription is adjudicated • Non-PDL prescriptions are denied at the point of sale if no trials of preferred drugs are in the patient's history

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• System edits are applied at the point of sale every time a prescription is adjudicated • The clinical pharmacists at the Rational Drug Therapy Program (RDTP), the state's pharmacy PA vendor, have discretion to issue a PA for a non-PDL drug if a clinical justification is provided by the prescriber	• System edits are applied at the point of sale every time a prescription is adjudicated • The clinical pharmacists at the RDTP, the state's pharmacy PA vendor, have discretion to issue a PA for a non-PDL drug if a clinical justification is provided by the prescriber

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
The PDL compliance rate was approximately 96% for quarter 4 of 2019 and quarter 1 of 2020	The PDL compliance rate of all drug classes minus mental health was approximately 90% for quarter 4 of 2019 and 91% for quarter 1 of 2020

9.3 Prior Authorization

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
All non-preferred drugs or drugs requiring a PA that are in therapeutic classes not included on the PDL	All non-preferred drugs or drugs requiring a PA that are in therapeutic classes not included on the PDL

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
• The two primary objectives of DUR systems are to improve quality of care and assist in containing costs • The DUR program assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes	• The two primary objectives of DUR systems are to improve quality of care and assist in containing costs • The DUR program assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
• Drugs or drug classes that are reviewed and found to be inappropriately utilized or have significant safety concerns are deemed candidates for PA • These reviews are considered by the DUR Board and appropriate criteria for approval are determined by them, with input from medical and pharmacy providers, drug manufacturers, and other experts • WV Medicaid PA criteria are developed by the BMS staff, with the assistance of the West Virginia University School of Pharmacy and are reviewed by the State's Medicaid DUR Board	• Drugs or drug classes that are reviewed and found to be inappropriately utilized or have significant safety concerns are deemed candidates for PA • These reviews are considered by the DUR Board and appropriate criteria for approval are determined by them, with input from medical and pharmacy providers, drug manufacturers, and other experts • WV Medicaid PA criteria are developed by the BMS staff, with the assistance of the West Virginia University School of Pharmacy and are reviewed by the State's Medicaid DUR Board

4. *Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the MCO, beneficiary, and provider perspectives).*

MH/SUD	M/S
• The PA process requires that non-preferred drugs meet specified criteria in order to be reimbursed by the BMS • PA requests may be made by telephone, fax, or mail • Clinical pharmacists employed by the PA vendor have discretion for approval and usually obtain more clinical information from the prescriber • A three-day emergency supply of prior-authorized drugs can be dispensed by a pharmacy until authorization is completed • If PA is needed and not obtained, or PA is not approved, the prescription is not filled for the member	• The PA process requires that non-preferred drugs meet specified criteria in order to be reimbursed by the BMS • PA requests may be made by telephone, fax, or mail • Clinical pharmacists employed by the PA vendor have discretion for approval and usually obtain more clinical information from the prescriber • A three-day emergency supply of prior-authorized drugs can be dispensed by a pharmacy until authorization is completed • If PA is needed and not obtained, or PA is not approved, the prescription is not filled for the member

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
• Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance • Trial criteria, PA criteria, and duration of PA are determined by the DUR Board with clinical recommendations provided by a vendor	• Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance • Trial criteria, PA criteria, and duration of PA are determined by the DUR Board with clinical recommendations provided by a vendor

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S
In the 1st quarter of 2020, as a whole, MH agents which may have required a PA were approved roughly 70% of the time with the initial contact, and roughly 13% were denied with the remaining requests requiring additional information from the provider	In the 1st quarter of 2020, a little over 50% of all PAs were granted with the initial contact. Roughly 25% were outright denied, and the remaining required additional contact with the provider

9.4 Prospective Review

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
All prescriptions	All prescriptions

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
• The two primary objectives of DUR systems are to improve quality of care and assist in containing costs • The DUR program assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes • Prescription claims are screened to identify potential drug therapy problems of the following types: ▪ Therapeutic duplication ▪ Ingredient duplication ▪ Adverse drug-drug interactions ▪ Early refill ▪ Late refill ▪ High dosage ▪ Low dosage ▪ Incorrect duration of drug treatment ▪ Age/gender precaution ▪ Pregnancy precaution ▪ Breast-feeding precaution	• The two primary objectives of DUR systems are to improve quality of care and assist in containing costs • The DUR program assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes • Prescription claims are screened to identify potential drug therapy problems of the following types: ▪ Therapeutic duplication ▪ Ingredient duplication ▪ Adverse drug-drug interactions ▪ Early refill ▪ Late refill ▪ High dosage ▪ Low dosage ▪ Incorrect duration of drug treatment ▪ Age/gender precaution ▪ Pregnancy precaution ▪ Breast-feeding precaution

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
• The DUR Board and BMS DUR pharmacists review the criteria regularly using surveys of current peer-reviewed literature and recommendations from FDB (creator of edits), DrugDex, MicroMedex, and American Hospital Formulary Drug Service • Lexicomp and UpToDate are clinical subscription services to which pharmacists	• The DUR Board and BMS DUR pharmacists review the criteria regularly using surveys of current peer-reviewed literature and recommendations from FDB (creator of edits), DrugDex, MicroMedex, and American Hospital Formulary Drug Service • Lexicomp and UpToDate are clinical subscription services to which pharmacists

MH/SUD	M/S
have access and regularly use during the course of their work	have access and regularly use during the course of their work

4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the MCO, beneficiary, and provider perspectives).

MH/SUD	M/S
• Due to the 2017 pharmacy carve-out, processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing • Pharmacists filling the prescriptions, clinical pharmacists at RDTP, and the DUR pharmacist at BMS are responsible for applying the policies • Claims deny for early refills, therapeutic duplications, ingredient duplications, or inappropriate dosages; or require additional review if they are flagged for these edits • Clinical personnel have discretion to make exceptions to the policy depending on the clinical information provided by the prescriber • Prescribers may appeal to the BMS medical director who works in conjunction with the BMS DUR pharmacist	• Due to the 2017 pharmacy carve-out, processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing • Pharmacists filling the prescriptions, clinical pharmacists at RDTP, and the DUR pharmacist at BMS are responsible for applying the policies • Claims deny for early refills, therapeutic duplications, ingredient duplications, or inappropriate dosages; or require additional review if they are flagged for these edits • Clinical personnel have discretion to make exceptions to the policy depending on the clinical information provided by the prescriber • Prescribers may appeal to the BMS medical director who works in conjunction with the BMS DUR pharmacist

5. Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing • Prescribers may appeal to the BMS medical director who works in conjunction with the BMS DUR pharmacist	• Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing • Prescribers may appeal to the BMS medical director who works in conjunction with the BMS DUR pharmacist

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

MH/SUD	M/S
Required by federal regulation	Required by federal regulation

9.5 Medicaid Covers Higher (Initial) Dose of Suboxone Only Once

WV Medicaid covers up to 24mg per day for the first 60 days of treatment. After this initial period, no more than 16mg per day may be covered without approval. Initial dosing is limited to once per lifetime. Medicaid will only pay for the higher dose once.

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
Opioid Withdrawal Agents	All classes of medications have dose optimization standards

2. Strategy: Why is the NQTL assigned to these services?

MH/SUD	M/S
• To encourage patients to stay on the program and not to drop out, reduce diversion, and contain costs • Medical research shows no therapeutic benefit for more than 16 mg except in very rare circumstances (e.g., pregnant enrollee with increased metabolism, in which case the increased dose would be approved if clinically appropriate)	• To reduce diversion and contain costs. Additionally, limits provide an opportunity to assess the patient for compliance and address reasons for therapeutic failure

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
• Current evidence reviewed by members of the P&T Committee, DUR Board, and BMS clinical staff shows that higher doses do not increase the success of the treatment program, but lead to an increased incidence of drug diversion and an unnecessary cost burden • 16 mg is more than adequate to cover opioid receptors and withdrawal symptoms • 16 mg is the dosage recommended in the package insert	• Current evidence reviewed by members of the DUR Board and BMS clinical staff • Package insert dosage recommendations

4. *Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the MCO, beneficiary, and provider perspectives).*

MH/SUD	M/S
• Dose optimization is required for prescriptions to process in the point of sale system. Edits are applied at the point of sale when the prescription is adjudicated • Prescriptions will deny at the point of sale if dose optimization is not applied	• Dose optimization is required for prescriptions to process in the point of sale system. Edits are applied at the point of sale when the prescription is adjudicated • Prescriptions will deny at the point of sale if dose optimization is not applied

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
• Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing • Prescriber must submit additional clinical information to clinical pharmacists at RDTP for authorization of a more customized dosage approach • Prescriber can appeal a denial	• Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing • Prescriber must submit additional clinical information to clinical pharmacists at RDTP for authorization of a more customized dosage approach • Prescriber can appeal a denial

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S
• Providers do not request 24 mg as the research no longer supports it • There have been no appeals	The process for prospective review and DUR captures inappropriate doses and drug interactions

9.6 Pharmacy Lock-in Program

1. *What benefits is the NQTL assigned to?*

MH/SUD	M/S

• As determined by the Retrospective DUR (RDUR) Committee through review of member drug utilization profiles:
  ○ Members who may be at risk for adverse effects due to the potential overutilization of controlled substances
	• As determined by the RDUR Committee through review of member drug utilization profiles:
	  ○ Members who may be at risk for adverse effects due to the potential overutilization of controlled substances

MH/SUD	M/S
○ Members who use pharmacy services excessively or inappropriately	○ Members who use pharmacy services excessively or inappropriately

2. *Strategy: Why is the NQTL assigned to these services?*

MH/SUD	M/S
Patient safety, prevention of drug diversion, and cost containment	Patient safety, prevention of drug diversion, and cost containment

3. *Evidentiary Standard: What evidence supports the rationale for the assignment?*

MH/SUD	M/S
• Criteria for lock-in are reviewed and approved by the DUR Board and Retrospective DUR Committee, which meets monthly. • Information used to develop and review this policy include the following: http://www.cdc.gov/drugoverdose/pdf/pdo_patient_review_meeting-a.pdf https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-March-2015.pdf • WV Safe & Effective Management of Pain Guidelines (SEMP) 2016 MME conversion chart	• Criteria for lock-in are reviewed and approved by the DUR Board and Retrospective DUR Committee, which meets monthly. • Information used to develop and review this policy include the following: http://www.cdc.gov/drugoverdose/pdf/pdo_patient_review_meeting-a.pdf https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-March-2015.pdf • WV Safe & Effective Management of Pain Guidelines (SEMP) 2016 MME conversion chart

4. *Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the MCO, beneficiary, and provider perspectives).*

MH/SUD	M/S
• The RDUR Committee, comprised of actively practicing healthcare professionals, meets monthly to review members' prescription and medical profiles that have been identified for drug utilization issues • WV Medicaid contracts with Health Information Design (HID) to conduct the initial reviews and referrals for the committee	• The RDUR Committee, comprised of actively practicing healthcare professionals, meets monthly to review members' prescription and medical profiles that have been identified for drug utilization issues • WV Medicaid contracts with HID to conduct the initial reviews and referrals for the committee

MH/SUD	M/S
• A series of warning letters is sent to the physician and the patient stating that continued overutilization of controlled substances might result in the member being restricted to a single pharmacy provider • If the lock-in criteria are met and the prescribing pattern does not change related to the warning letters, then the member is asked to select a single pharmacy for future controlled substance prescriptions • The chosen pharmacy's participation is voluntary. The pharmacists at these locations are asked to use their professional judgment when filling controlled substances for the member • At the end of the 12-month period, the RDUR Committee reviews the member's prescription profile to determine if the lock-in should be continued for another 12-month period	• A series of warning letters is sent to the physician and the patient stating that continued overutilization of controlled substances might result in the member being restricted to a single pharmacy provider • If the lock-in criteria are met and the prescribing pattern does not change related to the warning letters, then the member is asked to select a single pharmacy for future controlled substance prescriptions • The chosen pharmacy's participation is voluntary. The pharmacists at these locations are asked to use their professional judgment when filling controlled substances for the member • At the end of the 12-month period, the RDUR Committee reviews the member's prescription profile to determine if the lock-in should be continued for another 12-month period

5. *Strategy: How frequently or strictly is the NQTL applied?*

MH/SUD	M/S
• On a monthly basis, the RDUR Committee reviews member profiles that have been selected because of therapeutic criteria exceptions, including potential overutilization of controlled substances • A prescriber can request an override for a lock-in to ensure patient access to treatment	• On a monthly basis, the RDUR Committee reviews member profiles that have been selected because of therapeutic criteria exceptions, including potential overutilization of controlled substances • A prescriber can request an override for a lock-in to ensure patient access to treatment

6. *Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?*

MH/SUD	M/S
The latest lock-in report run for the month of June 2020 indicates 193 patients are currently locked into a pharmacy	The latest lock-in report run for the month of June 2020 indicates 193 patients are currently locked into a pharmacy

7. *Compliance Determination*

Based on review of the comparability and stringency of processes, strategies, and evidentiary standards, this NQTL is compliant with the MH Parity requirements.

10.0 Availability of Information

10.1 Criteria for Medical Necessity Determination

The Medicaid/CHIP parity rule requires that the criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries (MCO enrollees and potential enrollees and CHIP beneficiaries who are enrollees or potential enrollees with a managed care entity) and affected Medicaid/CHIP providers upon request.

10.1.1 FFS Benefits

WV Medicaid makes the criteria for medical necessity determinations for FFS MH/SUD benefits available to beneficiaries and affected providers upon request.

10.1.2 MCOs

The following excerpt from WV Medicaid's SFY2021 MCO contract, Section 3.8.1 Resolution of Enrollee Issues, sub-section 5.a.i and 5.a.ii (see Article III, page 113) demonstrates compliance with this availability of information requirement:

"5. Notice of Action

The notice of action must be in writing and must meet the readability requirements of Article III, Section 3.4 of this contract.

a. The notice must include the following information:

i. The action taken or intended to be taken by the MCO;

ii. The reasons for the action, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. This information includes medically necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits…"

10.2 Reason for Denial of Payment

The Medicaid/CHIP parity rule requires that the reason for any denial of reimbursement or payment for MH/SUD benefits must be made available to the beneficiary, including the applicable medical necessity criteria as applied to that enrollee. This should include providing any processes, strategies, or evidentiary standards used in applying the medical necessity criteria to that enrollee.

10.2.1 FFS Benefits

WV Medicaid makes the reason for any denial of reimbursement or payment for a FFS MH/SUD benefit available to the beneficiary.

10.2.2 MCOs

The following excerpt from WV Medicaid's SFY2021 MCO contract, Section 3.8.1 Resolution of Enrollee Issues, sub-sections 5.a.ii and 5.b.iv (see Article III, pages 106-107) demonstrates compliance with this availability of information requirement.

"5. Notice of Action

The notice of action must be in writing and must meet the readability requirements of Article III, Section 3.4 of this contract.

a. The notice must include the following information:

i. The action taken or intended to be taken by the MCO;

ii. The reasons for the action, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. This information includes medically necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits…

b. The notice of action must be mailed…

iv. For denial of payment, at the time of any action affecting the claim…"

Appendix A – Documentation to the General Public

Mental Health (MH) Parity Summary

1.0 Medicaid MH Parity Overview

1.1 Background and Purpose

On March 30, 2016, CMS issued a Final Rule applying the MHPAEA parity requirements to coverage offered by Medicaid MCOs, CHIP, and Medicaid benchmark and benchmark-equivalent plans (referred to as ABPs in the Final Rule) (Federal Register Vol. 81, No. 61 March 30, 2016, Part V Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), 42 CFR Parts 438, 440, 456, et al.). The Final Rule explains roles and responsibilities for determining and monitoring compliance, as well as parity requirements.

1.2 General Parity Requirements

The MHPAEA requires insurers and plans to guarantee that all FR (i.e., deductibles, co-pays), as well as caps and limitations on benefits, be no more restrictive for MH and SUD services then for medical and surgical (M/S) counterparts under the same plan. Specific MHPAEA requirements include aggregate lifetime and annual dollar limits (AL/ADL); FRs and QTLs; NQTLs; and the availability of information, including the reason for denial of services.

This document is intended to fulfill the Final Rule requirement that states provide documentation of compliance with Final Rule requirements to the general public and post this information on their State Medicaid Website.

2.0 Parity Analysis Approach

2.1 Benefit Package and Delivery Systems

The Traditional Medicaid benefit package is for all Medicaid members. It can be delivered to members by FFS, MCOs, or a mixture of both FFS and MCO. WV currently has three MCOs as part of its managed care program, Mountain Health Trust. MHT covers the majority of the benefits in the Traditional Medicaid benefit package. Some benefits are carved out of the MCOs' responsibility and are covered by FFS, such as pharmacy, school-based health services, and children's residential treatment.

2.2 Methodology

In order to determine compliance, DHHR followed the process provided by CMS in the January 17, 2017, "Parity Compliance Toolkit Applying Mental Health, and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs."

The Department also met with the FFS program managers and representatives from the MCOs to review policies and procedures to determine compliance.

2.2.1 Definitions

For the purpose of the parity analysis, the Department used the following definitions to group and classify benefits.

Term	Definition
Medical/Surgical (M/S) Benefits	Benefits for items or services for medical conditions or surgical procedures, as defined by the State and in accordance with applicable federal and State law, but do not include MH or SUD benefits.
Mental Health (MH) Benefits	MH services are those billed with a principal diagnosis from the DSM-V, excluding any diagnosis in SUD range of F10 – F19.99.
Substance Use Disorder (SUD) Benefits	SUD services are those billed with a principal diagnosis in the range F10 – F19.99 using the DSM-V.
Inpatient	Services provided to a patient who has been formally admitted to a hospital or long-term care facility on the recommendation of a physician and is receiving room, board, and professional services in the institution on a continuous, 24-hour-a-day basis. Inpatient services include all treatments, pharmaceuticals, equipment, tests, and procedures provided during an inpatient treatment episode.
Outpatient	Services provided to a patient who is evaluated or treated at a hospital emergency department, medical clinic, diagnostic center, or other appropriate medical facility who is not receiving room, board, and professional services on a 24-hour-a-day basis, and who is not receiving CPT services 99281-99285 during the treatment episode. Outpatient services include all treatments, equipment, tests, procedures, and clinician-administered pharmaceuticals provided during an outpatient treatment episode.
Emergency Care	Services that are part of a treatment episode that includes CPT codes 99281-99285.
Prescription Drug	Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance. Prescription drugs dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children to age 21, and prenatal vitamins.

3.0 Parity Analysis Findings

3.1 AL/ADLs

WV Medicaid has determined the applicable FFS programs, including school-based health services, children's residential treatment, and pharmacy benefits, as well as the three MCOs, to be in compliance with the parity regulations for AL/ADLs.

3.2 FRs

WV Medicaid has determined the applicable FFS programs, including school-based health services, children's residential treatment, and pharmacy benefits, as well as the MCOs, to be in compliance with the parity regulations for FRs.

3.3 QTLs

Only a few MH/SUD FFS services have QTLs (e.g., psychology services as part of school based services), and as such, WV has determined the benefit package to compliance with the parity regulations for QTLs. WV plans a comprehensive review and analysis of QTLs.

3.4 NQTLs

WV Medicaid has determined the applicable FFS programs, including school-based health services, children's residential treatment, and pharmacy benefits to be in compliance with the parity regulations for NQTLs. The MCOs are in compliance with, or have agreed to update their policies to come into compliance with the parity regulations for NQTLs.

3.5 Availability of Information

WV Medicaid has determined the applicable FFS programs, including school-based health services, children's residential treatment, and pharmacy benefits, as well as the MCOs, to be in compliance with the parity regulations for the availability of information.

Appendix B – MCO Contract

Separate file attached in delivery to CMS.