State of West Virginia

Department of Health and Human Resources

Mental Health Parity

Compliance Documentation

February 7, 2018

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Bureau for Medical Services

Department of Health and Human Resources

State of West Virginia

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Common Acronyms

Acronym	Term
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, West Virginia's State Medicaid Agency
CAD	Coronary Artery Disease
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 of Health and Human Resources
DME	Durable Medical Equipment
DRG	Drug Related Group
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUR	Drug Utilization Review
ECT	Electro-Convulsive Treatment
EEG	Electroencephalogram
E & M	Evaluation and Monitoring
EHB	Essential Health Benefit
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment

Acronym	Term
ER	Emergency Room
FDA	Food and Drug Administration
FDB	First Data Bank
FFS	Fee-For-Service
FQHCs	Federally Qualified Health Centers
FR	Financial Requirements
GMLOS	Geometric Mean Length of Stay
HCERA	Health Care and Education Reconciliation
HEDIS	Healthcare Effectiveness Data and Information Set
HID	Health Information Design
ICD	International Classification of Diseases
IOP	Intensive Outpatient Services
IP	Inpatient
LTSS	Long-Term Services and Supports
MCE	Managed Care Entity
MCO	Managed Care Organization
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
NQTL	Non-Qualitative Treatment Limit
OP	Outpatient
PA	Prior Authorization
PCP	Primary Care Provider
PDL	Preferred Drug List

Acronym	Term
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
SFY	State Fiscal Year
SIU	Special Investigations Unit
SPA	State Plan Amendment
SUD	Substance Use Disorder
TMJ	Temporomandibular Joint (TMJ) syndrome
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 (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, 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 MCOs, Medicaid benchmark and benchmark-equivalent plans (referred to in this rule as Medicaid ABPs), as well as CHIP.

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

This document analyzes and demonstrates West Virginia Medicaid's compliance with the MHPAEA. West Virginia administers CHIP in a separate program and is submitting separate parity compliance documentation.

2.0 Methodology

2.1 Benefit Package Identification Process

West Virginia Medicaid has two benefit plans. The Traditional Medicaid benefit package is for all Medicaid members except the expansion population, unless attesting to being medically frail, at which time the Traditional benefit package is accessible by expansion members. The West Virginia Health Bridge Alternative Benefit Plan (ABP) is for expansion members. The ABP State Plan Amendment (SPA) was last revised and approved in July 2015 and is therefore deemed compliant and not part of this analysis.

2.2 Process to Determine Responsibility for Parity Analysis

For the MCO population, West Virginia Medicaid delivers most benefits in the Traditional package using managed care; a few services are carved out and provided through fee-for-service (FFS) delivery systems. Three MCOs[1] deliver most benefits to West Virginia Medicaid members: Aetna; The Health Plan; and UniCare Health Plan of West Virginia (UniCare). 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

West Virginia created a workgroup focused on MH parity. The workgroup consisted of the Medicaid Pharmacy Director; Assistant to the Deputy Secretary of Public Health, Insurance, and Strategic Planning, who oversees the MCO contracts; and the Medicaid Program Manager for School-Based Health Services. Other Bureau for Medical Services (BMS) program managers were consulted as needed. This workgroup met as needed and participated in multiple MH parity webinars. This workgroup participated in each step of the MH parity analysis process including approving definitions, selecting the standards to define conditions, grouping and classifying benefits, and providing information on Non-Qualitative Treatment Limits (NQTLs) for FFS programs. West Virginia Medicaid contracted with its project management services vendor

[1] West Virginia Family Health did not renew its contract for fiscal year 2020.

to facilitate the workgroups and provide subject matter expertise, project coordination, research, data analysis, and project management support.

3.0 Definitions

3.1 Benefit Groupings

3.1.1 Medical/Surgical (M/S) Benefits

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 but do not include MH or SUD benefits.

3.1.2 MH Benefits

The State of West Virginia subject matter experts met and selected the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) as the generally recognized diagnostic standard for identifying MH and 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

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

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.

3.2.3 Emergency Care

Emergency care services are services that are part of a treatment episode that includes CPT codes 99281-99285.

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.

3.2.4 Prescription Drug

Simple or compound substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance. Prescription drugs are dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children to age 21, and prenatal vitamins. (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, the team examined the primary diagnosis for a benefit in order to group the benefit as M/S, MH, or SUD, based on the definitions provided in Section 3.1.

To group the pharmacy benefits, West Virginia used the First Databank HIC3 Class Codes, which group drugs into therapeutic classes. Subject matter experts manually reviewed covered therapeutic classes and assigned them to MH/SUD, M/S, or both.

West Virginia's MH parity workgroup reviewed the final grouping of benefits for both pharmacy and non-pharmacy benefits.

4.1.2 Benefit Classification Process

To map non-pharmacy benefits to the inpatient, outpatient, prescription drug, and emergency care classifications as defined above, West Virginia reviewed the benefits in the Traditional Medicaid benefit package 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.

West Virginia'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 West Virginia Medicaid non-pharmacy benefits grouped as MH, SUD, and M/S and classified as Inpatient, Outpatient, and Emergency Care. West Virginia 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) • Laboratory Services and Testing • Psychiatric Residential Treatment Facility (Children <21) • Hospital Services, Inpatient – Behavioral Health and Substance Abuse Stays • Hospice • Crisis Residential Unit • Crisis Stabilization Unit • Evaluation and Monitoring Services	• Clinic Services • Physician Services • Rural Health Clinic Services: Including Federally Qualified Health Centers (FQHCs) • Specialty Care • Behavioral Health Outpatient Services • Psychological 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	• Emergency Room (ER) • Outpatient Hospital Services • Emergency Transportation/ Ambulance • Prescription Drugs (administered in the ER) • Laboratory Services and Testing

	Inpatient	Outpatient	Emergency Care
		• Community psychiatric supportive treatment • 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 • Multi-family psychotherapy • Initial evaluation without medication services • 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 • Assertive Community treatment (ACT) • Behavioral Health Home Visits • Psychological/Neuropsychological testing • Outpatient electro-convulsive treatment (ECT) • Psychotherapy visits, after 12 visits, for nonbiologically based diagnoses (treatment plan must be submitted) • Intensive outpatient testing • Transcranial magnetic stimulation for depression • Psychiatric diagnostic interview	

	Inpatient	Outpatient	Emergency Care
		• Case consultation • Behavioral health counseling, professional, individual and group • MH assessment (non-physician) • MH service plan development • Crisis intervention • Screening by licensed psychologist • Physician coordinated care oversight services • Developmental testing • Nonemergency medical transportation	
SUD	• Inpatient Hospital Care • Inpatient Psychiatric Hospital • Rehabilitative Psychiatric Treatment (<21) • Prescription Drugs (Physician administered) • Laboratory Services and Testing • Psychiatric Residential Treatment Facility (Children <21) • Hospital Services, Inpatient – Behavioral Health and Substance Abuse Stays • Inpatient Psychiatric Services for Individuals Under Age 21 • Crisis Residential Unit • Crisis Stabilization Unit • Evaluation and Monitoring Services • Inpatient Detoxification	• Clinic Services • 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 • Intensive outpatient services (IOP) • Behavioral Health Home Visits • Case consultation • Behavioral health counseling, professional, individual and group • Targeted case management, each 15 minutes • Comprehensive community support services	• ER • Emergency Transportation/ Ambulance • Prescription Drugs (administered in the ER) • Laboratory Services and Testing

	Inpatient	Outpatient	Emergency Care
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) • Laboratory Services and Testing • EPSDT • Organ Transplant Services • Inpatient Hospice Care • Elective C-sections and all elective inductions	• 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 • 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 • 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	• Diagnostic X-Ray • ER • Emergency Transportation/ Ambulance • Laboratory Services and Testing • Prescription Drugs (administered in the ER) • Durable Medical Equipment • Laboratory Services and Testing • Dental Services (Adult) • Dental Services (Children)

	Inpatient	Outpatient	Emergency Care
		• Personal Care Services • Abortion Services • School-Based Services • Organ Transplant Services • Automatic implantable cardioverter-defibrillator (AICD) • Bi-ventricular pacemaker • Cardiac catheterization • Chemotherapy • Clinical trials • CT scans • Dental treatment for dental accidents • 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 • Outpatient polysomnograms • Outpatient surgery • Pain management services/programs, including epidural steroid injections • SPECT MPI (myocardial perfusion imaging) • Virtual colonoscopy • Hysterectomy • Tonsillectomy with or without adenoidectomy • Sleep studies • Spinal injections • Video EEG • Radiation treatments	

	Inpatient	Outpatient	Emergency Care
		• Venous ablation • Septoplasty • Nuclear cardiology	

4.3 Pharmacy Benefit Grouping and Classification

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

Pharmacy_Benefits.xlsx

5.0 Managed Care Organization Contract Compliance

West Virginia Medicaid's SFY2018 MCO contract includes the following provisions requiring compliance with federal MH parity regulations, demonstrating compliance with 42 CFR Part 438.6(n). West Virginia's SFY2018 MCO contract is included in this report as Appendix C.

5.1 Article II, Section 4.11 Utilization Review and Control

Pages 16 – 17: "The MCO may place appropriate limits on the covered services provided under this Contract on the basis of criteria applied under the 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 Mental Health Parity and Addiction Equity Act of 2008 and its respective federal regulations."

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

Page 21: "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 abusers;
- 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;
- Section 29a of the West Virginia Code;
- 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

Page 140: "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.[15] The benefit must be provided in accordance with 42 CFR Subpart K, Parity in Mental Health and Substance Use Disorder Benefits." (Footnote 15: 42 CFR § 438.210)

6.0 Financial Requirements and Quantitative Treatment Limits (QTLs)

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

6.1.1 Fee-for-Service Benefits

West Virginia 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 West Virginia Medicaid does not impose this type of treatment limitation, West Virginia has determined Medicaid to be in compliance with the parity regulations for AL/ADLs.

6.1.2 Managed Care Organizations

West Virginia 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 West Virginia Medicaid's SFY2018 MCO contract, Section 10.1 MCO Behavioral Services Administration (see Appendix C, page 140), which states: "The MCO may not impose an aggregate lifetime, annual dollar limits, or other cumulative financial limits on mental health or substance use disorder services." Because West Virginia Medicaid does not allow MCOs to utilize this type of treatment limitation, West Virginia has determined the Medicaid MCOs to be in compliance with the parity regulations for AL/ADLs.

6.2 Financial Requirements

6.2.1 Fee-for-Service Benefits

West Virginia Medicaid does not use co-insurance or deductibles in the FFS delivery system.

West Virginia Medicaid does not charge co-payments on non-pharmacy behavioral health services provided through the FFS delivery system.

West Virginia's prescription drug co-payment structure applies different levels of financial requirements 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 Managed Care Organizations

West Virginia Medicaid behavioral health services provided through the managed care delivery system are not subject to premiums or deductibles as evidenced in West Virginia Medicaid's SFY2018 MCO contract Definition of Cost-Sharing on page 6, which states: "There are no premiums or deductibles under the West Virginia Medicaid program."

West Virginia Medicaid behavioral health services provided through the managed care delivery system are not subject to copayments as evidenced in West Virginia Medicaid's SFY2018 MCO contract, Section 3.9.1 Services and Members Exempt from Cost-Sharing Obligations of West Virginia Medicaid's SFY2018 MCO contract (see Appendix C, pages 101 – 102), 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;
- Members receiving hospice care;
- Members in nursing homes;
- Any additional members or services excluded under the State Plan authority; and
- Members who have met their household maximum limit for the cost-sharing obligations per calendar quarter."

Because West Virginia Medicaid prohibits the MCOs from charging co-pays for behavioral health services, West Virginia has determined the Medicaid MCOs to meet the parity regulations regarding financial requirements.

6.3 Quantitative Treatment Limits (QTLs)

6.3.1 Fee-for-Service Benefits

West Virginia Medicaid does not have any QTLs for MH/SUD benefits delivered through the FFS system. 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. West Virginia Medicaid has determined that the FFS benefits satisfy the parity regulations regarding QTLs.

6.3.2 Managed Care Organizations

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 Non-Quantitative Treatment Limits (NQTLs)

7.1 NQTL Identification and Analysis Process

7.1.1 NQTL Identification

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

To identify additional NQTLs and collect information about how they are applied in operation, West Virginia created a comprehensive NQTL workbook and distributed it to the MCOs and carved-out FFS programs. In order to prepare the FFS program directors and MCOs for this process, West Virginia held an orientation meeting to review the workbook and provide additional information about the purpose of the MH parity regulations and analysis process. The MCOs and FFS program directors were given approximately two weeks to complete the workbooks.

School-Based Health Services do not have any NQTLs applied to MH/SUD services that could limit patients' access to care. Pharmacy NQTLs that may limit patient's access to care are analyzed in section 7.2.4.

West Virginia participated in a technical assistance call with CMS MH parity subject matter experts to answer questions and focus the NQTL information collection and evaluation process on CMS priorities.

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?

After receiving completed workbooks from the MCOs, the State requested additional information from the MCOs as needed regarding strategies, evidentiary standards, and other factors used in applying NQTLs. West Virginia also held additional meetings with the MCOs to explain the importance of understanding how the NQTLs are applied in writing and in operation, and address follow-up questions in order to complete the analysis.

7.2 NQTL Documentation

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: List of MH/SUD NQTLs by Classification

ID	MH/SUD NQTL	Delivery System	Compliance Analysis Result
	Inpatient		
IP.1	Concurrent Review	MCO – Aetna	Compliant
IP.2	Concurrent Review	MCO – The Health Plan	Compliant
IP.3	Prior Authorization	MCO - Aetna	Compliant
IP.4	Prior Authorization	MCO – The Health Plan	Compliant
IP.5	Prior Authorization	MCO - UniCare	Compliant
IP.7	Retrospective Review	MCO - Aetna	Compliant
IP.8	Retrospective Review	MCO – The Health Plan	Compliant
	Outpatient		
OP.1	Prior Authorization	MCO - Aetna	Compliant
OP.2	Prior Authorization	MCO – The Health Plan	Compliant
OP.3	Preservice Review	MCO - UniCare	Compliant
	Prescription Drug		
RX.1	Use of a Preferred Drug List (PDL)	FFS – BMS	Compliant
RX.2	Drugs on the PDL must be tried first (step therapy/fail first)	FFS – BMS	Compliant
RX.3	Prior Authorization	FFS – BMS	Compliant
RX.4	Prospective Review	FFS – BMS	Compliant
RX.5	Medicaid covers a three-month supply of tobacco cessation products per year	FFS – BMS	Compliant

ID	MH/SUD NQTL	Delivery System	Compliance Analysis Result
	Inpatient		
RX.6	Pharmacy Lock-in Program	FFS – BMS	Compliant

7.2.1 Inpatient NQTLs

7.2.1.1 NQTL IP.1: Concurrent Review (Aetna)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
• MH/SUD Inpatient services • Crisis Residential Unit • Psychiatric Residential Treatment Facilities	• M/S Inpatient hospital care • Inpatient hospice care

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

MH/SUD	M/S
Objectives/Strategies • Reduce occurrences of misuse, over-or–underutilization of services • Promote improvement of inpatient care outcomes • Increase cost-effectiveness of the services • Determine whether an admission and subsequent stay are medically necessary • Confirm that the member receives appropriate, efficient, and timely services • Screen for potential quality, risk, or utilization issues • Document authorizations, review updates, clinical consultations, and decisions accurately and in a timely matter • Confirm that discharge planning is begun early in the stay and assist with coordination of post-discharge services • Identify alternative care options (e.g., skilled nursing facility, home health,	Objectives/Strategies • Reduce occurrences of misuse, over-or – underutilization of services • Promote improvement of inpatient care outcomes • Increase cost-effectiveness of the services • Determine whether an admission and subsequent stay are medically necessary • Confirm that the member receives appropriate, efficient, and timely services • Screen for potential quality, risk, or utilization issues • Document authorizations, review updates, clinical consultations, and decisions accurately and in a timely matter • Confirm that discharge planning is begun early in the stay and assist with coordination of post-discharge services • Identify alternative care options (e.g., skilled nursing facility, home health,

MH/SUD	M/S
rehabilitation unit, hospice care, partial hospitalization, intensive outpatient program, and make recommendations to the discharge planner or treating physician • 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 potential clinical issues based on established criteria and present them to the chief medical officer for discussion with eth member's primary care provider or treating practitioner/provider • Confirm that the facility complied with Aetna's Better Health's notification requirements • 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 • Crisis residential units are intended to be short term for member assessment, stabilization, and to identify the optimal type of treatment (e.g., inpatient, outpatient, residential), comparable to an Emergency Department. Concurrent review facilitates initiation of a treatment plan.	rehabilitation unit, hospice care, partial hospitalization, intensive outpatient program, and make recommendations to the discharge planner or treating physician • 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 potential clinical issues based on established criteria and present them to the chief medical officer for discussion with eth member's primary care provider or treating practitioner/provider • Confirm that the facility complied with Aetna's Better Health's notification requirements • 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, identifying areas of concern. The CMO presents quarterly summaries of this information to the Quality Management/Utilization Management Committee (QM/UM). This information assists with updating the list of services requiring prior authorization 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. Persons with mental health conditions should be treated in the **l**east 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.	Monthly, the chief medical officer (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 Quality Management/Utilization Management Committee (QM/UM). This information assists with updating the list of services requiring prior authorization 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 expensive costlier than most outpatient services.

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
Inpatient psychiatric, detoxification, or residential facility: 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.	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 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 (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
For the time period 10/1/2016 - 9/29/2017, there was only one MH/SUD complaint, and it was unrelated to access/authorization (inpatient and outpatient combined). 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)	For the time period 10/1/2016 - 9/29/2017, there were 209 complaints, and there were seven complaints related to access/authorization (inpatient and outpatient combined). 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 review of the comparability and stringency of processes, strategies and evidentiary standards, this NQTL is compliant with MH Parity requirements.

7.2.1.2 NQTL IP.2: Concurrent Review (The Health Plan)

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, past medical/surgical history, and network capabilities are considered.	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, 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 review of the comparability and stringency of processes, strategies and evidentiary standards, this NQTL is compliant with MH Parity requirements.

7.2.1.3 NQTL IP.3: Prior Authorization (Aetna)

Aetna also refers to Prior Authorization as Prospective Review.

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
MH/SUD Inpatient services Crisis Residential Unit Psychiatric Residential Treatment Facilities Emergency services received in or out of network do not need prior authorization. Notification of emergency treatment is encouraged, but not required, for coordination of care.	M/S Inpatient hospital care Inpatient hospice care Emergency services received in or out of network do not need prior authorization. Notification of emergency treatment is encouraged, but not required, for coordination of care.

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

MH/SUD	M/S
To evaluate and determine medical necessity of care and to direct members to the appropriate level of care and place of service. Additional reasons include: • Accurately document all authorization requests • Verify member eligibility	To evaluate and determine medical necessity of care and to direct members to the appropriate level of care and place of service. Additional reasons include: • Accurately document all authorization requests • Verify member eligibility

MH/SUD	M/S
• Verify the service is a covered benefit • Verify contractual requirements with external providers • Assist practitioners and providers in providing appropriate, timely and cost effective services • Direct members to the appropriate level of care and place of service • Verify practitioner's or provider's network participation • Coordination of care • Facilitate timely claims payment • Identify high-cost cases for reinsurance notification • Determine and report whether a request is subject to coordination of benefits or third party liability conditions • Avoid duplicating services • Not issue arbitrary denial or reductions in the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member • Determine that services are sufficient in amount, duration and scope for the same services to members under the Medicaid State Plan; • Place appropriate limits on a service on the basis of medical necessity for the purposes of utilization management, provided the services can reasonably expected to achieve their purpose in accordance with 42 CFR § 438.210. • Crisis Residential Unit services are comparable to Emergency services. The individual is assessed, stabilized, and the appropriate level of care is determined.	• Verify the service is a covered benefit • Verify contractual requirements with external providers • Assist practitioners and providers in providing appropriate, timely and cost effective services • Direct members to the appropriate level of care and place of service • Verify practitioner's or provider's network participation • Coordination of care • Facilitate timely claims payment • Identify high-cost cases for reinsurance notification • Determine and report whether a request is subject to coordination of benefits or third party liability conditions • Avoid duplicating services • Not issue arbitrary denial or reductions in the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member • Determine that services are sufficient in amount, duration and scope for the same services to members under the Medicaid State Plan; • Place appropriate limits on a service on the basis of medical necessity for the purposes of utilization management, provided the services can reasonably expected to achieve their purpose in accordance with 42 CFR § 438.210.

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, identifying areas of concern. The CMO presents quarterly summaries of this information to the Quality Management/Utilization Management Committee (QM/UM). This information assists with updating the list of services requiring prior authorization 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 tend to be costlier than most outpatient services. Persons with mental health conditions should be treated in the **l**east restrictive environment and in a manner designed to preserve their dignity and autonomy and to maximize the opportunities for recovery.	Monthly, the Chief Medical Officer (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 Quality Management/Utilization Management Committee (QM/UM). This information assists with updating the list of services requiring prior authorization 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 tend to be costlier than most outpatient services.

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
For Urgent pre-service approval/denial, decision must be made within 72 hours or three calendar days from receipt of request. For non-urgent preapproval/denial, decision must be communicated within seven calendar days. For inpatient psychiatric, detoxification, or residential facility: the initial review is to be completed within twenty-four (24) hours of Aetna Better Health's receipt of notification of admission.	For Urgent pre-service approval/denial, decision must be made within 72 hours or three calendar days from receipt of request. For non-urgent preapproval/denial, decision must be communicated within seven calendar days. Aetna utilizes a Medical Necessity Criteria Hierarchy for use when making medical necessity decisions. All denials of service require a medical director review with the exception of administrative denials (e.g., contractual limitation).

MH/SUD	M/S
Aetna utilizes a Medical Necessity Criteria Hierarchy for use when making medical necessity decisions. For MH/SUD inpatient services, initial authorization of 1 - 3 days as determined by clinical review and based on medical necessity. All denials of service require a medical director review with the exception of administrative denials (e.g., contractual limitation). For the crisis residential unit, authorization is not required until 144-unit service limit is met, and decisions for services are based on medical necessity (+ or – 244 units).	Members may stay in the Emergency Department 48 hours.

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

MH/SUD	M/S
Service limit may be exceeded based on clinical review and medical necessity. 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%).	Service limit may be exceeded based on clinical review and medical necessity. 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
For the time period 10/1/2016 - 9/29/2017, 98% of behavioral health inpatient admissions were approved. For the time period 10/1/2016 - 9/29/2017, there was only one MH/SUD complaint, and it was unrelated to access/authorization (inpatient and outpatient combined). 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. Aetna performs monthly monitoring of denials by type (administrative/medical necessity)	For the time period 10/1/2016 - 9/29/2017, 82% of M/S inpatient admissions were approved. For the time period 10/1/2016 - 9/29/2017, there were 209 complaints, and there were seven complaints related to access/authorization (inpatient and outpatient combined). 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. Aetna performs monthly monitoring of denials by type (administrative/medical necessity)

7. Compliance Determination

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

7.2.1.4 NQTL IP.4: Prior Authorization (The Health Plan)

The Health Plan also refers to Prior Authorization as Prospective Review.

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 No prior authorization is needed for emergency or urgently needed services within or outside The Health Plan's service area.	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 No prior authorization is needed for emergency or urgently needed services within or outside The Health Plan's service area.

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

MH/SUD	M/S
Prior authorization is required for the following reasons: • Coordination of care • Discharge planning • Quality of care review • Confirm eligibility and benefits • Medical appropriateness of services to be rendered and level of care utilized For urgent/emergent admissions, prior authorization is performed for an early discussion of member's needs as related to the admission or alternative health care services.	Prior authorization is required for the following reasons: • Coordination of care • Discharge planning • Quality of care review • Confirm eligibility and benefits • Medical appropriateness of services to be rendered and level of care utilized For urgent/emergent admissions, prior authorization is performed for an early discussion of member's needs as related to the admission or alternative health care services.

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. THP's Clinical Analytics program analyzes cost drivers, quality of services, and care delivery to provide support for PA assignment. Early identification of discharge needs allows for planning and coordination of care. Continuity and coordination of care between primary care provider (PCP) and specialist, emergency room and PCP, urgent care and PCP, and inpatient stay and PCP is measured during an annual audit by the Quality Improvement Department.	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. THP's Clinical Analytics program analyzes cost drivers, quality of services, and care delivery to provide support for PA assignment. Early identification of discharge needs allows for planning and coordination of care. Continuity and coordination of care between PCP and specialist, emergency room and PCP, urgent care and PCP, and inpatient stay and PCP is measured during an annual audit by the Quality Improvement Department.

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
The process is initiated by the member's primary care practitioner or referring participating specialist with nurse inpatient navigators. For urgent/emergent admissions, prior authorization is required at the time of, or as soon as practically possible after admission. Initial days are determined by Geometric Mean Length of Stay (GMLOS) for admission diagnostic related group (DRG). See concurrent review for frequency of ongoing review. Timeframes: • Non-urgent pre-service decisions: Provided as expeditiously as the member's health condition requires and within State-established time periods that do not exceed seven calendar days	The process is initiated by the member's primary care practitioner or referring participating specialist with nurse inpatient navigators. For urgent/emergent admissions, prior authorization is required at the time of, or as soon as practically possible after admission. For elective inpatient care, initial authorization is the GMLOS for admission DRG. Timeframes: • Non-urgent pre-service decisions: Provided as expeditiously as the member's health condition requires and within State-established time periods that do not exceed seven calendar days following receipt of a request for services

MH/SUD	M/S
following receipt of a request for services (with a possible extension of an additional seven days). • Expedited Organization Determinations: As expeditiously as the member's health condition requires, but no later than three days after receipt of the request for authorization (with possible extension of up to five additional business days). For post-stabilization care: 1. The Health Plan is notified by the admitting practitioners/providers of the member's admission, within one day when feasible. 2. Demographic information is obtained and entered into system. 3. All pertinent clinical information is obtained by the nurse inpatient navigator, nurse pre-authorization navigator, or nurse care/complex case navigator. 4. Continued care needs are discussed with primary care practitioner, attending practitioners, and member/family, and a plan of care is developed. When appropriate, transport back to the area for continued care and services is arranged.	(with a possible extension of an additional seven days). • Expedited Organization Determinations: As expeditiously as the member's health condition requires, but no later than three days after receipt of the request for authorization (with possible extension of up to five additional business days). For post-stabilization care: 1. The Health Plan is notified by the admitting practitioners/providers of the member's admission, within one day when feasible. 2. Demographic information is obtained and entered into system. 3. All pertinent clinical information is obtained by the nurse inpatient navigator, nurse pre-authorization navigator, or nurse care/complex case navigator. 4. Continued care needs are discussed with primary care practitioner, attending practitioners, and member/family, and a plan of care is developed. When appropriate, transport back to the area for continued care and services is arranged.

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

MH/SUD	M/S
Prior authorization of urgent/emergent admissions, by the admitting practitioner is required at the time of, or as soon as practically possible after admission (preferably within 48 hours, although services are still covered if timeframe not met). Interrater reliability surveys are summarized monthly and reported annual to Continuous Quality Improvement (CQI). Based on results, employees are given education or disciplinary interventions.	Prior authorization of urgent/emergent admissions, by the admitting practitioner is required at the time of, or as soon as practically possible after admission (preferably within 48 hours, although services are still covered if timeframe not met). Interrater reliability surveys are summarized monthly and reported annual to CQI. Based on results, employees are given education or disciplinary interventions. Denials:

MH/SUD	M/S
Denials: • Denial decisions are made by a licensed practitioner and reviewed by medical director. Board-certified practitioners in the applicable specialty are consulted when needed. • Members are held harmless when medically inappropriate days are identified (hospital responsible). • InterQual criteria used.	• Denial decisions are made by a licensed practitioner and reviewed by medical director. Board-certified practitioners in the applicable specialty are consulted when needed. • Members are held harmless when medically inappropriate days are identified (hospital responsible). • InterQual criteria used.

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

MH/SUD	M/S
The member is held harmless if PA is not performed because of a variety of reasons (e.g., member did not have eligibility card, the provider forgot). When PA is not performed, THP's provider relations department follows up with the hospital. The MCO/hospital contract provides for hospital financial responsibility when PA is not performed (although this rarely happens). Member complaints and appeals data is collected and analyzed for evidence that NQTLs are applied more stringently to MH/SUD.	The member is held harmless if PA is not performed because of a variety of reasons (e.g., member did not have eligibility card, the provider forgot). When PA is not performed, THP's provider relations department follows up with the hospital. The MCO/hospital contract provides for hospital financial responsibility when PA is not performed (although this rarely happens). 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 review of the comparability and stringency of processes, strategies and evidentiary standards, the NQTL is compliant with MH Parity requirements.

7.2.1.5 NQTL IP.5: Prior Authorization (UniCare)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
All inpatient hospital services including:	All inpatient hospital services except emergency and obstetrical care require Prior Authorization including:

• Observation, Subsequent or Inpatient Care, New or Established: low, moderate or high complexity • Psychiatric Residential Treatment Facility (PRTF) – MH • PRTF – Substance Abuse • Inpatient Psychiatric • Inpatient Detoxification • Inpatient Substance Use Treatment • Evaluation and Monitoring Services	• Long-term acute care facility • Newborn stays beyond federally mandated timeframes • Rehabilitation facility admissions

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 • Patient safety is a concern • They are high cost and PA provides an opportunity to reduce unnecessary costs by preventing overutilization through medical necessity review and facilitating discharge planning.	Non-emergent/elective inpatient admissions are assigned PA because: • PA assures the appropriate level of care for the condition, OR • The procedure is considered high risk, OR • They are high cost and PA provides an opportunity to reduce unnecessary costs by preventing overutilization through medical necessity review and facilitating discharge planning.
Consistent with federal regulations, only non-emergent inpatient services have PA.	Consistent with federal regulations, PA for emergency services is prohibited.

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. The following data sources may be used in utilization monitoring: • Claims Reports • Member Complaints and Appeals Analysis • HEDIS findings	Evidence of the high cost of inpatient services includes monthly and annual cost and utilization reports. The following data sources may be used in utilization monitoring: • Claims Reports • Member Complaints and Appeals Analysis • HEDIS findings

MH/SUD	M/S
• Focus Studies that evaluate access to care, use of preventative care services and other services	• Focus Studies that evaluate access to care, use of preventative care services and other services
Persons with MH disorders should be provided with healthcare that is the least restrictive. Components [Source: Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocols] 1. Items to be considered in the selection of least restrictive alternatives include: a. The disorder involved b. The available treatments c. The person's level of autonomy d. The person's acceptance and cooperation e. The potential that harm be caused to self or others 2. Community-based treatment should be made available to qualifying patients 3. Institution-based treatments should be provided in the least-restrictive environment, and treatments involving the use of physical (e.g., isolation rooms, camisoles) and chemical restraints, if at all necessary, should be contingent upon: a. Sustained attempts to discuss alternatives with the patient b. Examination and prescription by an approved health care provider c. The necessity to avoid immediate harm to self or others d. Regular observation e. Periodical reassessments of the need for restraint (e.g., every half hour for physical restraint) f. A strictly limited duration (e.g., four hours for physical restraint) g. Documentation in patient's medical file	

4. ***Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the managed care organization, 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.
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	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	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

MH/SUD	M/S
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).	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.
For routine, non-urgent requests, the UM department will complete pre-service reviews within 14 calendar days of receiving the request. This 14-day review period may be extended up to seven additional calendar days upon request of the member or provider, or if UniCare receives written approval from the West Virginia BMS in advance that the member will benefit from such extension. For urgent preservice requests, the UM department completes the pre-service review within three calendar days (72 hours) of the receipt of the 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 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.	For routine, non-urgent requests, the UM department will complete pre-service reviews within 14 calendar days of receiving the request. This 14-day review period may be extended up to seven additional calendar days upon request of the member or provider, or if UniCare receives written approval from the West Virginia BMS in advance that the member will benefit from such extension. For urgent preservice requests, the UM department completes the pre-service review within three calendar days (72 hours) of the receipt of the 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 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	Non-clinical administrative staff gathers information and conducts pre-review screening

MH/SUD	M/S
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.	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 UniCare-authorized appropriately licensed practitioner can deny a request for services for lack of medical necessity.	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.	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
The initial authorization period is determined based on the preservice review of the patient's information.	The initial authorization period is determined based on the preservice review of the patient's information.
The duration of initial authorizations for acute inpatient care 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 preservice review, or when the inpatient stay did not have preservice review, the hospital must contact us for continued stay review. We require clinical reviews on all members admitted as inpatients to: • Acute care hospitals • Intermediate facilities	When a member's hospital stay is expected to exceed the number of days authorized during preservice review, or when the inpatient stay did not have preservice review, the hospital must contact us for continued stay review. We require clinical reviews on all members admitted as inpatients to: • Acute care hospitals • Intermediate facilities

MH/SUD	M/S
• Inpatient rehabilitation facilities We perform these reviews to assess medical necessity and determine whether the facility and level of care are appropriate.	• Inpatient rehabilitation facilities We perform these reviews to assess medical necessity and determine whether the facility and level of care are appropriate.
The UM department will complete continued-stay inpatient reviews within 24 hours of receipt of the request, consistent with the member's medical condition, if the request is made more than 24 hours before the expiration of the initial authorization. UM staff will request clinical information from the hospital on the same day of the continued-stay request. If the information meets medical necessity review criteria, we will approve the request within 24 hours of receipt of the information. We will send requests that do not meet medical policy guidelines to the physician advisor or medical director for further review. We will notify providers of the decision within 24 hours.	The UM department will complete continued-stay inpatient reviews within 24 hours of receipt of the request, consistent with the member's medical condition, if the request is made more than 24 hours before the expiration of the initial authorization. UM staff will request clinical information from the hospital on the same day of the continued-stay request. If the information meets medical necessity review criteria, we will approve the request within 24 hours of receipt of the information. We will send requests that do not meet medical policy guidelines to the physician advisor or medical director for further review. We will notify providers of the decision within 24 hours.
If the continued stay request is made within 24 hours of the expiration of the initial authorization, the decision will be made within 72 hours.	If the continued stay request is made within 24 hours of the expiration of the initial authorization, the decision will be made within 72 hours.

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

MH/SUD	M/S
Over the last four quarters, the denial rate for MH/SUD inpatient admissions has ranged from 1.5% to 3.4%.	Over the last four quarters, the denial rate for M/S inpatient admissions has ranged from 17.36% to 20.45%.
	MCG provides recommendations for average length of stay, which are the basis for authorization length.

7. Compliance Determination

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

7.2.1.6 NQTL IP.7: Retrospective Review (Aetna)

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
MH/SUD Inpatient services Crisis Residential Unit Psychiatric Residential Treatment Facilities	M/S Inpatient hospital care Inpatient hospice care

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

MH/SUD	M/S
Objectives/Strategies • Reduce occurrences of misuse, over-or – underutilization of services • Promote improvement of inpatient care outcomes • Increase cost-effectiveness of the services • Determine whether an admission and subsequent stay were medically necessary • Confirm that the member received appropriate, efficient, and timely services • Screen for potential quality, risk, or utilization issues • Ascertain that authorizations, review updates, clinical consultations, and decisions are documented accurately and in a timely matter • Confirm that discharge planning was begun early in the stay and assist with coordination of post-discharge services • Identify alternative care options (e.g., skilled nursing facility, home health, rehabilitation unit, hospice care, partial hospitalization, intensive outpatient program, and make recommendations to	Objectives/Strategies • Reduce occurrences of misuse, over-or – underutilization of services • Promote improvement of inpatient care outcomes • Increase cost-effectiveness of the services • Determine whether an admission and subsequent stay were medically necessary • Confirm that the member received appropriate, efficient, and timely services • Screen for potential quality, risk, or utilization issues • Ascertain that authorizations, review updates, clinical consultations, and decisions are documented accurately and in a timely matter • Confirm that discharge planning was begun early in the stay and assist with coordination of post-discharge services • Identify alternative care options (e.g., skilled nursing facility, home health, rehabilitation unit, hospice care, partial hospitalization, intensive outpatient program, and make recommendations to

MH/SUD	M/S
the discharge planner or treating physician • 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 potential clinical issues based on established criteria and present them to the chief medical officer for discussion with eth member's primary care provider or treating practitioner/provider • Confirm that the facility complied with Aetna's Better Health's notification requirements • 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	the discharge planner or treating physician • 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 potential clinical issues based on established criteria and present them to the chief medical officer for discussion with eth member's primary care provider or treating practitioner/provider • Confirm that the facility complied with Aetna's Better Health's notification requirements • 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, identifying areas of concern. The CMO presents quarterly summaries of this information to the Quality Management/Utilization Management Committee (QM/UM). This information assists with updating the list of services requiring prior authorization and is updated at least annually and revised periodically as appropriate.	Monthly, the chief medical officer (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 Quality Management/Utilization Management Committee (QM/UM). This information assists with updating the list of services requiring prior authorization and is updated at least annually and revised periodically as appropriate.

MH/SUD	M/S
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. Persons with mental health conditions should be treated in the **l**east restrictive environment and in a manner designed to preserve their dignity and autonomy and to maximize the opportunities for recovery.	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 expensive costlier than most outpatient services.

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
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. Post service determinations are reviewed against the same criterial used for pre-service determinations for the same service. Decisions are communicated to the requesting practitioner/provider and the member, if applicable, within thirty (30) days of receipt of the request.	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. Post service determinations are reviewed against the same criterial used for pre-service determinations for the same service. Decisions are communicated to the requesting practitioner/provider and the member, if applicable, within thirty (30) days of 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 members 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
For the time period 10/1/2016 - 9/29/2017, 98% of behavioral health inpatient admissions were approved. For the time period 10/1/2016 - 9/29/2017, there was only one MH/SUD complaint, and it was unrelated to access/authorization (inpatient and outpatient combined). 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)	For the time period 10/1/2016 - 9/29/2017, 82% of M/S inpatient admissions were approved. For the time period 10/1/2016 - 9/29/2017, there were 209 complaints, and there were seven complaints related to access/authorization (inpatient and outpatient combined). 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 review of the comparability and stringency of processes, strategies, and evidentiary standards, this NQTL is compliant with MH Parity requirements.

7.2.1.7 NQTL IP.8: Retrospective Review (The Health Plan)

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 managed care organization, beneficiary, and provider perspectives)

MH/SUD	M/S
Retrospective review is conducted only when The Health Plan 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 The Health Plan 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 review of the comparability and stringency of processes, strategies, and evidentiary standards, this NQTL is compliant with MH Parity requirements.

7.2.2 Outpatient NQTLs

7.2.2.1 NQTL OP.1: Prior Authorization (Aetna)

Aetna also refers to Prior Authorization as Prospective Review.

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

MH/SUD	M/S
Intensive outpatient services (IOP) Partial hospitalization program Assertive Community treatment (ACT) Behavioral Health Home Visits Psychological/Neuropsychological testing Outpatient electro-convulsive treatment (ECT)	AICD Bi-ventricular pacemaker Cardiac catheterization Chemotherapy Clinical trials CT scans Dental treatment for dental accidents

MH/SUD	M/S
	Genetic testing Hospice and home care 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 Orthotics Speech therapy Occupational therapy Physical therapy Outpatient polysomnograms Outpatient surgery Pain management services/programs, including epidural steroid injections No prior authorization is needed, whether provided by a network or non-network provider or practitioner, for family planning services or well-woman services.

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

MH/SUD	M/S
Evaluate and determine medical necessity and to direct members to the appropriate level of care and place of service. Additional reasons for requiring preauthorization for services include: • Accurately document all authorization requests; verify member eligibility; • Verify that the service is a covered benefit; verify contractual requirements with external vendors;	Evaluate and determine medical necessity and to direct members to the appropriate level of care and place of service. Additional reasons for requiring preauthorization for services include: • Accurately document all authorization requests; verify member eligibility; • Verify that the service is a covered benefit; verify contractual requirements with external vendors;

MH/SUD	M/S
• Assist practitioners and providers in providing appropriate, timely and cost effective services; • Verify the practitioner's or provider's network participation; • Collaborate and communicate as appropriate for the coordination of members' care; facilitate timely claims payment by issuing prior authorization numbers to practitioners and providers for submission of claims for approved services; • Identify high-cost cases for reinsurance notification; • Determine and report whether a request is subject to coordination of benefits or third part liability conditions; • Research a member's authorization history to avoid duplicating services or authorizations; • Not issue arbitrary denial or reductions in the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member; • Determine that services are sufficient in an amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished and are no less than the amount, duration or scope for the same services furnished to members under the Medicaid State Plan; • Place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization management (with the exception of Early and Periodic Screening, Diagnosis and Treatment [EPSDT services]), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210. • To prevent overutilization: ACT, IOP, and PHP	• Assist practitioners and providers in providing appropriate, timely and cost effective services; • Verify the practitioner's or provider's network participation; • Collaborate and communicate as appropriate for the coordination of members' care; facilitate timely claims payment by issuing prior authorization numbers to practitioners and providers for submission of claims for approved services; • Identify high-cost cases for reinsurance notification; • Determine and report whether a request is subject to coordination of benefits or third part liability conditions; • Research a member's authorization history to avoid duplicating services or authorizations; • Not issue arbitrary denial or reductions in the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member; • Determine that services are sufficient in an amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished and are no less than the amount, duration or scope for the same services furnished to members under the Medicaid State Plan; • Place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization management (with the exception of Early and Periodic Screening, Diagnosis and Treatment [EPSDT services]), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.

MH/SUD	M/S
	• To prevent overutilization: Speech Therapy, Occupational Therapy, and Physical Therapy.

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, identifying areas of concern. The CMO presents quarterly summaries of this information to the Quality Management/Utilization Management Committee (QM/UM). ACT, IOP, and Partial Hospitalization Program have been identified as services that are often ordered inappropriately and over-utilized. This information assists with updating the list of services requiring prior authorization 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.	Monthly, the chief medical officer (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 Quality Management/Utilization Management Committee (QM/UM). Speech Therapy, Occupational Therapy, and Physical Therapy have been identified as services that are often ordered or continued inappropriately and over-utilized. This information assists with updating the list of services requiring prior authorization 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.

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
Decision Timeframes: Urgent pre-service approval/denial: 72 hours or three calendar days from receipt of request. Non-urgent pre-service approval/denial: seven calendar days from receipt of request. All denials of service require a medical director review with the exception of administrative denials (e.g., contractual limitation).	Decision Timeframes: Urgent pre-service approval/denial: 72 hours or three calendar days from receipt of request. Non-urgent pre-service approval/denial: seven calendar days from receipt of request. All denials of service require a medical director review with the exception of administrative denials (e.g., contractual limitation).

MH/SUD	M/S
For ACT, initial authorization for six months of service; clinical review every six months to determine medical necessity. For IOP, initial authorization of four weeks; additional visits authorized determined by clinical review and based on medical necessity. For Partial Hospitalization Program (PHP), initial authorization of 1 - 2 weeks; additional visits determined by clinical review and based on medical necessity. 40 units/per year service per State Medicaid Plan.	

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

MH/SUD	M/S
Authorization of continued services beyond service limits based on medical necessity. 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%).	Authorization of continued services beyond service limits based on medical necessity. 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 that is applied?

MH/SUD	M/S
For the time period 10/1/2016 - 9/29/2017, 96% of MH/SUD outpatient services were approved. For the time period 10/1/2016 - 9/29/2017, there was only one MH/SUD complaint, and it was unrelated to access/authorization.	For the time period 10/1/2016 - 9/29/2017, 95% of M/S outpatient services were approved. For the time period 10/1/2016 - 9/29/2017, there were 209 complaints, and there were seven complaints related to access/authorization (inpatient and outpatient combined).

7. Compliance Determination

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

7.2.2.2 NQTL OP.2: Prior Authorization (The Health Plan)

The Health Plan also refers to Prior Authorization as Prospective Review.

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) • Intensive outpatient testing • Psychological testing • Neuropsychological testing • Outpatient ECT • Transcranial magnetic stimulation for depression • Out-of-area & out-of-network care • Partial hospitalization • Intensive outpatient services	• MRIs (shoulder, knee, hip, extremity, elbow, ankle, foot, wrist, spine • Low-dose CT for lung cancer • CT/MRI (other than listed above)/MRA • CT angiography for Coronary Artery Disease (CAD) • SPECT MPI (myocardial perfusion imaging) • PET scan/PET/CT fusion scan • Virtual colonoscopy

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

MH/SUD	M/S
Prior Authorization is required • Quality of care • Correct level of care • Coordination of care • Overutilization • Case management • High-cost services • Determine benefit limits	Prior authorization is required • Overutilization • Patient safety • High-cost services • Coordination of care • Care coordination • Determine benefit limits • Potential for fraud • Prevent inappropriate use of technology

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.	Utilization data is monitored monthly and annually to identify potential patterns of underutilization and overutilization. • Established thresholds are used to detect inappropriate utilization.

MH/SUD	M/S
• 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.	• 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.

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
MH/SUD services: • Members may directly access services from network behavioral health practitioners and providers. • Policy CL-18 indicates that a treatment plan needs to be submitted by behavioral health practitioners after the initial evaluation is completed, but plan representatives indicated that the treatment plan needs to be submitted after 12 visits for further services to be authorized. • Reviews for intensive out-patient (IOP) are done biweekly. • Reviews for partial hospitalization (PH) are done weekly or more often as necessary. Procedure: (1) The nurse navigator or behavioral health pre-authorization navigator obtains and reviews relevant clinical information for requested services. (2) The nurse navigator or behavioral health pre-authorization navigator makes	Outpatient M/S services: • Ancillary services receive pre-authorization through the referral process. • Evaluation of the medical appropriateness of the service is based on clinical information submitted by the provider and/or practitioner. • Any referral or prior authorization in which the medical appropriateness is questioned is referred to the medical director. • Nationally recognized clinical criteria is utilized to perform reviews for medical appropriateness allowing for consideration of the needs of the individual member, their circumstances, medical history and availability of care and services within The Health Plan network. Procedure: (1) The nurse navigator or behavioral health pre-authorization navigator obtains and reviews relevant clinical information for requested services.

MH/SUD	M/S
multiple attempts to obtain the necessary information for the request. (3) All relevant information gathered is utilized to support the decision-making process. The process is based on the needs of the individual patient. (4) If a decision cannot be reached by the nurse navigator or behavioral health pre-authorization navigator for medical appropriateness or coverage, the case is referred to the medical director for the decision. If necessary, a board certified specialist is consulted. (5) The characteristics of the member's local delivery system to provide for members are reviewed for requested services. Timeframes: • Non-urgent pre-service decisions: Provided as expeditiously as the member's health condition requires and within State-established time periods that do not exceed seven calendar days following receipt of a request for services (with a possible extension of an additional seven days). • Expedited Organization Determinations: As expeditiously as the member's health condition requires, but no later than three days after receipt of the request for authorization (with possible extension of up to five additional business days). The Behavioral Health Unit staff includes registered nurses and licensed social workers or licensed therapists. • The Health Plan members may directly access services from network behavioral health practitioners and providers. • The Health Plan provides 24-hour service through their after-hours nurse available to assist members with questions about accessing services.	(2) The nurse navigator or behavioral health pre-authorization navigator makes multiple attempts to obtain the necessary information for the request. (3) All relevant information gathered is utilized to support the decision-making process. The process is based on the needs of the individual patient. (6) If a decision cannot be reached by the nurse navigator or behavioral health pre-authorization navigator for medical appropriateness or coverage, the case is referred to the medical director for the decision. If necessary, a board certified specialist is consulted. (4) The characteristics of the member's local delivery system to provide for members are reviewed for requested services. Timeframes: • Non-urgent pre-service decisions: Provided as expeditiously as the member's health condition requires and within State-established time periods that do not exceed seven calendar days following receipt of a request for services (with a possible extension of an additional seven days). • Expedited Organization Determinations: As expeditiously as the member's health condition requires, but no later than three day after receipt of the request for authorization (with possible extension of up to five additional business days).

MH/SUD	M/S
Customer service staff, during regular business hours, may provide members information about provider or service availability with the network and direct the member to the Behavioral Health Unit staff for additional assistance if requested.	

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

MH/SUD	M/S
Members may directly access services from network behavioral health practitioners and providers. Customer service staff are available during regular business hours to provide members information about provider or service availability within the network. If a member receives a service from a provider, and that service was not prior authorized, the member is held harmless.	If a member receives a service from a provider, and that service was not prior authorized, the member is held harmless.

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

MH/SUD	M/S
The NQTL is not rigorously enforced. Members are held harmless if a service is received that has not undergone prior authorization. Member complaints and appeals data are collected and analyzed for evidence that NQTLs are applied more stringently to MH/SUD.	The NQTL is not rigorously enforced. Members are held harmless if a service is received that has not undergone prior authorization. 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 review of the comparability and stringency of processes, strategies, and evidentiary standards, the requirement that a treatment plan be submitted by behavioral health practitioners in order to authorize additional visits after 12 (with no compelling strategy/reason for this limitation), without a corresponding M/S requirement is an area of noncompliance.

7.2.2.3 NQTL OP.3: Preservice Review (also known as Prior Authorization) and Preservice Continued Review (UniCare)

UniCare performs pre-service review to determine medical necessity of selected covered services.

- Some services do not require pre-service review to commence or continue treatment, such as individual, family and group psychotherapy
- Some services do not require preservice review to commence treatment, but require preservice review to continue treatment after established limits are met
- Some services require preservice review in order to commence treatment
  - Of these services, some have limits and require preservice continued review to extend treatment beyond the limits
  - Others have no limits after prior authorization
- There are no hard limits for any MH/SUD services

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
Preservice review required from start; no limits: • Comprehensive community support • Evaluation and monitoring services • Intensive outpatient services • Electroconvulsive therapy (ECT) • Anesthesia for ECT Preservice review required from start; limits establish need for continued review: • Community psychiatric supportive treatment (CSU) • Assertive community treatment (ACT) • Psychological testing (MH and SU) • Neuropsychological testing	No preservice review required until limit met: • Therapy services (physical, occupational, speech) Preservice review required from start; no limits: • Genetic testing • Hysterectomy • Advanced radiology services (CT, CTA, MRI, PET) • Tonsillectomy with or without adenoidectomy • Sleep studies • Spinal injections • Video EEG • Prosthetics • Radiation treatments • Venous ablation • Septoplasty • Nuclear cardiology • Orthotics Preservice review required from start; limits establish need for continued review: • Home health care services, including hospice care • DME

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

MH/SUD	M/S

Selected outpatient MH/SUD services are assigned preservice review:
• Because of their potential for overutilization
  ◦ Psychological and neuropsychological testing
  ◦ Comprehensive community support
  ◦ Inpatient evaluation and monitoring services
  ◦ Intensive outpatient services
  ◦ CSU
  ◦ ACT
• For patient safety
  ◦ 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
	  ◦ Physical therapy
	  ◦ Speech therapy
	  ◦ Inpatient evaluation and monitoring services
	  ◦ Venous ablation
	  ◦ Hysterectomy
	  ◦ DME
	  ◦ Orthotics
	  ◦ Prosthetics
	  ◦ Nuclear cardiology
	  ◦ Septoplasty
	• For patient safety
	  ◦ Advanced radiology services (CT, CTA, MRI, PET)
	  ◦ Spinal injections
	  ◦ Venous ablation
	• To control costs
	• To avoid waste and abuse of Medicaid funds
	• 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 evaluation and monitoring services, ACT, Intensive outpatient services, and CSU are frequently ordered inappropriately.	Evidence of the utilization of outpatient services includes monthly and annual cost and utilization reports. • In Unicare's experience, physical therapy, speech therapy, inpatient evaluation and monitoring services, venous ablation, hysterectomy, DME, orthotics, prosthetics, nuclear cardiology, and septoplasty are frequently ordered inappropriately.

MH/SUD	M/S
• 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.	• 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.
Service limits contained in West Virginia BMS Provider Manuals	Service limits contained in West Virginia BMS Provider Manuals
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 Treatment • National Alliance on Mental Illness • SAMHSA • Cumulative professional expertise and experience	

4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the managed care organization, 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 Agency For Healthcare Research and Quality (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	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 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.	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.

MH/SUD	M/S
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).	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.	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.	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.	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.
For routine, non-urgent requests, the UM department will complete preservice reviews within 14 calendar days of receiving the request. This 14-day review period may be extended up to seven additional calendar days upon request of the member or provider, or if UniCare receives written approval from the West Virginia BMS in advance that the member will benefit from such extension. For urgent preservice requests, the UM department completes the preservice review within three calendar days (72 hours) of the receipt of the request.	For routine, non-urgent requests, the UM department will complete preservice reviews within 14 calendar days of receiving the request. This 14-day review period may be extended up to seven additional calendar days upon request of the member or provider, or if UniCare receives written approval from the West Virginia BMS in advance that the member will benefit from such extension. For urgent preservice requests, the UM department completes the preservice review within three calendar days (72 hours) of the receipt of the request.
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	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

MH/SUD	M/S
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.	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.	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.	Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement.

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

MH/SUD	M/S
Initial authorization limits vary based on medical necessity review.	Initial authorization limits vary based on medical necessity review.
“Soft Limits” vary by service. These limits are established by BMS (e.g., psychological testing is limited to four hours per member per provider per year before further review and authorization).	For physical, occupational, and speech therapy, the “soft limit” is 10 visits before authorization is required. These limits are established by BMS.
The Preservice Continued Review Process enables the extension of previously approved, ongoing courses of treatment. It follows the same process as described in item four above.	The Preservice Continued Review Process enables the extension of previously approved, ongoing courses of treatment. It follows the same process as described in item four 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.	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
During FY2016, zero medical necessity appeals related to MH/SUD services were made.	During FY2016, 188 medical necessity appeals related to M/S services were made. • About 20% were resolved in favor of the member • About 55% were resolved against the member

7. Compliance Determination

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

7.2.3 Emergency Care NQTLs

There are no emergency care NQTLs applicable to MH/SUD benefits.

7.2.4 Prescription Drug NQTLs

7.2.4.1 NQTL RX.1: Use of a Preferred Drug List

1. What benefits is the NQTL assigned to?

MH/SUD	M/S
The preferred drug list (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
West Virginia uses a formulary, or PDL, to control costs.	West Virginia uses a formulary, or PDL, to control costs.

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

MH/SUD	M/S
The West Virginia 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 • 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 • Ensuring 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.	The West Virginia 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 • 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 • Ensuring 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 managed care organization, 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.	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.

MH/SUD	M/S
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.	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. 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.	Incorporating all this information, the PDL vendor makes suggestions to the State's Medicaid P&T Committee regarding the PDL status of each medication. 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.	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.	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.	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 PDL vendor, which are reviewed and approved by the P&T Committee.	The trial criteria and exceptions for a PDL drug are established based on clinical evidence and the recommendations of the PDL vendor, which are reviewed and approved by the P&T Committee.
Therapeutic classes are reviewed annually, at a minimum. Classes may be reviewed more often if new drugs are introduced to the class.	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.	The PDL is reviewed in total annually and updated quarterly.

MH/SUD	M/S
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 Food and Drug Administration (FDA), the BMS and the P&T Chair may, based on clinical judgment, exempt the drug from the six-month rule.	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 BMS and the 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 is 92% across all drug classes.	The PDL compliance rate is 92% across all drug classes.

7. Compliance Determination

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

7.2.4.2 NQTL RX.2: Drugs on 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: • Anticonvulsants • Antidepressants, Other • Antidepressants, SSRIs • Antipsychotics, Atypical • Opiate Dependence Treatments • Sedative Hypnotics • Stimulants and Related Agents	Drugs in these therapeutic classes: • Acne Agents, Topical • Analgesics, Narcotic Short-Acting (Non-parenteral) • Androgenic Agents • Anesthetics, Topical • Angiotensin Modulators • Antianginal and Anti-ischemic

MH/SUD	M/S
	• Antibiotics, GI & Related Agents • Antibiotics, Inhaled • Antibiotics, Topical • Antibiotics, Vaginal • Anticoagulants • Anticonvulsants • Antiemetics • Antifungals, Oral • Antihypertensives, Sympatholytics • Antihyperuricemics • Antimigraine Agents, Other • Antimigraine Agents, Triptans • 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

MH/SUD	M/S
	• 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 • 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 • Macrolides/Ketolides • Multiple Sclerosis 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

MH/SUD	M/S
	• Skeletal Muscle Relaxants • Steroids, Topical • Tetracyclines • Ulcerative Colitis Agents • Vasodilators, Coronary

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

MH/SUD	M/S
West Virginia uses a formulary, or PDL, to control costs.	West Virginia uses a formulary, or PDL, to control costs.

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

MH/SUD	M/S
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.	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 managed care organization, 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.	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.	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.	System edits are applied at the point of sale every time a prescription is adjudicated.

MH/SUD	M/S
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 the prescriber provides a clinical justification.	The clinical pharmacists at the RDTP, the state's pharmacy PA vendor, have discretion to issue a PA for a non-PDL drug if the prescriber provides a clinical justification.

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

MH/SUD	M/S
The PDL compliance rate is 92% across all drug classes.	The PDL compliance rate is 92% across all drug classes.

7. Compliance Determination

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

7.2.4.3 NQTL RX.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
Non-PDL drugs are assigned PA because of the potential for adverse effects, misuse, or high cost.	Non-PDL drugs are assigned PA because of the potential for adverse effects, misuse, or high cost.

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	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

MH/SUD	M/S
approval are determined by them, with input from medical and pharmacy providers, drug manufacturers, and other experts.	approval are determined by them, with input from medical and pharmacy providers, drug manufacturers, and other experts.
West Virginia 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.	West Virginia 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 managed care organization, 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.	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.	PA requests may be made by telephone, fax, or mail.
Clinical pharmacists employed by the PA vendor have discretion for approval and usually obtain additional clinical information from the prescriber.	Clinical pharmacists employed by the PA vendor have discretion for approval and usually obtain additional clinical information from the prescriber.
A three-day emergency supply of prior-authorized drugs can be dispensed by a pharmacy until authorization is completed.	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.	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.	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.

MH/SUD	M/S
Trial criteria, PA criteria, and duration of PA are determined by the DUR Board with clinical recommendations provided by a vendor.	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 August – September 2017 (the WV Pharmacy Program was transitioned from the MCOs to BMS as of July 1, 2017), 74.4% of PA requests for Opioid Withdrawal Agents were approved, and 7.02% were denied.	In August – September 2017 (the WV Pharmacy Program was transitioned from the MCOs to BMS as of July 1, 2017), 71.68% of PA requests for Multiple Sclerosis Agents were approved and 11.5% were denied.

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.

7.2.4.4 NQTL RX.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
Potential for adverse effects and inappropriate use, and cost containment.	Potential for adverse effects and inappropriate use, and cost containment.

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

MH/SUD	M/S
The DUR Board and BMS DUR pharmacist review the criteria regularly using surveys of current peer-reviewed literature and recommendations from First Data Bank (creator of edits), DrugDex,	The DUR Board and BMS DUR pharmacist review the criteria regularly using surveys of current peer-reviewed literature and recommendations from First Data Bank (creator of edits), DrugDex,

MH/SUD	M/S
MicroMedes, and American Hospital Formulary Drug Service.	MicroMedes, and American Hospital Formulary Drug Service.

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

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.	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.	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.	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.	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.	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 drug utilization review (DUR) edits to pharmacy claims as they are processing.	Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies drug utilization review (DUR) edits to pharmacy claims as they are processing.

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.

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.

7.2.4.5 NQTL RX.5: Medicaid covers a three-month supply of tobacco cessation products per year

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

MH/SUD	M/S
Tobacco cessation products	Medications (e.g., antibiotics and Hepatitis C treatment) are authorized for specific therapeutic durations.

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

MH/SUD	M/S
To reduce diversion and contain costs.	To reduce diversion and contain costs.

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

MH/SUD	M/S
Current evidence reviewed by members of the DUR Board and BMS clinical staff (e.g., Mayo Clinic guidelines). The State has found that the initial three-month limit encourages members to choose a quit date.	Current evidence reviewed by members of the DUR Board and BMS clinical staff.
Package insert dosage recommendations.	Package insert dosage recommendations.

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

MH/SUD	M/S
Members may receive a three-month supply of tobacco cessation products annually without a prescription. This limit does not apply to pregnant women, and the limit can be exceeded for members with cardiovascular disease or those would benefit clinically from taking it longer.	Medications such as antibiotics and Hepatitis C medications are authorized by their recommended length of treatment. This can be exceeded if the member would benefit by longer treatment time.

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

MH/SUD	M/S
The NQTL is not applied to tobacco cessation products provided to pregnant members and the three-month limit can be exceeded for those with cardiovascular disease and others who would clinically benefit from taking it longer.	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 for medically necessary treatment beyond three months.	Prescriber must submit additional clinical information to clinical pharmacists at RDTP for authorization of a more customized dosage/length of treatment approach.
Prescriber can appeal a denial.	Prescriber can appeal a denial.

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

MH/SUD	M/S
The WV Pharmacy Program was transitioned from the MCOs to BMS July 1, 2017. Sufficient data is not available at this time.	The WV Pharmacy Program was transitioned from the MCOs to BMS July 1, 2017. Sufficient data is not available at this time.

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.

7.2.4.6 NQTL RX.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 • Members who use pharmacy services excessively or inappropriately	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 • 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.	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) West Virginia Safe & Effective Management of Pain Guidelines (SEMP) 2016 MME conversion chart	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) West Virginia 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 managed care organization, 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. West Virginia 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. West Virginia Medicaid contracts with HID to conduct the initial reviews and referrals for the committee.
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.	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.	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.	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.	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.	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.

MH/SUD	M/S
A prescriber can request an override for a lock-in to ensure patient access to treatment.	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 WV Pharmacy Program was transitioned from the MCOs to BMS July 1, 2017. Sufficient data is not available at this time.	The WV Pharmacy Program was transitioned from the MCOs to BMS July 1, 2017. Sufficient data is not available at this time.

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.

8.0 Availability of Information

8.1 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, ABP beneficiaries, and CHIP beneficiaries who are enrollees or potential enrollees with a managed care entity) and affected Medicaid/CHIP providers upon request.

8.1.1 Fee-for-Service Benefits

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

8.1.2 Managed Care Organizations

The following excerpt from West Virginia Medicaid's SFY2018 MCO contract, Section 3.8.1 Resolution of Enrollee Issues, sub-section 5.a.ii (see Appendix B, Article III, pages 98 – 99) 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…"

8.2 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.

8.2.1 Fee-for-Service Benefits

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

8.2.2 Managed Care Organizations

The following excerpt from West Virginia Medicaid's SFY2018 MCO contract, Section 3.8.1 Resolution of Enrollee Issues, sub-sections 5.a.ii and 5.b.iv (see Appendix B, Article III, pages 98 – 100) 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, the Centers for Medicare & Medicaid Services (CMS) issued a Final Rule applying the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) parity requirements to coverage offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Medicaid benchmark and benchmark-equivalent plans (referred to as Alternative Benefit Plans 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, 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 financial requirements (i.e., deductibles, co-pays), as well as caps and limitations on benefits, be no more restrictive for MH and substance use disorder (SUD) services then for medical and surgical (M/S) counterparts under the same plan. Specific MHPAEA requirements include aggregate lifetime and annual dollar limits; financial requirements (FR) and quantitative treatment limitations (QTL); non-quantitative treatment limitations (NQTL); 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 Web site.

2.0 Parity Analysis Approach

2.1 Benefit Packages and Delivery Systems

2.1.1 Medicaid Benefit Packages

West Virginia Medicaid has two benefit plans. The Traditional Medicaid benefit package is for all Medicaid members except the expansion population, unless attesting to being medically frail, at which time the Traditional benefit package is accessible by expansion members. The West Virginia Health Bridge Alternative Benefit Plan (ABP) is for expansion members. The ABP State Plan Amendment (SPA) was last revised and approved in July 2015, and is therefore deemed compliant and not part of this analysis.

2.1.2 Traditional Medicaid Delivery Systems

The Traditional Medicaid benefit package can be delivered to members by fee-for-service (FFS), managed care organizations (MCO), or a mixture of both FFS and MCO. West Virginia currently has four MCOs, which cover 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, the Department of Health and Human Resources (Department or 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 the four 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 substance use disorder benefits.
Mental Health (MH) Benefits	MH services are those billed with a principal diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (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

Term	Definition
	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 Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)

West Virginia Medicaid has determined the applicable Fee-for-Service programs, including school-based health services, children's residential treatment, and pharmacy benefits, as well as the four managed care organizations, to be in compliance with the parity regulations for AL/ADLs.

3.2 Financial Requirements (FRs)

West Virginia Medicaid has determined the applicable Fee-for-Service programs, including school-based health services, children's residential treatment, and pharmacy benefits, as well as the four managed care organizations, to be in compliance with the parity regulations for FRs.

3.3 Quantitative Treatment Limitations (QTLs)

West Virginia Medicaid has determined the applicable Fee-for-Service programs, including school-based health services, children's residential treatment, and pharmacy benefits, as well as the four managed care organizations, to be in compliance with the parity regulations for QTLs.

3.4 Non-Quantitative Treatment Limitations (NQTLs)

West Virginia Medicaid has determined the applicable Fee-for-Service programs, including school-based health services, children's residential treatment, and pharmacy benefits to be in compliance with the parity regulations for NQTLs. The managed care organizations 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

West Virginia Medicaid has determined the applicable Fee-for-Service programs, including school-based health services, children's residential treatment, and pharmacy benefits, as well as the four managed care organizations, to be in compliance with the parity regulations for the availability of information.

Appendix B – Managed Care Organizations Compliance Letters

Aetna Better Health of West Virginia

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
Commissioner's Office
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3712
Telephone: (304) 558-1700 Fax: (304) 558-1451

Jim Justice
Governor

Bill J. Crouch
Cabinet Secretary

December 6, 2017

Todd White, Chief Executive Officer
Aetna Better Health of West Virginia
500 Virginia Street, East
Suite 400
Charleston, West Virginia 25301

RE: Mental Health Parity Compliance

Dear Mr. White:

Pursuant to the State Fiscal Year 2018 Purchase of Service Provider Agreement between the State of West Virginia Department of Health and Human Resources Bureau for Medical Services (referred to as "Department" hereafter) and Aetna, all covered services must be provided in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its respective federal regulations. The requirements are cited in Article II, Section 4.11 Utilization Review and Control; Article II, Section 5.14 Compliance with Applicable Laws, Rules, And Policies; and Article III, Section 10.1 MCO Behavioral Services Administration.

The MHPAEA requires insurers and plans to guarantee that all financial requirements (i.e., deductibles, co-pays), as well as caps and limitations on benefits, be no more restrictive for mental health and substance use disorder services then for medical and surgical (M/S) counterparts under the same plan. Specific MHPAEA requirements include aggregate lifetime and annual dollar limits; quantitative treatment limitations; nonquantitative treatment limitations (NQTL); and the availability of information, including the reason for denial of services.

On March 30, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a Final Rule applying MHPAEA parity requirements to coverage offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program, and Medicaid benchmark and benchmark-equivalent plans (referred to as Alternative Benefit Plans 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, 42 CFR Parts 438, 440, 456, et al.). The Final Rule explains roles and responsibilities for determining and monitoring compliance, as well as mental health parity requirements.

In order to determine compliance, the Department 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."

Thank you for responding to the recent requests for information. After meeting with representatives from Aetna and reviewing Aetna's submitted documentation, the Department has not identified any MCO policies as an area of non-compliance of the MHPAEA that require remediation.

All MCOs that contract with the Department to provide services to Medicaid beneficiaries must develop an MHPAEA compliance plan. By December 31, 2017, please provide Aetna's plan for monitoring and ensuring ongoing compliance with the MHPAEA and its respective federal regulations. The following resources may assist with this process.

- https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf
- https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-roadmap.pdf
- https://www.federalregister.gov/public-inspection
- https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-03-29.html

In addition, the State Fiscal Year 2019 Purchase of Service Provider Agreement between the Department and Aetna may include additional requirements to support the State's compliance with the MHPAEA such as additional reporting.

If you have any questions about the Department's requests, please contact Jeff Wiseman, Assistant to the Deputy Secretary, West Virginia DHHR at (304) 558-6052 or Jeff.A.Wiseman@wv.gov. Thank you for your cooperation and your attention to this important issue.

Sincerely,

Cynthia Beane, MSW, LCSW
Commissioner

The Health Plan

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
Commissioner's Office
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3712
Telephone: (304) 558-1700 Fax: (304) 558-1451

Jim Justice
Governor

Bill J. Crouch
Cabinet Secretary

December 6, 2017

Christy Donohue, Medicaid Director
The Health Plan
141 Summers Street
Charleston, West Virginia 25301

RE: Mental Health Parity Compliance

Dear Ms. Donohue:

Pursuant to the State Fiscal Year 2018 Purchase of Service Provider Agreement between the State of West Virginia Department of Health and Human Resources Bureau for Medical Services (referred to as "Department" hereafter) and The Health Plan (referred to as "THP" hereafter), all covered services must be provided in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its respective federal regulations. The requirements are cited in Article II, Section 4.11 Utilization Review and Control; Article II, Section 5.14 Compliance with Applicable Laws, Rules, And Policies; and Article III, Section 10.1 MCO Behavioral Services Administration.

The MHPAEA requires insurers and plans to guarantee that all financial requirements (i.e., deductibles, co-pays), as well as caps and limitations on benefits, be no more restrictive for mental health and substance use disorder (MH/SUD) services then for medical and surgical (M/S) counterparts under the same plan. Specific MHPAEA requirements include aggregate lifetime and annual dollar limits; quantitative treatment limitations; nonquantitative treatment limitations (NQTL); and the availability of information, including the reason for denial of services.

On March 30, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a Final Rule applying MHPAEA parity requirements to coverage offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program, and Medicaid benchmark and benchmark-equivalent plans (referred to as Alternative Benefit Plans 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, 42 CFR Parts 438, 440, 456, et al.). The Final Rule explains roles and responsibilities for determining and monitoring compliance, as well as mental health parity requirements.

In order to determine compliance, the Department 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."

Thank you for responding to the recent requests for information. After meeting with representatives from THP and reviewing THP's submitted documentation, the Department has identified the following areas of non-compliance of the MHPAEA and require remediation:

1) Policy CL-18 requires a treatment plan to be submitted to continue care beyond 12 psychotherapy visits. The Health Plan provided no comparable requirement for M/S services and did not provide any strategy that would explain its application to only a behavioral health service.

During the review, Mountain Health Trust (MHT) reports were reviewed for January 1, 2016 – December 31, 2016.

2) The MHT report for calendar year 2016 indicates that the percentage of appeals resolved in the members' favor was 66% for medical services and 18% for mental health services. As appeals information can provide evidence to suggest that non-quantitative treatment limits are, in operation, applied more stringently to mental health services than medical services, the Department requests additional information.

   Specifically:

   a. A description of the appeals process (including the credential of the parties making determinations) for MH/SUD compared to appeals process for M/S appeals process.

   b. A detailed report about the nature and disposition of the MH/SUD appeals for the relevant time period.

   c. A summary and action plan to address the identified opportunities for improvement (e.g., improved education of beneficiaries or providers) from an analysis of "a" and "b."

Within seven business days of receipt of this letter, please provide a written statement that acknowledges receipt of this letter, agrees to provide the additional information and remediate the identified areas of non-compliance as soon as possible, and describes the specific steps and timeline the MCO will take to remediate the identified areas of non-compliance. If you are in disagreement with these findings, please provide justification within seven business days.

As required by CMS, the State must post documentation of mental health parity compliance on its Medicaid website. The October 2, 2017, compliance date has already

passed. We need to post the required documentation as soon as possible, and in order to do so need your MCO's agreement to remediate identified areas of non-compliance.

By December 31, 2017, please provide THP's plan for monitoring and ensuring ongoing compliance with the MHPAEA and its respective federal regulations. The following resources may assist with this process.

- https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf
- https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-roadmap.pdf
- https://www.federalregister.gov/public-inspection
- https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-03-29.html

In addition, the State Fiscal Year 2019 Purchase of Service Provider Agreement between the Department and The Health Plan may include additional requirements to support the State's compliance with the MHPAEA such as additional reporting.

If you have any questions about the Department's requests, please contact Jeff Wiseman, Assistant to the Deputy Secretary, West Virginia DHHR at (304) 558-6052 or Jeff.A.Wiseman@wv.gov. Thank you for your cooperation and your attention to this important issue.

Sincerely,

Cynthia Beane, MSW, LCSW
Commissioner

Cc: JS/jw

UniCare

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES
Commissioner's Office
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3712
Telephone: (304) 558-1700 Fax: (304) 558-1451

Jim Justice
Governor

Bill J. Crouch
Cabinet Secretary

December 6, 2017

Mitch Collins, Plan President
UniCare
200 Association Drive
Suite 200
Charleston, West Virginia 25311

RE: Mental Health Parity Compliance

Dear Mr. Collins:

Pursuant to the State Fiscal Year 2018 Purchase of Service Provider Agreement between the State of West Virginia Department of Health and Human Resources Bureau for Medical Services (referred to as "Department" hereafter) and UniCare, all covered services must be provided in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its respective federal regulations. The requirements are cited in Article II, Section 4.11 Utilization Review and Control; Article II, Section 5.14 Compliance with Applicable Laws, Rules, And Policies; and Article III, Section 10.1 MCO Behavioral Services Administration.

The MHPAEA requires insurers and plans to guarantee that all financial requirements (i.e., deductibles, co-pays), as well as caps and limitations on benefits, be no more restrictive for mental health and substance use disorder (MH/SUD) services then for medical and surgical (M/S) counterparts under the same plan. Specific MHPAEA requirements include aggregate lifetime and annual dollar limits; quantitative treatment limitations; nonquantitative treatment limitations (NQTL); and the availability of information, including the reason for denial of services.

On March 30, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a Final Rule applying MHPAEA parity requirements to coverage offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program, and Medicaid benchmark and benchmark-equivalent plans (referred to as Alternative Benefit Plans 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, 42 CFR Parts 438, 440, 456, et al.). The Final Rule explains roles and responsibilities for determining and monitoring compliance, as well as mental health parity requirements.

In order to determine compliance, the Department 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."

Thank you for responding to the recent requests for information. After meeting with representatives from UniCare and reviewing UniCare's submitted documentation, the Department has concluded that UniCare's policies in priority areas (those that most significantly impact members' access to care) are in compliance with the MHPAEA.

By December 31, 2017, please provide UniCare's plan for monitoring and ensuring ongoing compliance with the MHPAEA and its respective federal regulations. The following resources may assist with this process.

- https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf
- https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-roadmap.pdf
- https://www.federalregister.gov/public-inspection
- https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-03-29.html

In addition, the State Fiscal Year 2019 Purchase of Service Provider Agreement between the Department and UniCare may include additional requirements to support the State's compliance with the MHPAEA, such as additional reporting.

If you have any questions about the Department's request, please contact Jeff Wiseman, Assistant to the Deputy Secretary, West Virginia DHHR at (304) 558-6052 or Jeff.A.Wiseman@wv.gov. Thank you for your cooperation and your attention to this important issue.

Sincerely,

Cynthia Beane, MSW, LCSW
Commissioner

Cc: JS/jw

Appendix C – Managed Care Organization Contract

Separate file attached in delivery to CMS.