BerryDunn

State of West Virginia Department of Health and Human Services

Medicaid Mental Health Parity Compliance Documentation

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Submitted by:
BerryDunn
2211 Congress Street
Portland, ME 04102-1955
207.541.2200

Eduardo Daranyi, Principal
edaranyi@berrydunn.com
Nicole Becnel, Principal
nbecnel@berrydunn.com
Valerie Hamilton, Senior Health Policy Manager
vhamilton@berrydunn.com

Submitted On: April 11, 2022
Revised: June 12, 2023

Table of Contents

List of Tables

List of Figures

Table 1: Common Terms and Acronyms[1]

Term/Acronym	Definition
Aetna	Aetna Better Health® of West Virginia
ACA	Affordable Care Act
ACT	Assertive Community Treatment
ADL	Annual Dollar Limit
AICD	Automatic Implantable Cardioverter-Defibrillator
AIM	American Imaging Management
AL	Aggregate Lifetime
ASAM®	American Society of Addiction Medicine
BCF	Bureau for Children and Families
BMS	Bureau for Medical Services, West Virginia's State Medicaid Agency
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPT®	Current Procedural Terminology
CSED	Children with Serious Emotional Disorders
DHHR, Department	Department of Health and Human Resources
DME	Durable Medical Equipment
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
E&M	Evaluation and Management
EHB	Essential Health Benefit
EPSDT	Early Periodic Screening, Diagnostic, and Treatment
ER	Emergency Room
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FR	Financial Requirements
HCBS	Home and Community-Based Services
ICD	International Classification of Diseases
IOP	Intensive Outpatient Services
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MCG™	Milliman Care Guidelines

[1] Common Terms and Acronyms updated May 8, 2023.

Term/Acronym	Definition
MECA	Medical Eligibility Contracted Agent
MH	Mental Health
MHPAEA	Mental Health Parity and Addiction Equity Act of 2008
MHT	Mountain Health Trust
M/S	Medical/Surgical
NCQA	National Committee for Quality Assurance
NQTL	Non-Quantitative Treatment Limit
OP	Outpatient
PDL	Preferred Drug List
PHP	Partial Hospitalization Program
PRTF	Psychiatric Residential Treatment Facility
QTL	Quantitative Treatment Limit
SA	Substance Abuse
SBIRT	Screening, Brief Intervention and Referral to Treatment
SED	Serious Emotional Disorder
SFY	State Fiscal Year
State	West Virginia
SUD	Substance Use Disorder
THP	The Health Plan
UniCare	UniCare Health Plan of West Virginia
WVCHIP	West Virginia Children’s Health Insurance Program

1.0 Introduction

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).[2] The MHPAEA requires insurers and plans to guarantee that all financial requirements (FR) (e.g., deductibles, copays), as well as caps and limitations on benefits, be no more restrictive for mental health (MH) services than for medical and surgical (M/S) counterparts under the same plan.

The Affordable Care Act (ACA) built on the MHPAEA by including MH services as an essential health benefit (EHB) and mandating that parity rules apply to individual and small-group markets. On March 30, 2016, the Centers for Medicare & Medicaid Services (CMS) finalized the MH and substance use disorder (SUD) parity rule for Medicaid and the Children's Health Insurance Program (CHIP) effective May 31, 2016. This final rule applied parity rules to Medicaid Managed Care Organizations (MCOs), Medicaid benchmark and benchmark-equivalent plans (referred to in this rule as Medicaid Alternative Benefit Plans), and CHIP.[3]

In January 2017, CMS issued rules, guidance, and a toolkit[4] to assist states in achieving compliance with the law.

Over 85% of West Virginia (WV) Medicaid members are enrolled in managed care, with a few services carved out and provided as fee-for-service (FFS). Mountain Health Trust (MHT) is the Medicaid managed care program for WV Medicaid and West Virginia CHIP. CHIP joined MHT on January 1, 2021. Three MCOs have entered contracts with WV to provide comprehensive health services, including Aetna Better Health of West Virginia (Aetna), The Health Plan (THP), and UniCare Health Plan of West Virginia (UniCare).

Update May 8, 2023

The Medicaid and Mountain Health Promise benefit packages did not change significantly since the time of the last comprehensive report (April 11, 2022). A mental health parity update for the time since the 2022 report is provided in Appendix E. In addition, because benefit limitations

---

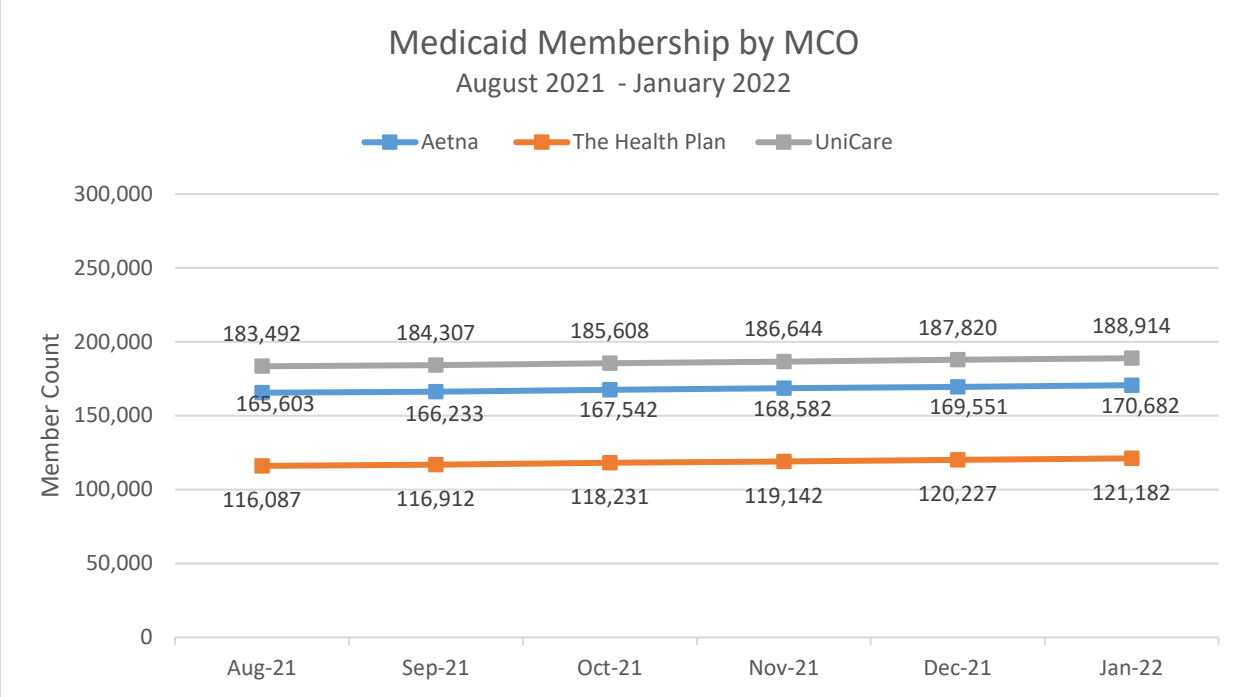
[2] Pub. L. 110-343, enacted on October 3, 2008. Available: https://www.govinfo.gov/content/pkg/PLAW-110publ343/html/PLAW-110publ343.htm.

[3] Centers for Medicare and Medicaid Services. Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the application of mental health parity requirements to coverage offered by Medicaid managed care organizations, the Children's Health Insurance Program (CHIP), and alternative benefit plans. Final rule. 81 FR 18389. 2016 Mar 30. Access: https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of Google Scholar

[4] Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs. Available: https://www.medicaid.gov/sites/default/files/2019-12/parity-toolkit.pdf.

may occur at the MCO level, the State collaborated with Aetna, THP, UniCare, and Bureau for Medical Services (BMS) pharmacy to update the NQTL Comparative Analyses (Appendix F).

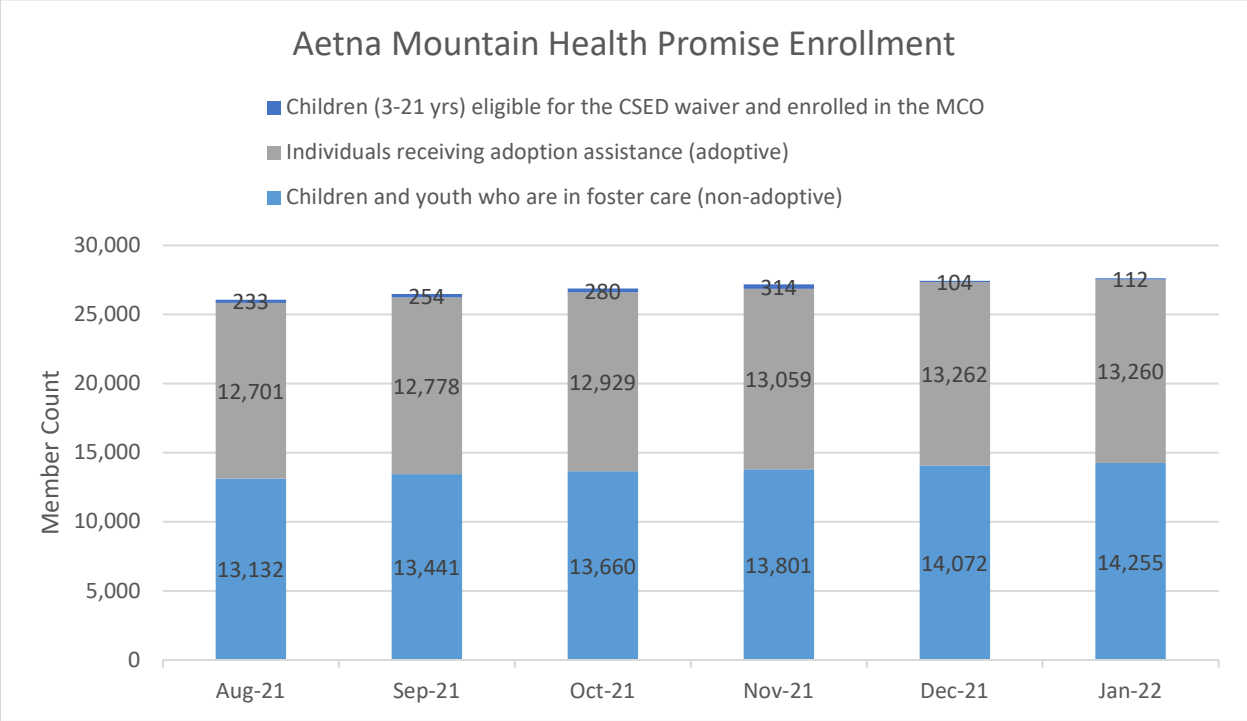
Figure 1: Medicaid Membership by MCO



Mountain Health Promise is a specialized managed care program for children and youth. Mountain Health Promise assists children in foster care, kinship care, adoptive care, and children from age three to twenty-one who are eligible for the Children with Serious Emotional Disorder (CSED) Home and Community-Based Services (HCBS) waiver program. Aetna is the single MCO for Mountain Health Promise. Aetna provides risk-based comprehensive health services, children's residential care services, and socially necessary services. The goal of the waiver is to reduce the number of children housed in Psychiatric Residential Treatment Facilities (PRTFs) and shorten length of stay for children who require acute care in PRTFs. Accordingly, the waiver prioritizes children with serious emotional disorder (CSED) who are:

1) In PRTFs or other residential treatment providers out-of-state; and
2) Other Medicaid-eligible children with SED who are at risk of institutionalization.

Figure 2: Aetna Mountain Health Promise Enrollment



The State's Medicaid and Mountain Health Promise managed care program will be reviewed together in this document, as the core benefits are the same. Relevant differences between the two will be detailed in each section.

The State will submit separate parity compliance documentation for WVCHIP.

2.0 Methodology

2.1 Benefit Package Identification Process

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

For the Medicaid benefit package, BMS has entered into contracts with three MCOs to provide risk-based comprehensive services to WV Medicaid/MHT's managed care enrollees: Aetna, THP, and UniCare.

For the Mountain Health Promise benefit package, BMS has entered a contract with Aetna to provide comprehensive services. These services are similar to the Medicaid benefits package, with the addition of socially necessary services (as defined by the Bureau for Children and Families [BCF]) and services specifically for CSED members (see Section 4.2). This contract commenced on March 1, 2020, and a new contract period will begin July 1, 2024.

2.2 Benefit Package Delivery Systems

The State's Medicaid program delivers most benefits using managed care; a few services are carved out and provided through FFS delivery systems. Pharmacy, school-based health services, and a few specific medical procedures are carved out of the MCO contract and provided on a FFS basis to MCO members. Pharmacy services are carved out of managed care and are covered on a FFS basis. Coverage for SUD waiver services transitioned from FFS to the MCOs in 2019, with the exception of Outpatient Treatment Programs (OTPs) for Methadone. The State has implemented statewide use of Screening, Brief Intervention and Referral to Treatment (SBIRT) screening and Naloxone distribution.

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

2.3 Stakeholder Participation

Stakeholders from DHHR BMS and the different delivery systems were involved in the review process, including the BMS Director of Managed Care, the BMS Director of Pharmacy Services, the BMS Director of Behavioral Health and Long-Term Care, and key individuals from Aetna (for the State Medicaid program and Mountain Health Promise), THP, and UniCare. BMS contracted with BerryDunn to facilitate workgroups and provide mental health parity subject matter expertise, research, information gathering, and project management support.

As part of the review, BerryDunn sent request for information (RFI) documents to representatives at each of the MCOs and BMS Pharmacy Services (Appendix C). BerryDunn interviewed the BMS Director of Behavioral Services for information specific to MH/SUD services.

Figure 3: MH Parity Review Process

3.0 Methodology

3.1 Benefit Groupings

Benefit grouping definitions for Medicaid and Mountain Health Promise remain the same as the August 2021 report.

3.1.1 Medical/Surgical (M/S) Benefits

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

3.1.2 MH Benefits

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) was used as the generally recognized diagnostic standard for identifying MH/SUD services, and distinguishing MH/SUD services for procedure codes that can be used in both a M/S and a 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 of F10 – F19.99 using the DSM-V.

3.2 Benefit Classifications

Benefit classification definitions for Medicaid and Mountain Health Promise remain the same as the August 2021 report.

3.2.1 Inpatient

Inpatient services are services provided to a patient who has been formally admitted to a hospital or long-term care facility[5] on the recommendation of a physician and is receiving room, board, and professional services in the institution on a continuous, 24-hour-a-day basis. Inpatient services include all treatments, pharmaceuticals, equipment, tests, and procedures provided during an inpatient treatment episode.

3.2.2 Outpatient

Outpatient services are services provided to a patient who is evaluated or treated at a hospital emergency department, medical clinic, diagnostic center, or other appropriate medical facility who is not receiving room, board, and professional services on a 24-hour-a-day basis, and who

[5] Long-term care facilities are carved out of managed care.

is not receiving Current Procedural Terminology (CPT®) services 99281 – 99285 during the treatment episode. Outpatient services include all treatments, equipment, tests, procedures, and clinician-administered pharmaceuticals provided during an outpatient treatment episode.

3.2.3 Emergency Care

Emergency care services are services that are part of a treatment episode that includes CPT® codes 99281 – 99285. For MH/SUD, crisis services (billed with CPT® code H2011) are included in the emergency care classification because the goals of treatment are to assess and stabilize the patient, after which the most appropriate disposition is determined. MCOs reviewed the emergency codes and updated as appropriate.

Table 2: 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.

CPT® Code	Definition
	Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
H2011	Crisis intervention services per 15 minutes.

3.2.4 Prescription Drug

Prescription drugs are drugs and medications that, by law, require a prescription. The MCO does not provide prescription drug coverage. BMS provides outpatient prescription drug coverage directly to Medicaid enrollees.

4.0 Grouping and Classification of Benefits

4.1 Methodology

4.1.1 Benefit Grouping Process

A Medicaid data claims extract with procedure codes and diagnosis codes was used to group benefits as M/S, MH, or SUD, based on primary diagnoses provided in Section 3.1.

To group the pharmacy benefits, the First Databank HIC3 Class Codes were used. In March 2022, a subject matter expert manually reviewed covered therapeutic classes to help ensure that pharmacy benefits were appropriately assigned to MH/SUD, M/S, or both.

Update May 8, 2022

Non-pharmacy benefit groupings were revised using the FY2023 Mountain Health Trust MCO Contract and the FY2023 Mountain Health Promise MCO Contract.

4.1.2 Benefit Classification Process

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

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

Update May 8, 2022

Non-pharmacy benefit classifications were revised using the FY2023 Mountain Health Trust MCO Contract and the FY2023 Mountain Health Promise MCO Contract.

4.2 Non-Pharmacy Benefit Grouping and Classification

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

Table 3: Non-Pharmacy Benefit Grouping and Classification[6,7]

	Inpatient	Outpatient	Emergency Care
MH/ SUD	• Hospital services, inpatient – behavioral health and substance use stays • Inpatient psychiatric services for individuals under age 21 • Behavioral health rehabilitation for Individuals (children <21 years of age), Psychiatric Residential Treatment Facility (PRTF) **Mountain Health Trust** • Inpatient psychiatric services for individuals age 21 – 64	• Behavioral health outpatient services (diagnosis, evaluation, therapies, medication-administered treatment (MAT), and other program services) • Drug screening • Psychological services (evaluation and treatment; includes telehealth) • SUD services (targeted case management and physician-supervised medication and counseling services provided to treat those with a SUD) • Tobacco cessation **Benefits Provided FFS:** • Early intervention services for children three (3) years and under • Intermediate care facility for members with intellectual/developmental disabilities • Opioid treatment program • Prescription drugs • School-based services • Transportation, non-emergency **Mountain Health Promise:** • Special intensive support services to help members	• All emergency services • Emergency transportation

[6] Benefit grouping and classification updated May 8, 2023.
[7] This benefit grouping and classification is provided for mental health parity analysis purposes, not as a statement of benefits for coverage purposes.

	Inpatient	Outpatient	Emergency Care
		stay in their homes and communities (See Table 4)	
M/S	• EPSDT • Hospital services, inpatient (all inpatient services, including bariatric surgery, corneal transplants, and long-term acute care) • Inpatient rehabilitation • Nurse practitioner's (NP) services (nurse midwife, nurse anesthetist, family, or pediatric nurse practitioner) **Benefits Provided FFS** • Nursing facility services • Organ transplant Services	• Ambulatory surgical center • Cardiac rehabilitation • Chiropractor services • Clinic services • Dental services (adult coverage limited to $1,000/calendar year) • Dental services (children) • EPSDT • Family planning services & supplies • Services for children with a disability and/or special health care needs • Home health care Services • Hospice • Hospital services, outpatient (preventive, diagnostic, all emergency services, or rehabilitative services) • Inpatient rehabilitation (MHT) • Laboratory and X-ray Services, non-hospital • Nurse practitioner's (NP) services (nurse midwife, family, or pediatric nurse practitioner) • Occupational therapy • Personal care services (medically necessary ordered by a physician) • Physical therapy • Physician services • Podiatry services	• All emergency services • Emergency transportation • Dental services (adult) • Dental services (children)

	Inpatient	Outpatient	Emergency Care
		• Private duty nursing (children <21 years of age) • Prosthetic devices and durable medical equipment • Pulmonary rehabilitation • Right from the Start Services • Rural health clinic services: Including federally qualified health centers • Speech therapy • Vision services **Benefits Provided FFS** • Abortion • Early intervention services for children three (3) years and under • Intermediate care facility for members with intellectual/developmental disabilities • Organ transplant services • Personal care for individuals enrolled in the aged/disabled waiver • Prescription drugs • School-based services • Transportation, non-emergency • Tubal ligation **Mountain Health Promise** • Emergency shelter services	

For children who are eligible for the CSED waiver services (a subset of the Mountain Health Promise membership), the following additional outpatient benefits are available. These services are all mapped to the MH grouping.

Table 4: Children with Serious Emotional Disorder Waiver (CSED) Services and Service Codes

CSED Service Name	Service Code
Assistive equipment	T2035-HA
Case management	T1016-HA
Community transition	T2038-HA
Independent Living/Skills Building	T2033-HA
In-home family therapy and support	H0004-HO-HA
Job development (prevocational services)	T2021-HA
Mobile response	H2017-HA
Non-medical transportation	A0160-HA
Peer parent support	H0038-HA
Respite care: in-home	T1005-HA
Respite care: out-of-home	T1005-HA-HE
Specialized therapy	G0176-HA
Supported employment: individual	T2019-HA

4.3 Pharmacy Benefit Grouping and Classification

The embedded Microsoft Excel file below groups and classifies approved prescription drugs according to MH/SUD and M/S.

Pharmacy G&C.xlsx

5.0 MCO Contract Compliance

WV Medicaid's State Fiscal Year (SFY) 2022 MCO contract and the Mountain Health Promise SFY 2022 Contract includes the following provisions related to compliance with federal parity regulations. WV's Medicaid MCO Contract is publicly available.[8]

5.1 Medicaid Article II, Section 4.10 / Mountain Health Promise Article II, Section 4.10: Utilization Review and Control

Medicaid: page 19; Mountain Health Promise: pages 30 – 31:

In accordance with 42 CFR §438.210(a)(4), the MCO may place appropriate limits on the covered services provided under this Contract on the basis of criteria applied under the Medicaid [or BCF] State Plan[s], such as medical necessity or for the purpose of utilization control, provided that:

1. *MCO services can reasonably be expected to achieve the purpose for which such services are furnished;*
2. *Services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and*
3. *Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.*

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 with EPSDT requirements, and the respective federal regulations.

5.2 Medicaid Article II, Section 5.14/Mountain Health Promise Article II, Section 5.14: Compliance with Applicable Laws, Rules, and Policies

Medicaid: pages 28 – 29; Mountain Health Promise: pages 35 – 36:

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

[8] WV DHHR: BMS. Managed Care Organization Contracts. https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOcontracts/Pages/default.aspx.

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… [Additional language in the Mountain Health Promise contract]: *Chapter 9, Article 5 and Chapter 49, Articles 1, 2, and 4 of the West Virginia Code pertaining to the state's foster care program and transitioning the foster care population to an MCO (2019 WV House Bill 2010)*]…Mental Health Parity and Addiction Equity Act of 2008…*and other pertinent Federal, State, or local laws, regulations, or policies in the performance of this contract.*

5.3 Medicaid Article III, Section 10.1/Mountain Health Promise Article III, Section 11.1: MCO Behavioral Services Administration

Medicaid: pages 164 – 165; Mountain Health Promise: pages 181 – 182:

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. The benfit must be provided in accordance with 42 CFR part 438 Subpart K, Parity in Mental Helath and SUD Benefits. The MCO must develop and maintain an ongoing Mental Health Parity Compliance Plan to be submitted BMS annually by June 30th. The MCO is not subject to implementation of parity requirement associated with quantitative treatment limits of prescription drugs, as this benefit is administered under FFS.

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

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

If an MCO enrollee is provided mental health or SUD benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or SUD benefits must be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided.

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

The MCO may cover, in addition to services covered under the Medicaid State Plan, any service necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR §457.496.

Mountain Health Promise: page 188:

[Additional language in Mountain Health Parity contract]: *A mental health screening shall be completed for any child not already known to be receiving mental health services when the child enters DHHR Youth Services, the child welfare system, or the juvenile justice system; or when the child or family requests mental health services or that a screen be conducted. Providers must incorporate the EPSDT HealthCheck screening questions into their mental health screening process as a critical means for determining trauma history and any current trauma-related symptoms. The MCO shall provide a quarterly report of all approved and denied mental health screenings and services. Failure to complete a mental health screening for any child not currently receiving mental health services shall result in a liquidated damage, as defined within Appendix F.*

In addition, the MCO shall provide a quarterly report of the average wait time to access mental health services from the date of referral by a primary care or other referring provider, to the time the youth is seen by a mental health care professional.

5.4 Medicaid Article III, Section 10.2/ Mountain Health Promise Article III, Section 11.2: MCO Behavioral Health Director

Medicaid: page 166:

The MCO must employ or Contract with a qualified West Virginia licensed physician to serve as the Behavioral Health Director for the covered behavioral services in accordance with Article II, Section 5.10.1 (Key Staff Requirements). When employed or contracted, the Behavioral Director must be available for behavioral utilization review decisions and must be authorized and empowered to respond to behavioral clinical issues, utilization review, and behavioral quality of care inquiries.

Mountain Health Promise: page 182:

The MCO must employ or Contract with a qualified West Virginia licensed physician to serve as the Behavioral Health Director for the covered behavioral services. When employed or contracted, the Behavioral Director must be available for behavioral utilization review decisions and must be authorized and empowered to respond to behavioral clinical issues, utilization review, and behavioral quality of care inquiries.

5.5 Medicaid Article III, Section 10.3/ Mountain Health Promise Section 11.3: MCO Behavioral Health Covered Services

Medicaid: page 166; Mountain Health Promise: page 182:

The MCO covered behavioral services must be rendered by providers within the scope of their license and in accordance with all State and Federal requirements. Behavioral services include:

mental health outpatient services, mental health inpatient services, SUD outpatient services (including but not limited to pharmacologic management and including methadone treatment), targeted case management, behavioral health rehabilitation and clinic services, and psychiatric residential treatment services. The MCO must follow BMS FFS policies specific to the drug testing limit requirements contained in Chapter 529 of the WV Medicaid Provider Manual for drug screening services. [Medicaid only]: *The MCO may implement its own prior authorization requirements for these services.*

5.6 Medicaid Article III, Section 10.5/ Mountain Health Promise Section Article III, Section 11.4: Coordination of Care

Medicaid: page 166:

Notwithstanding *internal care coordination of care requirements outlined in Article III, Section 5.3 of this Contract, the MCO's primary care provider must coordinate the enrollee's health services, as appropriate, with behavioral health providers.*

The MCO must initiate care coordination services for enrollees being discharged from crisis stabilization units.

If an enrollee is identified as having a dependence disorder including alcohol, opiate, amphetamine, benzodiazepine, or poly substance, and in need of engagement of treatment, the MCO must assign the enrollee a MCO Care Coordinator, at a minimum, through the duration of the treatment process.

Mountain Health Promise: page 182:

The MCO must initiate care coordination services for enrollees being discharged from crisis stabilization units.

If an enrollee is identified as having a dependence disorder including alcohol, opiate, amphetamine, benzodiazepine, or poly substance, and in need of engagement of treatment, the MCO must assign the enrollee a MCO Care Coordinator, at a minimum, through the duration of the treatment process. MCO Care Coordinators should coordinate with Assertive Community Treatment (ACT) Case Managers when the enrollee requires an intensive and highly integrated approach for community mental health service delivery.

5.7 Medicaid Article III, Section 10.11.2 / Mountain Health Promise Article III, Section 11.10.2: 1115 Demonstration Waiver

Medicaid: page 169; Mountain Health Promise: page 184:

Building on legislative and health systems activities, the goal is to create a seamless continuum of care to support enrollees in their recovery. The MCO is expected to support the following goals:

- *Improve quality of care and population health outcomes for Medicaid enrollees with SUD;*

- *Increase enrollee access to and utilization of appropriate SUD treatment services based on American Society of Addiction Medicine (ASAM®) Criteria;*
- *Decrease medically inappropriate and avoidable utilization of high-cost emergency department and hospital services by enrollees with SUD;*
- *Improve care coordination and care transitions for Medicaid enrollees with SUD; and*
- *Follow the CMS standards and guidelines as stated in the Special Terms and Conditions of the West Virginia approved 1115 SUD Waiver.*

BMS [Mountain Health Promise: "The Department"] has established standards of care for SUD demonstration waiver services that incorporate industry standard benchmarks from the ASAM® Criteria for patient assessment and placement, service, and staffing specifications.

5.8 Medicaid Article III, Section 10.11.3/Mountain Health Promise: Article III, Section 11.10.3: SUD Services Continuum of Care

Medicaid: page 169; Mountain Health Promise: pages 184 – 185:

The MCO will be responsible for a seamless continuum of care for SUD treatment to all West Virginia Medicaid enrollees who meet medical necessity criteria for services. These services include standard SUD services authorized under the West Virginia Medicaid State Plan as well as SUD services authorized under West Virginia's SUD 1115 demonstration waiver. The MCO must follow all standards and criteria adopted by BMS regarding SUD services as outlined in the West Virginia Medicaid Provider Manual, Chapter 504: Substance Use Disorder Services. [Medicaid only]: *The MCO must make all reasonable efforts to contract with all SUD service providers.*

5.9 Medicaid Article III, Sectional 10.11.3.1; Mountain Health Promise Article III, Section 11.10.3.1: Medicaid Sate Plan SUD Services

Medicaid: page 169; Mountain Health Promise: page 185:

Medicaid State Plan SUD services include:

- *Targeted Case Management;*
- *Naloxone Administration Services (non-covered MCO service);*
- *Screening, Brief Intervention and Referral to Treatment (0.5 ASAM® Level of Care);*
- *Outpatient Services (1.0 ASAM® Level of Care);*
- *Intensive Outpatient Services (2.1 ASAM® Level of Care);*
- *Partial Hospitalization Services (2.5 ASAM® Level of Care);*

- *Medically Monitored Intensive Inpatient Services (3.7 ASAM® Level of Care);*
- *Medically Managed Intensive Inpatient Services (4.0 ASAM® Level of Care);*
- *Ambulatory Withdrawal Management Services (1-WM & 2-WM ASAM® Level of Care);*
- *Medically Monitored Inpatient Withdrawal Management Services (3.7-WM ASAM® Level of Care); and*
- *Non-Methadone Medication Assisted Treatment (MAT).*

5.10 Medicaid Article III, Section 10.11.2/Mountain Health Promise Article III, Section 11.10.2

Medicaid: page 169; Mountain Health Promise: page 185:

SUD 1115 demonstration waiver services include:

- *Peer Recovery Support Services (1.0 ASAM® Level of Care);*
- *Clinically Managed Low Intensity Residential Services (3.1 ASAM® Level of Care);*
- *Clinically Managed Population-Specific High Intensity Residential Services (3.3 ASAM® Level of Care);*
- *Clinically Managed High Intensity Residential Services (3.5 ASAM® Level of Care); and*
- *Clinically Managed Residential Withdrawal Management Services (3.2-WM ASAM® Level of Care).*

Opioid Treatment Program services (methadone only) included in the SUD waiver will be provided through Medicaid FFS. The MCO will be responsible for assisting an enrollee during the admission and discharge transition process for Opioid Treatment Program services.

5.11 Article III; Section 11.11 Mountain Health Promise CSED Waiver Services

Mountain Health Promise: page 188:

The [Children with] Serious Emotional Disorder (CSED) is a §1915(c) Medicaid HCBS waiver that provides additional HCBS beyond what is covered under the state's Medicaid State Plan. The [C]SED waiver permits the Department to provide an array of HCBS that enable children who would otherwise require institutionalization to remain in their homes and communities. In addition, it is anticipated that this waiver will reduce the number of children housed both in-state and out-of-state in PRTFs and shorten the lengths of stay for children who require acute care.

The MCO is expected to contract with all CSEDW [CSED] approved providers within the State, and will also be required to implement solutions (e.g., Non-Emergency Medical Transportation) to assist members in accessing necessary providers if there is a network gap in certain areas. The MCO will also be required to perform prospective member forecasting, in accordance with

the CSEDW [CSED] enrollment requirements, to ensure that the MCO's network is continually sufficient to meet the access needs of the population.

… The MCO must reimburse at least one hundred percent (100%) of the current FFS Medicaid fee schedule to in-network CSED waiver providers, unless such provider agreed to an alternative payment schedule. The Department will notify the MCO of any changes in the FFS Medicaid schedule as soon as administratively possible. The MCO must adjust the reimbursement schedule to in-network provider within thirty (30) calendar days of the Department's notification of any changes in the FFS Medicaid schedule.

5.12 Mountain Health Promise Article III, Section 11.11.1 [C]SED HCBS Waiver Eligibility

To be eligible for the waiver children must be at least three (3) years old and under twenty-one (21) and currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Disease (ICD) equivalent that is current at the date of evaluation. The evaluation must state that the [C]SED has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities.

The Department will contract with an ASO and psychological practice to serve as the Medical Eligibility Contracted Agent (MECA) to determine [C]SED waiver eligibility and manage allotted waiver slots and enrollment into the MCO.

5.13 Mountain Health Promise Article III, Section 13.1 Provider Network

Mountain Health Promise: page 195:

The MCO is required to make all reasonable efforts to contract with all currently enrolled residential treatment facilities. The State shall define for the MCO the category by which each facility falls in alignment with FFPSA6.0 FR and Quantitative Treatment Limits (QTLs).

6.0 Financial Requirements and Quantitative Treatment Limits

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

6.1.1 Fee-for-Service (FFS) Benefits

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

6.1.2 Managed Care Organizations (MCOs)

WV Medicaid behavioral health services provided through the managed care delivery system are not subject to AL, ADL, or other cumulative financial limits as evidenced in WV Medicaid's SFY2022 MCO contract, Section 10.1 MCO Behavioral Services Administration (see Appendix B, page 158), which states: "The MCO may not impose any aggregate lifetime, annual dollar limits, or other cumulative financial limits on mental health or SUD services." Because WV Medicaid does not allow MCOs to utilize this type of treatment limitation, WV has determined the Medicaid MCOs to be in compliance with the parity regulations for AL/ADLs.

6.2 Financial Requirements (FR)

6.2.1 Fee-for-Service (FFS) Benefits

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

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

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

6.2.2 Managed Care Organizations (MCOs)

WV Medicaid behavioral health services provided through the managed care delivery system are not subject to premiums or deductibles as evidenced in WV Medicaid's SFY2022 MCO contract Definition of Cost-Sharing on page 6, which states: "There are no premiums or deductibles under the WV Medicaid program."

WV Medicaid behavioral health services provided through the managed care delivery system are not subject to copayments as evidenced in WV Medicaid's SFY2022 MCO contract, Section 3.9.1 Services and Members Exempt from Cost-Sharing Obligations of WV Medicaid's SFY2022 MCO contract (pages 113 – 114), and for Mountain Health Promise MCO Contract, 4.9.1 (pages 117 – 118), 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*
- *Enrollees under age twenty-one (21)*

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

WV Medicaid prohibits the MCOs from charging copayments for behavioral health services, so there was no quantitative treatment limit (QTL) analysis performed, as it would meet the parity test for FRs.

For CSED services provided by Mountain Health Promise, assistive equipment (T2035-HA) has a limit of $500 per service plan year, specialized therapy (G0176-HA) has a limit of $500 per services plan year, and community transition (T2038-HA) has a limit of $3,000 one-time only. However, if a beneficiary required additional equipment, specialized therapy, or transition services, the request would be reviewed as a “soft limit.” Beneficiaries have not requested to exceed these caps since Mountain Heath Promise was established in 2020.

6.3 Quantitative Treatment Limits (QTLs)

6.3.1 Fee-for-Service Benefits (FFS)

In the August 2021 review, a few QTLs were identified for FFS behavioral health services (e.g., school-based services). In practice, these QTLs were treated as NQTLs and “hard limits” were not enforced. However, WV is in the process of updating documentation to update documentation to be consistent with its practice.

6.3.2 Managed Care Organizations (MCOs)

The MCOs do not have any QTLs for MH/SUD benefits. Any service identified with a QTL, such as number of visits, is a “soft limit” and requires prior authorization to receive additional visits.

Mountain Health Promise includes CSED services for a medically eligible subset of its population in its benefit package, which includes limitations on services. These waiver services are treated as soft limits.

Table 5: CSED Service Names, Service Codes, and Limitations

CSED Service Name	Service Code	Limitation
Case Management	T1016-HA	Capped at 874 units per service plan year. Caseloads capped at 20 per Case Manager.
Independent Living/Skills Building	T2033-HA	Capped at 160 units per week (40 hours) in combination with Job Development and Supported Employment.
In-Home Family Support	H0004-HO-HA	Capped at 8 units per day (2 hours) or 56 units per week (14 hours).
Job Development	T2021-HA	Capped at 160 units per week (40 hours) in combination with Job Development and Supported Employment.
Mobile Response	H2017-HA	Capped at 56 units per week (14 hours).
Non-Medical Transportation	A0160-HA	Capped at 800 miles per month. Must be provided within WV or within 30 miles of the WV border.
Peer Parent Support	H0038-HA	Capped at 8 units per week (2 hours) or 32 units per month (8 hours).
Respite Care: In-Home	T1005-HA	Capped at 24 days per year in combination with Out-of-Home Respite. Not available to foster parents as this is a benefit they receive as a foster parent from the Bureau for Children and Families. 96 Units = 1 day.
Respite Care: Out-of-Home	T1005-HA-HE	Capped at 24 days per year in combination with In-Home Respite. Not available to foster parents as this is a benefit they receive as a foster parent from the Bureau for Children and Families.
Supported Employment: Individual	T2019-HA	Capped at 160 units per week (40 hours) in combination with Job Development and Independent Living/Skills Building.

6.3.3 Conclusion

BMS Pharmacy has softened language for Suboxone and tobacco cessation agents to indicate in writing that the limits are NQTLs rather than QTLs.

CSED services, provided to an eligible subset of beneficiaries in Mountain Health Promise, have several services with financial restrictions. BMS amended the CSED waiver, and it was approved by CMS on July 1, 2021. The CSED waiver was designed with stakeholders from BMS, CMS, and MCOs, in consultation with clinical and non-clinical professionals and best practices, including the National Wraparound Initiatives. The limits would be treated as soft limits if beneficiaries required services over the prescribed limits.

7.0 Non-Quantitative Treatment Limits (NQTLs)

7.1 Non-Quantitative Treatment Limit Identification and Analysis Process

7.1.1 Non-Quantitative Treatment Limit Identification

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

To identify NQTLs and collect information about how they are applied in operation, the State met with the MCOs to identify changes within the past year. WV developed NQTL grids, distributed them to the MCOs for information gathering, and met with stakeholders from FFS programs. The State held an educational session with key individuals from the MCOs to discuss the review process and provide additional information about the purpose of the MH parity regulations and the analysis process. Pharmacy NQTLs are evaluated in Appendix E.

7.1.2 Non-Quantitative Treatment Limit Analysis Process

After BerryDunn received all requested information about NQTLs, the firm analyzed them for comparability and stringency based on the federal guidance provided in the “Parity Compliance Toolkit.” Based on the guidance provided in the CMS 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?

The State held meetings with the MCOs to determine whether NQTLs were the same in writing and in operation and to address follow-up questions to complete the analysis.

7.2 Non-Quantitative Treatment Limit Classification

Table 6 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. Reviews of each NQTL are in

Appendix E and grouped by MCO. Section 8 discusses compliance findings and recommendations.

Table 6: Non-Pharmacy NQTLs by MCO and Classification

NQTLs	Inpatient			Outpatient		
	THP	UniCare	Aetna	THP	UniCare	Aetna
Medical management standards						
• Medical necessity criteria development	x	x	x	x	x	x
Utilization review standards						
• Prior authorization	x	x	x	x	x	x
• Concurrent review	x	x	x	x		x
• Retrospective review	x	x	x	x	x	x
• Practice guideline selection/criteria	x	x	x	x	x	x
Provider network						
• Network size (patient-to-provider ratio, location, etc.)	x	x	x	x	x	x

Table 7: Pharmacy NQTLs

Pharmacy NQTLs
Prior Authorization
Use of a Preferred Drug List (PDL)
Prospective Review
Retrospective Review
Pharmacy Lock-In Program
Suboxone-Specific Requirements
Tobacco Cessation-Specific Requirements

7.3 Non-Quantitative Treatment Limitation (NQTL) Analysis

Appendix A provides UniCare's, THP's, and Aetna's (Medicaid and Mountain Health Promise) NQTL worksheets. The following provides common findings.

7.3.1 Medical Management

Under the MCO contract, the MCO must provide all contracted services that are medically necessary. All MCOs base medical necessity on federal and state law, member benefits, medical and scientific sources (e.g., peer-reviewed studies), and nationally recognized guidelines including:

- ASAM® Criteria
- InterQual® Criteria
- CMS
- BMS
- American Imaging Management (AIM) Clinical Guidelines
- MCG™
- IngenioRx

Practice guidelines are used to base care on evidence-based medical literature and reduce variation in care, with the goal of improving outcomes.

7.3.2 Utilization Review

All three MCOs perform utilization review (i.e., prior authorization, concurrent review, and retrospective review). For inpatient services, strategies for performing prior authorization include (for MH/SUD and M/S) to confirm eligibility, manage costs by helping to ensure requested services are medically necessary (e.g., to prevent overutilization), and for MH/SUD, to help ensure patients are admitted to the least-restrictive environments. The same strategies apply for concurrent review, but also include connecting patients with the needed resources in anticipation of discharge of the patient. Prior authorization is also performed for inpatient and outpatient services for patient safety reasons—to confirm the procedure is clinically indicated.

Commencing with the last calendar quarter of 2021, MCOs submit quarterly data to BMS to identify MH parity red flags (denials, appeals, overturned denials, credentialing termination and denials, and complaints by MH/SUD and M/S). Pharmacy submits data related to denials, appeals, and overturned denials classified as MH/SUD and M/S.

All three MCOs require their utilization reviewers for MH/SUD and M/S to undergo regular interrater reliability testing and have action plans in place to address any deficiencies. All three MCOs reported interrater scores >90% in the 4th quarter of 2021.

7.3.3 Provider Networks

All three MCOs must meet network adequacy criteria, detailed in the MCO contract. The complete Medicaid 2020 GeoAccess® report, dated November 25, 2020, had several M/S specialist deficiencies (e.g., obstetrician/gynecologist, allergist, audiologist, cardiologist, dermatologist) and no MH/SUD individual provider deficiencies. One county (Wyoming) did not meet the standard for inpatient psychiatric unit, and four counties did not meet the standard for residential SUD providers (adult and pediatric). In these cases, MCOs were required to document how members in these counties would receive services.

7.3.4 Pharmacy

The language in the smoking cessation policy has been updated to be consistent with practice—making the number of attempts a “soft limit.” Smoking cessation requirements are evaluated as an NQTL in Appendix E.

8.0 Compliance Steps

Based on the review, the State will take the following steps:

1) Send a memo to MCOs requiring them to update their beneficiary-facing online materials
    a. One MCO will be asked to clarify in its member handbook that behavioral health does not require a referral.
    b. One MCO will be asked to clarify in its member handbook that emergency psychiatric services are available immediately.
2) Update the state plan pursuant to the August 2021 review, to remove MH/SUD QTLs in FFS benefits (e.g., school-based services).
3) Update the CSED waiver documentation to treat FR and QTLs as “soft limits” (i.e., NQTLs that can be exceeded with medical necessity).
4) Provide an internal compliance plan template (Appendix D) to the MCOs—MCOs will be encouraged to tailor the document to their organization
5) MCOs and Pharmacy will continue the quarterly submission of data to BMS pertaining to MH parity (Appendix A), with an explanation of any unfavorable findings for MH/SUD

Revision #	Revision Date	Description of Changes
Original	April 11, 2023	N/A
1.0	May 8, 2023	Revised Table 3: Table of Contents, Table 1: Common Terms and Acronyms, Non-Pharmacy Benefit Grouping and Classifications, spelled Section Titles out, added Update (Appendix E), and revised NQTL Comparative Analyses (Appendix F).
1.1	June 12, 2023	Several unsubstantial editing and grammatical edits throughout report.

Appendix A: MCO and Pharmacy Quarterly Submissions to BMS

MCO_____

Year_____Quarter_____

Outpatient Prior Authorization Counts by Benefit Type

Benefit Type	# of PA Requests	#of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
MH/SUD							
M/S							

Inpatient Prior Authorization Counts by Benefit Type

Benefit Type	# of PA Requests	#of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
MH/SUD							
M/S							

Enrollment/Credentialing Counts by Provider Type

Provider Type	Average # of Enrolled Providers	# of Providers Terminated	% Terminated	# of Credentialing Requests	# of Credentialing Requests Denied/Not Accepted	% of Credentialing Requests Denied/Not Accepted
MH/SUD						
M/S						

Enrollee Complaints by National Committee for Quality Assurance (NCQA) Category

Provider Type	# Access	# Billing and Financial	# Attitude and Service	# Quality of Care	# Quality of Practitioner Office Site
MH/SUD					
M/S					
Total					

Pharmacy

Year_____Quarter_____

Medication Prior Authorization Counts by Benefit Type

Benefit Type	# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
MH/SUD							
M/S							

Appendix B: Documents Reviewed

Documents reviewed for this report:

Document Name	Source
Memorandum from Susan Hall (BMS) to Aetna dated February 7, 2022, re: ABHWV Provider Network Adequacy Findings	
Aetna Better Health® of West Virginia 2021-2022 Member Handbook Mountain Health Trust – Medicaid 2021-2022 Member Handbook Aetna Better Health® of West Virginia Mountain Health Promise Aetna Better Health® of West Virginia Mental Health Parity Compliance Plan SFY21 Aetna Better Health® of West Virginia Policies: Practitioner and Provider Availability: Network Composition and Contracting Plan Policy Number 6400.06 Effective Date 09/26/2016 Assessment of Network: Adequacy, Availability and Access to Care Monitoring Plan Policy Number 6400.41 Effective Date 05/25/2017 Access to Care Plan Policy Number 6400.45 Effective Date 09/26/2016 Process for Approving and Applying Medical Necessity Criteria Policy Number 7000.30 Effective Date 09/26/2016 Prior Authorization Policy Number 7100.05 Effective Date 09/26/2016 Assessment/Credentialing of Organizational Providers Policy Number QM51A Effective Date 09/26/2016 Credentialing Allied Health Practitioners Policy Number QM53 Effective Date 09/26/2016 Practitioner Credentialing, Recredentialing Policy Number QM54A Effective Date 09/26/2016 Practitioner Application Policy Number QM56 Effective Date 09/26/2016 Delegated Credentialing/Recredentialing Policy Number QM59 Effective Date 09/26/2016 Practitioner Participation and Peer Review Policy Number QM62 Effective Date 12/15/2021 Credentialing Policy and Procedure Development Amendment Policy Number QM75A Effective Date 09/26/2016	Aetna ABHWV_2021-2022_Medicaid HB_final (aetnabetterhealth.com) https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/west-virginia/pdf/abhwv_mountain_health_promise_handbook.pdf

Document Name	Source
Consistency in Applying Clinical Criteria 2021 Annual Evaluation of the Consistency in Applying Clinical Criteria Using Inter-Rater Reliability Testing 11-12-21	
West Virginia Medicaid Managed Care Member Handbook SFY 2022 (July 1, 2021 – June 30, 2022) Medicaid Telehealth Diagnoses CY2022 COVID Policies 2021 Nurse (Prior Authorization) Interrater Reliability Monitoring Report Annual Summary January 2022 2021 Practitioner Competency Monitoring Prior Authorizations Credentialing of Providers, CR-01 Effective 7/30/2021 Credentialing Ancillary Providers, CR-07 Effective 9/14/2021 Credentialing of APRNs (CNP, CNM, CNS) and Physician Assistants, CR-14 Effective 7/30/2021 Interdisciplinary Care Team for Behavioral Health Effective 3/15/2021 Network Analysis (Medicaid 2021 Geo Access Standards) October 29, 2021 Mountain Health Trust Availability and Access Standards Effective 6/3/2021 Mountain Health Trust Care Coordination Program Description Effective 1/3/2022 Mountain Health Trust Covered Service, Utilization Review and Control Effective 9/14/2021 SFY 2022 THP Medicaid Network Response 02222022 Mental Health Parity Compliance Plan for WV Medicaid Prepared for State Fiscal Year 2022	The Health Plan https://www.healthplan.org/application/files/5816/3967/3802/Member_handbook_SFY22_Clean_12142021.pdf
Member Handbook Mountain Health Trust, West Virginia Health Bridge, West Virginia Children's Health Insurance Program Network Submission and Network Adequacy Evaluation CY2021 West Virginia Medicaid Network Analysis Behavioral Health Providers October 19, 2021 West Virginia Medicaid Network Analysis Children Dental October 16, 2021 West Virginia Medicaid Network Analysis Hospitals and Essential Care Providers (ECPs) October 17, 2021 West Virginia Medicaid Network Analysis PCPs and OB/GYN & Certified Nurse Midwife October 16, 2021	UniCare Health Plan of West Virginia, Inc. https://mss.unicare.com/west-virginia/wvwv_caid_mhb_eng_member_link.pdf

Document Name	Source
West Virginia Medicaid Network Analysis – Behavioral Health Supporting Data West Virginia Medicaid Network Analysis – Dental Supporting Data West Virginia Medicaid Network Analysis – Hospitals Supporting Data West Virginia Medicaid Network Analysis – Network Supporting Data UniCare Health Plan of West Virginia Credentialing Policy West Virginia State Specific Credentialing Policy Standards for the Number and Geographic Distribution of Providers – WV Date of Last Revision 01/27/2022 Continued Stay Review/Care Coordination/Discharge Planning – WV Date of Last Revision 02/14/2022 Non-Authorization of Medical Services – WV Date of Last Revision 02/14/2022 Post-service Clinical Claims Review – WV Date of Last Revision 06/17/2021 Application of Utilization Management Criteria – WV Date of Last Revision 02/14/2022	
Bureau for Medical Services Medicaid Policy Manual	https://dhhr.wv.gov/bms/pages/manuals.aspx
Requests for Information (RFI) Written Responses from MCOs	Aetna (Medicaid and Mountain Health Promise), The Health Plan, UniCare
State Fiscal Year 2022 Model Purchase of Service Provider Agreement between State of West Virginia Department of Health and Human Resources Bureau for Medical Services and (Managed Care Organization) (Mountain Health Trust MCO Contract)	https://dhhr.wv.gov/bms/Members/Managed%20Care/Documents/Contracts/WV%20SFY22%20MCO%20MHT%20Model%20Contract%20Clean_FINAL.docslh.pdf
State Fiscal Year 2021 Model Purchase of Service Provider Agreement between State of West Virginia Department of Health and Human Resources Bureau for Medical Services Bureau for Children and Families and Aetna Better Health of West Virginia (Mountain Health Promises MCO Contract)	https://dhhr.wv.gov/bms/Members/Managed%20Care/MHP/Documents/SFY21%20MCO%20Mountain%20Health%20Promise%20Contract%205.18%20%28002%29.pdf

Appendix C: MCO Request for Information

Medicaid: Request for Information – Update 2022

As used in this document:

Acronym	Definition
CPT®	Current Procedural Technology
MCO	Managed Care Organization
MH/SUD	Mental Health/Substance Use Disorder
M/S	Medical/Surgical
PHE	Public Health Emergency
NQTL	Non-Quantitative Treatment Limit
QTL	Quantitative Treatment Limit

General

1. Please provide total Medicaid membership in [the MCO].

COVID-19-Related

1. Since August 2021, what COVID-19-related changes (e.g., utilization review, medical management) have been made that impact MH/SUD services? Please include cessation of temporary measures related to the public health emergency (PHE), as well as any new measures.
2. Please describe other changes that have occurred related to/or that impact MH/SUD services.

Telehealth

1. If available, please provide telehealth utilization data by month for the past 12 months, separated by MH/SUD and M/S.
2. Is there a policy and procedure related to telehealth? If so, please provide.
3. Are there any differences in the authorization or provision of MH/SUD versus M/S services?
4. Does the MCO provide cell phones to members? Please describe.
5. If yes to #4, do members have access to video on the phones? Are they given unlimited calls for MH/SUD or M/S telehealth services? Please explain. [Broadband challenges are acknowledged. The purpose of the question is to understand any differences between the ability to use provided phones for MH/SUD versus M/S services].

Miscellaneous

1. Do behavioral health services remain exempt from copayments? If yes, does the MCO make the lack of copays for behavioral health services known to members? If so, how is it communicated to members?
2. Please add additional Emergency Care CPT® Codes used (see list below).

CPT® Code	Type of Service
99281-99285	Emergency department visit
S9484-S9485	Crisis intervention mental health services
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H2011	Crisis intervention services per 15 minutes

3. Do any of the above emergency CPT® codes (including additional CPT® codes added by MCO in #4) require prior authorization? If so, please describe.
4. For the August 2022 report, the following NQTLs were reviewed for The Health Plan. Are all of these still in place?
    a. Prior authorization (inpatient, outpatient)
    b. Concurrent review (inpatient, outpatient)
    c. Retrospective review (inpatient, outpatient)
    d. Practice guideline selection/criteria (inpatient, outpatient)
5. Does the MCO have any CPT® for MH/SUD benefits (e.g., # of visits that may not be exceeded regardless of prior authorization—also known as, “hard caps”)?

Document Request

1. Please provide current medical management, utilization review, network adequacy, credentialing, and telehealth policies and procedures.

Data Request

1. Please provide interrater reliability testing scores for the past six months. What is considered passing? What remediation steps were taken for non-passing scores?
2. Please provide the most recent network adequacy analysis submitted to BMS.
3. BMS has asked the MCOs to provide the following data on a quarterly basis. While BMS has allowed for the first quarterly submission to take place in May 2022 (for time period

Jan-March 2022), does [the MCO] have any of the following information for the last calendar quarter of 2021? [If previously submitted, you may skip this request].

MCO: October – December 2021[9]

Outpatient Prior Authorization Counts by Benefit Type							
Benefit Type	# of Requests	#of Requests Denied	% of Requests Denied	# of Denials Appealed	% of Denials Appealed	# of Denials Overturned	% of Denials Overturned
MH/SUD							
M/S							
Inpatient Prior Authorization Counts by Benefit Type							
Benefit Type	# of Requests	#of Requests Denied	% of Requests Denied	# of Denials Appealed	% of Denials Appealed	# of Denials Overturned	% of Denials Overturned
MH/SUD							
M/S							

Enrollment/Credentialing Counts by Provider Type						
Provider Type	Average # of Enrolled Providers	# Providers Terminated	% Terminated	# of Credentialing Requests	# of Credentialing Requests Denied/Not Accepted	% of Credentialing Requests Denied/Not Accepted
MH/SUD						
M/S						

Enrollee Complaints by NCQA Category					
Provider Type	# Access	# Billing and Financial	# Attitude and Service	# Quality of Care	# Quality of Practitioner Office Site
MH/SUD					
M/S					
Total					

[9] This is the same information that the MCOs submit quarterly.

Aetna/Mountain Health Promise: Request for Information – Update 2022

Please note: if the answer is the same as for Medicaid, the MCO may note, "Please see Medicaid."

COVID-19-Related

1. Since August 2021, what COVID-19-related changes (e.g., utilization review, medical management) have been made that impact MH/SUD services? Please include cessation of temporary measures related to the public health emergency (PHE), as well as any new measures.
2. Please describe other changes that have occurred related to/or that impact MH/SUD services.

Telehealth

1. If available, please provide telehealth utilization data by month for the past 12 months, separated by MH/SUD and M/S.
2. Are there any differences in the authorization or provision of MH/SUD versus M/S telehealth services?

Miscellaneous

1. Does the MCO collect copayments/coinsurance for MH/SUD services?
2. If your answer is no to #1, how does the MCO make the lack of copays for behavioral health services known to enrollees? If so, how is it communicated?
3. Please provide additional Emergency Care CPT® Codes used (see list below).

CPT® Code	Type of Service
99281-99285	Emergency department visit
S9484-S9485	Crisis intervention mental health services
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H2011	Crisis intervention services per 15 minutes

4. Do any of the above emergency CPT® codes (including additional CPT® codes added by MCO in #3) require prior authorization? If so, please describe.
5. For the August 2022 report, the following NQTLs were reviewed for The Health Plan. Are all of these still in place?

a. Prior authorization (inpatient, outpatient)

b. Concurrent review (inpatient, outpatient)

c. Retrospective review (inpatient, outpatient)

d. Practice guideline selection/criteria (inpatient, outpatient)

6. Does the MCO have any QTLs for MH/SUD benefits (e.g., # of visits that may not be exceeded regardless of prior authorization—also known as, “hard caps”)?

Document Request

1. Please provide current medical management, utilization review, network adequacy, credentialing, and telehealth policies and procedures.

Data Request

1. Please provide interrater reliability testing scores for the past six months. What is considered passing? What remediation steps were taken for non-passing scores?
2. Please provide the most recent network adequacy analysis submitted to BMS.
3. BMS has asked the MCOs to provide the following data on a quarterly basis. While BMS has allowed for the first quarterly submission to take place in May 2022 (for time period Jan-March 2022), does the MCO have any of the following information for the last calendar quarter of 2021? [If previously submitted, the MCO may skip this request].

Outpatient Prior Authorization Counts by Benefit Type							
Benefit Type	# of Requests	#of Requests Denied	% of Requests Denied	# of Denials Appealed	% of Denials Appealed	# of Denials Overturned	% of Denials Overturned
MH/SUD							
M/S							

Inpatient Prior Authorization Counts by Benefit Type							
Benefit Type	# of Requests	# of Requests Denied	% of Requests Denied	# of Denials Appealed	% of Denials Appealed	# of Denials Overturned	% of Denials Overturned
MH/SUD							
M/S							

Enrollment/Credentialing Counts by Provider Type						
Provider Type	Average # of Enrolled Providers	# of Providers Terminated	% Terminated	# of Credentialing Requests	# of Credentialing Requests Denied/Not Accepted	% of Credentialing Requests Denied/Not Accepted
MH/SUD						
M/S						

Enrollee Complaints by NCQA Category					
Provider Type	# Access	# Billing and Financial	# Attitude and Service	# Quality of Care	# Quality of Practitioner Office Site
MH/SUD					
M/S					
Total					

Appendix D

West Virginia Medicaid Managed Care Organization Mental Health Parity Compliance Plan

A Template for Managed Care Organizations for Medicaid Beneficiaries

The managed care organization (MCO) contract with the Bureau for Medical Services (BMS) requires the MCO to submit a Mental Health Parity Compliance Plan annually. The purpose of the Mental Health Parity Compliance Plan is for the MCO to document the processes it has in place to monitor compliance with federal and contractual mental health requirements.

The MCO Mental Health Parity Compliance Plan must contain at a minimum the following sections and content. The MCO may provide additional information as desired.

1.0 Governance

1.1 Identify the role(s) at the MCO designated as responsible for mental health parity compliance and monitoring, including where that role fits in the organization chart.

1.2 Identify and define the roles and responsibilities of any other MCO positions, committees, workgroups, stakeholder groups, etc., involved in monitoring the MCO's mental health parity compliance. Please include an organizational chart that illustrates the flow of reporting from the different MCO areas to the mental health parity lead(s).

2.0 Processes

2.1 Describe the MCO's process for maintaining compliance with the following contractual and federal requirements:

1) The MCO may not impose an aggregate lifetime, annual dollar limits, or other cumulative financial limits on MH/SUD services.
2) The MCO may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or requirement limitation of any type applied to substantially all M/S benefits in the same classification furnished to enrollees, to maintain compliance with the Bureau's Mental Health Parity Plan.

2.2 Describe the MCO's process(es) for ensuring that non-quantitative treatment limits (NQTLs) to MH/SUD benefits reported to BMS annually are applied as written and in operation.

2.3 Describe the MCO's process(es) for:

1) Identifying changes or additions to benefit design and/or operations that may impact mental health parity compliance.
2) Assessing their mental health parity compliance impacts.

2.4 Describe the MCO's process(es) for identifying, communicating internally, and addressing:

1) Early warning signs of an access to MH/SUD care issue.
2) Red flags that an access to MH/SUD care issue is occurring.

2.5 Describe the MCO's process to ensure the requirements of availability of information:

1) Criteria for medical necessity determinations regarding MH/SUD benefits must be made available to enrollees, potential enrollees, and contracting providers upon request.
2) The reasons for any denials of reimbursement or payment for MH/SUD benefits must be made to the beneficiaries.

3.0 Data Collection and Reporting

3.1 Describe the MCO's process(es) for collecting and internal reporting of the required data elements for quarterly mental health parity reporting to BMS.

3.2 Describe what actions the MCO takes when disparate MH/SUD findings are identified.

Required Quarterly Reporting Data Elements:

Outpatient Prior Authorization (PA) Counts by Benefit Type and PA Disposition

- Data Source:
- Process for Compiling Data:

Inpatient Prior Authorization (PA) Counts by Benefit Type and PA Disposition

- Data Source:
- Process for Compiling Data:

Enrollment/Credentialing Counts and Results by Provider Type

- Data Source:
- Process for Compiling Data:

Enrollee Complaints by NCQA Category

- Data Source:
- Process for Compiling Data:

Appendix E: West Virginia Medicaid and Mountain Health Promise Mental Health Parity Update

5/8/2023

WV Medicaid had only one significant change to its benefit structure since the time of the last mental health parity review (April 11, 2022). This change was to add medically necessary gender affirmation surgery as a covered service; therefore, the WV Department of Health and Human Resources (DHHR, Department) Bureau for Medical Services (BMS) elected to perform a review of the non-quantitative treatment limitation (NQTL) comparative analyses because the strategies, processes, and evidentiary standards often differ by managed care organization (MCO). BerryDunn sent requests for information (RFIs) to each of the MCOs providing managed care services to WV Medicaid members, including:

- Aetna Better Health® of West Virginia (Aetna)
- The Health Plan (THP)
- UniCare Health Plan of West Virginia (UniCare)

BerryDunn asked representatives from each MCO to review the 2022 NQTL comparative analyses and update the analyses as needed. After BerryDunn reviewed the updated NQTL comparative analyses, BerryDunn sent additional questions to the MCOs. Most changes to the NQTL comparative analyses were insignificant. BerryDunn also met with the BMS pharmacy director and requested that he complete an RFI and update the pharmacy NQTL comparative analyses. There were no significant changes to the BMS pharmacy policies. The updated MCO and BMS Pharmacy NQTL comparative analyses are provided as Appendix F.

In addition, Section 4 of the Medicaid Mental Health Parity Compliance Documentation (April 11, 2022) list of benefits grouped by MH/SUD and M/S and classified by inpatient, outpatient, and emergency services was updated using the FY2023 Mountain Health Trust MCO Contract and the FY2023 Mountain Health Promise MCO Contract.

On September 1, 2022, the BMS Provider Manual released “Chapter 519.24 Gender Affirmation Surgery.” “Transgender” is an umbrella term used to describe individuals who have a gender identity that does not align with their assigned gender.[10] Gender Dysphoria is defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) as marked incongruence between an individual’s assigned gender and gender identity.[11] Pursuant to the

[10] American Psychological Association. Understanding transgender people, gender identity and gender expression. March 9, 2023. https://www.apa.org/topics/lgbtq/transgender-people-gender-identity-gender-expression.
[11] American Psychiatric Association. What is Gender Dysphoria? August 2022. https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-

Gender Affirmation Surgery policy, WV Medicaid currently covers medically necessary surgical procedures for gender affirmation for gender dysphoria when certain criteria are met and prior authorization is obtained.

The following is an NQTL comparative analysis for NQTLs specifically related to conditions of overage for gender affirmation surgery:

dysphoria#:~:text=Gender%20dysphoria%3A%20A%20concept%20designated,diverse%20people%20experience%20gender%20dysphoria.

Specify terms regarding the NQTL and provide a description of services to which the NQTL applies.	Factors used to determine that the NQTL (conditions of coverage) will apply to gender affirmation services/ surgery.	Evidentiary standards used for the factors in Step 2.	Comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL, as written and in operation, are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to M/S services.	Specific findings and conclusions reached by BMS.
Covered Services (See conditions below): **Male to female** • Orchiectomy • Penectomy • Vaginopasty • Colovaginoplasty • Clitoroplasty • Labiaplasty • Augmentation Mammoplasty • Perineoplasty **Female to male**	**Patient safety:** Members require a safe and effective hormone regimen and surgery monitored by healthcare providers who have expertise in gender-affirming care. Confirmation that surgery will promote health and well-being of the member.	World Professional Association for Transgender Health (WPATH) Standards of Care[12] Endocrine Society Clinical Practice Guidelines[13]	Gender affirmation surgery is a unique procedure involving mental health and medical/surgical (M/S) providers. There are M/S procedures that would provide a suitable comparison. Hormone therapy for gender-affirming purposes does not require prior	Gender-affirming surgery involves complexities absent in other types of surgical procedures. The conditions for coverage for gender-affirming surgery are based on evidenced-based guidelines and intended to provide safe and

• Breast reduction (e.g., mastectomy, reduction mammoplasty) • Hysterectomy • Salpingo-oophorectomy • Colpectomy/ Vaginectomy • Trachelectomy (Cervicectomy) • Vulvectomy • Metoidioplasty • Phalloplasty • Scrotoplasty • Testicular prosthesis implantation ***Conditions of Coverage*** • Members must be 21 years or older prior to being considered for these procedures • Written clinical evaluation documenting eligibility and medical necessity from two qualified mental health professionals demonstrating: ○ Two qualified mental health professionals have separately assessed the member, resulting in a			authorization. Hormone therapy for other M/S diagnoses require prior authorization and laboratory hormone level testing.	effective treatment.

[12] WPATH. World Professional Association for Transgender Health. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Version 7. www.wpath.org.
[13] Hembree W, Cohen-Kettenis P, Gooren L, et.al., Endocryne Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline.

diagnosis of Gender Dysphoria meeting DSM-V criteria; and ○ The qualified mental health professionals are unaffiliated • Completion of at least 12 months of living as a transgender male to female or female to male • Documentation of 12 months of hormone therapy as appropriate to the member's gender goals • Documentation of follow-up every three months during the first year of hormone therapy to monitor hormone levels • Documentation that the member has received counseling about the risks, benefits, and alternatives of hormone therapy and surgery				

Appendix F: NQTL Comparative Analyses

Contents

Table of Acronyms

Acronym	Definition	Acronym	Definition
ACT	Assertive Community Treatment	MDOC	Medical Director Oversight Committee
AHRQ	Agency for Healthcare Research and Quality	MH	Mental Health
AICD	Automatic Implantable Cardioverter Defibrillator	MHPAEA	Mental Health Parity and Addiction Equity Ac
ASAM®	American Society of Addiction Medicine	MPI	Myocardial Perfusion Imaging
BHP	Behavioral Health Provider	MPTAC	Medical Policy Technology Assessment Committee
BMS	Bureau for Medical Services	MRA	Magnetic resonance angiography
CAD	Coronary Artery Disease	MRI	Magnetic Resonance Imaging
CALOCUS	Child and Adolescent Level of Care Utilization System	M/S	Medical/Surgical
CASII	Child and Adolescent Service Intensity Instrument	NCQA	National Committee for Quality Assurance
CDC	Centers for Disease Control and Prevention	NQTL	Non-Quantitative Treatment Limit
CMO	Chief Medical Officer	PA	Prior Authorization
CMS	Centers for Medicare & Medicaid Services	P&T	Pharmaceutical and Therapeutics
CPB	Clinical Policy Bulletins (Aetna)	PCP	Primary Care Provider
CQI	Continuous Quality Improvement	PDL	Preferred Drug List
CSU	Crisis Stabilization Unit	PET	Positron Emission Tomography
CT	Computerized Tomography	PH(P)	Partial Hospitalization (Program)
CTA	Computed Tomography Angiography	PQIC	Physician Quality Improvement Committee
DHHR	Department of Health and Human Services	PRSS	Peer Recovery Support Services
DME	Durable Medical Equipment	PRTF	Psychiatric Residential Treatment Facility

Acronym	Definition	Acronym	Definition
DUR	Drug Utilization Review	PSCCR	Post-Service Clinical Claim Review
ECT	Electroconvulsive Treatment	QAPI	Quality Assurance and Performance Improvement
EEG	Electroencephalography	QI	Quality Improvement
E&M	Evaluation and Management	QM	Quality Management
FDA	Food & Drug Administration	RDTP	Rational Drug Therapy Program
FDB	First Data Bank	RDUR	Retrospective Drug Utilization Review
FQHC	Federally Qualified Health Center	Rx	Pharmacy
HEDIS	Healthcare Effectiveness Data and Information Set	SAMHSA	Substance Abuse and Mental Health Services Administration
HID	Health Information Design	SIC	Service Improvement Committee
ICER	Institute for Clinical and Economic Review	SIU	Special Investigations Unit
IOP	Intensive Outpatient Program	SPECT	Single Photon Emission Computed Tomography
L(I)CSW	Licensed (Independent) Clinical Social Worker	SUD	Substance Use Disorder
LOCUS	Level of Care Utilization System	THP	The Health Plan
LPC	Licensed Professional Counselor	TOC	Transition of Care
MCG™	Milliman Care Guidelines™	UM	Utilization Management
MCO	Managed Care Organization		

1.0 UniCare: Medicaid

1.1 UniCare: Prior Authorization, Retrospective Review, and Concurrent Review

PA, Concurrent Review, and Retrospective Review – Inpatient To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
Inpatient hospital services including: • Psychiatric residential treatment facility • Inpatient psychiatric • Inpatient detoxification • Inpatient SUD treatment	All inpatient services except emergency and obstetrical care including: • Long-term acute care facility • Rehabilitation facility admissions • Inpatient hospice • Newborn stays beyond federally mandated time frames	Inpatient MH/SUD services are assigned PA because: • PA assures the least restrictive safe environment to promote dignity and function • These are high-cost services and PA provides an opportunity to reduce unnecessary costs by preventing overutilization through medical necessity review and facilitating	• Evidence of the high cost of inpatient services includes monthly and annual cost and utilization reports • For these services, high variability in length of stay The following data sources may be used in utilization monitoring: • Claims reports • Member complaints, denials, approvals, and appeals analysis • Authorization/cost reports • Audits of appropriate clinical criteria • HEDIS findings • Focus studies that evaluate access to care, use of preventative care	• PA must be obtained prior to admission, except in the case of emergencies, when notification is required within 24 hours of admission. UM staff will request clinical information from the hospital on the same day they are notified of the member's admission • All inpatient and residential services regardless of MH/SUD or M/S designation must be made via phone, fax, or electronic request • Decision and screening criteria are designed to assist UM Program associates in assessing the appropriateness of care and length of stay for clinical health situations. Application of criteria is not absolute but based upon the	• Initial authorization limits vary based on medical necessity review • The duration of initial authorizations for acute inpatient care vary based on medical necessity review When a member's hospital stay is expected to exceed the number of days authorized during preservice review, or when the inpatient stay did not have preservice review, the hospital must contact UniCare for continued stay review. UniCare requires clinical reviews on all members admitted as inpatients to: • Acute care hospitals (including MH/SUD) • Intermediate facilities • Inpatient rehabilitation facilities The decision to approve, deny, or modify post-service requests is made within 30 calendar days of PSCCR's	• NQTL Self-Compliance Tool for Utilization Management Reviews has been developed • 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. These results are analyzed and reported to the UM Committee. Reviewers must score 90% or above • UniCare monitors authorization requests, approvals, denials, and appeals to ensure parity for M/S and MH/SUD

PA, Concurrent Review, and Retrospective Review – Inpatient To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
		discharge planning • High variability in length of stay • Only non-emergent inpatient services have PA	services, and other services UniCare Medicaid staff reviewers use the following criteria when making a medical necessity determination: • Applicable state and federal guidelines • Member benefits • Medical policy and clinical guidelines applicable to UniCare • Physician specialty societies where publicly available for peer-reviewed literature, including AHRQ • MCG™ Evidence-Based Clinical Guidelines • ASAM® • Carelon Rx Clinical Criteria • UniCare policies and procedures	individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems • UniCare applies evidenced-based and consensus-driven criteria for UM screening and decisions in accordance with the member's specific benefit plan. Actively practicing physicians are involved in the development and adoption of the review criteria • Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the PQIC • The decision to approve, modify, or deny requested non-urgent, non-electronic preservice requests made within seven calendar days of receiving the request, within	receipt of request. If the decision is a denial or modification, the provider is also notified electronically or in writing within 30 days of the receipt of the request	

PA, Concurrent Review, and Retrospective Review – Inpatient To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			• UniCare behavioral health medical necessity criteria, as applicable • Carelon Clinical Appropriateness Guidelines • Member characteristics/factors/ circumstances • Characteristics of the local delivery system that are available for the particular patient	which time the provider will be notified of the decision • The decision to approve, modify, or deny requested non-urgent, preservice, electronic requests is made within two business days, as long as all information is included in the request. If additional information is required, then the decision will be made within seven calendar days • Written or electronic confirmation of deferrals, denials, modifications, reductions, suspensions, or terminations of covered services will be sent to provider and member within seven calendar days of the request • The decision and notification to approve, modify, or deny requested urgent or expedited services are made as expeditiously as the member's health condition requires, and		

PA, Concurrent Review, and Retrospective Review – Inpatient To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				no later than within two business days or three calendar days of receipt of request (whichever is the least from the request receipt date) • UniCare makes decisions regarding approval or denial of urgent care continued stay services within two business days or three calendar days of the receipt of request (whichever is the least from the request receipt date) • 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 identification card.		

PA, Concurrent Review, and Retrospective Review – Inpatient To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				If the PCP does not respond within one hour, all necessary services will be considered authorized • Non-clinical administrative staff gather information and conduct pre-review screening under the guidance and direction of licensed health professionals • Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care) • The clinician reviewer can approve the requested services after establishing medical necessity. If the clinical information submitted does not allow an approval decision to be made, the reviewer will forward the request to a peer clinical reviewer		

PA, Concurrent Review, and Retrospective Review – Inpatient To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				• Only a licensed medical professional can deny an authorization request. The provider may request a peer-to-peer to discuss the care, submit a reconsideration, and/or can appeal the decision • Except in an emergency, failure to obtain PA may result in a denial for reimbursement • Per the Post-Service Clinical Claims Review policy, the provider can submit clinical information with the claim if it has been more than three business days since discharge but the provider believes there is an administrative exception		

1.2 UniCare: Outpatient Prior Authorization

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• Partial Hospitalization Program • Intensive outpatient services • Psychology and neuropsychology testing • Community psychiatric supportive treatment, after first three days of treatment • Out-of-network services • Behavioral health services do not need a referral/behavioral health screening and assessment does not require PA • ECT	• Advanced radiology services, CT, MRI, PET scan • Out-of-network services • DME • Genetic testing • Home healthcare services, including hospice care • Drug screenings Select outpatient surgeries/ procedures, including but not limited to: • Hysterectomy • Bariatric surgery	• Because of their potential for overutilization • For patient safety (e.g., ECT) • To control costs • To avoid waste and abuse of Medicaid funds • To ensure services are meeting their objectives	**MH/SUD** Evidence of the utilization of outpatient services includes monthly and annual cost and utilization reports • In UniCare's experience, psychological and neuropsychological testing, comprehensive support, inpatient E&M services, ACT, IOP, and CSU are frequently ordered inappropriately • Medical necessity is based on national guidelines and reviewed annually by the internal medical advisory Committee	**MH/SUD** UniCare Medicaid staff reviewers use the following criteria when determining medical necessity: • 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 • ASAM® • UniCare policies and procedures	• Initial authorization limits vary based on medical necessity review • Some services require continued review after predetermined visits (e.g., for physical, occupational, and speech therapy, the "soft limit" is 10 visits before authorization is required) • The Preservice Continued Review Process enables the extension of previously approved, ongoing courses of treatment. It follows the same process as described above	• The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability, and these results are analyzed and reported to the UM Committee • UniCare monitors authorization requests, approvals, denials, and appeals to ensure parity for M/S and MH/SUD • NQTL Self-Compliance Tool for Utilization Management Reviews has been developed

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• Peer Recovery Support Services			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	• UniCare behavioral health medical necessity criteria, as applicable • Carelon Clinical Appropriateness 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		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			For patient safety, nationally recognized standards of care and practice from sources including: • NCQA • American Psychiatric Association • ASAM® Treatment • National Alliance on Mental Illness • SAMHSA • Cumulative professional expertise and experience Evidence of the utilization of outpatient services includes monthly and annual cost and utilization reports **M/S** Evidence of the utilization of outpatient	plan and the capability of healthcare delivery systems • UniCare applies evidenced-based and consensus-driven criteria for UM screening and decisions in accordance with the member's specific benefit plan. Actively practicing physicians are involved in the development and adoption of the review criteria • Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the PQIC • The treating physician or provider initiates a preservice/ urgent preservice request prior to		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			services includes monthly and annual cost and utilization reports • In UniCare's experience, physical therapy, speech therapy, inpatient E&M services, venous ablation, hysterectomy, DME, orthotics, prosthetics, nuclear cardiology, and septoplasty are frequently ordered inappropriately • Medical necessity is based on national guidelines and reviewed annually by the internal medical advisory Committee The following data sources may be used in utilization monitoring:	rendering services to the member • The provider may submit PA requests by fax, telephone, or electronic submission using approved forms • UniCare only collects information necessary to perform utilization review and only requires submission of the section(s) of the medical record necessary for each case reviewed, to not be overly burdensome for the member, provider, or the healthcare delivery organization's staff • **Pre-Review Process:** Non-clinical administrative staff gather information and conduct pre-review screening under the guidance and direction of		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			• Claims reports • Member complaints and appeals analysis • HEDIS findings • Focus studies that evaluate access to care, use of preventative care services, and other services **M/S** • 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	licensed health professionals • **Review of Medical Necessity:** Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care) • The clinician reviewer can approve the requested services after establishing medical necessity. If the clinical information submitted does not allow 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		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			indications and/or for patients for whom spinal injections 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	services for lack of medical necessity • Except in an emergency, failure to obtain PA may result in a denial for reimbursement • The decision to approve, modify, or deny requested non-urgent, non-electronic preservice requests is made within seven calendar days of receiving the request, within which time the provider will be notified of the decision • The decision to approve, modify, or deny requested non-urgent, preservice, electronic requests is made within two business days, as long as all information is included in the request. If additional information is required, then the decision will be		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				made within seven calendar days • Written or electronic confirmation of deferrals, denials, modifications, reductions, suspensions, or terminations of covered services will be sent to provider and member within seven calendar days of the request • The decision and notification to approve, modify, or deny requested urgent or expedited services are made as expeditiously as the member's health condition requires, and no later than within two business days or three calendar days of receipt of request (whichever is the least from the request receipt date) • UniCare makes decisions regarding approval or		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				denial of urgent care continued stay services within two business days or three calendar days of the receipt of request (whichever is the least from the request receipt date) **M/S** UniCare Medicaid staff reviewers use the following criteria when determining medical necessity: • Applicable state and federal guidelines • Member benefits • Medical policy and clinical guidelines applicable to UniCare • Physician specialty societies that publish peer-reviewed literature, including AHRQ • MCG™ Evidence-Based Clinical Guidelines		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				• UniCare policies and procedures • Carelon Appropriateness Guidelines • Carelon Rx Clinical Criteria • 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		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and 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 MPTAC and the PQIC • The treating physician or provider initiates a preservice/ urgent preservice request prior to		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				rendering services to the member • The provider may submit PA requests by fax, telephone, or electronic submission • **Pre-Review Process:** Non-clinical administrative staff gather information and conduct pre-review screening under the guidance and direction of licensed health professionals • **Review of Medical Necessity:** Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care)		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				• 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 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 PA may result in a denial for reimbursement • The decision to approve, modify, or deny requested non-urgent, non-electronic preservice requests are made within seven calendar days of receiving		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				the request, within which time the provider will be notified of the decision • Written or electronic confirmation of deferrals, denials, modifications, reductions, or suspensions of covered services will be sent to the provider and member within seven calendar days of the request • The decision and notification to approve, modify, or deny requested urgent or expedited services are made as expeditiously as the member's health condition requires, and no later than within two business days or three calendar days of receipt of request (whichever is the least from the request receipt date)		

Outpatient PA: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				• UniCare makes decisions regarding approval or denial of urgent care continued stay services within two business days or three calendar days of the receipt of request (whichever is least from the request receipt date)		

1.3 UniCare: Medical Necessity Criteria

Medical Necessity Criteria: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
Refers to all contractually obligated services	Refers to all contractually obligated services	N/A	• Review of denials/approvals, appeals/overturned appeals, along with authorization volume/cost and the continued presence of appropriate clinical criteria are done on a semi-annual basis for each service on PA • Medical necessity criteria based on national guidelines are reviewed annually by the internal medical advisory Committee The Clinical Review Hierarchy is as follows: • Federal and state mandates • Member benefits (contract language, including definitions and	**MH/SUD** • PA is performed by a registered nurse, LCSW, LICSW, psychologist, or LPC • If the registered nurse, LCSW, LICSW, psychologist, or LPC cannot approve the service based on medical necessity criteria review, the case will go to the physician for review • Only a physician can deny an authorization request • PRTF admissions require a mandatory physician review upon admission and as required • Policies and procedures reflect this process **M/S** • PA is performed by a registered nurse • If the registered nurse cannot approve the service based on medical necessity criteria	Medical necessity criteria is based on national guidelines and reviewed annually by the internal medical advisory Committee	• NQTL Self-Compliance Tool for UM reviews has been developed. Reviewers are audited annually for inter-rater reliability and must score 90%

Medical Necessity Criteria: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			specific contract provisions/exclusions) • Elevance medical policies • Carelon Clinical Appropriateness Guidelines (diagnostic imaging, sleep diagnostic and treatment management guidelines) are approved for use by MPTAC • Elevance Clinical UM Guidelines • MCG™ care guidelines • Other vendor documents (e.g., Orthonet, American Specialty Health) • ASAM® • Carelon Rx Clinical Criteria	review, the case will go to the physician for review • Only a licensed medical professional can deny an authorization request • Acute Inpatient Rehab admission and continued stay requires a mandatory physician review • Policies and procedures reflect this process		

1.4 UniCare: Practice Guidelines

Medical Necessity Criteria: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
Practice guidelines are available for a variety of behavioral health disorders commonly seen	Practice guidelines are available for a variety of medical conditions	• To base care on evidenced-based medical literature and reduce variation in care • To improve outcomes	UniCare adopts nationally recognized clinical practice guidelines and encourages physicians to use these guidelines to improve the health of members	• The guidelines, which UniCare uses for quality and disease management programs, are based on reasonable medical evidence • Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the PQIC	• Physicians are encouraged to use available guidelines	Guidelines are updated when changes are made in national guidelines, new technology advances are made, and/or changes occur in recent medical resource

1.5 UniCare: Network Size

Medical Necessity Criteria: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
UniCare is obligated to meet required patient-to-provider ratios for all services it is contractually obligated to provide	UniCare is obligated to meet required patient-to-provider ratios for all services it is contractually obligated to provide	• To develop and maintain an adequate provider/practitioner network capable of meeting the healthcare needs of UniCare MCO membership in an accessible way and in accordance with plan contract requirements	• The MCO must establish a sufficient number of providers to maintain sufficient access in accordance with Bureau for Medical Services' Medicaid managed care network standards, state regulations, accreditation standards for all enrollees • To be included in the network, a provider must meet all credentialing requirements (in accordance with NCQA and state/UniCare requirements) and sign a contract	• UniCare allows out-of-state providers to join the network if they are located in states bordering West Virginia • UniCare uses the time/distance requirements in the MCO Contract • If no in-network provider is available to provide the medically appropriate care or the member meets continuity of care criteria, UniCare will authorize out-of-network care • Members may access emergency care in or out of network	The MCO is required to meet Medicaid's managed care network standards for all enrollees; exceptions are permitted when travel time to a provider is better than what exists in the community at large	• Annually, UniCare reviews the geographic market and network adequacy for specialties; these are reviewed by the health plan, network relations, and modified as needed

Medical Necessity Criteria: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			agreeing to all UniCare policies/regulations and rates			

2.0 The Health Plan

2.1 The Health Plan: Prior Authorization and Concurrent Review/Inpatient

Prior Authorization and Concurrent Review/Inpatient: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• Elective Inpatient Care • Tertiary Care • Out-of-Network Care • SUD Rehabilitation • Psychiatric Residential Treatment Facilities <21 years of age	• Elective Inpatient Care • Tertiary Care • Out-of-Network Care • Elective Obstetric Care • Medical Rehabilitation • Long-Term Acute Care Hospital	• Proactive assessment of the member receiving the most appropriate care and treatment at the most appropriate facility • Medical necessity review of the elective service based on the individualized need of the member and coverage supported by the contracted benefit plan utilizing nationally recognized criteria • Preauthorization of elective admission is performed to confirm eligibility, benefits, and appropriateness of services to be	• Monthly, the chief medical officer (CMO), in conjunction with the Director of UM and Director of Clinical Programs for analyzing utilization data and identifying areas of concern • The CMO presents quarterly summaries of utilization information to the CQI Committee. Utilization data assists with updating the list of services requiring PA, and the list of services requiring PA is updated at least annually and revised	• Preauthorization is not required for urgent admissions—notification is required as soon as practically possible after admission • Reviews are conducted of members' acute care hospitalizations as clinically indicated, by telephone or facsimile and decisions are based on medical necessity • Concurrent review is performed telephonically or by facsimile and involves communication with practitioners, hospital utilization review and social services staff, and family members as necessary • Gender affirming care: Assessment by two mental health professionals, with a	• Evidence-based criteria is the basis of all decisions • Members are regarded as individuals with specific care needs (e.g., age, living conditions, support systems, etc., taken into consideration) • Only a physician may make an exception or issue a denial related to a pre-service determination • No vendors are utilized for MH/SUD or M/S concurrent review • Each practitioner who makes medical review necessity decisions will have randomly selected cases evaluated quarterly--individual results will be tabulated and reviewed by the CMO and reported to the Executive Committee as part their oversight annually	• Complaints for MH/SUD and M/S enrollees are addressed and reviewed for opportunities for improvement • Utilization tracking and trending is reviewed by the CMO monthly and is reported at a minimum of quarterly to the CQI Committee • Annual report of inter-rater reliability assessment results • Monthly monitoring of denials by type (administrative/medical necessity) • Member complaints and appeals data are collected and analyzed for evidence that NQTLs are applied more stringently to MH/SUD **M/S** • The Health Plan has a 30-day readmission review policy to examine appropriate utilization practices in the inpatient setting

Prior Authorization and Concurrent Review/Inpatient: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
		rendered and level of care to be utilized • Continuing necessity review for inpatient level of care for oversight of efficacy and quality of care, coordination of care/discharge planning/transitional care planning to facilitate effective timely transition to appropriate lower level of care • Concurrent review is performed to assist with discharge planning to ascertain quality of care and allows for identification of patients with potential discharge planning needs • Patients are referred by the nurse inpatient	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 • Review of preauthorization lists, denial rate reports, and out-of-network reports	written clinical evaluation by a mental health professional. • Gender affirming care: Review of documentation to determine required steps have been met prior to procedure (12 continuous month of living as transgender; 12 months continuous hormone therapy; follow up every 3 months during first year of hormone therapy; documentation of counseling about risks, benefits, etc. of procedure). **MH/SUD** • Members of THP are afforded direct access to behavioral healthcare, meaning they have no need to obtain a preauthorization in times of crisis or to be directed for evaluation of a behavioral health issue **Concurrent Review-MH/SUD** Concurrent review frequency is determined by InterQual criteria	• Collected scores will be used as a basis for individual assessment and for CQI within the group Practitioner Inter-rater reviews: • Practitioner inter-rater review will be performed at least quarterly and analyzed annually • Compliance of 90% or greater is acceptable • Ad hoc reviews may be performed at any time as part of a performance evaluation • Annual results will be reported to Medical Director Oversight Committee (MDOC) and to the CQI Committee	

Prior Authorization and Concurrent Review/Inpatient: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
		navigator to the Behavioral Health Transition of Care program upon admit for the TOC manager to work with the facilities on transition of care and safe discharge planning **MH/SUD** • Individuals with MH conditions should be treated in the least restrictive environment and in a manner designed to preserve their dignity and autonomy, and to maximize the opportunities for recovery • To ensure factors such as the member's age, living conditions, support systems, past medical/surgical history, and network		and acuity of member. Frequently occurs as often as every one to two days. **Concurrent Review-M/S** Concurrent review is determined by InterQual criteria, acuity of the member, and input from the medical director. Frequently occurs as often as daily.		

Prior Authorization and Concurrent Review/Inpatient: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
		capabilities are considered				

2.2 The Health Plan: Outpatient Prior Authorization (PA)

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		Strategy: Why is the NQTL assigned to these services?	Evidentiary Standard: What evidence supports the rational for the assignment?	Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	In Operation: How frequently or strictly is the NQTL applied?	Evidentiary Standard: What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• Outpatient ECT • Urine Drug Testing • IOP (after 30 sessions/days) • ACT • Genetic, pharmacokinetic, pharmacogenomics, and pharmacodynamics testing • Peer Review Recovery Support – 90 units of PRSS is given without authorization at the beginning of each month, additional units require prior authorization • Out-of-area and out-of-network care • PHP (after 30 sessions/days)	• All out-of-network care per plan design • All services require preauthorization per plan design (tertiary care) • CT/MRI/MRA • CT angiography (CTA) for Coronary Artery Disease (CAD) • Cardiac Imaging (CT/MRI/PET) • Urine drug testing • CT/CTA • MPI (Nuclear Stress) • Echo/Echo Stress • Medical Procedures (including services	PA is required for the following reasons: • Quality of care/Patient safety • Correct level of care • Coordination of care • Overutilization • Case management • High-cost services • Determine benefit limits • Confirm most appropriate care, treatment, and setting • Perform medical necessity review of the service with consideration of the individualized need of the member • All reviews for medical appropriateness by THP are determined by written criteria that are based on medical evidence	Utilization data is monitored monthly and annually to identify potential patterns of underutilization and overutilization • Established thresholds are used to detect inappropriate utilization • Contributing causes are identified, and effective interventions are developed • A summary report of monthly referrals regarding the authorization of services and denials is reviewed to determine the rate of authorization and	The UM program specifies the use of qualified health professionals whose education and experience are commensurate with the UM reviews or member navigation they perform • All care/complex case and chronic disease navigation, preauthorization, and inpatient navigation decisions are made by individuals who have knowledge and skills to evaluate working diagnoses and proposed treatment plans • All registered nurses and social workers maintain, and show proof of, continued licensing and continuing education, credentialing, and	• Nationally recognized, evidence-based criteria is the basis of all decisions; however, review decisions are not made solely based on criteria. Members are regarded as individuals with specific care needs. • Only a physician may make an exception or issue a denial related to a pre-service determination. • Evicore is the only vendor performing M/S services for Medicaid member elective procedures, and their inpatient PA review is limited to spinal surgery. EviCore is NCQA accredited and subject to external audit in that fashion as well as	• Complaints for MH/SUD enrollees are addressed and reviewed for opportunities for improvement • Utilization tracking and trending is reviewed by the CMO monthly 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)

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		Strategy: Why is the NQTL assigned to these services?	Evidentiary Standard: What evidence supports the rational for the assignment?	Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	In Operation: How frequently or strictly is the NQTL applied?	Evidentiary Standard: What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• Crisis Stabilization Unit (CSU) (after 144 units) (Emergent Care) • Ambulance/ambulette – non-emergent	related to spine management) • Ambulatory services (including ambulatory blood pressure monitoring) • Ancillary providers and services (including ambulance/ambulette – non-emergent) • New medical technologies (including artificial urinary sphincter)		any need for continued preauthorization of the services • Clinical Analytics program analyzes cost drivers, quality of services, and care delivery to provide support for PA assignment • Review of preauthorization lists, pre-service denial reports • Any outpatient pre-service that requires preauthorization is reviewed through the use of evidence-based criteria (InterQual, ASAM®, CMS/BMS criteria, , Hayes, UpToDate) and/or expert medical review	certification, when appropriate • Those who are certified complex case navigators maintain continued certification in complex case navigation • All registered nurses in the medical and behavioral health units are hired as per the qualifications required in the job description for a nurse navigator • A senior-level physician oversees the UM program, and a designated behavioral healthcare practitioner oversees the behavioral health aspects of the program • Management staff (director, managers, supervisors) have day-to-day involvement in medical department and	sharing data with THP monthly • Each practitioner who makes medical review necessity decisions will have randomly selected cases evaluated quarterly. Individual results will be tabulated and reviewed by the Medical Directors Oversight Committee and reported to the Executive Committee as part of their oversight annually. Collected scores will be used as a basis for individual assessment and for CQI within the group Practitioner Inter-rater reviews: • Practitioner inter-rater review will be performed at least quarterly and analyzed annually	

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		Strategy: Why is the NQTL assigned to these services?	Evidentiary Standard: What evidence supports the rational for the assignment?	Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	In Operation: How frequently or strictly is the NQTL applied?	Evidentiary Standard: What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				behavioral health activities daily and dedicated MH/SUD and MDs are available after regular business hours • Management staff participate in staff training, conduct staff meetings with responsibility for agendas and minutes, and provide guidance during “grand rounds” • Management staff complete inter-rater reliability review as per the Inter-rater Review Reliability Monitoring Policy • All non-authorizations of services that result from a determination of medical appropriateness are made by a licensed practitioner. This ensures that appropriate clinical judgment is used in making the denial determination. The	• Compliance of 90% or greater is acceptable • Ad hoc reviews may be performed at any time as part of a performance evaluation • Annual results will be reported to MDOC and to the CQI Committee	

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		Strategy: Why is the NQTL assigned to these services?	Evidentiary Standard: What evidence supports the rational for the assignment?	Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	In Operation: How frequently or strictly is the NQTL applied?	Evidentiary Standard: What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				practitioner(s) maintains continued licensing without restriction and board certification if applicable • Managed care experience in a managed care setting or behavioral health preferred • Any non-authorization of care or service based on medical appropriateness is reviewed by a practitioner, dentist, behavioral health practitioner, or pharmacist, as appropriate--the non-authorization rationale is documented in the system with electronic practitioner signature, date, and time • All cases that require clinical judgment outside the expertise of the medical directors are reviewed by Advanced		

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		Strategy: Why is the NQTL assigned to these services?	Evidentiary Standard: What evidence supports the rational for the assignment?	Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	In Operation: How frequently or strictly is the NQTL applied?	Evidentiary Standard: What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				Medical Review, THP's specialty review company The following staff may approve services: • Staff who under the supervision of an appropriately licensed health professional, when there are explicit UM criteria, and no clinical judgment is required • Licensed healthcare professionals		

2.3 The Health Plan: Inpatient Retrospective Review

Inpatient Retrospective Review: To which benefits is the NQTL assigned?		Strategy: Why is the NQTL assigned to these services?	Evidentiary Standard: What evidence supports the rational for the assignment?	Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	In Operation: How frequently or strictly is the NQTL applied?	Evidentiary Standard: What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• Elective inpatient care • Tertiary care • Out-of-network care • SUD	• All elective inpatient care • Out-of-network/out-of-area care • All elective C-sections and all elective inductions • Tertiary care	Retrospective review takes place to determine if a stay, in part or totally, was medically appropriate	• See prior authorization and concurrent review. • Retrospective review is for those stays that should have received prior authorization.	• Registered 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	• Retrospective review is conducted only when THP is informed of an admission after the admission has taken place • All inpatient admissions that are not initially authorized undergo retrospective review Department • ASAM® Criteria, InterQual criteria, and BMS criteria are used	• 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 are collected and analyzed for evidence that NQTLs are applied more stringently to MH/SUD

2.4 The Health Plan: Medical Necessity Criteria

Medical Necessity Criteria: To which benefits is the NQTL assigned?		Strategy: Why is the NQTL assigned to these services?	Evidentiary Standard: What evidence supports the rational for the assignment?	Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	In Operation: How frequently or strictly is the NQTL applied?	Evidentiary Standard: What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
Refers to all contractually obligated services	Refers to all contractually obligated services	N/A	Nationally recognized criteria is utilized. Interqual, ASAM®, CMS/BMS, review of medical and scientific sources including peer-reviewed studies in medical journals that meet nationally recognized standards including sources such as Hayes Inc., National Institute of Health's National Library of Medicine, Federal AHRQ, National Comprehensive Cancer Network, and others	Medical necessity reviews are performed during all utilization reviews (prior authorization, concurrent review, retrospective reviews)	All contractually obligated services must be medically necessary	Quarterly monitoring and reporting to appropriate Committees of service authorizations and member complaints and appeals including: • Number of service authorizations requested • Number of service authorizations denied • Number of denied service authorizations with member appeal • Number of denied service authorizations with member appeal upheld • Number of denied service authorizations with member appeal reversed • Complaints by NCQA category (quality of care, access, attitude & service, billing and financial; and quality-of-office site) • The Service Improvement Committees reviews all the above

Medical Necessity Criteria: To which benefits is the NQTL assigned?		Strategy: Why is the NQTL assigned to these services?	Evidentiary Standard: What evidence supports the rational for the assignment?	Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	In Operation: How frequently or strictly is the NQTL applied?	Evidentiary Standard: What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
						for Parity Rule compliance concerns • If there are any indications of potential noncompliance with the Parity Rule exists, the underlying data will be comprehensively reviewed, and if necessary, the appropriate actions will be taken

2.5 The Health Plan: Practice Guidelines

Practice Guidelines: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
Clinical guidelines topics are related to areas determined to be high risk, high volume, and/or problem prone areas are selected	Clinical guidelines topics are related to areas determined to be high risk, high volume, and/or problem prone areas are selected	• Clinical guidelines measure quality across the organization and ensure content is consistent for each condition managed as well as ensuring appropriate practitioner oversight of programs • Evidence-based clinical guidelines are valuable to The Health Plan in analyzing performance, taking action for quality improvement and demonstrating improvement	Evidentiary standard: Interqual, ASAM®, CMS/BMS, review of medical and scientific sources including peer-reviewed studies in medical journals that meet nationally recognized standards including sources such as Hayes Inc., National Institute of Health's National Library of Medicine, Federal AHRQ, National Comprehensive Cancer Network, and other	Practice guidelines require a consistent and uniform approach to their development, accomplished through the following objectives: • Ensuring the involvement of the medical directors, the Quality Improvement Committee, and The Health Plan practitioners • Ensuring the distribution of the guidelines to all applicable practitioners. Our guidelines are on our website for practitioners to access. Practitioners are also notified of their availability • Ensuring the development of methods for the regular evaluation of the delivery of clinical care consistent with guidelines. Clinical practice guidelines will be researched, adopted, and distributed to appropriate participating practitioners to ensure the most current clinical practices are in	• Two non-preventive behavioral health guidelines are available upon request • Topics related to areas determined to be high-risk, high-volume, and/or problem prone areas are selected for additional guideline development • Guidelines are made available to the appropriate practitioners, and they are provided with education	Topics related to areas determined to be high-risk, high-volume, and/or problem prone areas are selected for additional guideline development--this ensures that the topics selected are worthwhile, population-based, and deserving of resource commitment

Practice Guidelines: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				place for the treatment of The Health Plan members • All practice guidelines adopted by The Health Plan are coordinated through the Physician Advisory Committee(s)		

2.6 The Health Plan: Network Size/Adequacy

Network Size/Adequacy: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard**: What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
All benefit services that THP is contractually obligated to provide	All benefit services that THP is contractually obligated to provide	THP must ensure that all covered services including additional or supplemental services contracted by or on behalf of MHT members, are available and accessible • BMS has set minimum provider network adequacy standards that THP must meet or exceed in all areas in which THP operates. THP must comply with all the network adequacy standards in the MCO Contract • The intent of the standards is to provide for access to services at least as good, if not better, than access to care under the traditional Medicaid program	• To ensure a robust network of providers, so enrollees have access to mental health services • The THP provides ongoing care by ensuring availability of high-volume behavioral health practitioners within our delivery system • The behavioral health practitioner network includes psychiatrists, psychologists, counselor/therapists, and social workers, some with sub-specialties	• If THP is unable to provide certain covered services, enrollees may get out-of-network services, and the cost is no greater than in-network services would have been • Enrollees may receive emergency care in- or out-of-network • THP must meet network adequacy standards (adult and pediatric) behavioral health providers and facilities, SUD providers and facilities, and additional providers to promote the objectives of the Medicaid program as determined by CMS • THP is required to comply with updated network standards within 90 calendar days of issuance, unless otherwise agreed to in writing by BMS within 60 calendar days of issuance	THP's goal is to meet or exceed network adequacy goals 100% of the time	• THP should meet network adequacy standards 100% of the time--however, in its sole discretion, BMS allows some exceptions to the provider access standards allowed under limited circumstances (e.g., if no appropriate provider types are located within the mileage standards) • Out-of-network/out-of-area utilization reviews

Network Size/Adequacy: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard**: What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			• Practitioners are available in all areas of THP network • Services are monitored quarterly related to MH and SUD to help ensure that benefits are not more limited in availability, scope, or duration than medical or surgical services in compliance with the MHPAEA • To ensure THP meets or exceeds all geographic network adequacy standards in the MCO contract			

3.0 Aetna: Medicaid and Mountain Health Promise

3.1 Aetna: Inpatient Prior Authorization

Inpatient Prior Authorization To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• MH/SUD Inpatient Services • Psychiatric Residential Treatment Facilities *Medical services for the treatment of an emergency condition, including emergency transportation, crisis intervention/ stabilization, and mobile response, are permitted to be delivered in or out-of-*	• M/S Inpatient Hospital Care • Inpatient Hospice Care, Out-of-Network *Medical services for the treatment of an emergency condition, including emergency transportation, are permitted to be delivered in or out-of-network*	• Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that might be approved, potentially denied, or reduced on the basis of medical necessity • Forward potential denials or reductions to the CMO or designated medical director for review • Ensure the services are in the defined benefits and are appropriate, timely, and cost-effective • Ensure the services to be provided are	**M/H** • The MCO adopts evidenced-based guidelines (e.g., MCG™, ASAM® Criteria) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives The following are clinical criteria/guidelines that might be used when making PA decisions:	• PAs are performed by telephone or facsimile, and decisions are based on medical necessity • For urgent pre-service approvals, decisions are based on need, but no more than two calendar days from receipt of request • For urgent pre-service denials, decisions are based on need, but no more than two calendar days from receipt of request • For non-urgent pre-service approvals, decisions are based on member's need but no more than seven calendar days from receipt of the request • For non-urgent pre-service approvals, decisions are based on member's need but no more than seven calendar	• The MCO annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision-making • A corrective education plan is put into place for staff members who score below Aetna's inter-rater reliability target (95%)	Quarterly monitoring and reporting to appropriate Committees of service authorizations and member complaints and appeals, including: • Number of service authorizations requested • Number of service authorizations denied • Number of denied service authorizations with member appeal • Number of denied service authorizations with member appeal upheld • Number of denied service authorizations with member appeal reversed • Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site) • The Service Improvement Committee (SIC) reviews all of the

Inpatient Prior Authorization To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
network without obtaining prior authorization	*without obtaining prior authorization*	sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished, and that the services are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan	• Criteria required by applicable state or federal regulatory agency • Aetna Medicaid Pharmacy Guidelines for pharmacy criteria • MCG™ (physical and behavioral health evidence-based clinical guidelines that are updated annually) • Level of Care Utilization System (LOCUS), Children & Adolescent Service Intensity Instrument (CASII) • ASAM® Criteria • Aetna Clinical Policy Bulletins (CPBs), which are based on evidence in the peer-reviewed published	days from receipt of the request		above for Parity Rule compliance concerns

Inpatient Prior Authorization To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally-recognized professional healthcare organizations and government public health agencies • Aetna Policy Council Review			

Inpatient Prior Authorization To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			• Other Specialty Criteria by contract[14] The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high-quality, and cost-effective care **M/S** • The MCO adopts evidenced-based guidelines (e.g., MCG™) that are updated annually to			

[14] When ABHWV consults with its vendor Eviti, for oncology/radiation service requests, the determination is reviewed for medical necessity against National Comprehensive Cancer Network (NCCN) Guidelines. NCCN Guidelines are evidence-based and consensus-driven to ensure all patients receive preventive, diagnostic, treatment, and supportive services that will most likely lead to optimal outcomes. The frequently updated guidelines currently apply to 97 percent of cancers affecting patients in the United States

Inpatient Prior Authorization To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives The following are clinical criteria/guidelines that might be used when making prior authorizations decisions: • Criteria required by applicable state or federal regulatory agency • Aetna Medicaid Pharmacy Guidelines for pharmacy criteria • MCG™ (physical and behavioral			

Inpatient Prior Authorization To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			health evidence-based clinical guidelines that are updated annually) • LOCUS, CALOCUS (Child and Adolescent Level of Care Utilization System) or behavioral health criteria • ASAM® Criteria • Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based			

Inpatient Prior Authorization To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			guidelines from nationally-recognized professional healthcare organizations and government public health agencies • Aetna Policy Council Review • Other Specialty Criteria by contract[15] The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and			

[15] When ABHWV consults with its vendor Eviti, for oncology/radiation service requests, the determination is reviewed for medical necessity against National Comprehensive Cancer Network (NCCN) Guidelines. NCCN Guidelines are evidence-based and consensus-driven to ensure all patients receive preventive, diagnostic, treatment, and supportive services that will most likely lead to optimal outcomes. The frequently updated guidelines currently apply to 97 percent of cancers affecting patients in the United States

Inpatient Prior Authorization To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			place of service to achieve timely, high-quality, and cost-effective care			

3.2 Aetna: Outpatient Prior Authorization

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• PH • Services from a Non-Participating Provider (except emergency services) • Clinic Services • Physician Services • Rural Health Clinic Services Including FQHCs • Specialty Care • Behavioral Health Outpatient Services • Psychological Services • Outpatient Hospital Services • Outpatient Psychiatric Treatment • Speech Therapy	• Ambulatory Surgical Center Services • Clinic Services • Children with Special Healthcare Needs Services • Physician Services • Private Duty Nursing • Right From the Start Services • Rural Health Clinic Services including FQHCs • Vision Services • Dental Services • Nurse Practitioners' Services • Nurse Midwife Services	• Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that might be approved, potentially denied, or reduced on the basis of medical necessity criteria • Forward potential denials or reductions to the CMO or designated medical director for review • Ensure requests are processed by urgency of request and provider and/or members are notified of the determination within required time frames • Ensure the services are in the defined benefits, and are appropriate, timely, and cost-effective	**MH/SUD** • The MCO adopts evidenced-based guidelines (e.g., MCG™) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives The following are clinical criteria/guidelines that might be used when making PA decisions: • Criteria required by applicable state or federal regulatory agency	• PAs are performed by telephone or facsimile, and decisions are based on medical necessity • For urgent pre-service approvals, decisions are based on need, but no more than two calendar days from receipt of request • For urgent pre-service denials, decisions are based on need, but no more than two calendar days from receipt of request • For non-urgent pre-service approvals, based on member's need but no more than seven calendar days from receipt of the request • For non-urgent pre-service approvals, based	• 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 (95%)	Quarterly monitoring and reporting to appropriate Committees of service authorizations and member complaints and appeals, including: • Number of service authorizations requested • Number of service authorizations denied • Number of denied service authorizations with member appeal • Number of denied service authorizations with member appeal upheld • Number of denied service authorizations with member appeal reversed • Complaints by NCQA category (quality of care, access, attitude and service, billing and

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• Laboratory Services and Testing • Nutritional Counseling • Tobacco Cessation • School-Based Services • Primary Care Office Visit • Nurse Practitioners' Services • EPSDT • Psychological Testing/Psychiatric Testing • Development Testing: Limited • Development Testing: Extended • Neurobehavioral Status Exam • Neuropsychological Testing Battery	• Primary Care Office Visit • Specialty Care • Podiatry • Chiropractic Services • Diagnostic X-Ray • Outpatient Hospital Services • Hospice if Out-of-Network • Outpatient/ Maternity • Physical Therapy • Occupational Therapy • Speech Therapy • Cardiac Rehabilitation • DME • Orthotics and Prosthetics	• Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished, and that are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan	• Aetna Medicaid Pharmacy Guidelines for pharmacy criteria • MCG™ (physical and behavioral health evidence-based clinical guidelines that are updated annually) • LOCUS, CALOCUS • ASAM® Criteria • Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from	on member's need but no more than seven calendar days from receipt of the request		financial; and quality of office site) The SIC reviews all the above for Parity Rule compliance concerns

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• Individual Psychophysiological Biofeedback Training • CSU • Day Treatment • Therapeutic Behavioral Services-Development and Implementation • Targeted Case Management, Each 15 Minutes • Comprehensive Community Support Services • Psychiatric Diagnostic Evaluation Without Medical Services	• Home Healthcare Services • Laboratory Services and Testing • Diabetes Education • Diabetes Management • EPSDT • Family Planning Services and Supplies • Nutritional Counseling • Tobacco Cessation • Personal Care Services		nationally-recognized professional healthcare organizations and government public health agencies • Aetna Policy Council Review • Other Specialty Criteria by contract[16] The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high-			

[16] When ABHWV consults with its vendor Eviti, for oncology/radiation service requests, the determination is reviewed for medical necessity against National Comprehensive Cancer Network (NCCN) Guidelines. NCCN Guidelines are evidence-based and consensus-driven to ensure all patients receive preventive, diagnostic, treatment, and supportive services that will most likely lead to optimal outcomes. The frequently updated guidelines currently apply to 97 percent of cancers affecting patients in the United States

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
(Initial) or Medical Services • Multifamily Psychotherapy • Initial Evaluation Without Medication Services • Individual Psychotherapy Services • Psychotherapy Patient and Family with E&M Services • Family Psychotherapy (Conjoint Psychotherapy) Occurs with and without Patient Present • Family Psychotherapy (with Patient Present) by Licensed Therapist • IOP	• Abortion Services • School-Based Services • Organ Transplant Services • AICD • Biventricular Pacemaker • Cardiac Catheterization • Chemotherapy • Clinical Trials • CT Scans • Dental Treatment for Dental Accidents (non-emergent) • Genetic Testing • Hyperbaric Oxygen • Injectable and Self-Administered Injectable Drugs (if		quality, and cost-effective care **M/S** • The MCO adopts evidenced-based guidelines (e.g., MCG™) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives The following are clinical criteria/guidelines that might be used when making prior authorizations decisions: • Criteria required by applicable state or			

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• PHP • ACT • Behavioral Health Home Visits • Psychological/Neuropsychological Testing • Outpatient ECT • Psychotherapy Visits, after 12 visits, for Nonbiologically Based Diagnoses • Intensive Outpatient Testing • Psychiatric Diagnostic Interview • Case Consultation • Behavioral Health Counseling, Professional, Individual and Group • MH Assessment (Non-Physician)	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 • Virtual Colonoscopy • Hysterectomy		federal regulatory agency • Aetna Medicaid Pharmacy Guidelines for pharmacy criteria • MCG™ (physical and behavioral health evidence-based clinical guidelines that are updated annually) • LOCUS, CALOCUS • ASAM® Criteria • Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of			

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• MH Service Plan Development • Crisis Intervention • Screening by Licensed Psychologist • Physician Coordinated Care Oversight Services • Developmental Testing • Nonemergency Medical Transportation • *Medical services for the treatment of an emergency condition, including emergency transportation, crisis*	• Tonsillectomy with or without Adenoidectomy • Sleep Studies • Spinal Injections • Video EEG • Radiation Treatments • Venous Ablation • Septoplasty • Nuclear Cardiology • *Medical services for the treatment of an emergency condition, including emergency transportation, are permitted to be delivered in or out-*		healthcare providers, and evidence-based guidelines from nationally-recognized professional healthcare organization and government public health agencies • Aetna Policy Council Review • Other Specialty Criteria by contract[17] The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation,			

[17] When ABHWV consults with its vendor Eviti, for oncology/radiation service requests, the determination is reviewed for medical necessity against National Comprehensive Cancer Network (NCCN) Guidelines. NCCN Guidelines are evidence-based and consensus-driven to ensure all patients receive preventive, diagnostic, treatment, and supportive services that will most likely lead to optimal outcomes. The frequently updated guidelines currently apply to 97 percent of cancers affecting patients in the United States

Outpatient Prior Authorization: To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
intervention/stabilization, and mobile response, are permitted to be delivered in or out-of-network without obtaining prior authorization	*of-network without obtaining prior authorization*		and ambulatory) and place of service to achieve timely, high-quality, and cost-effective care			

3.3 Aetna: Inpatient and Outpatient Concurrent Review

Inpatient and Outpatient Concurrent Review To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• MH/SUD Inpatient Services • Psychiatric Residential Treatment Facilities • Rehabilitative Psychiatric Treatment (<21) • Crisis Stabilization Unit • Day Treatment • IOP	• M/S Inpatient Hospital Care • Hospice Care (Inpatient) • Hospice Care, Outpatient Services • Hospital Inpatient/Maternity Services • Organ Transplant Services	• Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that may be approved, potentially denied, or reduced on the basis of medical necessity • Forward potential denials or reductions to the CMO or designated medical director for review • Ensure requests are processed by urgency of request and provider and/or members are notified of the determination	**MH/SUD** • Monthly, the CMO, in conjunction with the director of Medical Management, is responsible for analyzing utilization data, identifying areas of concern. The CMO presents quarterly summaries of this information to the QM/UM • This information assists with updating the list of services requiring prior authorization/concurrent review and is updated at least annually and revised periodically as appropriate • The QM/UM Committee is responsible to provide feedback to the CMO and provide	Reviews are conducted of members' acute care hospitalizations as clinically indicated, either on-site or by telephone or facsimile and decisions 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	• Typically, on a monthly basis SIC will review UM statistics which is broken out by M/S and MH/SUD • On a quarterly basis SIC will review the MH Parity reporting • During SIC any committee member can ask any question or raise any concerns on the data that is presented

Inpatient and Outpatient Concurrent Review To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
		within require time frames • Ensure the services are in the defined benefits, and are appropriate, timely, and cost-effective • Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished, and that are no less than the amount, duration or scope for the same services furnished to members under the Medicaid State Plan	action plans including adjustments to the QAPI program • Criteria required by applicable state or federal regulatory agency • Aetna Medicaid Pharmacy Guidelines for pharmacy criteria • MCG™ (physical and behavioral health evidence-based clinical guidelines that are updated annually) • LOCUS, CALOCUS • ASAM® • Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert			

Inpatient and Outpatient Concurrent Review To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			opinions of healthcare providers, and evidence-based guidelines from nationally-recognized professional healthcare organization and government public health agencies • Aetna Policy Council Review • Other Specialty Criteria by contract[18] People with mental health conditions should be treated in the least restrictive environment and in a manner designed to preserve their dignity and autonomy and to			

[18] When ABHWV consults its vendor Eviti, for oncology/radiation service requests, the determination is reviewed for medical necessity against National Comprehensive Cancer Network (NCCN) Guidelines. NCCN Guidelines are evidence-based and consensus-driven to ensure all patients receive preventive, diagnostic, treatment, and supportive services that will most likely lead to optimal outcomes. The frequently updated guidelines currently apply to 97 percent of cancers affecting patients in the United States

Inpatient and Outpatient Concurrent Review To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			maximize the opportunities for recovery **M/S** • Monthly, the CMO, in conjunction with the director of Medical Management, is responsible for analyzing utilization data, identifying areas of concern • The CMO presents quarterly summaries of this information to the QM/UM • This information assists with updating the list of services requiring prior authorization/concurrent review and is updated at least annually and revised periodically as appropriate • The QM/UM Committee is responsible to provide feedback to the CMO and provide			

Inpatient and Outpatient Concurrent Review To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			action plans including adjustments to the QAPI program The Clinical Review Hierarchy is as follows: • Criteria required by applicable state or federal regulatory agency • Aetna Medicaid Pharmacy Guidelines for pharmacy criteria • MCG™ (physical and behavioral health evidence-based clinical guidelines that are updated annually) • LOCUS, CALOCUS • ASAM® • Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence			

Inpatient and Outpatient Concurrent Review To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What evidence supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally-recognized professional healthcare organization and government public health agencies • Aetna Policy Council Review • Other Specialty Criteria by contract[19]			

[19] When ABHWV consults with its vendor Eviti, for oncology/radiation service requests, the determination is reviewed for medical necessity against National Comprehensive Cancer Network (NCCN) Guidelines. NCCN Guidelines are evidence-based and consensus-driven to ensure all patients receive preventive, diagnostic, treatment, and supportive services that will most likely lead to optimal outcomes. The frequently updated guidelines currently apply to 97 percent of cancers affecting patients in the United States

3.4 Aetna: Retrospective Review—Inpatient and Outpatient

Inpatient and Outpatient Retrospective Review To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• MH/SUD Inpatient Services • Psychiatric Residential Treatment Facilities • Inpatient Detoxification	• M/S Inpatient Hospital Care • Inpatient Maternity Care	• Ensure services are provided at an appropriate level of care and place of service • Evaluate service requests that may be approved, potentially denied, or reduced on the basis of medical necessity • Forward potential denials or reductions to the CMO or designated medical director for review • Ensure requests are processed by urgency of request and provider and/or members are notified of the determination within required time frames • Ensure the services are in the defined benefits, and are appropriate, timely, and cost-effective • Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for	• The MCO adopts evidenced-based guidelines (e.g., MCG™) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives • The guidelines help assure utilization review decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high-quality, and cost-effective care	Retrospective reviews are based solely on the medical information available to the attending physician or ordering practitioner/provider at the time the healthcare services were provided	• The MCO annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision-making • A corrective education plan and monitoring of staff members who score below Aetna's inter-rater reliability target	Retroactive reviews are done on a limited basis, with few exceptions, equally for MH/SUD and M/S. Examples include: • Exception Facility requests (contract specific language excluding them from certain administrative denials) • A request received within 30 days of the members eligibility (30 Day Grace Rule) • A request to add or delete a service/code from a previously approved authorization, when received within 10 days of the service being completed. For example, during an approved abdominal surgery, it becomes necessary to address large amounts of found scar tissue that was not anticipated at the time of the original request. • Substance Use Disorder (SUD) facility admissions must notify the Plan of admission by the next business day, to allow capture of late evening and weekend start dates

Inpatient and Outpatient Retrospective Review To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
		which the services that are furnished, at no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan				

3.5. Aetna: Medical Necessity Criteria

Medical Necessity Criteria To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
Per MCO Contract: For Medicaid-covered medical or other health services to children under 21, “medically necessary” refers to services which are: • Reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions,	Per MCO Contract: For Medicaid-covered medical or other health services to children under 21, “medically necessary” refers to services which are: • Reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions,	N/A	**MH/SUD** The MCO uses the following criteria for physical health and behavioral health consulted in the order listed below; as applicable: • Criteria required by applicable state or federal regulatory agency • Aetna Medicaid Pharmacy Guidelines for pharmacy criteria • MCG™ for physical and behavioral health criteria	• Aetna is responsible for review and approval of the utilization management criteria used for 95 • determinations • Additionally, Aetna is responsible to confirm that medical necessity criteria are established in accordance with generally accepted standards of medical practice and are objective, based on medical evidence, and clinically appropriate for the member’s condition and characteristics of the local delivery system[21] • Service authorization staff who make medical necessity determinations are trained on	• The determination of whether a service is medically necessary is made on a case-by-case basis, taking into account the individual needs of the member and allowing for consultation with requesting practitioners/providers when appropriate • Aetna considers at least the following individual characteristics when applying criteria: age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable[24]	Quarterly monitoring and reporting to appropriate Committees of service authorizations and member complaints and appeals including: • Number of service authorizations requested • Number of service authorizations denied • Number of denied service authorizations with member appeal • Number of denied service authorizations with member appeal upheld • Number of denied service authorizations with member appeal reversed • Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site) The SIC reviews all the above for Parity Rule compliance concerns.

[21] NCQA HP 2020 UM2 A1-3
[24] NCQA HP 2020 UM2 A2

Medical Necessity Criteria To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
and/or treatment for conditions that cause suffering or pain, cause physical deformity, or limitation in function, cause illness or infirmity, endanger life, or worsen disability; • Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions; • Consistent with the	and/or treatment for conditions that cause suffering or pain, cause physical deformity, or limitation in function, cause illness or infirmity, endanger life, or worsen disability; • Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions; • Consistent with the		• LOCUS, CALOCUS, or CASII for behavioral health • ASAM® • Aetna CPBs • Aetna Clinical Policy Council Review • Other Specialty Criteria by contract **M/S** The MCO uses the following criteria for physical health and behavioral health consulted in the order listed below; as applicable: • Criteria required by applicable state or federal regulatory agency • Aetna Medicaid Pharmacy Guidelines for pharmacy criteria	the criteria and the criteria are accepted and reviewed according to Aetna policies and procedures • Medical necessity initial and annual review processes consist of an evaluation of existing criteria, determination of any recommendations or changes, and final acknowledgment or acceptance of criteria • The process involves appropriate practitioners in developing adopting, and reviewing criteria, per NCQA standards • Annually the UM Steering Committee reviews national criteria sets and the procedures for applying them against current clinical and medical evidence • The UM Steering Committee is comprised of senior and plan medical directors representing a broad range of		

Medical Necessity Criteria To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
diagnosis of the conditions; • No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence, and e) will assist the individual to achieve or maintain maximum functional capacity in performing	diagnosis of the conditions; • No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence, and e) will assist the individual to achieve or maintain maximum functional capacity in performing		• MCG™ for physical and behavioral health criteria • LOCUS, CALOCUS or CASII for behavioral health • ASAM® • Aetna CPBs • Aetna Clinical Policy Council Review • Other Specialty Criteria by contract[20]	specialties such as emergency medicine, behavioral health, pediatrics, surgery, family medicine, and internal medicine • The UM Steering Committee review and recommendations of criteria sets are then taken to the QM/UM Committee • The QM/UM Committee membership includes local medical directors and community practitioners who review criteria sets in comparison to state requirements, update, and adopt final criteria sets as appropriate • Adopted criteria are submitted to the Aetna Quality Management Oversight		

[20] When ABHWV consults with its vendor Eviti, for oncology/radiation service requests, the determination is reviewed for medical necessity against National Comprehensive Cancer Network (NCCN) Guidelines. NCCN Guidelines are evidence-based and consensus-driven to ensure all patients receive preventive, diagnostic, treatment, and supportive services that will most likely lead to optimal outcomes. The frequently updated guidelines currently apply to 97 percent of cancers affecting patients in the United States

Medical Necessity Criteria To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
daily activities, taking into account the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.	daily activities, taking into account the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.			Committee for review and adoption • If primary criteria are not clear enough to make a determination and the requested service is not addressed by the Aetna CPBs, the medical director may submit a request for a position determination to the Aetna Clinical Policy Council • The policy council will research literature applicable to the specific request and, when a determination is reached, will respond to the medical director • When criteria are present but unclear in relation to the situation, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area		

Medical Necessity Criteria To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				before making a determination of medical necessity [22] Practitioners/providers are notified in the denial letter (i.e., Notice of Action) that they may request a peer-to-peer consultation to discuss denied authorizations, including behavioral health decisions with the medical director reviewer by calling Aetna[23]		

[22] NCQA HP 2020 UM4 F1
[23] NCQA HP 2020 UM7A, D

3.6 Aetna: Practice Guidelines

Practice Guidelines To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
Practice guidelines provide decision-making criteria to practitioners, providers, and members	Practice guidelines provide decision-making criteria to practitioners, providers, and members	• To promote consistent application of evidence-based treatment methodologies • Facilitate improvement of healthcare • Reduce unnecessary variations in care	The MCO uses the following criteria for physical health and behavioral health consulted in the order listed below; as applicable: • Criteria required by applicable state or federal regulatory agency • Aetna Medicaid Pharmacy Guidelines for pharmacy criteria • MCG™ for physical and behavioral health criteria • LOCUS, CALOCUS, or CASII for behavioral health • ASAM® • Aetna CPBs • Aetna Clinical Policy Council Review	Practice guidelines are made available to practitioners, providers, or members	Medical necessity decisions are determined by evidenced-based guidelines	

Practice Guidelines To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			• Other Specialty Criteria by contract[25]			

[25] When ABHWV consults with its vendor Eviti, for oncology/radiation service requests, the determination is reviewed for medical necessity against National Comprehensive Cancer Network (NCCN) Guidelines. NCCN Guidelines are evidence-based and consensus-driven to ensure all patients receive preventive, diagnostic, treatment, and supportive services that will most likely lead to optimal outcomes. The frequently updated guidelines currently apply to 97 percent of cancers affecting patients in the United States

3.7 Aetna: Network Size

Network Size To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
All benefit services that the MCO is contractually obligated to provide	All benefit services that the MCO is contractually obligated to provide	• To develop and maintain a robust provider/practitioner network capable of meeting the healthcare needs of the MCO membership in an accessibly, timely, and convenient manner, and in accordance with plan contract requirements	• The SIC, consisting of the managers of Member Services, Provider Relations, Medical Management, Quality Management, and The Health Plan Administration, meets at least quarterly to receive network data, analyze network data, identify opportunities for improvement, develop action items, and monitor outcomes of the changes for member access to services • SIC tracks the nature of these	**M/H** • The Network manager, with input from the National Medicaid Data and Reporting Team, plan departments and providers/practitioners, regularly monitors network adequacy parameters on both a scheduled and ad hoc basis These parameters include: • Accessibility of practitioners (telephone and ease of scheduling appointment) • Availability of practitioners (extent to which practitioners are geographically distributed, and the presence of the right number and type of providers to meet the needs of its membership) • Network adequacy • GeoAccess Reports are analyzed to determine the geographic distribution and	The goal is to meet network adequacy goals 100% of the time	• The SIC, consisting of the managers of Member Services, Provider Relations, Medical Management, Quality Management, and The Health Plan Administration, meets at least quarterly to receive network data, analyze network data, identify opportunities for improvement, develop action items, and monitor outcome of the changes for member access to services • SIC tracks the nature of these issues and identifies trends that might be indicative of network need Networks are monitored for adequacy by several methods: • Number of service issues • Number of providers/practitioners by type • Percent outside acceptable ranges • Ratio of practitioner/providers required per 1,000 members • PCP panel status

Network Size To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			issues and identifies trends that might be indicative of network need	cultural background of providers/practitioners in relation to member demographics To confirm the availability of practitioners who provide PCP services, including general and internal medicine, family practice, nurse practitioners, pediatrics, or other provider/practitioner types designated by government sponsor as a PCP, Aetna: • Establishes measurable standards for the number of each type of practitioner providing primary care • Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care • Annually analyzes performance against the standards for the number of		•Network reporting: ○ Monthly provider/practitioner add/termination report to BMS ○ Annually Adequacy and GeoAccess reporting ○ Quarterly provider/practitioner panel size reporting • Annual Assessment of Network Adequacy

Network Size To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				each type of practitioner providing primary care • Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care • During the network development process, Aetna will determine whether practitioners have capacity in their practice and are accepting new patients • If a practitioner is a PCP, the maximum panel size will be 2,000 patients; Aetna reviews the availability of PCPs with an open panel annually, and the goal is <5% of PCPs having a closed panel • Aetna's high-volume behavioral health practitioners are defined by BMS		

Network Size To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				To confirm the availability of high-volume BHPs within its delivery system, Aetna: • Defines which practitioners serve as high-volume BHPs • Establishes quantifiable and measurable standards for the number of each type of high-volume BHP • Establishes quantifiable and measurable standards for the geographic distribution of each type of high-volume behavioral health provider • Annually analyzes performance against the standards **M/S** • The Network manager, with input from the National Medicaid Data and Reporting Team, plan departments, and providers/practitioners, regularly monitors network adequacy parameters on both a scheduled and ad hoc basis		

Network Size To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				These parameters include: • Accessibility of practitioners (telephone and ease of scheduling appointment) • Availability of practitioners (extent to which practitioners are geographically distributed, and the presence of the right number and type of providers to meet the needs of its membership) • Network adequacy • GeoAccess Reports are analyzed to determine the geographic distribution and cultural background of providers/practitioners in relation to member demographics To confirm the availability of practitioners who provide PCP services, including general and internal medicine, family practice, nurse practitioners, pediatrics, or other provider/practitioner types		

Network Size To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				designated by government sponsor as a PCP, Aetna: • Establishes measurable standards for the number of each type of practitioner providing primary care • Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care • Annually analyzes performance against the standards for the number of each type of practitioner providing primary care • Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care • During the network development process, Aetna will determine whether practitioners have the capacity		

Network Size To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				in their practice and are accepting new patients • If a practitioner is a PCP, the maximum panel size will be 2,000 patients; Aetna reviews the availability of PCPs with an open panel annually, and the goal is <5% of PCPs having a closed panel To confirm the availability of high-volume and high-impact specialists within its delivery system, Aetna: • Defines which practitioners serve as high-volume and high-impact specialists. At minimum: ○ High-volume specialties include obstetrics/ gynecology ○ High-impact specialties include oncology • Establishes measurable standards for the number of each type of high-volume and high-impact specialist		

Network Size To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				• Establishes measurable standards for the geographic distribution of each type of high-volume and high-impact specialist • Annually analyzes performance against established standards		

4.0 Pharmacy

4.1 Pharmacy: Prior Authorization

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rationale for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
All non-preferred drugs or drugs requiring a PA that are in therapeutic classes not included on the preferred drug list (PDL)	All non-preferred drugs or drugs requiring a PA that are in therapeutic classes not included on the PDL	• The two primary objectives of Drug Utilization Review (DUR) systems are to improve quality of care and assist in containing costs • The DUR program ensures prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes	Specific PA criteria are based on review of: • The most current clinical information • Food and Drug Administration (FDA)-approved indications • Manufacturers' recommendations The above criteria are reviewed by the Medicaid Utilization Review (DUR) Board and recommended to the Bureau for Medical Services (BMS).	• The PA process requires non-preferred drugs meet specified criteria in order to be reimbursed by BMS • PA requests may be made by telephone, fax, or mail • Clinical pharmacists employed by the PA vendor have discretion for approval and usually obtain more clinical information from the prescriber • A three-day emergency supply of prior-authorized drugs can be dispensed by a pharmacy until authorization is completed • If PA is needed and not obtained, or PA is not approved, the prescription is not filled for the member	• PA for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance • Trial criteria, PA criteria, and duration of PA are determined by the DUR Board with clinical recommendations provided by a vendor • PA is used in cases when a patient is has not undergone treatment for a particular indication, but a non-preferred psychiatric medication was chosen with no clinical rationale as to why a formulary option cannot be used • PA may be applied when a medication is prescribed for a non-FDA-indicated use that does not have clinical data supporting its usage, or when the dosing	• MH/SUD members do not have their MH/SUD medications transitioned to PDL medications if they are well controlled on the current regimen • Greater percentage of PAs are granted for MH/SUD medications

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rationale for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
					is outside of the FDA-recommended dose	

4.2 Pharmacy: Use of a PDL

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• The PDL only addresses certain drug classes • Some classes of drugs will not be reviewed for preferential agents because of no or limited cost savings • Drugs that have historically been covered by Medicaid and are not listed on the PDL will continue to be covered	• The PDL only addresses certain drug classes • Some drug classes 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	• Drugs are designated as “preferred” for their clinical significance and overall cost efficiencies	• The State Medicaid program Pharmaceutical and Therapeutics (P&T) Committee is committed to: ○ Objectively recommending drugs for inclusion on the WV PDL that are effective and cost efficient, while providing maximum safety—the Institute for Clinical and Economic Review (ICER) recommendations are researched ○ Examining the scientific literature (found in labeling, drug compendia, and peer-reviewed clinical literature) for sound clinical evidence that supports selecting	• Each drug is reviewed on its clinical merits relative to other medications in the same therapeutic class • Published, peer-reviewed clinical trials are the primary source of information used by the State’s PDL vendor for this review • Data regarding efficacy, effectiveness, adverse effects, and tolerability is analyzed and compared to other drugs within the therapeutic class • From this analysis, the clinical staff determines an agent’s superiority, equivalency, or inferiority relative to the comparator drugs • After the clinical review, a financial analysis is performed; this analysis incorporates utilization data from the State as well as net drug costs from the manufacturers • With this data, the financial staff determines the fiscal impact of the PDL status (preferred or non-preferred) of each medication	• The trial criteria and exceptions for a PDL drug are established based on clinical evidence and the recommendations of the BMS Department of Pharmacy Services, which are reviewed and approved by the WV DUR Board • Therapeutic classes are reviewed, at a minimum, annually; classes may be reviewed more often if new drugs are introduced to the class • The PDL is reviewed in total annually and updated quarterly • If a therapeutic class has been reviewed by the P&T Committee, and the Secretary of DHHR has approved the recommended drugs in that category, new chemical entities must be listed in First	• New members do not have their MH/SUD medications transitioned to PDL medications if they are well controlled on the current regimen. This NQTL is applied more stringently to MH/SUD medications.

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
			specific drugs to be included on the PDL ○ Helping to ensure that the PDL provides for medically appropriate drug therapies for use in the general Medicaid population, allowing healthcare providers to care for the majority of their patients without a PA 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	• 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 • The P&T Committee meets three times per year, and as necessary, to review the PDL and new drugs as they become available • New drugs introduced into the marketplace in therapeutic classes that have been reviewed will be considered non-preferred until the annual review of the particular therapeutic class • Exceptions to this policy will be made for drugs that the U.S. FDA has given priority status	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 as 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	

4.3 Pharmacy: Prospective Review

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
All prescriptions	All prescriptions	• The two primary objectives of DUR systems are to improve quality of care and assist in containing costs • The DUR program ensures hat prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes • Prescription claims are screened to identify potential drug therapy problems of the following types: ○ Therapeutic duplication ○ Ingredient duplication ○ Adverse drug interactions ○ Early refill ○ Late refill ○ High dosage ○ Low dosage ○ Incorrect duration of drug treatment ○ Age/gender precaution ○ Pregnancy precaution ○ Breast-feeding precaution	• The DUR Board and BMS DUR pharmacists review the criteria regularly using surveys of current peer-reviewed literature and recommendations from FDB (creator of edits), DrugDex, MicroMedex, and the American Hospital Formulary Drug Service • Lexicomp and UpToDate are clinical subscription services to which pharmacists have access and regularly use during the course of their work	• Due to the 2017 pharmacy carve-out, processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing • Pharmacists filling the prescriptions, clinical pharmacists at RDTP, and the DUR pharmacist at BMS are responsible for applying the policies • Claims might be denied for early refills, therapeutic duplications, ingredient duplications, or inappropriate dosages; or require additional review if they are flagged for these edits • Clinical personnel have discretion to make exceptions to the policy depending on the clinical information provided by the prescriber • Prescribers may appeal to the BMS medical director who works in conjunction with the BMS DUR pharmacist	• Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing • Prescribers may appeal to the BMS medical director who works in conjunction with the BMS DUR pharmacist	• Required by federal regulation

4.4 Pharmacy: Retrospective Review

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
DUR votes on types of reviews based on issues identified during surveys of enrollee medications	DUR votes on types of reviews based on issues identified during surveys of enrollee medications	• The reason for retrospective is for patient safety • Enrollee medications are checked for interactions, contraindications, appropriate drug/dose for age range, appropriate dosing, and drug duplication • Behavioral health medications narrow therapeutic windows (difference between harm and benefit small)	• Diagnoses are not always known when enrollee picks up medication, and there may be contraindications • Surveys of enrollee medications identify a particular issue (e.g., a patient is not treating a chronic condition during the pandemic)	• DUR Committee reviews certain medications • Coding edit will not catch the diagnosis • Look at compliance retrospectively • Send message to provider • Performed once a month • The system is built over time, reviewing claims and diagnoses, internal rating systems, and additional encounter data • Performed by Marshall University	• Retrospective reviews are used only to improve clinical benefits (identify contraindications with diagnoses or other medications) • Behavioral health is difficult to treat, so no changes are recommended unless patient safety is an issue; the same is true for medications for rheumatoid arthritis and anticonvulsants	Surveys identify potential issues or conditions that should be reviewed.

4.5 Pharmacy: Lock-In Program

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and 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	• Patient safety, prevention of drug diversion, and cost containment	• Criteria for lock-in are reviewed and approved by the RDUR Board and the RDUR Committee, who meet monthly • WV Safe & Effective Management of Pain Guidelines 2021	• The RDUR Committee, composed of practicing healthcare professionals, meets monthly to review members' prescription and medical profiles that have been identified for drug utilization issues • The State Medicaid program contracts with Health Information Design (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 • 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	• On a monthly basis, the RDUR Committee reviews member profiles that have been selected because of therapeutic criteria exceptions, including potential overutilization of controlled substances • A prescriber can request an override for a lock-in to ensure patient access to treatment • The criteria for this program is: "1. High Average Daily Dose: ≥ 50 morphine milligram equivalents per	• The lock-in program is designed for patient safety, prevention of drug diversion, and cost containment—and it can be overridden to ensure patient access to treatment

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
				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	day over the past 90 days 2. Overutilization: Filling of ≥ 5 claims for all controlled substances in the past 60 days 3. Doctor/Pharmacy Shopping: ≥ 3 prescribers OR ≥ 3 pharmacies writing/filling claims for any controlled substance in the past 60 days 4. Use with a History of Dependence/Overdose: Any use of a controlled substance in the past 60 days with at least 1 occurrence of a medical claim for	

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
					Substance Abuse, Dependence, or Overdose in the past 720 days 5. “Frequent Flyer”: ≥ 3 Emergency department visits in the last 60 days 6. Cash Payments: Review of the Controlled Substance Automated Prescription Program (CSAAP) report indicates cash purchases of controlled substances covered by Medicaid 7. Positive Drug Screen: Report by medical provider of abnormal or	

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
					unexpected drug screen result" Patients with cancer might be excluded from the program depending on their individual case	

4.6 Pharmacy: Suboxone: Limitation in Maintenance Dose

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• All MH/SUD medications have dose optimization standards and not-to-exceed dosages	• All M/S medications have dose optimization standards and not-to-exceed dosages • PA required to exceed	• All medications are reviewed for quality of patient care/safety and cost savings • The lowest dose that provides the therapeutic effect is recommended to minimize side effects	• Scientific literature, including in labeling, drug compendia, and peer-reviewed clinical literature • The lowest therapeutic dose is the goal for both MH/SUD and M/S medications for several reasons: 1) lower risk of side effects, especially long-term side effects, and 2)	• The claims processing system applies DUR edits to pharmacy claims as they are processing to check for safety, therapeutic dose, interactions, and contraindications • Claims might be denied for early refills, therapeutic duplications, ingredient duplications, or inappropriate dosages—or claims	• All medications are reviewed for safety, interactions, and contraindications • Formulary options are encouraged • Excursions above 16 mg/day and back to a maximum of 24 mg/day	• Prescriber can appeal a denial • The medical literature does not support maintenance doses of 24 mg/day or higher • Lowest therapeutic dose is supported by the literature—16

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
	maximum dose • Medications exceeding the FDA-recommended dosage need medical director approval	**MH/SUD** Buprenorphine with naloxone reduces misuse and diversion, and has been found to be safe for pregnant women and their neonates[26]	by not treating the patient with the maximum dose, the prescriber can reserve higher doses during times of stress (e.g., M/S migraine medications for increased headaches; MH/SUD suboxone for stressful times of SUD triggers) **MH/SUD** **Suboxone** • FDA package insert indicates the recommended target maintenance dosage of suboxone is 16 mg/day • Maintenance doses higher than 24mg have not been demonstrated to provide any clinical advantage	require additional review if they are flagged for these edits • Clinical personnel have discretion to make exceptions to the policy depending on the clinical information provided by the prescriber • Prescribers may appeal to the BMS medical director who works in conjunction with the BMS DUR pharmacist	of suboxone are allowed at the discretion of the medical director • Very few patients have required maintenance doses greater than 16 mg/day	mg/day is the target dose

[26] Lofwall Michelle R. and Sharon L. Walsh. September/October 2015. “A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences From Around the World.” *Journal of Addiction Medicine* 8(5): 315 – 326. Accessed April 11, 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4177012/

4.7 Pharmacy: Tobacco Cessation:

Coaching Program; 12-Week Limit; Lapse in Treatment

To which benefits is the NQTL assigned?		**Strategy:** Why is the NQTL assigned to these services?	**Evidentiary Standard:** What evidence supports the rational for the assignment?	**Processes:** Describe the NQTL procedures (e.g., steps, timeliness, and requirements)	**In Operation:** How frequently or strictly is the NQTL applied?	**Evidentiary Standard:** What standard supports the frequency or rigor that is applied?
MH/SUD	**M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**	**MH/SUD and M/S**
• Tobacco cessation agents	• No direct M/S comparison, although all M/S medications have dosage optimization standards	• A coaching program is required to provide support and structure to the tobacco cessation attempt • Requiring an appeal for repeated attempts prevents beneficiaries from sustained periods of tobacco cessation product use without a plan to quit	• Medical research supports the combination of support and cessation agents • CDC recommends support through a quit-line • The 12-week limit is to ensure patient commitment—tobacco cessation agents are ineffective for continuous usage; repeated attempts allowed	• Beneficiaries first sign up for a quit-line program (the Bureau for Public Health Quit-line for Aetna or UniCare or The Health Plan's program for individuals in The Health Plan managed care organization [MCO]) • Tobacco cessation services more than 12 weeks, or in the case of a greater than a five-day lapse in treatment, require a written appeal with documentation of efficacy and patient compliance	• Generally, beneficiaries are required to sign up for an approved phone coaching program; however, if a beneficiary is being discharged from the hospital, or there is another sense of urgency, beneficiaries are permitted to receive agents prior to signing up for the quit-line • Initial approval is for 12 weeks, and additional therapy may be approved	• Tobacco cessation program limits are in place to encourage success, and beneficiaries are permitted multiple attempts