Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Report

Prepared by:

Mississippi Division of Medicaid

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Introduction

The Mississippi Medicaid Program and Children's Health Insurance Program (CHIP) are operated by the Division of Medicaid (DOM). DOM covers about 30 percent of its beneficiaries through a fee-for-service model, managing delivery and administration of services. DOM also oversees coverage for beneficiaries delivered through Coordinated Care Organizations (CCOs), which includes about 70 percent of all Medicaid beneficiaries in Mississippi, including 100 percent of CHIP recipients.

On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) issued regulations governing the application of mental health parity requirements to Medicaid CCOs and CHIP (*see* 42 C.F.R. Part 438, Subpart K and 42 C.F.R. §457.496). These regulations were created based on the Mental Health Parity and Addiction Equity Act (MHPAEA) and require that state Medicaid programs ensure that beneficiaries in CCOs and CHIP receive mental health and substance use disorder (MH/SUD) services that are "comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors" that are used in delivery of medical/surgical (M/S) benefits in the same treatment classification (*see* 42 C.F.R. §457.496).

DOM reviewed CCO member handbooks, links to which are included in Appendix A. Each CCO was asked to do an internal analysis their management and delivery of both M/S and MH/SUD care to ensure that parity exists. These analyses, included in Appendix B of this report, were submitted to and reviewed by DOM. This report details DOM's compliance with parity requirements.

Process Overview

CMS supplied a compliance analysis process to ensure that parity exists. That process includes the following steps:

1. Identify all benefits packages to which parity requirements apply.
2. Define MH/SUD benefits.
3. Classify benefits by type.
4. For each classification, identify and analyze aggregate lifetime and annual dollar limits.
5. For each classification, identify and analyze other qualitative treatment limitations (QTLs) and financial requirements (FRs).
6. For each classification, identify and analyze non-quantitative treatment limitations (NQTLs).
7. Document the results and make changes as needed for compliance.

Benefit Packages and MississippiCAN

DOM oversees three CCOs for the delivery of services to 70 percent of the state's Medicaid beneficiaries. Those CCOs are:

- United Healthcare
- Molina Healthcare
- Magnolia Health

Mississippi Coordinated Access Network (MississippiCAN) is the DOM COO program. It encompasses multiple programs, including Medicaid and CHIP. United Healthcare and Molina Healthcare both offer CHIP services; Magnolia Health does not. The Mississippi legislature first authorized MississippiCAN in 2009, with implementation following in 2011. The program was developed with the specific goals of improving access to needed medical services, improving quality of care, and increasing cost predictability.

Since its inception, MississippiCAN has continually evolved and expanded. In the beginning, the program only applied to a few categories of eligibility (or populations of beneficiaries), such as disabled children at home and the working disabled. In 2015, MississippiCAN expanded to include all categories of children on Medicaid and inpatient hospital services. As of 2018, state law requires mandatory beneficiary participation in MississippiCAN, except for those individuals excluded by federal law from mandatory participation. Individuals eligible for Medicaid in the following coverage groups are mandated to participate:

- Supplemental Security Income (SSI) (ages 19-65)
- Working Disabled (ages 19-65)
- Breast/Cervical Cancer Group (ages 19-65)
- Parents and Caretakers (Temporary Assistance for Needy Families (TANF)) (ages 19-65)
- Pregnant women (ages 8-65)
- Newborns (ages 0-1)
- Children (TANF) (ages 1-19)
- Children up to age 19; 100 percent of the federal poverty level (FPL) (ages 6-19)
- Quasi-CHIP (ages 6-19)
- Children (Beginning CY 2015) ages 1-19

Individuals eligible for Medicaid in the following coverage groups have optional participation:

- SSI (ages 0-19)
- Disabled Child Living at Home (ages 0-19)
- Foster Care Children IV-E and CWS
- Foster Care Children with Adoption Assistance (ages 0-19)

Individuals not covered by CCOs (and therefore not the subject of this report):

- Beneficiaries in any waiver programs: Elderly and Disabled (ED), Independent Living (IL), Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI), Assisted Living (AL), and Intellectual Disabilities/Developmental Disabilities (ID/DD)
- Beneficiaries who have both Medicare and Medicaid
- Beneficiaries who are in institutions such as: Nursing Facilities, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID), Correctional Facilities, and others

Defining Mental Health and Substance Use Disorder Benefits

The parity rule defines mental health benefits as items or services for mental health conditions, as defined by the state and in accordance with applicable federal and state law. Substance use disorder benefits are defined as items or services for substance use disorders, as defined by the state and in accordance with applicable federal and state law. State definitions of mental health conditions and substance used disorders are required to be consistent with generally recognized independent standards of current medical practice.

MH/SUD benefits available to all Mississippi Medicaid beneficiaries include inpatient psychiatric care, outpatient hospital services, residential treatment facilities, therapeutic and evaluative services, emergency services, and pharmaceutical services. Each CCO evaluated the delivery of each of these services in the MH/SUD context and compared the application of the services with analogous services and processes in the M/S context. DOM reviewed these analyses as well.

Benefit Classification Types

The parity rule directs states to conduct their parity analyses across four benefit classifications:

1. Inpatient Care
2. Outpatient Care
3. Emergency Care
4. Pharmaceutical Care

Each M/S and MH/SUD benefit must fall into one of these four classifications. In defining what benefits are included in each classification, each state must apply the same reasonable standard for both M/S and MH/SUD benefits. DOM used the following classification definitions:

Classification	Definition
Inpatient Care	Medical (including behavioral health) services that are provided in a hospital or other facility that require at least one overnight stay with a physician's written order for admission. Other facilities include other behavioral health residential facilities. Inpatient services include room and board, nursing services, diagnostic or therapeutic services, and medical, surgical and behavioral health services
Outpatient Care	Diagnostic, therapeutic, and rehabilitative services that are provided to individuals in a facility or other community setting that does not require a physician's written order for admission.
Emergency Care	Services needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. These services are provided in a variety of settings including an emergency department/emergency room, urgent care setting, etc. Emergency services are provided under medical

	supervision and include: a) Immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization; and, b) Continuity of care through discharge planning identification of referral resources for ongoing community stabilization and outpatient treatment.
Pharmaceutical Care	Covered medications, drugs and associated supplies that legally require a medical prescription to be dispensed.

Financial Requirements, Quantitative Limitations, and Aggregate Lifetime/Annual Dollar Limits

The parity rule requires states to identify any aggregate lifetime or annual dollar limits imposed on MH/SUD services in each benefit classification, and to evaluate whether those limits are more restrictive than the aggregate lifetime and annual dollar limits imposed on M/S services in the same classification. Definitions for each of the relevant elements of this analysis are as follows:

Term	Definition
Financial Requirements	Financial Requirements (FRs) are payments by enrollees for services received that are in addition to payments made by the CCO such as copayments, coinsurance, deductibles, and out-of-pocket maximums. FRs that apply to MH/SUD benefits within a classification may not be more restrictive than the predominant FR that applies to substantially all M/S benefits in that classification. "Substantially all" means that an FR must apply to at least two-thirds of the expected payments in a year for all M/S benefits in the same classification. "Predominant" means that the level of the type of FR (e.g., co-payment) applied to a MH/SUB benefit also must apply to more than half of the payments for M/S benefits in the classification that are subject to that type of FR.
Quantitative Limitations	Quantitative Treatment Limitations (QTLs) are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. QTLs that apply to MH/SUD benefits within a classification may not be more restrictive than the predominant QTL that applies to substantially all M/S benefits in that classification.

Aggregate Lifetime Limits and Annual Dollar Limits	Aggregate Lifetime/Annual Dollar Limits (AL/ADL) are dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis. An AL/ADL cannot be applied to MH/SUD benefits unless it applies to at least one-third of M/S benefits. If the AL/ADL applies to less than one-third of M/S benefits, then the AL/ADL must be eliminated. If the AL/ADL applies to at least two-thirds of M/S benefits then it must be applied no more restrictively to MH/SUD benefits. If the AL/ADL applies to between one-third and two-thirds of the M/S benefits, then it may be applied to MH/SUD benefits if it is no more restrictive than the weighted average of the limit applied to M/S benefits.

Non-Quantitative Treatment Limits

Non-quantitative treatment limitations (NQTLs) are limits on the scope or duration of benefits that generally cannot be expressed numerically. An illustrative list of NQTLs is provided at 42 C.F.R. §438.910(d)(2). The parity rule prohibits states and coordinated care contractors from imposing an NQTL on MH/SUD services unless, under the policies and procedures of the state or coordinated care contractor, as written and in operation, any processes, strategies, and evidentiary standards used in applying the NQTL to MH/SUD benefits are comparable to, and applied no more stringently than, the processes, strategies, and evidentiary standards used in applying the NQTL to M/S benefits.

In analyzing the comparability and stringency of the NQTL in the classification, CCOs and DOM review policies and procedures, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the MH/SUD and M/S NQTL.

Some examples of NQTLs include, but are not limited to:

1. Medical management standards
    - Medical necessity criteria development
    - Prior authorization
    - Concurrent review
    - Retrospective review
    - Outlier management
    - Experimental/investigational determinations
    - Fail first requirements (e.g., Refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective)
    - Exclusions (e.g., based on a failure to complete treatment)
    - Medical appropriateness reviews
    - Practice guideline selection/criteria
    - Requirements for lower cost therapies to be tried first

2. Network admission standards
    - Reimbursement rates
    - Geographic restrictions
    - Specialty requirements or exclusions
    - Facility type requirements or additional requirements for certain facility types
    - Network tiers
3. Out-of-network access standards
4. Methods for determining usual, customary, and reasonable charges
5. Formulary design for prescription drugs
6. Prescription drug benefit tiers

The first step in conducting an NQTL analysis is to identify all of the NQTLs applicable to MH/SUD benefits in each classification. A type of NQTL must be tested in each classification in which it applies, and the CCO must identify any limits on the scope or duration of a MH/SUD benefit. Some NQTLs (e.g., prior authorization requirements) are readily identifiable. Other NQTLs require more in-depth analysis of written policies and procedures, and their operations related to utilization and quality management, provider network admission standards, reimbursement rates, and other NQTLs embedded in operations.

Once NQTLs were identified for a classification, the CCOs collected information about the processes, strategies, evidentiary standards, and other factors applicable to each type of NQTL relative to M/S and MH/SUD benefits. The CCOs then conducted the NQTL analysis on the basis of that information to determine compliance with parity requirements of comparability and stringency.

Upon receipt, the state reviewed the information submitted by each health plan to evaluate whether the information provided indicated that the plan was applying NQTLs in a manner that complied with parity requirements.

Below, DOM outlines analysis of some NQTLs. This outline is not comprehensive, but serves as an overview of how NQTLs were reviewed. For a comprehensive look at NQTL analyses conducted by CCOs, refer to Appendix B.

Medical Necessity

Each CCO provided information outlining their review of services for medical necessity. The processes described by each conform to standards set by DOM (*see* Miss. Admin. Code Title 23, Part 200, Rule 5.1). Those criteria are as follows:

“Medically necessary” or “medical necessity” is defined as health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the patient’s medical condition,
2. Compatible with the standards of acceptable medical practice in the United States,

3. Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms,
4. Not provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider,
5. Not primarily custodial care
6. There is no other effective and more conservative or substantially less costly treatment service and setting available, and
7. The service is not experimental, investigational or cosmetic in nature.

Each CCO is applying these standards using processes, strategies, and evidentiary standards to MH/SUD services that are comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards used to review M/S services.

Prior Authorization

The goals of prior authorization processes are to ensure timely and appropriate access to medically necessary covered services, to ensure care is delivered in accordance with generally accepted standards of medical practice, and to prevent inappropriate utilization. The prior authorization processes described by CCOs for use in both M/S and MH/SUD services are applied using analogous methods. The processes, strategies, and evidentiary standards used to apply prior authorization to MH/SUD services are comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards used to apply prior authorization to M/S services.

Concurrent Review

All health plans reported requiring concurrent review for some MH/SUD services and some M/S services in the inpatient and outpatient benefit classifications. Within each plan, the reasons for applying concurrent review requirements were the same for MH/SUD services and M/S services, and generally included ensuring that continued services are delivered in the most appropriate setting, monitoring for transition of care, identifying potentially long-term or complex cases for care management programs, and identifying potential quality of care issues. For each health plan, the processes, strategies, and evidentiary standards used to apply concurrent review to MH/SUD services are comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards used to apply concurrent review to M/S services.

Pharmacy Services

Each CCO does not delineate between M/S and MH/SUD prescriptions in authorization reviews. The clinical review process used to determine each drug's preferred/non-preferred status and prior authorization requirements (if any) are the same for all drugs, regardless of whether a specific drug is generally prescribed for MH/SUD or M/S conditions.

Summary and Findings

Each CCO provided an internal analysis based on the above-referenced categories and definitions. These analyses are included in this document as Appendix B. CCO member handbooks, linked in Appendix A,

also provided information for DOM's review. DOM conducted an independent analysis of the information supplied by each CCO and correlating handbooks, and key findings of the DOM analysis include:

- ***Aggregate Lifetime and Annual Dollar Limits.*** None of the CCOs in Mississippi apply aggregate lifetime or annual dollar limits to MH/SUD care. Therefore, parity requirements have been met.
- ***Quantitative Treatment Limits.*** None of Mississippi's CCOs impose quantitative benefit limits on MD/SUD services in the inpatient, outpatient, or emergency classification. There is a limitation of six prescriptions per month for beneficiaries (with more available for children if deemed medically necessary). This limitation is applied equally to M/S and MH/SUD-associated medications.
- ***Financial Requirements.*** Mississippi's CCOs apply financial requirements consistently and equally, no matter if related treatment is for an M/S or an MH/SUD malady.
- ***Non-Quantitative Treatment Limits.*** Each CCO applies a variety of non-quantitative treatment limitations for both MH/SUD and M/S benefits. DOM required each CCO to provide information about their application of NQTLs. Upon review of the information provided by the CCOs, it was determined that CCOs are applying NQTLs to MH/SUD services in a manner that is comparable to, and no more stringent than, as applied to M/S services.

Based on the outcome of its analysis, DOM has determined that Mississippi is in compliance with federal parity requirements. DOM will update its analysis as needed to reflect changes in delivery and availability of services as defined and outlined in this document.

Appendix A: CCO Handbook Links

Below are listed links to member handbooks for each subject CCO policy.

- MississippiCAN United Healthcare Member Handbook
- CHIP United Healthcare Member Handbook
- MississippiCAN Molina Healthcare Member Handbook
- CHIP Molina Healthcare Member Handbook
- MississippiCAN Magnolia Health Member Handbook

Appendix B: Parity Analyses from Coordinated Care Organizations

The following includes parity analyses conducted by Mississippi's CCOs in preparation for DOM's submission of its CHIP SPA 19-0011 – CHIP Mental Health Parity. DOM has reviewed these analyses and confirmed with each CCO that the details provided therein conform with policies that apply not only to CHIP beneficiaries, but to all beneficiaries under CCO care in Mississippi as appropriate for adult beneficiaries.

Mississippi Parity Analysis

INTRODUCTORY STATEMENT

The purpose of this Mississippi Parity Analysis Template is to provide detailed information and guidance to help MHMS assess compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). The template was developed utilizing the CMS Parity Compliant Toolkit (Toolkit), published in January 2017, as the foundational document. The Toolkit can be referenced for additional information regarding completion of any of the sections of this template.

The template is organized into the following four sections:

I. Benefit Classification Definitions and Mapping

II. Analysis of Financial Requirements, Quantitative Treatment Limitations, and Aggregate Lifetime / Annual Dollar Limits

III. Non-Quantitative Treatment Limits Analysis

IV. Compliance Monitoring Plan

I. BENEFIT CLASSIFICATION DEFINITIONS AND MAPPING

To conduct a parity analysis, the State must first define the four classifications of benefits under which each Medical / Surgical (M/S) and Mental Health / Substance Use Disorder (MH/SUD) service falls. For the purpose of Mississippi' parity analysis, the following benefit classification definitions will be utilized:

Definitions

Inpatient: medical (including behavioral health) services that are provided in a hospital or other facility that require at least one overnight stay with a physician's written order for admission. Other facilities include other behavioral health residential facilities. Inpatient services include room and board, nursing services, diagnostic or therapeutic services, and medical, surgical and behavioral health services.

Outpatient: diagnostic, therapeutic, and rehabilitative services that are provided to individuals in a facility or other community setting that does not require a physician's written order for admission.

Emergency Care: services needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. These services are provided in a variety of settings including an emergency department / emergency room, urgent care setting, etc. Emergency services are provided under medical supervision and include: a) Immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization; and, b) Continuity of care through discharge planning identification of referral resources for ongoing community stabilization and outpatient treatment.

Pharmacy: covered medications, drugs and associated supplies that legally require a medical prescription to be dispensed.

II. ANALYSIS OF FINANCIAL REQUIREMENTS, QUANTITATIVE TREATMENT LIMITATIONS, AND AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS

Utilizing the classification definitions MHMS should complete the following tables to analyze the financial requirements (FR), quantitative treatment limitations (QTL), aggregate lifetime and annual dollar limits (AL/ADL) associated with each classification indicated. In each category, MHMS should identify the services that are subject to the specific limitation, the type of limitation applied and the dollar amount or percentage of the limitation.

1. **Financial Requirements Testing (FR) –** Financial Requirements (FRs) are payments by enrollees for services received that are in addition to payments made by the MCO such as copayments, coinsurance, deductibles, and out-of-pocket maximums. FRs that apply to MH/SUD benefits within a classification may not be more restrictive than the *predominant* FR that applies to *substantially all* M/S benefits in that classification.

   Substantially all means that an FR must apply to at least two-thirds of the expected payments in a year for all M/S benefits in the same classification.

   Predominant means that the level of the type of FR (e.g., co-payment) applied to a MH/SUB benefit also must apply to more than half of the payments for M/S benefits in the classification that are subject to that type of FR.

Classification	Medical/Surgical FR (type and $ amount or percentage)	Mental Health / SUD FR (type and $ amount or percentage)	Outcome Justification (include brief description of FR analysis for each classification with justification of pass / fail outcome)
Inpatient	Members do not incur out-of-pocket expenses for services.	Members do not incur out-of-pocket expenses for services.	Molina Healthcare does not apply any out of –pocket expenses in accordance with organizational guidelines
Outpatient	Members do not incur out-of-pocket expenses for services.	Members do not incur out-of-pocket expenses for services.	Molina Healthcare does not apply any out of –pocket expenses in accordance with organizational guidelines
Emergency	Members do not incur out-of-pocket expenses for services.	Members do not incur out-of-pocket expenses for services.	Molina Healthcare does not apply any out of –pocket expenses in accordance with organizational guidelines
Pharmacy	Members do not incur out-of-pocket expenses for services.	Members do not incur out-of-pocket expenses for services.	Molina Healthcare does not apply any out of –pocket expenses in accordance with organizational guidelines

2. **Quantitative Treatment Limitations (QTL) –** Quantitative Treatment Limitations (QTLs) are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. QTLs that apply to MH/SUD benefits within a classification may not be more restrictive than the predominant QTL that applies to substantially all M/S benefits in that classification.

Classification	**Medical/Surgical limits** (specific service and limitation)	**Mental Health/SUD limits** (specific service and limitation)	**Outcome Justification** (include brief description of QTL analysis for each classification with justification of pass / fail outcome)

Inpatient	**Hospice-Continuous Care Respite care** – limited to five (5) consecutive days at a time **Inpatient Admissions:** Require prior authorization. Elective, Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility. **Palliative and supportive Care-**For child members aged 20 and under who are receiving Hospice services curative services are also covered in addition to palliative car General/Short-term Inpatient Care **Service Intensity Add-on (SIA**) - registered nurse or social worker services during the last seven (7) days of life **Bereavement Counseling-** Bereavement Counseling shall be provided to the	**Inpatient Psychiatric** No Limitations **ECT (add-on service)** No Limitations There are no (QTL) day or visit limits for Mental Health or SUD inpatient stays (inclusive SAT, SUD Psychiatric Residential Treatment, Physician Services, Psychiatric Services and EPSDT). The duration of an inpatient Mental Health or SUD inpatient stay is defined by the clinical need for that level of care based on each presenting Member's clinical. Molina requires provider notifications within 24 hours of admission in order to obtain initial approval of the stay. Because most of these admissions are under crisis circumstances facilities do not need to request authorization prior to the admission. Providers are required to submit appropriate clinical information including diagnostic criteria, medication changes, treatment	Molina renders Utilization Management decisions for standard authorization request within three (3) calendar days and/or two (2) business days of receipt of request. For expedited request decisions are rendered within 24 hours of receipt. Molina utilizes standardized nationally recognized review criteria that are based on sound scientific medical evidence for making decisions concerning medical necessity and appropriateness of services. The criteria sources used are for one or more of the following: • Medicaid Coverage Guidelines; Administration Codes • Corporate Guidance Documents addressing new or existing technology; • Change Healthcare InterQual® Criteria • Physical/Occupational Therapy and Rehabilitation Care Manual; • Algorithms and guidelines from recognized professional societies; . • Advice from authoritative review articles and textbooks.

	beneficiary's family after the beneficiary's death up to twelve (12) months. **Maternity Services** Birthing Center/Home Birth Doctor/mid-wife and hospital services Newborn nursery care Pregnancy Care **Physician Services-** No Limitations Emergency Services Immunizations Vaccine for Children (VFC) administration Nurse Practitioner Services Newborn Care Physician Assistant Services Preventative visits Routine Office Visits Telehealth Services Remote glucose monitoring **Surgical Services-** No Limitations There are no (QTL) day or visit limits for Medical/Surgical inpatient stays other than that listed above relating to inpatient medical detox admissions. The duration of an inpatient	planning and discharge plans demonstrating the need for an inpatient level of care. Providers are required to update Molina at regular intervals that are dependent on clinical need, to continuously demonstrate medical necessity. Based upon the length of time initially approved for the admission, the update required by providers for continuing the stay varies and is determined on each individual case by the reviewer. Failure to submit appropriate clinical could result in denial of claims payment. Providers may request reconsideration regarding these determinations if they can demonstrate medical necessity or encounter extenuating circumstances. Qualifications required for persons reviewing the PA request include an active nursing license or an active Clinical Social Work or Clinical Licensed	

	medical/surgical inpatient stay is defined by the clinical need for that level of care based on each presenting Member's clinical. Molina requires provider notifications within 24 hours of admission in order to obtain initial approval of the stay. Because most of these admissions are under crisis circumstances facilities do not need to request authorization prior to the admission. Providers are required to submit appropriate clinical information including diagnostic criteria, medication changes, treatment planning and discharge plans demonstrating the need for an inpatient level of care. Providers are required to update Molina at regular intervals that are dependent on clinical need, to continuously demonstrate medical necessity. Based upon the length of time initially approved for	Counselor license in the state of Mississippi (RN, LCSW, LPC, LMFT) and completion of orientation and training programs designed to provide the understanding of the decision-making process. Education includes, but may not be limited to, systems training classes, web-based learning, and individual mentoring and supervision Strategies: Authorization provided within 24 hours of receipt of the Member's clinical by the facility, is required for all MH/SUD inpatient benefits. Molina requires authorization of all MH/SUD IP benefits due to the cost of the benefit, regardless of the approval rate. Molina monitors inpatient care to ensure quality care, evaluate provider performance (ALOS, readmission rates), and determine transition needs. Inpatient reviews include an evaluation of previous treatment	

	the admission, the update required by providers for continuing the stay varies and is determined on each individual case by the reviewer. Failure to submit appropriate clinical could result in denial of claims payment. Providers may request reconsideration regarding these determinations if they can demonstrate medical necessity or encounter extenuating circumstances. Denial rates for inpatient medical/surgical benefits are monitored on a monthly basis during a Utilization Review meeting comprised of Healthcare Services management and Medical Directors. Qualifications required for persons reviewing the PA request include an active nursing license in the state of Mississippi (RN) and completion of orientation and training programs designed to provide the understanding of the decision-making	failures and provider quality issues, and overall trends identified with particular providers or treatment standards that lead to unnecessary hospitalizations.	

	process. Education includes, but may not be limited to, systems training classes, web-based learning, and individual mentoring and supervision. Strategies: Authorization provided within 24 hours of receipt of the Member's clinical by the facility, is required for all inpatient benefits. Molina requires authorization of all IP medical benefits due to the cost of the benefit, regardless of the approval rate. Molina monitors inpatient care to ensure quality care, evaluate provider performance (ALOS, readmission rates), and determine transition needs. Inpatient reviews include an evaluation of previous treatment failures and provider quality issues, and overall trends identified with particular providers or treatment standards that lead to unnecessary hospitalizations are		

	reported to oversight committees such as the Clinical Quality Oversight Committee or Medical Affairs Committee for further action.		

Outpatient	**Ambulatory Surgery-** Requires prior authorization **Dental Services**- Covered by vendor, Avesis Covered dental services include: • Limited oral evaluation, problem-focused, • Radiographs, 2 • Gingivectomy and/or gingivoplasty for Dilantin therapy only, • Oral surgery, • Extractions, and • Alveoloplasty. Dental Services Children • Preventive • Diagnostic • Restorative • Orthodontia Adults • Emergency pain relief • Palliative care Certain services have limitations. **Dialysis Service and Supplies-Renal Dialysis, including hemodialysis and peritoneal dialysis services-** No limitations **Durable Medical Equipment** Depending on the	**Crisis Residential** Adult (T2048) requires prior authorization, 1 unit daily and 60 units yearly. **Intensive Outpatient Program** (S9480) , requires a prior authorization;1 unit daily and 270 units yearly. **Assertive Community Treatment (ACT)** (H0039)Requires prior authorization, up to 40 units daily; 1600 yearly **Mississippi Youth Programs Around the Clock (MYPAC) (**H2022); requires prior authorization, no limitations. **Outpatient maintenance ECT** (90870) No Limitations **Outpatient psychotherapy** No limitations for PAR providers. Prior-authorization required for non-par providers **Community Mental Health (CMHC)**	Molina renders Utilization Management decisions for standard authorization request within three (3) calendar days and/or two (2) business days of receipt of request. For expedited request decisions are rendered within 24 hours of receipt. Molina utilizes standardized nationally recognized review criteria that are based on sound scientific medical evidence for making decisions concerning medical necessity and appropriateness of services. The criteria sources used are for one or more of the following: • Medicaid Coverage Guidelines; Administrative Code • Corporate Guidance Documents addressing new or existing technology; • Change Healthcare InterQual® Criteria • Physical/Occupational Therapy and Rehabilitation Care Manual; • Algorithms and guidelines from recognized professional societies; • Advice from authoritative review articles and textbooks.

	DME item, there could be quantity limits per time period **Hearing Services-** Hearing Aids -• Eligible members under age twenty-one (21) are covered for one (1) hearing aid per fiscal year (July 1 – June 30). • Hearing aids are not covered for beneficiaries age twenty-one (21) and older. Hearing Aid Repairs- Repair services are reimbursed at invoice cost, not to exceed $95.00 Audiometric Examinations and Testing Bone Anchored Hearing Aids (BAHAs) Implantable and Non-Implantable Auditory Osseointegrated Devices (AODs) Cochlear implantations Newborn Hearing Screening **Home Health Services** **Skilled Nursing-** Home health visits are limited to twenty-five (25) per state fiscal	**Services – Psychotherapeutic Services** No prior-authorization required; Individual therapy is limited to thirty-six (36) sessions per state fiscal year; Family therapy is limited to twenty four (24) sessions per state fiscal year; Group therapy is limited to forty (40) sessions per state fiscal year; Multi-family therapy is limited to forty (40) sessions per state fiscal year and that limit includes group therapy and multi-family group therapy **Community Mental Health (CMHC) Services – Targeted Case Management** No Prior Authorization required; 2 units daily and 260 units yearly. **Community Mental Health (CMHC) Services – Community Support Services (CSS)** No Prior Authorization needed; 6 units daily and 400 units yearly. **Community Mental**	

	year (July 1 - June 30) for members age 21 and over. Additional visits are available for children under age 21 through the Expanded EPSDT Program when Approved **Hospital Services** No Limitations **Laboratory Services** No Limitations **Maternity Services** No Limitations **Non-Emergency Transportation (NET)** No Limitation **Physician Services** No Limitations **Chiropractic –** The fee for chiropractic manipulation shall be reimbursed per the fee schedule and shall not exceed seven hundred dollars ($700) per fiscal year (July 1 - June 30) per member (x-rays will count toward the dollar limit). Members under 21 can receive additional with authorization. **Prosthetics-** No Limitations **Preventive Services** No Limitations **Private Duty Nursing** Limitations apply Based on medical necessity for the	**Health (CMHC) Services – Peer Support Services** No Prior Authorization; 6 units daily and 200 units yearly. **Community Mental Health (CMHC) Services – Crisis Response Services** No Prior Authorization; 32 units daily and 224 units yearly. **Community Mental Health (CMHC) Services – Medication Evaluation & Monitoring** No Limitations **Community Mental Health (CMHC) Services – Nursing Assessment** Is limited to one hundred forty-four (144) units (15 minute units) per state fiscal year and four (4) units per day. **Non-Emergency Transportation (NET)** No Limitations **Neuropsychological and Psychological Testing** (96146,	

	member **Rehabilitative Services (PT, OT, ST)** **Physical Therapy-** Requires a PA after the initial evaluation plus six visits per calendar year, for office and outpatient setting. **Occupational Therapy-** Requires a PA after the initial evaluation plus six visits per calendar year, for office and outpatient setting. **Speech Therapy**- Requires a PA after the initial evaluation plus six visits for office and outpatient settings. **Smoking Cessation** No Limitations **Vision Services-** Eye care including emergency, preventive and routine services- Covered via Vendor, March Vision Eye exams: Members 21 and older can get 1 exam every calendar year (beginning Jan 1)	96132, 96133, 96136, 96137, 96132, 96133, 96138, 96139, 96116, 96121, 96130, 96131, 90791, 95950, 95951, 95953, 95956, 95957) Require prior authorization, limited to 4 hours per state fiscal year. **Partial Hospitalization** (H0035), require prior authorization, up to 1 unit per day; 100 units yearly (H2012) up to 5 units per day; no yearly limits **Psychosocial Rehabilitation** (H2030) up to 20 units per daily; no yearly limits **Applied Behavioral Analysis:** Screening, diagnosis, and treatment of autism spectrum disorders **Prior Authorization Process:** There are no (QTL) day or visit limits on residential substance abuse, sub-acute detox services. Intensive Outpatient Program, Outpatient	

	Members under 21 can get 2 exams every calendar year (beginning Jan 1) and additional if medically necessary. Vision Hardware- Covered via Vendor, March Vision Enhanced Benefits: •For members 20 and under: 2 pairs of glasses every calendar year. •For members 21 and older: 1 pair of glasses every calendar year. $ 100 credit for frames and lenses in addition to the standard Medicaid coverage. *Allowance can be used for multiple pairs of eyeglasses, better frames or contact lenses **EPSDT** No Limitations **Chiropractic –** The fee for chiropractic manipulation shall be reimbursed per the fee schedule and shall not exceed seven hundred dollars ($700) per fiscal year (July 1 - June 30) per member	Maintenance ECT and Outpatient psychotherapy. The duration of services is defined by the clinical need for that level of care based on each presenting Member's clinical. Molina requires provider notifications for residential treatment in order to obtain initial approval of the stay. Providers may submit clinical prior to Residential placement to obtain prior approval. For all services mentioned above (except for in-network outpatient psychotherapy which doesn't require prior authorization) Providers are required to submit the Molina PA request form along with appropriate clinical information including diagnostic criteria, medication changes, treatment planning and discharge plans demonstrating the need for the level of	

	(x-rays will count toward the dollar limit). Members under 21 can receive additional with authorization. **Prosthetics-** No Limitations **Prior Authorization Process:** The duration of services is defined by the clinical need for that level of care based on each presenting Member's clinical. We continue to review for over and under-utilization of services, which help us determine which codes require authorization. For those services requiring authorization, Providers are required to submit the Molina PA request form along with appropriate clinical information including diagnostic criteria, medication changes, treatment planning and discharge plans (as appropriate to the service being provided)	care requested. Providers are required to update Molina at regular intervals that are dependent on clinical need, to continuously demonstrate medical necessity. Based upon the length of time initially approved, the update required by providers for continuing the services varies and is determined on each individual case by the reviewer. Failure to obtain approval or PA for MH/SUD benefits (apart from in-network outpatient psychotherapy which doesn't require PA, or during a Continuity of Care Period during which time PA's with an existing provider will be honored) could result in denial of claims payment. Providers may request reconsideration regarding these determinations if they can demonstrate medical necessity or encounter extenuating circumstances. Denial rates for MH/SUD benefits are monitored on a monthly basis during a Utilization		

	demonstrating the need for the level of care requested. Providers are required to update Molina at regular intervals that are dependent on clinical need, to continuously demonstrate medical necessity. Based upon the length of time initially approved for the service, the update required by providers for continuing the service varies and is determined on each individual case by the reviewer based on the criteria/clinical. Failure to obtain approval or PA for benefits could result in denial of claims payment. Providers may request reconsideration regarding these determinations if they can demonstrate medical necessity or encounter extenuating circumstances. Denial rates are monitored on a monthly basis during a Utilization Review meeting comprised of Healthcare Services management and Medical Directors. Qualifications required	Review meeting comprised of Healthcare Services management and Medical Directors. Qualifications required for persons reviewing the PA request include an active nursing license or an active Licensed Clinical Social Work or Licensed Professional Counselor, Licensed Marriage and Family Therapist (RN, LCSW, LPC, LMFT, PhD) and completion of orientation and training programs designed to provide the understanding of the decision-making process. Education includes, but may not be limited to, systems training classes, web-based learning, and individual mentoring and supervision.	

	for persons reviewing the PA request include an active nursing license in the state of Mississippi (RN) and completion of orientation and training programs designed to provide the understanding of the decision-making process. Education includes, but may not be limited to, systems training classes, web-based learning, and individual mentoring and supervision.		
Emergency	There are no Emergency Service limitations	There are no Emergency Service limitations	
Pharmacy	Limitations apply Based on medical necessity	Limitations apply Based on Medical necessity	Molina utilizes standardized nationally recognized review criteria that are based on sound scientific medical evidence for making decisions concerning medical necessity and appropriateness of services.

3. **Aggregate Lifetime and Annual Dollar Limits (AL/ADL) –** AL/ADL are dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis. An AL/ADL cannot be applied to MH/SUD benefits unless it applies to at least one-third of M/S benefits. If the AL/ADL applies to less than one-third of M/S benefits, then the AL/ADL must be eliminated. If the AL/ADL applies to at least two-thirds of M/S benefits then it must be applied no more restrictively to MH/SUD benefits. If the AL/ADL applies to between one-third and two-thirds of the M/S benefits, then it may be applied to MH/SUD benefits if it is no more restrictive than the weighted average of the limit applied to M/S benefits.

Classification	**Medical/Surgical limits** (specific service and limitation)	**Mental Health/SUD limits** (specific service and limitation)	**Outcome Justification** (include brief description of AL/ADL analysis for each classification with justification of pass/fail for 1/3 and Restrictive Tests)

Inpatient	There are no aggregate lifetime or annual dollar limits on inpatient health services.	There are no aggregate lifetime or annual dollar limits on inpatient behavioral health services.	Molina Healthcare does not apply AL/ADL for inpatient services
Outpatient	There are no aggregate lifetime or annual dollar limits on outpatient health services.	There are no aggregate lifetime or annual dollar limits on sub-acute detox or residential SUD services.	Molina Healthcare does not apply AL/ADL for outpatient services
Emergency	There are no aggregate lifetime or annual dollar limits on emergency services.	There are no aggregate lifetime or annual dollar limits on emergency services.	Molina Healthcare does not apply AL/ADL for emergency services
Pharmacy	There are no aggregate lifetime or annual dollar limits on pharmacy services.	There are no aggregate lifetime or annual dollar limits on pharmacy services.	Molina Healthcare does not apply AL/ADL for pharmacy services

III. NON-QUANTATIVE TREATEMENT LIMITS ANALYSIS

Non-Quantitative Treatment Limits (NQTL) are any limits on the scope or duration of benefits, such as prior authorization or network admission standards. An NQTL may not apply to MH/SUD benefits in a classification unless the NQTL for MH/SUD benefits in the classification are **comparable to** and **applied no more stringently** than the NQTL for M/S benefits in the classification. In analyzing the comparability and stringency of the NQTL in the classification, the MCO should review policies and procedures, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the MH/SUD and M/S NQTL.

Some examples of NQTLs include, but are not limited to:

1) Medical management standards
   - Medical necessity criteria development
   - Prior authorization
   - Concurrent review
   - Retrospective review
   - Outlier management
   - Experimental/investigational determinations
   - Fail first requirements (e.g., Refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective)
   - Exclusions (e.g., based on a failure to complete treatment)
   - Medical appropriateness reviews
   - Practice guideline selection/criteria

- Requirements for lower cost therapies to be tried first

2) Network admission standards
   - Reimbursement rates
   - Geographic restrictions
   - Specialty requirements or exclusions
   - Facility type requirements or additional requirements for certain facility types
   - Network tiers

3) Out-of-network access standards
4) Methods for determining usual, customary, and reasonable charges
5) Formulary design for prescription drugs
6) Prescription drug benefit tiers

The first step in conducting an NQTL analysis is to identify all of the NQTLs applicable to MH/SUD benefits in each classification. A type of NQTL must be tested in each classification in which it applies, and the MCO must identify ANY limits on the scope or duration of a MH/SUD benefit. Some NQTLs (e.g., prior authorization requirements) are readily identifiable. Other NQTLs require more in-depth analysis of written policies and procedures, and their operations related to utilization and quality management, provider network admission standards, reimbursement rates, prescription drug tiering factors, medication dispensing requirements, and other NQTLs embedded in operations.

Once NQTLs are identified for a classification, the MCO must collect information about the processes, strategies, evidentiary standards, and other factors applicable to each type of NQTL relative to M/S and MH/SUD benefits. The MCO will then conduct the NQTL analysis on the basis of that information to determine compliance with parity requirements of **comparability** and **stringency**.

The table below should be used to document the NQTLs by classification along with the analysis of the NQTL's application to M/S and to MH/SUD benefits within the classification. Any supporting documentation (e.g., policies, procedures, data, reports, etc.) should be noted in the last column and submitted with the MCO's completed Parity Analysis Template. Some example NQTLs are listed under each classification, along with example questions that should be answered for each identified NQTL. MCOs must identify ANY limits that apply in each classification and should add additional rows to the table to fully discuss any limits not already included in the table.

NQTL Parity Analysis Table: To complete the table below, identify all NQTLs that apply to each classification (pre-printed examples are offered for consideration but ARE NOT EXHAUSTIVE, all additional NQTLs must be analyzed). Indicate how the NQTL is applied for both M/S services AND MH/SUD services. Indicate under MH/SUD how the NQTL meets or does not meet criteria for comparability and stringency when compared to M/S. Reference any policy, procedure, data, reports, etc. in the last column.

NQTL	Medical/Surgical	Mental Health/Substance Use Disorder
Inpatient **Medical Necessity and Appropriateness Criteria and Application –** What criteria are applied to make a medical necessity/ appropriateness determination and how are they developed or selected? Describe the processes, strategies, evidentiary standards, and other factors applicable to developing/selecting your medical necessity and appropriateness criteria. What are the processes, strategies, evidentiary standards, and other factors applied in assigning medical necessity/ appropriateness reviews to inpatient benefits? What are the written and operating processes, strategies, evidentiary standards, and other factors applied during a medical necessity/ appropriateness review? Specifically address how frequency of review is determined and potential results following such a review. Do your medical necessity or appropriateness criteria include any of the following: - Fail first requirements or step-therapies (e.g., prescription drugs)? If yes, describe the processes, strategies, evidentiary standards, and other factors in writing and in operation for fail first requirements. - Exclusions based on failure to complete a course of treatment (e.g., tobacco use disorder treatment)? If yes, describe the processes, strategies, evidentiary standards, and other factors in writing and in operation for these exclusions.	Molina reviews clinical criteria and individual circumstances for Med/Surg benefits to ensure medical necessity requirements are met. Nationally recognized, evidence-based criteria are utilized when making determinations. The review is based on benefit authorization requirements and decision algorithms. Molina's decision algorithms are established by the Medical Affairs team and integrate state regulatory requirements for the management of Medicaid Med/Surg benefits based on clinical guidelines from Interqual for inpatient care and InterQual for Outpatient services. The hierarchy for medical necessity reviews of Medicaid Med/Surg benefits is: State criteria > Medical necessity criteria (InterQual on level of care for Inpatient) or (InterQual for outpatient services)> Molina Care Policy criteria. This process is reviewed every year and adjusted accordingly. Any new clinical subsets from practice guidelines are reviewed at this time and potentially incorporated by the PURC Committee (Peer Review and Utilization Review Committee) annually. Molina's process for developing, adapting or adopting medical necessity and appropriateness criteria is managed at the Molina Healthcare Senior Leadership level. Molina primarily uses InterQual vendor to provide and evaluate medical necessity/appropriate criteria on an annual basis for inpatient services and InterQual for outpatient services. The annual evaluation includes; reviews of all applicable medical literature on evidence-based practice guidelines, review of key medical society literature, and consider input from panels of medical experts for the development of their clinical guidelines. If nationally recognized guidelines are not available from a vendor for a service, then Molina Care Policy (MCP) criteria are developed at the corporate level based upon medical research on standards of care and is reviewed annually.	Molina reviews clinical criteria and individual circumstances for MH/SUD benefits to ensure medical necessity requirements are met. Nationally recognized, evidence-based criteria are utilized when making determinations. The review is based on benefit authorization requirements and decision algorithms. Molina's decision algorithms are established by the Medical Affairs team and integrate state regulatory requirements for the management of Medicaid MH/SUD benefits (e.g., ECT, BH Inpatient) based on clinical guidelines from InterQual. The hierarchy for medical necessity reviews of Medicaid MH/SUD benefits is: State criteria > Medical necessity criteria (InterQual) based on level of care) > Molina Care Policy criteria. This process is reviewed every year and adjusted accordingly. Any new clinical subsets from practice guidelines are reviewed at this time and potentially incorporated by the PURC Committee (Peer Review and Utilization Review Committee) annually. Molina's process for developing, adapting or adopting medical necessity and appropriateness criteria is managed at the Molina Healthcare Senior Leadership level. Molina primarily uses one Change Healthcare InterQual® vendor to provide and evaluate medical necessity/appropriate criteria on an annual basis. The annual evaluation includes; reviews of all applicable medical literature on evidence-based practice guidelines, review of key medical society literature, and consider input from panels of medical experts for the development of their clinical guidelines. If nationally recognized guidelines are not available from a vendor for a benefit, then Molina Care Policy (MCP) criteria are developed at the corporate level based upon medical research on standards of care and is reviewed annually. Senior Leadership discusses the addition of new criteria subsets into InterQual software during the annual vendor meetings, including any criteria developed as Molina Care Policies. A Molina Care Policy is retired as a separate reference document once the policy is embedded into vendor software.

	Strategies: For all benefits, Molina monitors quality of care incidents, utilization and billing practices. Licensure and certification requirements are reviewed during provider contracting. Timeframes for review: Medicaid: Molina renders Utilization Management decisions for initial routine requests with-in 2 business days/ 3 Calendar days of receipt of request. For emergent IP admissions, decisions are rendered within 24 hours of receipt of request	Strategies: For all benefits, Molina monitors quality of care incidents, utilization and billing practices. Licensure and certification requirements are reviewed during provider contracting. Timeframes for review: Medicaid: Emergent inpatient admissions are reviewed within 24 hours of notification. Standard preservice authorization request determination is provided within 3 calendar days and/or 2 business days. The frequency of the review for inpatient cases depends on the acuity and numbers of days recommended by the nationally accepted criteria. All inpatient cases require authorization. Outpatient services are reviewed for over and under-utilization quarterly and recommendations for authorization are based on those results. Evidentiary Standards: Quality of care reviews consider whether evidence-based practice guidelines are being followed. Clinical staff are trained to report potential concerns about quality of care when they notice from clinical information received or from direct observation that the care members are receiving falls outside of evidence based practice guidelines (i.e., InterQual/Molina Care Policy). PA staff can also use their own clinical judgment to report medical errors when clearly demonstrated. **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity.**

NQTL	**Medical/Surgical**	**Mental Health/Substance Use Disorder**
Prior Authorization Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to inpatient M/S services, and the administration of this requirement. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to MH/SUD inpatient services for which prior authorization is required.	Molina requires authorization of all M/S IP services due to the cost of the benefit, and to ensure each Member is receiving medical services at the appropriate of level of care for the safety of the member and to maximize on clinical outcomes, regardless of the approval rate. Molina monitors inpatient, inpatient medical detox, Skilled Nursing Facility and Long Term Acute Care to ensure quality care, evaluate provider performance (ALOS, readmission rates), and determine transition needs. Molina applies PA for all M/S benefits requiring inpatient stay on the Molina PA list. Molina processes PA requests within 10 calendar days for non-urgent and within 72 hours for urgent requests for all benefits. Providers are required to submit similar forms and document clinical/medical need with the request. For services rendered without the appropriate authorization, providers can request a retrospective review for reimbursement. All benefits that require prior authorization must be performed by appropriate provider types contracted with Molina, and the PA request must clearly define appropriate diagnosis codes. Molina ensures PA requirements meet all regulatory guidelines and there is peer reviewed supported evidence prior to implementation. Exceptions to the process are made when members are transitioning from one plan to another. PA is applied to benefits to ensure medical necessity to avoid unnecessary costs, prevent unnecessary intrusiveness and prevent inadvertent coverage of experimental or investigational services. For pre-service authorizations, Molina use InterQual for M/S services as clinical guidelines. Strategies: Prior authorization is required for all M/S inpatient benefits. Sub-acute detox services, SNF and LTAC are intensive in terms of staffing, the level of services provided, and the time commitment by the beneficiary. Inpatient services are high intensity services because they are offered 24 hours a day and require removal from the member's home. PA was included for all Inpatient PA in an effort drive the system toward the least restrictive level care according to the criteria in InterQual.	Molina requires authorization of all MH/SUD IP services due to the cost of the benefit, and to ensure each Member is receiving medical services at the appropriate of level of care for the safety of the member and to maximize on clinical outcomes, regardless of the approval rate. Molina monitors inpatient, sub-acute detox and residential care to ensure quality care, evaluate provider performance (ALOS, readmission rates), and determine transition needs. Molina applies PA for certain MH/SUD and M/S benefits on the Molina PA list. Molina processes PA requests within 3 calendar days and/or 2 business days for non-urgent and within 24 hours for urgent requests for all benefits. Providers are required to submit similar forms and document clinical/medical need with the request. For services rendered without the appropriate authorization, providers can request a retrospective review for reimbursement. All benefits that require prior authorization must be performed by appropriate provider types contracted with Molina, and the PA request must clearly define appropriate diagnosis codes. Molina ensures PA requirements meet all regulatory guidelines and there is peer reviewed supported evidence prior to implementation. Exceptions to the process are made when members are transitioning from one plan to another. PA is applied to benefits to ensure medical necessity to avoid unnecessary costs, prevent unnecessary intrusiveness and prevent inadvertent coverage of experimental or investigational services. Molina use InterQual for MH/SUD benefits and InterQual M/S benefits as clinical guidelines. Strategies: Prior authorization is required for all MH/SUD inpatient benefits. SUD Residential and sub-acute detox services are intensive in terms of staffing, the level of services provided, and the time commitment by the beneficiary. Inpatient services are high intensity services because they are offered 24 hours a day and require removal from the member's home. PA was included for SUD Residential and sub-acute detox in an effort to drive the system toward the least restrictive level of SUD care as the providers moved toward the use of all levels of ASAM. **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity.**

NQTL	Medical/Surgical	Mental Health/Substance Use Disorder
Concurrent Review What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review for inpatient services? Provide average denial rates and appeal overturn rates for concurrent review for M/S and MH/SUD. Identify the factors (e.g., cost of treatment, high cost growth, variability in cost and quality, elasticity of demand, provider discretion in determining diagnosis, type or length of treatment, clinical efficacy of treatment or service, licensing and accreditation of providers, fraud potential) that determine the services selected for concurrent review. What evidentiary standards support their use? Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 30 visits, and every refill).	Providers are required to update Molina at regular intervals that are dependent on clinical need, to continuously demonstrate medical necessity. Based upon the length of time initially approved for admission, the update required by providers for continuing stay varies and is determined on each individual case by the reviewer. Failure to demonstrate medical necessity criteria for M/S services could result in denial of claims payment. Providers may request reconsideration regarding these determinations if they can demonstrate medical necessity or encounter extenuating circumstances. Denial rates for M/S benefits are monitored on a monthly basis during a Utilization Review meeting comprised of Healthcare Services management and Medical Directors.	Providers are required to update Molina at regular intervals that are dependent on clinical need, to continuously demonstrate medical necessity. Based upon the length of time initially approved for admission, the update required by providers for continuing stay varies and is determined on each individual case by the reviewer. Failure to demonstrate medical necessity criteria for MH/SUD benefits could result in denial of claims payment. Providers may request reconsideration regarding these determinations if they can demonstrate medical necessity or encounter extenuating circumstances. Denial rates for MH/SUD benefits are monitored on a monthly basis during a Utilization Review meeting comprised of Healthcare Services management and Medical Directors. **-Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity**.

NQTL	Medical/Surgical	Mental Health/Substance Use Disorder
Network Admission Requirements What are your network admission requirements? Describe the written and operational processes, strategies, evidentiary standards, or other factors applied in setting network admission standards and implementing them. Include information regarding network adequacy. Are any practitioner types (e.g., social workers, recreational therapists), facility types (e.g., chemical dependency facilities, skilled nursing facilities), or specialty providers excluded in writing or in operation from providing covered benefits? If yes, describe the written and operating processes, strategies, evidentiary standards, or other factors applied for this exclusion. Are there any geographic limitations on provider inclusion? If yes, describe the written and operating processes, strategies, evidentiary standards, or other factors applied for this limitation. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits. Indicate whether and how each of the listed factors affects how professional provider reimbursement rates are determined: -Service type -Geographic market -Service demand -Provider supply – based on membership capacity -Practice size -Medicare reimbursement rates -Licensure -Other	Molina requires that Practitioners have admitting privileges in good standing in their specialty without restrictions with Molina participating hospital. If the practitioner does not hold privileges, they must have a plan for hospital admission by using a Hospital Inpatient Team or have an arrangement with a credentialed Molina participating practitioner that has the ability to admit Molina patients at a participating hospital. 1) Molina runs all practitioners (initial and re-credentialing) through the Social Security Death Master File (Social Security Administration database). 2) Practitioners going through recredentialing must have documented review of performance indicators collected through clinical quality monitoring process, the utilization management system, the grievance system, enrollee satisfaction surveys, and other quality indicators. 3) Practitioners terminated by the Molina Professional Review Committee or terminated from the Molina network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, practitioner must meet all criteria for participation. 4) Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a general practitioner in the Molina network. To be eligible, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Reimbursement rates are at 100% of Medicaid.	Mental health and/or substance abuse benefits must fall within the scope of the provider's license. Molina requires that Practitioners have admitting privileges in good standing in their specialty without restrictions with Molina participating hospital. If the practitioner does not hold privileges, they must have a plan for hospital admission by using a Hospital Inpatient Team or have an arrangement with a credentialed Molina participating practitioner that has the ability to admit Molina patients at a participating hospital. 1) Molina runs all practitioners (initial and re-credentialing) through the Social Security Death Master File (Social Security Administration database). 2) Practitioners going through recredentialing must have documented review of performance indicators collected through clinical quality monitoring process, the utilization management system, the grievance system, enrollee satisfaction surveys, and other quality indicators. 3) Practitioners terminated by the Molina Professional Review Committee or terminated from the Molina network for cause are not eligible to reapply until five years after the date of termination. At the time of reapplication, practitioner must meet all criteria for participation. 4) Practitioners without a board certification (e.g. psychiatry, psychology, etc.) and specialty training program from an accredited training program will be considered for participation as a general practitioner in the Molina network. To be eligible, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Reimbursement rates are at 100% of Medicaid. **Meets comparability and stringency as policies for enrollment apply for providers to be enrolled within Molina's network**

NQTL	**Medical/Surgical**	**Mental Health/Substance Use Disorder**
Other- Court Ordered Services	All court ordered services must meet medical necessity and any prior authorization guidelines.	All court ordered services must meet medical necessity and any prior authorization guidelines. **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity.**

NQTL	**Medical/Surgical**	**Mental Health/Substance Use Disorder**
Outpatient **Medical Necessity and Appropriateness Criteria and Application** (requirements outlined in Inpatient services section apply)	Molina utilizes standardized nationally recognized review criteria that are based on sound scientific medical evidence for making decisions • Medicaid Coverage Guidelines; • Corporate Guidance Documents addressing new or existing technology; • InterQual® Criteria • Hayes Medical Technology Directory; • Apollo Managed Care Managing Physical/Occupational Therapy and Rehabilitation Care Manual; • Algorithms and guidelines from recognized professional societies; • Advice from authoritative review articles and textbooks;. Actively practicing practitioners are involved in the development and adoption of criteria specific to their area of expertise. When specific criteria are not available, reviewing Medical Directors may use textbooks, evidence-based reviews from the medical literature, or consultation with appropriate specialists to help make Authorization decisions.	Molina reviews clinical criteria and individual circumstances for the following outpatient MH/SUD benefits to ensure medical necessity requirements are met: Nationally recognized, evidence-based criteria are utilized when making determinations. The review is based on benefit authorization requirements and decision algorithms. Molina's decision algorithms are established by the Medical Affairs team and integrate state regulatory requirements for the management of Medicaid MH/SUD benefits based on clinical guidelines from InterQual. The hierarchy for medical necessity reviews of Medicaid MH/SUD benefits is: State criteria > Medical necessity criteria (InterQual based on level of care) > Molina Care Policy criteria. This process is reviewed every year and adjusted accordingly. Any new clinical subsets from practice guidelines are reviewed at this time and potentially incorporated. Molina's process for developing, adapting or adopting medical necessity and appropriateness criteria is managed at the Molina Healthcare Senior Leadership level. Molina primarily uses one (InterQual) vendor to provide and evaluate medical necessity/appropriate criteria on an annual basis. The annual evaluation includes; reviews of all applicable medical literature on evidence-based practice guidelines, review of key medical society literature, and consider input from panels of medical experts for the development of their clinical guidelines. If nationally recognized guidelines are not available from a vendor for a benefit, then Molina Care Policy (MCP) criteria are developed at the corporate level based upon medical research on standards of care and is reviewed every two years. Senior Leadership discusses the addition of new criteria subsets into InterQual software during the annual vendor meetings, including any criteria developed as Molina Care Policies. A Molina Care Policy is retired as a separate reference document once the policy is embedded into vendor software.
Prior Authorization (requirements outlined in Inpatient services section apply)	Molina requires prior authorization for certain services according to the Molina Prior Authorization guidelines and code matrix.	Molina requires prior authorization for certain Behavioral Health Services according to the Molina Prior Authorization guidelines and code matrix. **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity.**
Concurrent Review (requirements outlined in Inpatient services section apply)	N/A	N/A

NQTL	**Medical/Surgical**	**Mental Health/Substance Use Disorder**
Network Admission Requirements (requirements outlined in Inpatient services section apply)	Molina requires that Practitioners have admitting privileges in good standing in their specialty without restrictions with Molina participating hospital. If the practitioner does not hold privileges, they must have a plan for hospital admission by using a Hospital Inpatient Team or have an arrangement with a credentialed Molina participating practitioner that has the ability to admit Molina patients at a participating hospital. 1) All Primary Care Practitioners are required to have 24-hour coverage. If applicable to the specialty, practitioner must have a plan for shared call coverage that includes 24-hours a day, seven days per week and 365 days per year. The covering practitioner(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day. 2) Molina runs all practitioners (initial and re-credentialing) through the Social Security Death Master File (Social Security Administration database). 3) Practitioners going through recredentialing must have documented review of performance indicators collected through clinical quality monitoring process, the utilization management system, the grievance system, enrollee satisfaction surveys, and other quality indicators. 4) Practitioners terminated by the Credentialing Committee or terminated from the network for cause are not eligible to reapply until one (1) year after the date of termination. At the time of reapplication, practitioner must meet all criteria for participation as outlined above. 5) Practitioners who are not Board Certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Molina network. Reimbursement rates are at 100% of Medicaid.	Molina requires that Practitioners have admitting privileges in good standing in their specialty without restrictions with Molina participating hospital. If the practitioner does not hold privileges, they must have a plan for hospital admission by using a Hospital Inpatient Team or have an arrangement with a credentialed Molina participating practitioner that has the ability to admit Molina patients at a participating hospital. 1) All Primary Care Practitioners are required to have 24-hour coverage. If applicable to the specialty, practitioner must have a plan for shared call coverage that includes 24-hours a day, seven days per week and 365 days per year. The covering practitioner(s) must be qualified to assess over the phone if a patient should immediately seek medical attention or if the patient can wait to be seen on the next business day. 2) Molina runs all practitioners (initial and re-credentialing) through the Social Security Death Master File (Social Security Administration database). 3) Practitioners going through recredentialing must have documented review of performance indicators collected through clinical quality monitoring process, the utilization management system, the grievance system, enrollee satisfaction surveys, and other quality indicators. 4) Practitioners terminated by the Credentialing Committee or terminated from the network for cause are not eligible to reapply until one (1) year after the date of termination. At the time of reapplication, practitioner must meet all criteria for participation as outlined above. 5) Practitioners who are not Board Certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Molina network. Reimbursement rates are either at 100% of Medicaid. **Meets comparability and stringency as policies for enrollment apply for providers to be enrolled within Molina's network**
Other- Court Ordered Services	All court ordered services must meet medical necessity and any prior authorization guidelines.	All court ordered services must meet medical necessity and any prior authorization guidelines. **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity.**

NQTL	**Medical/Surgical**	**Mental Health/Substance Use Disorder**
Emergency **Medical Necessity and Appropriateness Criteria and Application** (requirements outlined in Inpatient services section apply)	Molina Healthcare does not require authorization for emergency services	Molina Healthcare does not require authorization for emergency services. **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity.**
Concurrent Review (requirements outlined in Inpatient services section apply)	N/A	N/A
Network Admission Requirements (requirements outlined in Inpatient services section apply)	Molina does not credential ER physicians (credentialed by hospital they hold privileges). Molina credentials contracted hospitals.	Molina does not credential ER physicians (credentialed by hospital they hold privileges). Molina credentials contracted hospitals. **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity.**
NQTL **Pharmacy** **Formulary Design/Construction** Are prescription drug benefits tiered? If yes, describe the processes, strategies, evidentiary standards, and other factors in writing and in operation that determine how prescription drug benefits are tiered. List the factors that determine the tiers (e.g., cost, brand name vs. generic). Indicate whether the condition treated affects tier assignment of a medication.	**Medical/Surgical** Prescription drug benefit is not tiered. All covered medications have $0 out of pocket expense.	**Mental Health/Substance Use Disorder** Prescription drug benefit is not tiered. All covered medications have $0 out of pocket expense. **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity.**

NQTL **Pharmacy** **Medical Necessity and Appropriateness Criteria and Application** (requirements outlined in Inpatient services section apply)	**Medical/Surgical** The Molina Pharmacy and Therapeutics Committee comprised of practicing pharmacists, physicians and nurses is responsible for developing, reviewing and approving pharmacy practice guidelines for medical necessary using information such as: 1. Professional or government associations/organizations (e.g. American Psychiatric Association, etc.) 2. Authoritative compendia 3. Peer-reviewed journals 4. Pharmaceutical manufacturers When a pharmacy practice guideline is not available, medical necessity is based on available clinical guidelines from professional societies along with peer-reviewed literature and clinical judgment.	**Mental Health/Substance Use Disorder** The Molina Pharmacy and Therapeutics Committee comprised of practicing pharmacists, physicians and nurses is responsible for developing, reviewing and approving pharmacy practice guidelines for medical necessary using information such as: 1. Professional or government associations/organizations (e.g. American Psychiatric Association, etc.) 2. Authoritative compendia 3. Peer-reviewed journals 4. Pharmaceutical manufacturers When a pharmacy practice guideline is not available, medical necessity is based on available clinical guidelines from professional societies along with peer-reviewed literature and clinical judgment. **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity**
Prior Authorization (requirements outlined in Inpatient services section apply)	Along with pharmacy practice guidelines, the following parameters may be considered when applying prior authorization criteria to specific drugs used for these indications. • Member diagnosis and relevant concurrent medical conditions • Member age and sex • Member allergies • Clinical rationale for selecting the drug • Condition being treated is consistent with FDA-approved indications and/or meets approved criteria for safe use • Expected outcome of therapy and methods to be used to measure outcome • Anticipated duration of therapy • Member's previous experience with this drug, if any • Member's previous drug therapy, drug responses and adverse effects • Member's concurrent drug therapy • Member's compliance history • Prescriber's familiarity with the drug • If other equivalent and/or alternative medication(s) that are on the Formulary (also known as the Preferred Drug List) have been used at an adequate dose for an adequate duration, if medically appropriate. Cost-effectiveness of the drug on overall healthcare costs.	Along with pharmacy practice guidelines, the following parameters may be considered when applying prior authorization criteria to specific drugs used for these indications. • Member diagnosis and relevant concurrent medical conditions • Member age and sex • Member allergies • Clinical rationale for selecting the drug • Condition being treated is consistent with FDA-approved indications and/or meets approved criteria for safe use • Expected outcome of therapy and methods to be used to measure outcome • Anticipated duration of therapy • Member's previous experience with this drug, if any • Member's previous drug therapy, drug responses and adverse effects • Member's concurrent drug therapy • Member's compliance history • Prescriber's familiarity with the drug • If other equivalent and/or alternative medication(s) that are on the Formulary (also known as the Preferred Drug List) have been used at an adequate dose for an adequate duration, if medically appropriate. Cost-effectiveness of the drug on overall healthcare costs.

NQTL	Medical/Surgical	Mental Health/Substance Use Disorder
Pharmacy **Concurrent Review** (requirements outlined in Inpatient services section apply)	Not Applicable to Pharmacy Benefit	Not Applicable to Pharmacy Benefit **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity.**
Network Admission Requirements (requirements outlined in Inpatient services section apply)	Pharmacy Network is owned and maintained by the Pharmacy Benefit Manager (PBM)	Pharmacy Network is owned and maintained by the Pharmacy Benefit Manager (PBM) **Meets comparability and stringency as the same rules that are applied to M/S are applied to MH/SUD. All services must meet medical necessity.**

SUMMARY OF NQTL ANALYSIS INCLUDING: 1) THE IDENTIFICATION OF ANY AREAS OF NON-COMPLIANCE, AND 2) A PLAN TO ADDRESS NON-COMPLIANCE:

Molina Healthcare has identified the NQTLs that are applicable to the MH/SUD benefits in each classification. The NQTLs were identified and the information was collected from various business departments about the processes, strategies, evidentiary standards, and other identifying factors used in applying the NQTL (in writing and in operation) to assess the comparability and stringency to which the NQTL is applied between Med/Surg. and the MH/SUD in all four classifications. The NQTL analysis was conducted for each type of classification. Based on the CMS guidance in the Toolkit, section 6; each type of NQTL was tested once in a classification, regardless of the type or number of services limitations. Molina Healthcare performed the required analysis to determine if parity was met.

It is Molina Healthcare's opinion that the non-quantitative treatment limitations are substantially consistent with parity standards.

COMPLIANCE MONITORING PLAN-

In collaboration with Molina Healthcare's Medical Affairs and Utilization Management departments, a review any potential benefit changes and requirements will present the need for an updated parity analysis to be submitted for approval of changes if compliance requirements are met. In addition, both parties will collaborate with business operational units on identifying key processes and procedures that could affect compliance with the MHPAEA, and require updated parity analysis be submitted prior to implementing any operational changes.

Once parity has been assessed as complete, Molina Healthcare's Medical Affairs and Utilization Management Department will monitor the trending patterns of medical/surgical and behavioral health data to identify potential data variances identified from baseline statistics established with the successful implementation of MHPAEA practices. If there are any variances there will be a review process and a thorough analysis completed to ensure that parity is maintained in accordance with state and federal requirements. Should monitoring efforts identify potential non-compliance, Compliance will request formal corrective action from the applicable business unit and perform follow-up procedures to validate action has been taken to remediate the potential non-compliance.

	Inpatient	**Outpatient**	**Pharmacy**	**Emergency**
Medical	Acute Care Inpatient Services Acute Inpatient Physical Rehabilitation Skilled Nursing Facilities Long Term Acute Care Facilities Inpatient Hospice	Outpatient Medical/Surgical Care Ambulatory Surgery Home Health Physical Therapy Occupational Therapy Speech Therapy Chiropractic Services	Pharmacy benefits are applied per the benefit plan and evidence based clinical criteria for use of medication, regardless of behavioral health or medical diagnosis.	Services covered in connection with a medical condition that occur suddenly and without warning with symptoms which are so acute and severe as to require immediate medical attention.
Behavioral	Inpatient Psychiatric Services Inpatient Substance Abuse treatment services Inpatient Rehabilitation Residential treatment- Substance Use Residential Treatment- Psychiatric Observation Partial Hospitalization	Outpatient mental health services Outpatient Substance use treatment services Community Based Services Electroconvulsive Therapy Applied Behavioral Analysis Intensive Outpatient		

Coverage Guidelines

	Cenpatico	Magnolia Health Plan
Purpose	The purpose of this policy is to provide guidelines on developing, reviewing, and approving medical necessity criteria based on sound clinical evidence, to ensure utilization decisions follow written criteria, and to specify procedures for appropriately applying the criteria.The purpose of the company's policy is that medical necessity criteria are objective, clinicaly valid, flexible and compatible with established principles of healthcare. The Company uses written, medically acceptable medical necessity criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from practicing psychiatrists and other behavioral health care providers. The criteria for determining medical necessity are clearly documented and include written procedures for applying the criteria based on the needs of individual enrollees and/or assessment of the local delivery system. We utilize InterQual (IQ) criteria and American Society of Addiction Medicine (ASAM) criteria. Both InterQual and ASAM criteria are evidence-based, standards for medical necessity reviews. These MNCs were selected for their nationally acceptance and therefore ability to be used across various markets and levels of care.	Magnolia has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from providers. In general, the Plan uses McKesson's InterQual guidelines to determine medical necessity and appropriateness of physical healthcare. InterQual is a recognized leader in development of clinical decision support tools, and is used by numerous organizations and agencies to assist in managing healthcare for more than 100 million people. InterQual is developed by generalist and specialist physicians representing a national panel from academic as well as community based practice, both within and outside the managed care industry. InterQual provides a clear, consistent, evidence-based platform for care decisions that promote appropriate use of services, enhance quality and improve health outcomes. The Plan will use InterQual's Level of Care and Care Planning Criteria for Pediatric Acute, Adult Acute, Long-Term Acute Care, Inpatient Rehabilitation, Home Care, Outpatient Rehabilitation and Chiropractic, Durable Medical Equipment, Imaging, Procedures, Molecular Diagnostics and also available Behavioral Health (BH) criteria including Geriatric Psychiatry, Adult Psychiatry, Adolescent Psychiatry, Child Psychiatry, Substance Use Disorders & Dual Diagnosis and Residential & Community-Based Treatment to determine medical necessity and appropriateness of care.
Development	Medical necessity criteria (MNC) are developed from the State's service definitions and provider manual(s). In addition to those criteria outlined, we utilize InterQual (IQ) criteria and American Society of Addiction Medicine (ASAM) criteria. IQ is a standardized, evidence-based clinical decision support providing appropriateness of care decision support across all levels of care. The ASAM criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of individuals with addiction and co-occurring conditions. In addition to application of MNC, reviewers use clinical judgment. Our workflows (WF) have very specific decision trees regarding which MNC to use for each classification. Review frequency is determined by the dates of service (DOS) requested by the provider as well clinical judgement. Medical Necessity reviews are assigned to benefits 1. which are not standard levels of treatment, which have specific/limited criteria which indicate the needs for the service and therefore review is needed to determine appropriateness, 2. to ensure member are receiving quality care. These guidlines are reviewed and approved in the Utilization Managment Committee.	In instances of determining benefit coverage and medical necessity of new and emerging technologies and the new application of existing technologies or application of technologies for which no InterQual Criteria exists, the Plan's Medical Director shall first consult Centene's available Medical Policy Statements. The Centene Clinical Policy Committee, with representation from the Plan and other Centene Health Plans, develops these statements. The Corporate Clinical Policy Committee (CPC) is responsible for evaluating new technologies or new applications of existing technologies for inclusion as medical necessity criteria. The CPC shall develop, disseminate and at least annually update medical policies related to: medical procedures, behavioral health procedures, pharmaceuticals and devices. The CPC or assigned designee shall review appropriate information to make the medical necessity decisions including published scientific evidence, applicable government regulatory body information, CMS's National Coverage Decisions database/manual and input from relevant specialists and professionals who have expertise in the technology. Practitioners are notified in writing through the provider newsletters and the practitioner web portal of new technology determinations made by the Plan. As with standard UM criteria, the treating practitioner may, at any time, request the medical policy criteria pertinent to a specific authorization by contacting the Medical Management Department or may discuss the UM decision with the Medical Director.

Coverage Guidelines 

	Cenpatico	Magnolia Health Plan
Committee(s)	The Utilization Management Committee has the responsibility to review and provide input into the criteria. Input from other stakeholders is solicited as needed. The Utilization Management Committee oversees the development, revision and implementation of the criteria with oversight by the Quality Improvement Committee (QIC), as per covered services for Mississippi's Medicaid program. The Company provides written instructions for practitioners to obtain case specific Medical Necessity criteria upon request. Annually the Company evaluates the consistency of application of the criteria by the health care professionals involved in utilization review via an inter-rater reliability survey and case audits. Updates and revisions to InterQual, ASAM are reviewed annually by the Utilization Management Committee. During this time, appropriate behavioral health practitioners, including but not limited to psychiatrists, psychologists, and social workers with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on adoption of UM criteria and on instructions for applying the criteria.	Daily oversight and operating authority of UM activities are delegated to the UMC, which reports to the Plan's QIC and ultimately to the BOD. The UMC is responsible for the review and appropriate approval of medical necessity criteria and protocols and UM policies and procedures. The UMC coordinates annual review and revision of the UM Program Description, UM Work Plan and UM Program Evaluation. These documents are presented to the UMC for review and approval. The UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate over or under-utilization (which may impact healthcare services), coordination of care and appropriate use of services and resources, as well as member and practitioner satisfaction with the UM process. Analysis of the above tracking and monitoring processes, as well as status updates of corrective action plans, as applicable, are reported to the QIC.
On-Going Review	Annually the Company evaluates the consistency of application of the criteria by the health care professionals involved in utilization review via an inter-rater reliability survey and case audits. • On at least an annual basis, the Medical Director or Clinical Director performs an evaluation of all UM Reviewers (Utilization Managers and Clinical Consultants) to determine whether Medical Necessity Criteria has been applied appropriately and whether there is consistency among the reviewers. This inter-rater reliability assessment will include decision-making for several levels of care and results are reviewed with the Reviewers and presented to the Utilization Management Committee. • On a monthly basis, the Utilization Management Supervisors conduct chart audits to assess accuracy and consistency in applying medical necessity criteria. Results are shared with the Utilization management staff members and used for ongoing evaluation of performance. • Weekly clinical rounds are conducted by the Medical Director.	At least annually, the CMD and VPMM assess the consistency in which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the VPMM or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. The established benchmark for acceptable consistency is a passing score of 90%. When an opportunity for improvement is identified through this process, the Plan's Medical Management leadership will take corrective action. New UM staff are required to successfully complete inter-rater reliability testing prior to being released from training oversight.
Archiving	All policies, past and newly approved, are stored in Compliance 360 for official company use.	All medical policies, past and present, approved by the Medical Policy Group are housed in the Centene Entreprise Governance, Risk and Compliance respository.
Access	The Company provides written instructions for practitioners to obtain case specific Medical Necessity criteria upon request.	The Plan Medical Director or appropriate practitioner reviewer (behavioral health practitioner, dentist, pharmacist, etc.) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Practitioners are notified of availability of an appropriate practitioner reviewer to discuss any UM decisions through the Provider Manual, New practitioner Orientation and/or the Provider Newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The Plan Medical Director may be contacted by calling the Plan's main toll-free phone number and asking for the Medical Director. A Care Manager, Prior Authorization Nurse, Concurrent Review Nurse or other designated UM staff may also coordinate communication between the Medical Director and requesting practitioner.

Emergency Classification Parity Status: ○○G

Product Name:	**Select One**

Non-Qualitative Treatment Limitation	Cenpatico Behavioral Health	Magnolia Medical	Rationale
Credentialing	Cenpatico does not credential emergency or urgent care services - claims are paid per and credentialed by the Magnolia Health Plan. The entity *** Note to health plan, we are assuming here that "emergency" is being defined as emergency room services, not IP MH or SUD services.	Magnolia has a contracted relationship with Mississippi Physicians Care Network (MPCN) to utilize MPCN's network of practitioners for the MS CHIP product. MPCN will manage the credentialing and re-credentialing processes for practitioners that have a relationship with MPCN for the MS CHIP product.	Credentialing processes are the same and represent industry standards and criteria for provider type and services.
Access to Care	Magnolia ensures access to care for Inpatient services.	Magnolia ensures access to services based upon the Geographic Access Standards as outlined in the MississippiCHIP contract	Processes are the same
Medical Mgmt/Policy - Pre Service	Cenpatico does not manage emergency or urgent care services - claims are paid per Magnolia claims system.	Emergency Care does not require prior authorization review. Once the recipient is stablized then care is reviewed for IP or OP services as appropriate.	Processes are the same
Medical Mgmt/Policy - Concurrent/Post Service	Emergency room service claims (for both behavioral health and medical services) do not suspend for concurrent or post-service review.		Parity exists because emergency room services - claims for both behavioral health and medical services do not suspend for concurrent or post-service review.
Medical Mgmt/Policy - Appeals	Magnolia pays emergency room service claims (for both behavioral health and medical services)		Parity exists because behavioral health and medical emergency room services are paid without authorization, certification, or notification.
Provider/ Facility Reimbursement	Magnolia pays emergency room service claims (for both behavioral health and medical services)		Parity exists because behavioral health and medical services emergency room services are paid without authorization, certification, or notification.
Provider Contract - Liability	Magnolia holds emergency room contracts.		Parity exists because behavioral health and medical services emergency room services are paid without authorization, certification, or notification. Free standing behavioral health facilities are not licensed to perform Emergency Room services. There is balance billing protection for the members.

Inpatient Classification Parity Status: ○○●

Product Name:	

Non-Qualitative Treatment Limitation	Cenpatico Behavioral Health	Magnolia Medical	Rationale
Credentialing	Magnolia performed credentialing for inpatient services for CHIP members during this time period.	Magnolia has a contracted relationship with Mississippi Physicians Care Network (MPCN) to utilize MPCN's network of practitioners for the MS CHIP product. MPCN will manage the credentialing and re-credentialing processes for practitioners that have a relationship with MPCN for the MS CHIP product.	Credentialing processes are the same and represent industry standards and criteria for provider type and services.
Access to Care	Magnolia ensures access to care for Inpatient services.	Magnolia ensures access to services based upon the Geographic Access Standards as outlined in the MississippiCHIP contract	Processes are the same.
Medical Mgmt/Policy - Pre Service	Prior Authorization is required for IP MH, IP CD, IP Rehab, Observation, Residential treatment, and facility based ECT. Prior authorization reviews are conducted by phone call, faxed clinical, or clinical submitted via web portal from the provider to ensure Medical Necessity Criteria is met for the level of care requested. Continued authorization can be requested by the facility or the provider by fax, phone, or web portal on the last day of the authorized service. Complete requests are processed and completed within 24 hrs. If MNC is met, the provider receives notification via phone or secure email. If MNC is not met, Utilization Manager (UM) will refer the review to an external peer reviewer (licensed psychiatrist or psychologist depending on requested level of care) who then applies the same MNC. UMs determine the authorization based on the peer review decision. Providers are notified of adverse determinations (including full denial and partial approvals). Requests that are received for extending services are completed as a new review. The Utilization Managers that implement the Medical necessity review for this NQTL are Master's Level Licensed Clinicians, Registered Nurses, or PhD.	UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of healthcare. Established timelines are in place for practitioners to notify the Plan of a service request and for the Plan to make UM decisions and subsequent notifications to the practitioner and member, as applicable. Requested information includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in an administrative denial of the requested service.	Processes are the same.
Medical Mgmt/Policy - Concurrent/Post Service	Concurrent reviews are conducted after the initial authorization to ensure Medical Necessity Criteria is met for continued services. Continued authorization can be requested by the facility or the Utilization Manager either telephonically, by fax, or via web portal on the last day of the authorized service. Concurrent review requests are completed within 24 hrs. The Utilization Managers that implement this NQTL are Master Level Licensed Clinicians. Retrospective reviews are conducted for enrollee facility admissions that were not authorized prior to, or at the time of admission. Requests for retrospective review must be received within 180 days from the date of service requested. When providers do not pre-certify treatment, the Utilization Management department may conduct retrospective review for medical necessity as appropriate. Providers are asked to submit documentation to support the need for service. Medical necessity determinations are made using solely the medical information available to the attending physician or ordering provider at the time the medical care was provided. This applies to facilities of the enrollees' residence as well as out of state facilities. All reviews are documented in an electronic information management system.	Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with a determination based on review of the member's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonic, as needed. The frequency of reviews are based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity, and are not routinely conducted on a daily basis. If, at any time, services cease to meet inpatient or ambulatory criteria, discharge criteria are met and/or alternative care options exist, the Prior Authorization Nurse or Concurrent Review Nurse contacts the facility and obtains additional information to justify the continuation of services. When the medical necessity for the case cannot be determined, the case is referred to the Medical Director for review. The need for CM or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-effective alternative to inpatient care. If at any time the Medical Management staff become aware of potential quality of care issues, the concern is referred to the Plan QI Department for investigation and resolution.	Processes are the same.

Inpatient Classification Parity Status: ○○●

Product Name:	

Non-Qualitative Treatment Limitation	Cenpatico Behavioral Health	Magnolia Medical	Rationale
Medical Mgmt/Policy - Appeals	Describe the internal appeal procedures. Include each step, associated triggers, timelines, forms and requirements. 1. Submission of an Appeal: A Member, Member's representative, including the Practitioner of a Member, or the legal representative of a deceased member's estate, hereafter referred to as "Member", may file an appeal within sixty (60) days from the date on the Company's Notice of Action. The member may file an appeal either verbally or in writing. A verbal filing does not require written follow up, but is preferred. You must complete and sign an Authorized Representative Designation form if you would like someone else to represent you in your appeal or other written consent must be provided. Appeals are to be sent to: 1.1. Cenpatico 1.1.1. Attn: Appeals Coordinator 1.1.2. 12515-8 Research Blvd., Suite 400 1.1.3. Austin, Texas 78759 2. Appeal Process Notices to Member: Written notices shall be in the primary language of the member, if identified. 3. Acknowledgement of Appeal: Within five (5) calendar days after receiving the appeal, the Company's Appeals Coordinator shall send the member a written notice acknowledging receipt of the appeal. The appeal acknowledgement letter contains the following elements: 3.1. Date of the Company receipt of appeal; 3.2. The name, address, and phone number of the Company representative that may be contacted about the appeal; 3.3. A list of documents the appealing party must submit to the Company for review and the time frame for response; and 3.4. All appeals are documented in the appeals log. Written appeals requests are date stamped on receipt.	Provider Appeals Magnolia is to resolve a provider appeal within forty five (45) calendar days from the receipt of the provider appeal or as expeditiously as the member's health condition requires. Expedited provider appeals are to be resolved within three (3) business days from the receipt of the expedited resolution request. Magnolia may extend the time frame for this request up to fourteen (14) calendar days upon information required to make a determination. Members, or healthcare professionals with the member's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to: Magnolia Health Clinical Appeals Coordinator 111 East Capitol Street, Suite 500 Jackson, MS 39201 1-866-912-6285 Fax 1-877-851-3995 Member Appeals Magnolia handles member appeals in compliance with NCQA and contractual requirements.	Processes are the same.
Medical Mgmt/Policy - Appeals	4. Untimely and Duplicate Appeals: Appeals not filed, either orally or in writing, within 30 days (plus three (3) calendar days if the notice is mailed) will not be considered. The Appeals Coordinator will notify the Member, or the Member's representative, in writing of the decision. Similarly, any duplicate appeal of an appeal already resolved will not be considered. The Appeals Coordinator will notify the Member, or the Member's representative, in writing of the decision. 5. Review Process: Following receipt of the appeal, the Company's Appeals Coordinator will thoroughly investigate each appeal using applicable statutory, regulatory, and contractual provisions and the Company's written policies and procedures. Clinical Consultants are: 5.1. Clinical peers to the consultant previously involved in the case, 5.2. Hold an active, unrestricted license to practice medicine or a health profession, 5.3. Board certified, 5.4. Are in the same profession and in a similar specialty as the ordering provider, 5.5. Are neither the individual who made the original non-certification, or the subordinate of such an individual. 5.6. The Clinical Consultant takes all information into account during the appeals process without regard to whether such information was submitted or considered in the initial consideration of the case. 5.7. The Clinical Consultant documents all review activity, the determination to uphold or overturn the adverse determination, and the rationale for the determination. The Clinical Consultant forwards this documentation to the Appeals Coordinator for communication of the determination to the member, treating and attending practitioners. The Company implements the decision of the clinical appeal if the initial denial is overturned.		

Inpatient Classification Parity Status: ○○●

Product Name:	

Non-Qualitative Treatment Limitation	Cenpatico Behavioral Health	Magnolia Medical	Rationale
Medical Mgmt/Policy - Appeals	6. Timeframes for Appeal Resolution Process: 6.1. Standard Appeal: The Company will resolve each appeal as expeditiously as the member's health condition requires but shall not exceed thirty (30) calendar days from the date the Company receives the appeal. 6.2. Expedited Appeal: A Member may request an expedited appeal when the time allowed for a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The request for an expedited resolution should be submitted to the Company. Request will be reviewed by appropriate Medical Director/Clinician to determine if the expedited appeal meets criteria or not for expedited appeals. If the expedited appeal request is determined to meet criteria, it will be resolved as expeditiously as the member condition warrants but will not exceed three (3) calendar days from receipt of the request, the Company shall provide make reasonable efforts to provide verbal communication and will provide written confirmation of the resolution. 6.2.1. The Company will take no punitive action against a Member or Provider who represents the member in an appeal for requesting an appeal. 6.2.2. If the Company denies the request for an expedited resolution, the Appeal will be transferred to the timeframe for standard appeal resolution. The Appeals Coordinator or Utilization Manager will provide verbal notice promptly and provide notice in writing to the Member/Provider within two (2) calendar days of receipt of the expedited appeal request. The content of written notice shall be approved by the State. The enrollee can grieve this decision but it is not a decision that can be appealed. As a part of the standard appeal process, an acknowledgement letter is required. 6.3. Extended Appeal Resolution Timeframe: The Company may extend the timeframe for a standard resolution of an Appeal by up to fourteen (14) days if the Member requests the extension or the Company demonstrates to the		
Medical Mgmt/Policy - Appeals	satisfaction of the state agency upon request that there is need for additional time needed to resolve the appeal and how that delay is in the Member's interest. Requests for additional time must be made two (2) business days in advance of the 30 calendar days of the deadline to the State for resolution. Information requiring approval and how the delay is in the Member's best interest. If the Company extends the timeframe, the Member shall be provided written notice including the reasons why additional time is required. 6.4. Resolution of Appeal: Standard appeals will be resolved as expeditiously as the member condition warrants and no later than thirty (30) calendar days from the receipt of the appeal. If an Appeal is extended, a decision will be made no later than fourty-four (44) calendar days from the date of receipt of the appeal. Requests for expedited resolution will be decided as expeditiously as the member condition warrants and within three (3) calendar days of the receipt of the appeal. 6.4.1. If the Member is not satisfied with the Company's resolution of the Appeal, the Member may access the State Fair Hearing process. Kansas members may only access the State Fair Hearing process after the Company appeal process is completed. 6.4.2. If the adverse determination reviewed is upheld, in whole or in part, the notice include: 6.4.2.1. Decision in clear terms, with benefits or medical necessity rationale. 6.4.2.2. Reference to benefit provision, guideline, protocol, or other similar criterion on which the decision is based. 6.4.2.3. Notification that Member can obtain, upon request, a copy of the benefit provision, guideline, protocol, or other similar criterion on which the decision is based. 6.4.2.4. Informs Member that he/she is entitled to receive free of charge copies of all documents, records and other relevant information upon request		

Inpatient Classification Parity Status: ○○●

Product Name:	

Non-Qualitative Treatment Limitation	Cenpatico Behavioral Health	Magnolia Medical	Rationale
Medical Mgmt/Policy - Appeals	regarding the appeal. 6.4.2.5. List of titles and qualifications of the individuals participating in the review, and the specialization of the providers consulted. 6.4.2.6. The Member's right to request a State Fair Hearing and instructions on filing that request. 6.4.2.7. The right to continue to receive benefits pending a state fair hearing including how to request this continuation. 6.4.2.8. Notice that the member may be liable for payment of services if decision is upheld. 6.4.3. Explanation that if the decision is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits. 6.4.4. If the decision is overturned wholly in the enrollee's favor, the notice includes the decision, and the medical or contractual reason for the decision. 6.4.5. If the adverse determination is overturned, the Appeal Coordinator notifies the Claims Department or Medical Management to generate the appropriate payment or authorization for the previously denied services. What are the required qualifications/training for persons implementing internal appeals process? High school diploma or equivalent. Associate's degree preferred. 2+ years grievance or appeals, claims or related managed care experience. Strong oral, written, and problem solving skills.		
Facility Rate Calculation	Magnolia performs facility contracting and rate calculations for inpatient services, and Cenpatico performs this for all other levels of care.		
Provider/ Facility Reimbursement	Cenpatico performs claims adjudication and payment for inpatient services.		
Provider Contract - Liability	Except in the case of an emergency medical condition, prior to providing services to a member, provider will comply with any preauthorization or pre-notification procedures of the plan or Cenpatico to verify that such person is a member, that the services to be provided constitute covered services, and that payment for the covered services is authorized. Members shall be held harmless if provider fails to obtain required authorizations. Reimbursement is an all inclusive per diem based reimbursement that is negotiated with the facilities.	Provider is reimbursed as appropriate and per contracted rates. Member would not be liable for difference between billed amount and contracted amount.	Processes are the same.
Network Tiering	Magolia performs facility contracting and rate calculations for inpatient services, and Cenpatico performs this for all other levels of care.		

Outpatient Classification Parity Status:

Product Name:	**Select One**

Outpatient - Professional Services

Types of Comparable Services	Cenpatico Behavioral Health	Medical Services
	Individual and group visits with psychologist, social worker, psychiatrist	Physician services and Physician extender services (i.e. CRNP, PA, SA, etc.)

Non-Qualitative Treatment Limitation	Cenpatico Behavioral Health	Magnolia Medical	Rationale
Credentialing	Cenpatico performed credentialing for inpatient services for CHIP members during this time period.	Magnolia has a contracted relationship with Mississippi Physicians Care Network (MPCN) to utilize MPCN's network of practitioners for the MS CHIP product. MPCN will manage the credentialing and re-credentialing processes for practitioners that have a relationship with MPCN for the MS CHIP product.	Credentialing processes are the same and represent industry standards and criteria for provider type and services.
Access to Care	Cenpatico is responsible for ensuring access to care based on required Geo- Access standards for Mississippi Medicaid.	Magnolia ensures access to services based upon the Geographic Access Standards as outlined in the MississippiCHIP contract	Processes are the same.
Medical Mgmt./Policy - Pre Service	Routine Outpatient services do not require Prior authorization. Non-Routine Outpatient services such as non -facility based ECT, Psychologic testing, ACT, Developmental testing, Neuropsychological testing, do require prior authorization. Prior authorization reviews are conducted by phone call, faxed clinical, or clinical submitted via web portal from the provider to ensure Medical Necessity Criteria is met for the level of care requested. Continued authorization can be requested by the facility or the provider by fax, phone, or web portal on the last day of the authorized service. Complete requests are processed and completed within 24 hrs. If MNC is met, the provider receives notification via phone or secure email. If MNC is not met, Utilization Manager (UM) will refer the review to an external peer reviewer (licensed psychiatrist or psychologist depending on requested level of care) who then applies the same MNC. UMs determine the authorization based on the peer review decision. Providers are notified of adverse determinations (including full denial and partial approvals). Requests that are received for extending services are completed as a new review. The Utilization Managers that implement the Medical necessity review for this NQTL are Master's Level Licensed Clinicians, Registered Nurses, or PhD.	UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of healthcare. Established timelines are in place for practitioners to notify the Plan of a service request and for the Plan to make UM decisions and subsequent notifications to the practitioner and member, as applicable. Requested information includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in an administrative denial of the requested service.	Processes are the same.
Medical Mgmt./Policy - Concurrent/Post Service	Concurrent review or its application is not applicable to Outpatient Services. Retrospective reviews are conducted for enrollee services that were not authorized prior to, or at the time of, services. Requests for retrospective review must be received within 180 days from the date of service requested. When providers do not pre-certify treatment, the Utilization Management department may conduct retrospective review for medical necessity as appropriate. Providers are asked to submit documentation to support the need for service. Medical necessity determinations are made using solely the medical information available to the attending physician or ordering provider at the time the medical care was provided. This applies to facilities of the enrollees' residence as well as out of state facilities. All reviews are documented in an electronic information management system.	Not applicable to Outpatient Services	Not Applicable
Medical Mgmt./Policy - Appeals	Describe the internal appeal procedures. Include each step, associated triggers, timelines, forms and requirements. 1. Submission of an Appeal: A Member, Member's representative, including the Practitioner of a Member, or the legal representative of a deceased member's estate, hereafter referred to as "Member", may file an appeal within sixty (60) days from the date on the Company's Notice of Action. The member may file an appeal either verbally or in writing. A verbal filing does not require written follow up, but is preferred. You must complete and sign an Authorized Representative Designation form if you would like someone else to represent you in your appeal or other written consent must be provided. Appeals are to be sent to: 1.1. Cenpatico 1.1.1. Attn: Appeals Coordinator 1.1.2. 12515-8 Research Blvd., Suite 400 1.1.3. Austin, Texas 78759 2. Appeal Process Notices to Member: Written notices shall be in the primary language of the member, if identified. 3. Acknowledgement of Appeal: Within five (5) calendar days after receiving the appeal, the Company's Appeals Coordinator shall send the member a written notice acknowledging receipt of the appeal. The appeal acknowledgement letter contains the following elements: 3.1. Date of the Company receipt of appeal; 3.2. The name, address, and phone number of the Company representative that may be contacted about the appeal; 3.3. A list of documents the appealing party must submit to the Company for review and the time frame for response; and 3.4. All appeals are documented in the appeals log. Written appeals requests are date stamped on receipt. 4. Untimely and Duplicate Appeals: Appeals not filed, either orally or in writing, within 30 days (plus three (3) calendar days if the notice is mailed) will not be considered. The Appeals Coordinator will notify the Member, or the Member's representative, in writing of the decision. Similarly, any duplicate appeal of an appeal already resolved will not be considered. The Appeals Coordinator will notify the Member, or the Member's representative, in writing of the decision. 5. Review Process: Following receipt of the appeal, the Company's Appeals Coordinator will thoroughly investigate each appeal using applicable statutory, regulatory, and contractual provisions and the Company's written policies and procedures. Clinical Consultants are: 5.1. Clinical peers to the consultant previously involved in the case, 5.2. Hold an active, unrestricted license to practice medicine or a health profession, 5.3. Board certified, 5.4. Are in the same profession and in a similar specialty as the ordering provider,	Provider Appeals Magnolia is to resolve a provider appeal within forty five (45) calendar days from the receipt of the provider appeal or as expeditiously as the member's health condition requires. Expedited provider appeals are to be resolved within three (3) business days from the receipt of the expedited resolution request. Magnolia may extend the time frame for this request up to fourteen (14) calendar days upon information required to make a determination. Members, or healthcare professionals with the member's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to: Magnolia Health Clinical Appeals Coordinator 111 East Capitol Street, Suite 500 Jackson, MS 39201 1-866-912-6285 Fax 1-877-851-3995 Member Appeals Magnolia handles member appeals in compliance with NCQA and contractual requirements.	Processes are the same.

Outpatient Classification Parity Status:

Product Name:	Select One

Outpatient - Professional Services

Types of Comparable Services	Cenpatico Behavioral Health	Medical Services	
Medical Mgmt./Policy - Appeals	5.5 Are neither the individual who made the original non-certification, or the subordinate of such an individual. 5.6. The Clinical Consultant takes all information into account during the appeals process without regard to whether such information was submitted or considered in the initial consideration of the case. 5.7. The Clinical Consultant documents all review activity, the determination to uphold or overturn the adverse determination, and the rationale for the determination. The Clinical Consultant forwards this documentation to the Appeals Coordinator for communication of the determination to the member, treating and attending practitioners. The Company implements the decision of the clinical appeal if the initial denial is overturned. 6. Timeframes for Appeal Resolution Process: 6.1. Standard Appeal: The Company will resolve each appeal as expeditiously as the member's health condition requires but shall not exceed thirty (30) calendar days from the date the Company receives the appeal. 6.2. Expedited Appeal: A Member may request an expedited appeal when the time allowed for a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The request for an expedited resolution should be submitted to the Company. Request will be reviewed by appropriate Medical Director/Clinician to determine if the expedited appeal meets criteria or not for expedited appeals. If the expedited appeal request is determined to meet criteria, it will be resolved as expeditiously as the member condition warrants but will not exceed three (3) calendar days from receipt of the request, the Company shall provide make reasonable efforts to provide verbal communication and will provide written confirmation of the resolution. 6.2.1. The Company will take no punitive action against a Member or Provider who represents the member in an appeal for requesting an appeal. 6.2.2. If the Company denies the request for an expedited resolution, the Appeal will be transferred to the timeframe for standard appeal resolution. The Appeals Coordinator or Utilization Manager will provide verbal notice promptly and provide notice in writing to the Member/Provider within two (2) calendar days of receipt of the expedited appeal request. The content of written notice shall be approved by the State. The enrollee can grieve this decision but it is not a decision that can be appealed. As a part of the standard appeal process, an acknowledgement letter is required. 6.3. Extended Appeal Resolution Timeframe: The Company may extend the timeframe for a standard resolution of an Appeal by up to fourteen (14) days if the Member requests the extension or the Company demonstrates to the satisfaction of the state agency upon request that there is need for additional time needed to resolve the appeal and how that delay is in the Member's interest. Requests for additional time must be made two (2) business days in advance of the 30 calendar days of the deadline to the State for resolution. Information requiring approval and how the delay is in the Member's best interest. If the Company extends the timeframe, the Member shall be provided written notice including the reasons why additional time is required. 6.4. Resolution of Appeal: Standard appeals will be resolved as expeditiously as the member condition warrants and no later than thirty (30)		
Medical Mgmt./Policy - Appeals	calendar days from the receipt of the appeal. If an Appeal is extended, a decision will be made no later than forty-four (44) calendar days from the date of receipt of the appeal. Requests for expedited resolution will be decided as expeditiously as the member condition warrants and within three (3) calendar days of the receipt of the appeal. 6.4.1. If the Member is not satisfied with the Company's resolution of the Appeal, the Member may access the State Fair Hearing process. Kansas members may only access the State Fair Hearing process after the Company appeal process is completed. 6.4.2. If the adverse determination reviewed is upheld, in whole or in part, the notice include: 6.4.2.1. Decision in clear terms, with benefits or medical necessity rationale. 6.4.2.2. Reference to benefit provision, guideline, protocol, or other similar criterion on which the decision is based. 6.4.2.3. Notification that Member can obtain, upon request, a copy of the benefit provision, guideline, protocol, or other similar criterion on which the decision is based. 6.4.2.4. Informs Member that he/she is entitled to receive free of charge copies of all documents, records and other relevant information upon request regarding the appeal. 6.4.2.5. List of titles and qualifications of the individuals participating in the review, and the specialization of the providers consulted. 6.4.2.6. The Member's right to request a State Fair Hearing and instructions on filing that request. 6.4.2.7. The right to continue to receive benefits pending a state fair hearing including how to request this continuation. 6.4.2.8. Notice that the member may be liable for payment of services if decision is upheld. 6.4.3. Explanation that if the decision is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits. 6.4.4. If the decision is overturned wholly in the enrollee's favor, the notice includes the decision, and the medical or contractual reason for the decision. 6.4.5. If the adverse determination is overturned, the Appeal Coordinator notifies the Claims Department or Medical Management to generate the appropriate payment or authorization for the previously denied services. What are the required qualifications/training for persons implementing internal appeals process? High school diploma or equivalent. Associate's degree preferred. 2+ years grievance or appeals, claims or related managed care experience. Strong oral, written, and problem solving skills.		
Provider/Facility Rate Calculation	Cenpatico contracts with outpatient behavioral health providers at rates determined by Cenpatico.		
Provider/ Facility Reimbursement	Cenpatico performs claims adjudication and processing for outpatient office visits.		
Provider Contract - Liability	No approval language, provider is reimbursed as appropriate and per contracted rates. Member would not be liable for difference between billed amount and contracted amount.	Provider is reimbursed as appropriate and per contracted rates. Member would not be liable for difference between billed amount and contracted amount.	Processes are the same.

Outpatient Classification Parity Status:

Product Name:	Select One

Outpatient - Professional Services

Types of Comparable Services	Cenpatico Behavioral Health	Medical Services

Outpatient - Other Services

Types of Comparable Services	Cenpatico Behavioral Health	Medical Services
	ABA , ECT, IOP, CBS	Office visits and consultations; surgery and anesthesia for a covered service; maternity care; diagnostic lab, x-rays, and pathology; chemotherapy and radiation therapy; physical, occupational and speech therapy

Non-Qualitative Treatment Limitation	Cenpatico Behavioral Health	Magnolia Medical	Rationale
Credentialing	Cenpatico performed credentialing for outpatient services for CHIP members during this time period.	Magnolia has a contracted relationship with Mississippi Physicians Care Network (MPCN) to utilize MPCN's network of practitioners for the MS CHIP product. MPCN will manage the credentialing and re-credentialing processes for practitioners that have a relationship with MPCN for the MS CHIP product.	Credentialing processes are the same and represent industry standards and criteria for provider type and services.
Access to Care	Cenpatico is responsible for ensuring access to care based on required Geo- Access standards for Mississippi Medicaid.	Magnolia ensures access to services based upon the Geographic Access Standards as outlined in the MississippiCHIP contract	Processes are the same.
Medical Mgmt./Policy - Pre Service	Routine Outpatient services do not require Prior authorization. Non-Routine Outpatient services such as non facility based ECT, Psychologic testing, ACT, Developmental testing, Neuropsychological testing, do require prior authorization. Prior authorization reviews are conducted by phone call, faxed clinical, or clinical submitted via web portal from the provider to ensure Medical Necessity Criteria is met for the level of care requested. Continued authorization can be requested by the facility or the provider by fax, phone, or web portal on the last day of the authorized service. Complete requests are processed and completed within 24 hrs. If MNC is met, the provider receives notification via phone or secure email. If MNC is not met, Utilization Manager (UM) will refer the review to an external peer reviewer (licensed psychiatrist or psychologist depending on requested level of care) who then applies the same MNC. UMs determine the authorization based on the peer review decision. Providers are notified of adverse determinations (including full denial and partial approvals). Requests that are received for extending services are completed as a new review. The Utilization Managers that implement the Medical necessity review for this NQTL are Master's Level Licensed Clinicians, Registered Nurses, or PhD.	UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of healthcare. Established timelines are in place for practitioners to notify the Plan of a service request and for the Plan to make UM decisions and subsequent notifications to the practitioner and member, as applicable. Requested information includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information can result in an administrative denial of the requested service.	Processes are the same.
Medical Mgmt./Policy - Concurrent/Post Service	Concurrent review or its application is not applicable to Outpatient Services. Retrospective reviews are conducted for enrollee services that were not authorized prior to, or at the time of, services. Requests for retrospective review must be received within 180 days from the date of service requested. When providers do not pre-certify treatment, the Utilization Management department may conduct retrospective review for medical necessity as appropriate. Providers are asked to submit documentation to support the need for service. Medical necessity determinations are made using solely the medical information available to the attending physician or ordering provider at the time the medical care was provided. This applies to facilities of the enrollees' residence as well as out of state facilities. All reviews are documented in an electronic information management system.	Not applicable to Outpatient Services.	Not Applicable

Outpatient Classification Parity Status:

Product Name:	**Select One**

Outpatient - Professional Services

Types of Comparable Services	Cenpatico Behavioral Health	Medical Services	
Medical Mgmt./Policy - Appeals	Describe the internal appeal procedures. Include each step, associated triggers, timelines, forms and requirements. 1. Submission of an Appeal: A Member, Member's representative, including the Practitioner of a Member, or the legal representative of a deceased member's estate, hereafter referred to as "Member", may file an appeal within sixty (60) days from the date on the Company's Notice of Action. The member may file an appeal either verbally or in writing. A verbal filing does not require written follow up, but is preferred. You must complete and sign an Authorized Representative Designation form if you would like someone else to represent you in your appeal or other written consent must be provided. Appeals are to be sent to: 1.1. Cenpatico 1.1.1. Attn: Appeals Coordinator 1.1.2. 12515-8 Research Blvd., Suite 400 1.1.3. Austin, Texas 78759 2. Appeal Process Notices to Member: Written notices shall be in the primary language of the member, if identified. 3. Acknowledgement of Appeal: Within five (5) calendar days after receiving the appeal, the Company's Appeals Coordinator shall send the member a written notice acknowledging receipt of the appeal. The appeal acknowledgement letter contains the following elements: 3.1. Date of the Company receipt of appeal; 3.2. The name, address, and phone number of the Company representative that may be contacted about the appeal; 3.3. A list of documents the appealing party must submit to the Company for review and the time frame for response; and 3.4. All appeals are documented in the appeals log. Written appeals requests are date stamped on receipt. 4. Untimely and Duplicate Appeals: Appeals not filed, either orally or in writing, within 30 days (plus three (3) calendar days if the notice is mailed) will not be considered. The Appeals Coordinator will notify the Member, or the Member's representative, in writing of the decision. Similarly, any duplicate appeal of an appeal already resolved will not be considered. The Appeals Coordinator will notify the Member, or the Member's representative, in writing of the decision. 5. Review Process: Following receipt of the appeal, the Company's Appeals Coordinator will thoroughly investigate each appeal using applicable statutory, regulatory, and contractual provisions and the Company's written policies and procedures. Clinical Consultants are: 5.1. Clinical peers to the consultant previously involved in the case, 5.2. Hold an active, unrestricted license to practice medicine or a health profession, 5.3. Board certified, 5.4. Are in the same profession and in a similar specialty as the ordering provider,	Provider Appeals Magnolia is to resolve a provider appeal within forty five (45) calendar days from the receipt of the provider appeal or as expeditiously as the member's health condition requires. Expedited provider appeals are to be resolved within three (3) business days from the receipt of the expedited resolution request. Magnolia may extend the time frame for this request up to fourteen (14) calendar days upon information required to make a determination. Members, or healthcare professionals with the member's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to: Magnolia Health Clinical Appeals Coordinator 111 East Capitol Street, Suite 500 Jackson, MS 39201 1-866-912-6285 Fax 1-877-851-3995 Member Appeals Magnolia handles member appeals in compliance with NCQA and contractual requirements.	Processes are the same.
Medical Mgmt./Policy - Appeals	5.5 Are neither the individual who made the original non-certification, or the subordinate of such an individual. 5.6. The Clinical Consultant takes all information into account during the appeals process without regard to whether such information was submitted or considered in the initial consideration of the case. 5.7. The Clinical Consultant documents all review activity, the determination to uphold or overturn the adverse determination, and the rationale for the determination. The Clinical Consultant forwards this documentation to the Appeals Coordinator for communication of the determination to the member, treating and attending practitioners. The Company implements the decision of the clinical appeal if the initial denial is overturned. 6. Timeframes for Appeal Resolution Process: 6.1. Standard Appeal: The Company will resolve each appeal as expeditiously as the member's health condition requires but shall not exceed thirty (30) calendar days from the date the Company receives the appeal. 6.2. Expedited Appeal: A Member may request an expedited appeal when the time allowed for a standard appeal could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The request for an expedited resolution should be submitted to the Company. Request will be reviewed by appropriate Medical Director/Clinician to determine if the expedited appeal meets criteria or not for expedited appeals. If the expedited appeal request is determined to meet criteria, it will be resolved as expeditiously as the member condition warrants but will not exceed three (3) calendar days from receipt of the request, the Company shall provide make reasonable efforts to provide verbal communication and will provide written confirmation of the resolution. 6.2.1. The Company will take no punitive action against a Member or Provider who represents the member in an appeal for requesting an appeal. 6.2.2. If the Company denies the request for an expedited resolution, the Appeal will be transferred to the timeframe for standard appeal resolution. The Appeals Coordinator or Utilization Manager will provide verbal notice promptly and provide notice in writing to the Member/Provider within two (2) calendar days of receipt of the expedited appeal request. The content of written notice shall be approved by the State. The enrollee can grieve this decision but it is not a decision that can be appealed. As a part of the standard appeal process, an acknowledgement letter is required. 6.3. Extended Appeal Resolution Timeframe: The Company may extend the timeframe for a standard resolution of an Appeal by up to fourteen (14) days if the Member requests the extension or the Company demonstrates to the satisfaction of the state agency upon request that there is need for additional time needed to resolve the appeal and how that delay is in the Member's interest. Requests for additional time must be made two (2) business days in advance of the 30 calendar days of the deadline to the State for resolution. Information requiring approval and how the delay is in the Member's best interest. If the Company extends the timeframe, the Member shall be provided written notice including the reasons why additional time is required. 6.4. Resolution of Appeal: Standard appeals will be resolved as expeditiously as the member condition warrants and no later than thirty (30)		

Outpatient Classification Parity Status:

Product Name:	Select One

Outpatient - Professional Services

Types of Comparable Services	Cenpatico Behavioral Health	Medical Services	
Medical Mgmt./Policy - Appeals	calendar days from the receipt of the appeal. If an Appeal is extended, a decision will be made no later than forty-four (44) calendar days from the date of receipt of the appeal. Requests for expedited resolution will be decided as expeditiously as the member condition warrants and within three (3) calendar days of the receipt of the appeal. 6.4.1. If the Member is not satisfied with the Company's resolution of the Appeal, the Member may access the State Fair Hearing process. Kansas members may only access the State Fair Hearing process after the Company appeal process is completed. 6.4.2. If the adverse determination reviewed is upheld, in whole or in part, the notice include: 6.4.2.1. Decision in clear terms, with benefits or medical necessity rationale. 6.4.2.2. Reference to benefit provision, guideline, protocol, or other similar criterion on which the decision is based. 6.4.2.3. Notification that Member can obtain, upon request, a copy of the benefit provision, guideline, protocol, or other similar criterion on which the decision is based. 6.4.2.4. Informs Member that he/she is entitled to receive free of charge copies of all documents, records and other relevant information upon request regarding the appeal. 6.4.2.5. List of titles and qualifications of the individuals participating in the review, and the specialization of the providers consulted. 6.4.2.6. The Member's right to request a State Fair Hearing and instructions on filing that request. 6.4.2.7. The right to continue to receive benefits pending a state fair hearing including how to request this continuation. 6.4.2.8. Notice that the member may be liable for payment of services if decision is upheld. 6.4.3. Explanation that if the decision is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits. 6.4.4. If the decision is overturned wholly in the enrollee's favor, the notice includes the decision, and the medical or contractual reason for the decision. 6.4.5. If the adverse determination is overturned, the Appeal Coordinator notifies the Claims Department or Medical Management to generate the appropriate payment or authorization for the previously denied services. What are the required qualifications/training for persons implementing internal appeals process? High school diploma or equivalent. Associate's degree preferred. 2+ years grievance or appeals, claims or related managed care experience. Strong oral, written, and problem solving skills.		
Provider/ Facility Reimbursement	Cenpatico performs claims adjudication and payment		
Provider Contract - Liability	Except in the case of an emergency medical condition, prior to providing services to a member, provider will comply with any preauthorization or pre-notification procedures of the plan or Cenpatico to verify that such person is a member, that the services to be provided constitute covered services, and that payment for the covered services is authorized. Members shall be held harmless if provider fails to obtain required authorizations. Reimbursement is an all inclusive per diem based reimbursement that is negotiated with the facilities.	Provider is reimbursed as appropriate and per contracted rates. Member would not be liable for difference between billed amount and contracted amount.	Processes are the same.

Pharmacy Classification Parity Status: 

Product Name:	**Select One**

Non-Qualitative Treatment Limitation	Cenpatico Behavioral Health	Medical	Rationale
Credentialing	Not Applicable	The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by Magnolia, as well as government regulations and standards of accrediting bodies. Magnolia follows NCQA standards.	**Credentialing processes represent industry standards and criteria for provider type and services.**
Access to Care	Not Applicable	Magnolia ensures access to services based upon the Geographic Access Standards as outlined in the MississippiCHIP contract	**Magnolia manages process**
Medical Mgmt/Policy - Pre Service	Cenpatico does not manage pharmacy	Magnolia pharmacy benefit manager, Envolve Pharmacy has developed clinical review criteria based on current clinical principles and processes. Envolve Pharmacy promotes adherence to regulatory guidelines regarding non-discrimination by utilizing similar processes and evidentiary standards across all therapeutic drug categories, including protected classes, so that decisions applied are uniform and no more stringent in one therapeutic drug category compared to others.	Pharmacy benefits are applied per the benefit plan and evidence based clinical criteria for use of medication, regardless of behavioral health or medical diagnosis.
Medical Mgmt/Policy - Concurrent/Post Service	Not Applicable	Not Applicable	
Medical Mgmt/Policy - Appeals	Cenpatico does not manage pharmacy	The Magnolia Appeals team handles member appeals and follows the same process as medical claims.	Pharmacy benefits are applied per the benefit plan and evidence based clinical criteria for use of medication, regardless of behavioral health or medical diagnosis.
Provider/ Facility Reimbursement	Not Applicable	Magnolia's Pharmacy Benefit Manager, Envolve Pharmacy reimburses both medical and behavorial health claims regardless of diagnosis.	Pharmacy benefits are applied per the benefit plan and evidence based clinical criteria for use of medication, regardless of behavioral health or medical diagnosis.
Provider Contract - Liability	Not Applicable	Not Applicable	Not applicable

Entity Name: State of Mississippi - UnitedHealthcare Type: Medicaid / CHIP SPA NQTL Analysis	Behavioral Health (Mental Health and Substance Use Disorder Services)	Medical/Surgical Services
Medical Necessity-Inpatient **(All Inpatient Services)**		
Criteria Utilized	Optum LOC Guidelines are used to determine medical necessity. The evidence-base for the Level of Care Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Such guidelines are reviewed and updated annually by CTAC. Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. Optum reserves the right to consult expert opinions in determining whether mental health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.	UHC relies on the National Recognized Practice Guidelines and review and approve the use of these guidelines annually. UHC reviews these documents to adhere to NCQA and URAC standards. Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinions in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.
Processes	Optum develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on Optum's member website or by calling the telephone number on the Covered Person's ID card. They are available to Physicians and other health care professionals on Optum's provider website or by calling the telephone number on the Covered Person's ID card.	UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on UnitedHealthcare's member website or by calling the telephone number on the Covered Person's ID card. They are available to Physicians and other health care professionals on UnitedHealthcare's provider website or by calling the telephone number on the Covered Person's ID card.
Strategies	Verification of medical necessity for individuals is required to determine that they meet requirements for the service. Individual must meet diagnosis criteria in order to receive services. Optum's CTAC committee (Clinical Technology Assessments Committee) functions within behavioral to review mental health technology as it emerges. Policies and procedures are reviewed annually or as mental health technology emerges.	Verification of medical necessity for individuals is required to determine that they meet requirements for the service. Individual must meet diagnosis criteria in order to receive services. MTAC (Medical Technology Assessments Committee) functions within medical to review medical technology as it emerges. Policies and procedures are reviewed annually or as new medical technology emerges.

Evidentiary Standards	Failure to meet medical necessity results in the issue of a denial subject to appeal. The provider has sole authority and responsibility for the medical care of patients. The plan's medical management decisions do not override those obligations. We simply inform the member of our determination. Based on the provider contract and members benefit plans, participating providers are required to cooperate with all medical plan requests for information, documents or discussions for purposes of medical necessity review including but not limited to: primary and secondary diagnosis, clinical information, treatment plan, and patient status. Staff is subject to a quality monitoring program. Quality Audit team conducts a review of Clinical Staff who make case Determinations based upon Level of Care guidelines. This ensures consistent application of Level of Care Guidelines, identifies areas for potential improvement of user knowledge and understanding of the Guidelines, and provides feedback to leadership.	Failure to meet medical necessity results in the issue of a denial subject to appeal The provider has sole authority and responsibility for the medical care of patients. The plan's medical management decisions do not override those obligations. We simply inform the member of our determination. Based on the provider contract and members benefit plans, participating providers are required to cooperate with all medical plan requests for information, documents or discussions for purposes of medical necessity review including but not limited to: primary and secondary diagnosis, clinical information, treatment plan, and patient status. Staff is subject to a quality monitoring program. UHC Audit-CCR team conducts an annual MCG Care Guidelines Interrater Reliability (IRR) for UCS Clinical Staff who make case Determinations based upon MCG Care Guidelines. The IRR ensures consistent application for MCG Care Guidelines, identifies areas for potential improvement of user knowledge and understanding of MCG Guidelines, and provides feedback to MCG Care Guideline users and leadership.
Comparability	Medical Necessity is used by both Medical and Behavioral for services that require authorization. Guidelines are used that are based on nationally recognized clinical guidelines and evidence base to assist clinicians in	
Medical Necessity - Outpatient	OP Services that are subject to prior authorization require medical necessity review.	OP Services that are subject to prior authorization require medical necessity review.
Criteria Utilized	Optum LOC Guidelines are used to determine medical necessity. The evidence-base for the Level of Care Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Such guidelines are reviewed and updated annually by CTAC. Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. Optum reserves the right to consult expert opinions in determining whether mental health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.	UHC relies on the National Recognized Practice Guidelines and review and approve the use of these guidelines annually. UHC reviews these documents to adhere to NCQA and URAC standards. Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinions in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.
Processes	Optum develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on Optum's member website or by calling the telephone number on the Covered Person's ID card. They are available to Physicians and other health care professionals on Optum's provider website or by calling the telephone number on the Covered Person's ID card.	UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on UnitedHealthcare's member website or by calling the telephone number on the Covered Person's ID card. They are available to Physicians and other health care professionals on UnitedHealthcare's provider website or by calling the telephone number on the Covered Person's ID card.
Strategies	Verification of medical necessity for individuals is required to determine that they meet requirements for the service. Individual must meet diagnosis criteria in order to receive services. Optum's CTAC committee (Clinical Technology Assessments Committee) functions within behavioral to review mental health technology as it emerges. • Policies and procedures are reviewed annually or as mental health technology emerges.	Verification of medical necessity for individuals is required to determine that they meet requirements for the service. Individual must meet diagnosis criteria in order to receive services. MTAC (Medical Technology Assessments Committee) functions within medical to review medical technology as it emerges. Policies and procedures are reviewed annually or as new medical technology emerges.

Evidentiary Standards	Failure to meet medical necessity results in the issue of a denial subject to appeal. The provider has sole authority and responsibility for the medical care of patients. The plan's medical management decisions do not override those obligations. We simply inform the member of our determination. Based on the provider contract and members benefit plans, participating providers are required to cooperate with all medical plan requests for information, documents or discussions for purposes of medical necessity review including but not limited to: primary and secondary diagnosis, clinical information, treatment plan, and patient status. Staff is subject to a quality monitoring program. Quality Audit team conducts a review of Clinical Staff who make case Determinations based upon Level of Care guidelines. This ensures consistent application of Level of Care Guidelines, identifies areas for potential improvement of user knowledge and understanding of the Guidelines, and provides feedback to leadership.	Failure to meet medical necessity results in the issue of a denial subject to appeal The provider has sole authority and responsibility for the medical care of patients. The plan's medical management decisions do not override those obligations. We simply inform the member of our determination. Based on the provider contract and members benefit plans, participating providers are required to cooperate with all medical plan requests for information, documents or discussions for purposes of medical necessity review including but not limited to: primary and secondary diagnosis, clinical information, treatment plan, and patient status. Staff is subject to a quality monitoring program. UHC Audit-CCR team conducts an annual MCG Care Guidelines Interrater Reliability (IRR) for UCS Clinical Staff who make case Determinations based upon MCG Care Guidelines. The IRR ensures consistent application for MCG Care Guidelines, identifies areas for potential improvement of user knowledge and understanding of MCG Guidelines, and provides feedback to MCG Care Guideline users and leadership.
Comparability	Medical Necessity is used by both Medical and Behavioral for services that require authorization. Guidelines are used that are based on nationally recognized clinical guidelines and evidence base to assist clinicians in	
Prior Authorization - Inpatient Services	All non-emergent or elective admissions	All non-emergent or elective admissions
Criteria Utilized	Optum develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. Optum's CTAC committee (Clinical Technology Assessments Committee) serves as the parallel arm to the MTAC committee described on Medical and functions within behavioral to review mental health technology as it emerges.	MCG Care Guidelines and InterQual Guidelines are nationally recognized sets of guidelines that are evaluated annually by the quality oversight committee and approved by the medical director or equivalent designee. These guidelines are not updated based on UHC provider complaints, high appeal overturn rate or high readmission rates. UHC release monthly provider bulletins with complete details on UnitedHealthcare Medical Policy updates. The inclusion of a health service in these bulletins indicates only that UnitedHealthcare has recently adopted a new policy and/or updated, revised, replaced or retired an existing policy.
Strategies	Prior Authorization (PA) is required before MH/SUD inpatient benefits are provided to ensure services meet medical necessity requirements. Policies and procedures are reviewed annually or as mental health technology emerges.	Prior Authorization is required for non-emergent admission to clinically assess the proposed service(s) based on clinical information provided and/or the health plan benefits before the service(s) are performed or delivered. Clinical and medical necessity requirements, level of care appropriateness, and/or health plan benefits must be met in order for services to be covered by the member's plan. Policies and procedures are reviewed annually or as mental health technology emerges.
Evidentiary Standards	The behavioral plan typically determines when prior authorization and other management interventions may be required by evaluating the potential administrative cost of these interventions when compared to their potential benefit. The following strategies, processes, evidentiary standards and Optum Level of Care Guidelines are used as part of this analysis: 1) Practice Variation/variability by a. Level of care b. Geographic region c. Diagnosis d. Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a. Preference driven b. Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost	The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs. These services/procedures were selected based on the following strategies, processes, evidentiary standards and other factors: 1) Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a) Preference driven b) Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost analysis
Comparability	Medical Necessity is used by both Medical and Behavioral for services that require authorization. Guidelines are used that are based on nationally recognized clinical guidelines and evidence base to assist clinicians in	
Prior Authorization - Outpatient Services	Select Outpatient services - PHP, IOP, Psych testing, ECT, ABA services	Certain CPT codes require prior authorization-refer to Prior Authorization list https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/PA-Provider-Information/PA-CHIP-UHCCP-Prior-Authorization-Effective-04012018.pdf

Criteria Utilized	Optum develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. Optum's CTAC (Clinical Technology Assessments Committee) serves as the parallel arm to the MTAC committee described on Medical and functions within behavioral to review mental health technology. Policies and procedures are reviewed annually or as mental health technology emerges.	The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions and determine length of authorizations. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs. UHC relies on the National Recognized Practice Guidelines and review and approve the use of these guidelines annually. UHC reviews these documents to adhere to NCQA and URAC standards MTAC (Medical Technology Assessments Committee) functions within medical to review medical technology. Policies and procedures are reviewed annually or as new medical technology emerges.
Strategies	The analysis does not utilize a set or automatic threshold for each factor looked at during the analysis as the metrics vary by the specific service under consideration. The analysis is done at the CPT/HCPCS/ICD code level for each service (or family of services) and starts with a determination of whether there is sufficient clinically-based medical evidence which can be used as the basis for identifying and managing quality and cost of care concerns for the service being studied, then that service is one that may be added to the prior authorization list.	The analysis does not utilize a set or automatic threshold for each factor looked at during the analysis as the metrics vary by the specific service under consideration. The analysis is done at the CPT/HCPCS/ICD code level for each service (or family of services) and starts with a determination of whether there is sufficient clinically-based medical evidence which can be used as the basis for identifying and managing quality and cost of care concerns for the service being studied, then that service is one that may be added to the prior authorization list.
Evidentiary Standards	A range of factors can influence the application of prior authorization requirements to outpatient MH/SUD benefits. Further, the application of prior authorization may be supported by more than one factor, but not necessarily all factors. In general, the following strategies, processes, evidentiary standards and other factors are used to determine the non-routine outpatient benefits for which prior authorization is required: 1) Practice Variation/variability by a. Level of care b. Geographic region c. Diagnosis d. Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a. Preference driven b. Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost	A range of factors can influence the application of prior authorization requirements to outpatient Medical benefits. Further, the application of prior authorization may be supported by more than one factor, but not necessarily all factors. In general, the following strategies, processes, evidentiary standards and other factors are used to determine the non-routine outpatient benefits for which prior authorization is required: 1) Practice Variation/variability by a. Level of care b. Geographic region c. Diagnosis d. Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a. Preference driven b. Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost
Comparability	Medical Necessity is used by both Medical and Behavioral for services that require authorization. Guidelines are used that are based on nationally recognized clinical guidelines and evidence base to assist clinicians in	
Concurrent Review - Inpatient Services	All inpatient admissions require concurrent review following the initial authorization. The concurrent review process for urgent/emergent services follows the same process as IP once the member is admitted. Emergency services are not reviewed. • Inpatient Mental Health • Inpatient Substance Abuse Detox • SA Rehabilitation • SA Residential Treatment • ECT	All inpatient admissions require concurrent review following the initial authorization. The concurrent review process for urgent/emergent services follows the same process as IP once the member is admitted. Emergency services are not reviewed. • Acute Inpatient

Criteria Utilized	Optum uses Level of Care Guidelines to assist clinicians in making informed decisions. This includes acute and sub-acute behavioral treatment. Optum develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Optum Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. As new information becomes available this is reviewed annually in the level of care guidelines and will therefore be revised accordingly.	All inpatient concurrent admissions are subject to medical necessity using MCG Care Guidelines and/or InterQual criteria. The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs.
Strategies	Concurrent review is applied uniformly for all non-emergent or elective inpatient admissions. Optum develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. Optum's CTAC committee (Clinical Technology Assessments Committee) serves as the parallel arm to the MTAC committee described on Medical and functions within behavioral to review mental health technology as it emerges. Policies and procedures are reviewed annually or as mental health technology emerges	Concurrent review is applied uniformly for all non-emergent or elective inpatient admissions. MCG Care Guidelines and InterQual Guidelines are nationally recognized sets of guidelines that are evaluated annually by the quality oversight committee and approved by the medical director or equivalent designee. These guidelines are not updated based on UHC provider complaints, high appeal overturn rate or high readmission rate Policies and procedures are reviewed annually or as mental health technology emerges.
Evidentiary Standards	The concurrent review considers such criteria as length of stay, diagnosis, treatment plan concerns, prior admissions, efficiency of treatment, quality of care concerns, social determinants of health, etc. An Optum reviewer (who is an independently licensed mental health clinician i.e. RN, LPCC, LISW, etc) determines if a continued stay does not meet medical necessity criteria. The reviewer may also refer the case to our Medical Director for either consultation or peer review. If the plan Medical Director determines that continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified.	Medical Director and other licensed clinical staff review hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. Inpatient review also gives the plan the opportunity to contribute to decisions about discharge planning and case management. In addition, the plan may identify opportunities for quality improvement and cases that are appropriate for referral to one of our disease management programs. • MCG Care Guidelines and InterQual Guidelines are nationally recognized sets of guidelines that are evaluated annually by the quality oversight committee and approved by the medical director or equivalent designee. These guidelines are not updated based on UHC provider complaints, high appeal overturn rate or high readmission rate • Policies and procedures are reviewed annually or as mental health technology emerges.
Comparability	Concurrent review is used by both Medical and Behavioral for inpatient services.	Guidelines are used that are based on nationally recognized clinical guidelines and evidence base to assist clinicians in making informed
Concurrent Review - Outpatient Services	Ongoing Outpatient services which require authorization beyond the initial. • MH/SA Partial Hospitalization • MH/SA Intensive Outpatient • Outpatient ECT • Psychological/Neuropsychological Testing • Autism Services	Ongoing Outpatient services which require authorization beyond the initial. • Enteral services • DME • Home Health • Injectable Medications • Private Duty Nursing • Pediatric Day Services • Radiation • Proton Beam Therapy • Chemotherapy
Criteria Utilized	Optum uses Level of Care Guidelines to assist clinicians in making informed decisions. This includes acute and sub-acute behavioral treatment. Optum develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Optum Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. As new information becomes available this is reviewed annually in the level of care guidelines and will therefore be revised accordingly.	The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions and determine length of authorizations. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs. UHC relies on the National Recognized Practice Guidelines and review and approve the use of these guidelines annually. UHC reviews these documents to adhere to NCQA and URAC standards. UnitedHealthcare Clinical Services Medical Management (UCSMM) utilizes external and internal clinical review criteria that are evaluated annually by the quality oversight committee and approved by the medical director or equivalent designee. External clinical review criteria are based on applicable state/federal law, contract or government program requirements, or the adoption of evidence-based clinical practice guidelines such as MCG Care Guidelines or InterQual. Internal clinical review criteria are developed by UnitedHealthcare (UHC) through review of current, new and emerging medical technologies.

Strategies	Concurrent review is applied uniformly for service requiring prior authorization and the provider is requesting service beyond the initial authorization. Optum develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. Optum's CTAC (Clinical Technology Assessments Committee) functions within behavioral to review mental health technology as it emerges. Policies and procedures are reviewed annually or as new mental health technology emerges.	Concurrent review is applied uniformly for service requiring prior authorization and the provider is requesting service beyond the initial authorization. The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions and determine length of authorizations. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs. UHC relies on the National Recognized Practice Guidelines and review and approve the use of these guidelines annually. UHC reviews these documents to adhere to NCQA and URAC standards MTAC (Medical Technology Assessments Committee) functions within medical to review medical technology as it emerges. Policies and procedures are reviewed annually or as new medical technology emerges.
Evidentiary Standards	The concurrent review considers such criteria as length of treatment, diagnosis, treatment plan concerns, prior services, efficiency of treatment, quality of care concerns, social determinants of health, etc. An Optum reviewer (who is an independently licensed mental health clinician i.e. RN, LPCC, LISW, etc) determines if a continued stay does not meet medical necessity criteria. The reviewer may also refer the case to our Medical Director for either consultation or peer review. If the plan Medical Director determines that continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified.	• The concurrent review considers such criteria as length of treatment, diagnosis, treatment plan concerns, prior services, efficiency of treatment, quality of care concerns, social determinants of health, etc. • A nurse reviewer determines if a continued stay does not meet medical necessity criteria. If the nurse is unable to obtain adequate information, the case will be referred to a Medical Director for review based on the available information. Medical Directors with experience in a broad array of situations review the cases in order to apply clinical judgment relevant to the specific needs of the patient. If the plan Medical Director determines that an admission or continued stay at the facility is not medically necessary, the facility and the physician will be notified.
Comparability	Concurrent review is used by both Medical and Behavioral for services that require prior authorization and treatment is needed after the initial authorization is exhausted. Guidelines are used that are based on	
Retrospective Review - Inpatient Services	All Inpatient services requiring authorization.	All Inpatient services requiring authorization.
Criteria Utilized	The Retrospective Review of an inpatient admission is conducted to ensure the inpatient stay meets medical necessity utilizing level of care guidelines The Post Service/Post Claim Denial Reconsideration Review Process would use the same clinical guidelines, medical and drug policies as followed by the prior authorization team. The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs.	The Retrospective Review of an inpatient admission is conducted to ensure the inpatient stay meets medical necessity utilizing evidenced based guidelines such as MCG and InterQual. The Post Service/Post Claim Denial Reconsideration Review Process would use the same clinical guidelines, medical and drug policies as followed by the prior authorization team. The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs.
Strategies	Post-service, pre-claim reviews are conducted on inpatient services and requires mitigating circumstances for failure to authorize to waive administrative penalty to provider. If mitigating circumstances exist, a clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary.	Post-service, pre-claim reviews are conducted on inpatient services and requires mitigating circumstances for failure to authorize to waive administrative penalty to provider. If mitigating circumstances exist, a clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary.

Evidentiary Standards	The following strategies, processes, evidentiary standards and Optum Level of Care Guidelines are used as part of this analysis: 1) Practice Variation/variability by a. Level of care b. Geographic region c. Diagnosis d. Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a. Preference driven b. Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost	The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs. These services/procedures were selected based on the following strategies, processes, evidentiary standards and other factors: 1) Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a) Preference driven b) Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost analysis
Comparability	Retrospective Review is used by both Medical and Behavioral for Outpatient services to determine initial medical necessity in situations where the prior authorization did not occur prior to services. Mitigating	
Retrospective Review - Oupatient Services	All Outpatient services requiring authorization.	All Outpatient services requiring authorization.
Criteria Utilized	For post services, pre claims review, providers should follow the same process as is applied for a standard Prior Authorization request. The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs.	For post services, pre claims review, a Network providers should follow the same process as is applied for a standard Prior Authorization request. The Post Service/Post Claim Denial Reconsideration Review Process would use the same clinical guidelines, medical and drug policies as followed by the prior authorization team. The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs.
Strategies	Post-service, pre-claim reviews are conducted on outpatient services for failure to authorize when mitigating circumstances exist to waive administrative penalty to provider. If mitigating circumstances exist, a clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary.	Post-service reviews are conducted on inpatient and outpatient services. A clinical coverage review will be done by qualified medical staff to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary.
Evidentiary Standards	Post-service, pre claim review is conducted by clinical staff based on established review guidelines and includes: • Review of medical necessity. • Appropriateness of level of care. • Identifying claims issues. • Eligibility determination. • Initiation of appropriate follow-up actions for utilization and quality issues. • Identifying appropriateness and administrative issues such as physician notification. • Retrospective Review does not differ by provider category or service type.	Post-service review is conducted by clinical staff based on established review guidelines and includes: • Review of medical necessity. • Appropriateness of level of care. • Identifying claims issues. • Eligibility determination. • Initiation of appropriate follow-up actions for utilization and quality issues. • Identifying appropriateness and administrative issues such as physician notification. • Retrospective Review does not differ by provider category or service type.
Comparability	Retrospective Review is used by both Medical and Behavioral for Outpatient services to determine initial medical necessity in situations where the prior authorization did not occur prior to services. Mitigating	
Provider Reimbursement - Inpatient Services	Inpatient Benefits	Inpatient Benefits

Criteria Utilized	Reimbursement rates are negotiated with providers as needed/requested within pre-established internal rate parameters/guidelines. Participating providers have all rights afforded to them via the participation agreement. Optum performs benchmarking of a provider's request by comparing the Medicaid relativity of similar facilities. Optum also benchmark to CMS, as well as compare a facility's specific rate requests to their cost taking into consideration a facility's DHS cost-to-charge ratio, CMS cost report and other factors. We have an extensive approval process and various financial assessments are performed when a higher premium is demanded by a provider. This process includes Medical Economics, Network Management (all levels), and the Health Plan, Executive Management and approvals, depending on the complexity of the contract, would be involved.	Reimbursement rates are negotiated with providers as needed/requested within pre-established internal rate parameters/guidelines. Participating providers have all rights afforded to them via the participation agreement. UHC performs benchmarking of a provider's request by comparing the Medicaid relativity of similar facilities. UHC also benchmark to CMS, as well as compare a facility's specific rate requests to their cost taking into consideration a facility's DHS cost-to-charge ratio, CMS cost report and other factors. We have an extensive approval process and various financial assessments are performed when a higher premium is demanded by a provider. This process includes Medical Economics, Network Management (all levels), and the Health Plan, Executive Management and approvals, depending on the complexity of the contract, would be involved.
Strategies	Rates are updated in accordance with DHS updates and/or the specific terms of a provider's contract. On an annual basis, Optum performs benchmarking of all providers by reviewing the Medicaid relativity, as well as benchmarking to CMS. Outliers are then reviewed and discussed for potential remediation. Internal rate parameters/guidelines are reviewed and updated, as necessary, at least annually. Other reasons for an ad hoc review could be changes to the DHS fee schedule, such as base rate, relative weight changes or a change in the grouper version.	Rates are updated in accordance with DHS updates and/or the specific terms of a provider's contract. On an annual basis, UHC performs benchmarking of all providers by reviewing the Medicaid relativity, as well as benchmarking to CMS. Outliers are then reviewed and discussed for potential remediation. Internal rate parameters/guidelines are reviewed and updated, as necessary, at least annually. Other reasons for an ad hoc review could be changes to the DHS fee schedule, such as base rate, relative weight changes or a change in the grouper version.
Evidentiary Standards	Reimbursement is primarily based on a % of current year DHS fee schedule, with a few exceptions. Optum is in the process of developing and implementing quality based incentive programs. We perform benchmarking of a provider's request by comparing the Medicaid relativity of similar facilities. Optum also benchmark to CMS, as well as compare a facility's specific rate requests to their cost taking into consideration a facility's DHS cost-to-charge ratio, CMS cost report and other factors. There is no set timeframe for a negotiation. We have an extensive approval process and various financial assessments are performed when a higher premium is demanded by a provider. Optum currently does not have any hospital incentive plans based on inpatient services, however, Optum continues to explore cost effective collaborations with our participating network. There are no differences by provider category or service type.	Reimbursement is primarily based on a % of current year DHS fee schedule, with a few exceptions. UnitedHealthcare is in the process of developing and implementing quality based incentive programs. We perform benchmarking of a provider's request by comparing the Medicaid relativity of similar facilities. UHC also benchmark to CMS, as well as compare a facility's specific rate requests to their cost taking into consideration a facility's DHS cost-to-charge ratio, CMS cost report and other factors. There is no set timeframe for a negotiation. We have an extensive approval process and various financial assessments are performed when a higher premium is demanded by a provider. UHC currently does not have any hospital incentive plans based on inpatient services, however, UHC continues to explore cost effective collaborations with our participating network. • There are no differences by provider category or service type.
Comparability	The methods used to determine and apply Provider Reimbursement for medical/surgical and mental health/substance use disorder IP services are similar. This is appropriate under Mental Health Parity Laws which	
Provider Reimbursement - Outpatient Services	**Outpatient benefits**	**Outpatient benefits**

Criteria Utilized	Reimbursement rates are negotiated with providers as needed/requested within pre-established internal rate parameters/guidelines. Participating providers have all rights afforded to them via the participation agreement. Optum performs benchmarking of a provider's request by comparing the Medicaid relativity of similar facilities. Optum also benchmark to CMS, as well as compare a facility's specific rate requests to their cost taking into consideration a facility's DHS cost-to-charge ratio, CMS cost report and other factors. We have an extensive approval process and various financial assessments are performed when a higher premium is demanded by a provider. This process includes Medical Economics, Network Management (all levels), and the Health Plan, Executive Management and approvals, depending on the complexity of the contract, would be involved.	Reimbursement rates are negotiated with providers as needed/requested within pre-established internal rate parameters/guidelines. Participating providers have all rights afforded to them via the participation agreement. UHC performs benchmarking of a provider's request by comparing the Medicaid relativity of similar facilities. UHC also benchmark to CMS, as well as compare a facility's specific rate requests to their cost taking into consideration a facility's DHS cost-to-charge ratio, CMS cost report and other factors. We have an extensive approval process and various financial assessments are performed when a higher premium is demanded by a provider. This process includes Medical Economics, Network Management (all levels), and the Health Plan, Executive Management and approvals, depending on the complexity of the contract, would be involved.
Strategies	Rates are updated in accordance with DHS updates and/or the specific terms of a provider's contract. On an annual basis, Optum performs benchmarking of all providers by reviewing the Medicaid relativity, as well as benchmarking to CMS. Outliers are then reviewed and discussed for potential remediation. • Internal rate parameters/guidelines are reviewed and updated, as necessary, at least annually. Other reasons for an ad hoc review could be changes to the DHS fee schedule, such as base rate, relative weight changes or a change in the grouper version.	Rates are updated in accordance with DHS updates and/or the specific terms of a provider's contract. On an annual basis, UHC performs benchmarking of all providers by reviewing the Medicaid relativity, as well as benchmarking to CMS. Outliers are then reviewed and discussed for potential remediation. • Internal rate parameters/guidelines are reviewed and updated, as necessary, at least annually. • Other reasons for an ad hoc review could be changes to the DHS fee schedule, such as base rate, relative weight changes or a change in the grouper version.
Evidentiary Standards	Reimbursement is primarily based on a % of current year DHS fee schedule, with a few exceptions. Optum is in the process of developing and implementing quality based incentive programs. We perform benchmarking of a provider's request by comparing the Medicaid relativity of similar facilities. Optum also benchmark to CMS, as well as compare a facility's specific rate requests to their cost taking into consideration a facility's DHS cost-to-charge ratio, CMS cost report and other factors. There is no set timeframe for a negotiation. We have an extensive approval process and various financial assessments are performed when a higher premium is demanded by a provider. Optum currently does not have any hospital incentive plans based on inpatient services, however, Optum continues to explore cost effective collaborations with our participating network. • There are no differences by provider category or service type.	Reimbursement is primarily based on a % of current year DHS fee schedule, with a few exceptions. UnitedHealthcare is in the process of developing and implementing quality based incentive programs. We perform benchmarking of a provider's request by comparing the Medicaid relativity of similar facilities. UHC also benchmark to CMS, as well as compare a facility's specific rate requests to their cost taking into consideration a facility's DHS cost-to-charge ratio, CMS cost report and other factors. There is no set timeframe for a negotiation. We have an extensive approval process and various financial assessments are performed when a higher premium is demanded by a provider. UHC currently does not have any hospital incentive plans based on inpatient services, however, UHC continues to explore cost effective collaborations with our participating network. • There are no differences by provider category or service type.
Comparability	The methods used to determine and apply Provider Reimbursement for medical/surgical and mental health/substance use disorder IP services are similar. This is appropriate under Mental Health Parity Laws which	
Experimental / Investigational - Inpatient & Outpatient Services	Unproven or experimental services are defined in clinical policy. They will be denied administratively as not covered by the benefit plan	Unproven or experimental services are defined in clinical policy. They will be denied administratively as not covered by the benefit plan

Criteria Utilized	Experimental or investigational services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination regarding coverage in a particular case is made, are determined to be any of the following: • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use. • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.) • The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.	Experimental or investigational services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination regarding coverage in a particular case is made, are determined to be any of the following: • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use. • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.) • The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
Strategies	Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded.	Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
Evidentiary Standards	Technology assessments and medical/drug policies are based on the graded hierarchy as follows: • Statistically robust, well-designed randomized controlled trials; • Statistically robust, well-designed cohort studies; • Multi-site observational studies; • Single-site observational studies; • In the absence of incontrovertible scientific evidence, medical policies may be based upon national consensus statements by recognized authorities. The following stratification describes the hierarchy of use of medical policies and clinical guidelines within UnitedHealthcare: o National guidelines and consensus statements Examples United States Preventive Services Task Force (USPSTF) National Institutes of Health (NIH) clinical statements	Technology assessments and medical/drug policies are based on the graded hierarchy as follows: • Statistically robust, well-designed randomized controlled trials; • Statistically robust, well-designed cohort studies; • Multi-site observational studies; • Single-site observational studies; • In the absence of incontrovertible scientific evidence, medical policies may be based upon national consensus statements by recognized authorities. The following stratification describes the hierarchy of use of medical policies and clinical guidelines within UnitedHealthcare: o National guidelines and consensus statements Examples: United States Preventive Services Task Force (USPSTF) National Institutes of Health (NIH) clinical statements
Fail First Requirements - Inpatient and Outpatient	Fail first therapy is not applicable to MH/SUD and therefore not a parity concern for MH/SUD and M/S benefits.	Fail first therapy is not applicable to MH/SUD and therefore not a parity concern for MH/SUD and M/S benefits.
Emergency Services - Prior Authorization	All emergency department and post-stabilization services are covered without authorization.	All emergency department and post-stabilization services are covered without authorization.
Emergency Services - Concurrent Review	All inpatient admissions require concurrent review following the initial authorization. The concurrent review process for urgent/emergent services follows the same process as IP once the member is admitted. Emergency services are not reviewed. • Inpatient Mental Health • Inpatient Substance Abuse Detox • SA Rehabilitation • SA Residential Treatment • ECT	All inpatient admissions require concurrent review following the initial authorization. The concurrent review process for urgent/emergent services follows the same process as IP once the member is admitted. Emergency services are not reviewed. • Acute Inpatient
Strategy	The concurrent review process for urgent/emergent services follows the same process as Inpatient once the member is admitted. Emergency services are not reviewed.	The concurrent review process for urgent/emergent services follows the same process as Inpatient once the member is admitted. Emergency services are not reviewed.