STATE OF HAWAII
Department of Human Services

2018 MEDICAID MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT REPORT – *12/20/18 ADDENDUM*

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SUMMARY OF REGULATIONS

Mental Health Parity and Addiction and Equity Act (MHPAEA) of 2008
The MHPAEA required group health plans to ensure that the financial requirements (i.e. deductibles, copayments, coinsurance) and treatment limitations (i.e. frequency of treatment, number of visits, days of coverage) applied to mental health (MH)/ substance use disorder (SUD) benefits are not more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits covered by the plan. [1]

Medicaid Parity Final Rule
Effective March 31, 2016, the Centers for Medicare and Medicaid (CMS) issued the Final Rule addressing the application of the MHPAEA of 2008. The Final Rule ensured parity requirements were a part of all covered services provided by Managed Care Organizations (MCO). [2]

21st Century Cures Act
In October 2017, Federal and State agencies coordinated efforts to ensure compliance and implementation of parity provisions set forth by the MHPAEA and extended protections to individual and small group health insurance plans. [3]

HAWAII SERVICE DELIVERY SYSTEM

The State of Hawaii delivers Medicaid benefits and services through five (5) MCOs via QUEST Integration (QI) which provides basic health care and behavioral health services to adults and children [includes Children's Health Insurance Program (CHIP)]. In addition, there is an additional behavioral health benefit through a carve-out program, Community Care Services (CCS).

QUEST Integration

QUEST stands for:
- **Q**uality care
- **U**niversal access
- **E**fficient utilization
- **S**tabilizing Costs
- **T**ransforming the way health care is provided

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[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services (March 30, 2016), Final Rule, Federal Register Vol. 81 No. 6, Retrieved from: https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf

[2] Centers for Medicare and Medicaid (March 29, 2016), *Application of MHPAEA to Medicaid and CHIP (CMS-2333-F)*, Retrieved from: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-parity-fr-rollout.pdf

[3] U.S. Department of Health & Human Services (October 17, 2017), *Achieving Parity in Health Insurance Coverage: 21st Century Cures Act Parity Listening Session*, Retrieved from: https://www.hhs.gov/programs/topic-sites/mental-health-parity/achieving-parity/cures-act-parity-listening-session/index.html

The QUEST Integration (QI) program is a melding of several programs into a State-wide program providing managed care services to Hawaii's Medicaid population. The goal of QI is to improve health care status, minimize administrative burdens, improve care coordination, expand access to home and community based services (HCBS), establish contractual accountability, and improve and strengthen a sense of member responsibility by promoting member independence and choice.

Hawaii currently has five (5) QI managed care organizations (MCOs) that provides Medicaid services on all islands throughout the state.

Community Care Services

The Community Care Services (CCS) is a carve-out program that provides intensive behavioral health services, in addition to the basic behavioral health services that the QI Medicaid health plans normally provide, to adults diagnosed with a qualifying serious mental illness (SMI) and/or a serious and persistent mental illness (SPMI) and determined to meet the other areas of the CCS eligibility criteria.

CCS is managed and provided by one (1) of the five (5) QI MCOs in the state of Hawaii.

Once approved, all behavioral health services are provided by CCS. All medical benefits and services continue to be provided by the member's chosen QI MCO.

PARITY ANALYSIS APPROACH

As required by the Centers for Medicare & Medicaid Services (CMS) Medicaid Parity Final Rule and the MHAPEA, the Department of Human Services (DHS) Hawaii, Med-QUEST Division (MQD), worked collaboratively with the five (5) QI MCOs and one (1) CCS MCO to analyze the necessary components to determine parity compliance.

The CMS Parity Toolkit and webinars steered the vision of what was needed for this effort. Meetings were held to determine what information was necessary and the steps to develop the appropriate tools to gather that information.

PHASE ONE – Determining the Course:

Discussions during the initial phase of this effort were to identify the scope of the parity analysis for the state. The CMS Toolkit provided the basis to initiate the process of gathering the information needed for this analysis. [4]

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[4] Parity Compliance Toolkit, dated January 17, 2017: https://www.medicaid.gov/medicaid/benefits/downoads/bhs/parity-toolkit.pdf

Requirements for analysis included the following:

- Aggregate lifetime and annual dollar limits (AL/ADLs)

- Financial requirements and treatment limitations
  - Copayments, coinsurance, deductibles, and out-of-pocket maximums
  - Quantitative Treatment Limits (QTLs)
  - Non-Quantitative Treatment Limits (NQTLs)

- Availability of information

Next steps included the following:

Identifying benefit package delivery systems and the scope of the parity analysis	Five (5) QI MCO's and one (1) CCS carve-out BH program. Each QI MCO provides M/S and basic MH/SUD services. The CCS program is an additional MH/SUD service for enrolled members who meet a specific criteria. The QI MCO will continue to provide M/S services while enrolled in CCS.
Defining M/S and MH/SUD services provided by the MCOs	MH/SUD: Services provided to Medicaid members who are emotionally disturbed, mentally ill, or addicted to or abuse alcohol, prescription drugs and/or other substances, with a diagnosis based on the current versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD). M/S: Services and benefits for medical conditions and surgical procedures provided by physicians, other health professionals, and paramedical personnel that diagnose, treat illnesses, injuries, conditions, diseases and/or symptoms, all in accordance with the current version of the ICD.
Definitions of the classifications applied to all M/S and MH/SUD benefits provided by the MCOs	INPATIENT: All covered services or items provided to a member during an admission to a facility. OUTPATIENT: All covered services or items that are provided to members in a setting that does not require an order for admission and does not meet the definition of emergency care. PRESCRIPTION DRUGS: Covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist/pharmacy. EMERGENCY CARE: All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency medical condition or crisis other than in an inpatient setting.

Financial requirements and QTLs	Financial Requirements: Payment by members, for services received, in addition to the reimbursed rate provided by the MCOs (co-payments, deductibles). Quantitative Treatment Limitations: Limits on the scope or duration of a benefit, numerically (day or visit limits).
NQTLs	NQTL: A limit on the scope or duration of benefits, such as a prior authorization or network admission standards. These are "soft limits" that allows exceeding of numerical limits for M/S or MH/SUD benefits based on medical necessity. The list of NQTLs includes but is not limited to the following: • Medical management standards that limit or excludes benefits based on medical necessity. • Formulary for prescription drugs. • Criteria/standards for providers in a network. • Step-therapy or Fail-first therapy: o Refusal to cover higher-cost treatments/therapy until it is proven that the lower-cost treatment/therapy was ineffective. o Conditions on benefits dependent on completion of a course of treatment. • Restrictions on providers by specialty, facility type and/or geographic location. • Standards for out-of-network providers.

PHASE TWO – Gathering Information:

Based on the discussions during the first phase, MQD moved into the second phase. As the requirements were to gather information related to QTLs and NQTLs, tools were developed to ascertain the information necessary for review and analysis to determine parity.

Based on the models provided via the CMS Toolkit, MQD developed tools to gather the following information:

1. QTLs – MCOs to provide information of financial and quantitative treatment limits for the four (4) classifications, in the table above, for M/S and MH/SUD services. *Aggregate lifetime, annual dollar limits and financial requirements are not a part of the Hawaii Medicaid system.*

2. NQTLs – MCOs to describe the process, strategies, evidentiary standards and other contributing factors as it applies to all four (4) classifications for M/S and MH/SUD services as follows:

- MEDICAL MANAGEMENT STANDARDS
  - Medical Necessity Criteria Development
  - Prior Authorization
  - Concurrent Review
  - Prescription Drugs

- NETWORK ADMISSION REQUIREMENTS
  - Provider types
  - Geographic limitations
  - Standard for access to out-of-network benefits
  - Rates for outpatient providers
  - Factors affecting provider reimbursement rates

PHASE THREE – Reviewing and Analyzing the Information:

Quantitative Treatment Limits (QTLs)

Each of the five (5) individual QI MCOs' QTL reports were reviewed for any discrepancies that possibly showed inequity of the delivery of services between M/S and MH/SUD. CCS submitted its own report with their SMI/SPMI services being compared to their QI component that provides both medical and basic behavioral health Medicaid services.

Review of the QTL reports revealed that there were no discrepancies found between the delivery of M/S and MH/SUD services within each QI MCO. No limitations were imposed on MH/SUD services.

To ensure parity existed between all M/S and MH/SUD services provided by the state to Medicaid members, MQD additionally compared the MH/SUD services from the CCS data to the M/S services of the five (5) QI MCOs' data. Analysis and comparative review of the data revealed that there were no limits imposed on MH/SUD services; therefore, this BH parity requirement was met. No further action by the MCOs or the State was needed.

Non-Quantitative Treatment Limits (NQTLs)

NQTL reports were reviewed for stringency and/or comparability between M/S and MH/SUD services. Each MCOs' analysis of their own practices were reviewed along with corresponding policies and procedures, national association guidelines, and Federal and State guidelines and regulations used to make determinations for the services provided for both M/S and MH/SUD.

Review of each of the five (5) QI MCOs comparison of M/S and basic MH/SUD services showed that services were comparable and/or MH/SUD services were not more stringent than M/S services. Therefore, each QI MCO met BH parity requirements.

To ensure that Medicaid services, across the State, aligned with BH parity requirements, the next step was comparing all five (5) QI MCOs' M/S services to the CCS MCO's MH/SUD services. The initial comparison revealed a need for further discussion to determine whether or not BH

parity requirements were met. After further review, analysis and discussion, there were areas where BH parity was in question. MQD determined that inquiries and clarification of internal processes would be conducted, for the areas in question, with each of the identified QI MCOs and the CCS MCO. Based on the responses provided by the QI MCOs and the CCS MCO, MQD would then determine the most feasible and effective course of action to ensure that less stringent or comparable means be implemented to provide MH/SUD services in comparison to M/S services.

To narrow down the areas where BH parity was in question, A NQTL summary was developed, for three (3) of the five (5) QI MCOs and the CCS MCO, to address specific areas that needed clarification or further explanation. The summaries were sent to each MCO and responses were due by 10/29/18.

After receiving the MCO's responses, the information was added to the NQTL analysis tool. Review of the updated tool revealed the areas needing remediation.

***12/20/18 ADDENDUM*:**

As per the action plan below, discussions were held with one QI MCO and the CCS MCO regarding the BH parity requirements needed for the state to come into compliance. With the MCOs having a better understanding of what was needed, updated NQTL summaries were sent out to the specific MCOs on 12/4/18 to address the outstanding issues needed for clarification and/or remediation.

On 12/5/18 and 12/12/18 the MCOs submitted their responses.

The responses were reviewed. After discussion, the state determined that the responses addressed the issues and no further clarification or remediation was needed. It was determined on 12/19/18, BH parity requirements were now met.

CURRENT ACTION PLAN TO ACHIEVE COMPLIANCE

On 11/5/18 and 11/9/18, an action plan for the MCOs, CCS and the state was developed. Meetings are being scheduled with the QI MCOs and the CCS MCO to discuss next steps to reach parity. The State is also currently working with CMS to update the two (2) contracts, QI and CCS RFPs to include BH parity requirements.

The goal of the state is to be in compliance with BH parity requirements by March 31, 2019.

***12/20/18 ADDENDUM*:**

The state will continue to work with CMS to update and finalize the QI and CCS RFPs to be in accordance with BH parity requirements.

MAINTAINING AND MONITORING COMPLIANCE

To ensure continued compliance:

1. The QI and CCS RFPs will include BH parity requirements; and

2. As per the changes to the contracts, there will be at least an annual submission of QTL and NQTL data using the same tools used for this report. If and when issues arise, the tools and frequency of submission of those tools will be adjusted to ensure continued compliance with BH parity.

For 2019, the initial focus will be areas of questionable BH parity found during this compliance analysis and report. Each prospective year, thereafter, will focus on problematic areas while continuing to monitor overall compliance.

ATTACHMENT (A)

QTL ANALYSIS

Benefit Plan Design #1: **Quest Integration**

Add or delete rows in each Classification/Subclassification, as needed ALOHACARE

Table 1: Financial Requirements - Deductibles

A. Are there any deductibles? (Y/N)	N
B. Identify the amount(s) of the deductible(s). If the product has different deductible amounts for different coverage units (e.g., individual and family deductibles) and/or for benefits separate from the overall deductible (e.g., a separate pharmacy deductible), clearly identify those amounts. Identify any benefits that are not subject to the deductible(s).	N/A
C. Does the deductible, or do the deductibles, apply to "substantially all" M/S benefits in each classification or subclassification to which the deductible applies? (See 45 C.F.R.§ 146.136(c)(3)(v)(B) Example 4.) Show proof in the Exhibit 2.	No. No deductibles in benefit plan.

Table 2: Financial Requirements - Out-of-Pocket Maximums

A. Identify the amount(s) of the out-of-pocket maximum(s). If there are different out-of-pocket maximums for different coverage units (e.g., individual and family out-of-pocket maximums), clearly identify these amounts.	out-of-pocket maximums in the benefit plan.
B. Identify any benefits that are not subject to the out-of-pocket maximum(s).	

Table 3: Financial Requirements - Copayments and Coinsurance

Medical/Surgical Benefits			Mental Health/Substance Use Disorder Benefits			
List All Benefits in Each Classification /Subclassification	**Copayment/Coinsurance for Each Benefit**		**List Benefits in Each Classification /Subclassification**	**Copayment/Coinsurance for Each Benefit**	**CCS**	
A. Inpatient, In-Network			**A. Inpatient, In-Network**		**A. Inpatient, In-Network**	
Hospital facility fee (e.g., hospital room)--acute inpatient	0		Hospital facility fee (e.g., hospital room)--acute MH inpatient	0	Inpatient Alcohol & Chemical Dependency Services	$0
Physician/surgeon fee--acute inpatient	0		Physician/surgeon fee--acute MH inpatient	0	Inpatient Detoxification Only	$0
Hospital facility fee (e.g., hospital room)--female sterilization	0		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	0	Inpatient Detoxification Only & Labs	$0
Physician/surgeon fee--female sterilization	0		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	0	Inpatient Emergency Care	$0
Hospital facility fee (e.g., hospital room)--maternity delivery	0		Hospital facility fee (e.g., hospital room)--SUD detoxification	0	Inpatient Psychiatric Services	$0
Professional fees--maternity delivery	0		Physician/surgeon fee--SUD detoxification	0		

Inpatient hospice facility fee (e.g., hospital room)	0		Short-term mental health crisis residential treatment	0		
Skilled nursing facility fee (e.g., hospital room)	0		SUD transitional residential recovery services	0		
			Residential treatment services for SMI and SED	0		
B. Inpatient, Out-of-Network	**List Copayment/Coinsurance for Each Benefit**		**B. Inpatient, Out-of-Network**	**List Copayment/Coinsurance for Each Benefit**	**B. Inpatient, Out-of-Network**	
Hospital facility fee (e.g., hospital room)--acute inpatient	0		Hospital facility fee (e.g., hospital room)--acute MH inpatient	0	N/A	N/A
Physician/surgeon fee--acute inpatient	0		Physician/surgeon fee--acute MH inpatient	0		
Hospital facility fee (e.g., hospital room)--female sterilization	0		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	0		
Physician/surgeon fee--female sterilization	0		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	0		
Hospital facility fee (e.g., hospital room)--maternity delivery	0		Hospital facility fee (e.g., hospital room)--SUD detoxification	0		
Professional fees--maternity delivery	0		Physician/surgeon fee--SUD detoxification	0		
Inpatient hospice facility fee (e.g., hospital room)	0		Short-term mental health crisis residential treatment	0		
Skilled nursing facility fee (e.g., hospital room)	0		SUD transitional residential recovery services	0		
			Residential treatment services for SMI and SED	0		
C. Outpatient, In-Network: Office Visits	**List Copayment/Coinsurance for Each Benefit**		**C. Outpatient, In-Network: Office Visits**	**List Copayment/Coinsurance for Each Benefit**	**C. Outpatient, In-Network: Office Visits**	
Primary care visit to treat an injury, illness, or condition	0		Individual and group mental health evaluation and treatment	0	Air Transportation	$0
Other practitioner office visit	0		Outpatient services for monitoring drug therapy	0	Alcohol & Chemical Dependency Services	$0
Specialist physician visit	0		Individual and group chemical dependency evaluation and counseling	0	Ambulatory Behavioral Health Services & Crisis Mgt	$0
Preventive care/screening/immunization	0		Medical treatment for withdrawal symptoms	0	Combined Therapy	$0
Family planning	0		Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	0	Consultation	$0
Prenatal care and preconception visits	0				Diagnostic Services	$0
Acupuncture	0				Electro-Convulsive Therapy (ECT)	$0
Health education	0				Group Therapy	$0
Child dental: diagnostic and preventive	N/A				Intensive Case Management	$0
Child eye exam	0				Interpretation Services	$0
					Maintenance Therapy	$0
					Medication Management	$0
					Member Education	$0
					Methadone Management Services	$0
					Non-Emergent Transportation	$0
					Nurses Hotline	$0
					Partial Hospitalization or Intensive Outpatient Hospitalization	$0
					Practitioner Services	$0
					Psychological Testing	$0
					Psychotherapy	$0
					Supported Employment Services	$0

					Therapeutic Living Supports-Specialized Residential	$0
					Treatment Facilities	$0
					Transitional Housing	$0
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)	**List Copayment/Coinsurance for Each Benefit**		**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each Benefit**	**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each**
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	0		Short-term partial hospitalization	0	See above Section C.	See above Section C.
Outpatient surgery--physician/surgeon fee	0		Short-term intensive outpatient psychiatric treatment	0		
Outpatient surgery facility fee--female sterilization	0		Outpatient psychiatric observation for an acute psychiatric crisis	0		
Outpatient surgery--physician/surgeon fee--female sterilization	0		Psychological testing to evaluate a mental disorder	0		
Outpatient visit regarding outpatient surgery	0		Day treatment program for substance use disorder	0		
BRCA testing and related genetic counseling	0		Intensive outpatient treatment for substance use disorder	0		
Laboratory tests	0		Behavioral health treatment delivered in the home for autism or PDD	0		
X-rays and diagnostic imaging	0		Nonemergency psychiatric transportation	0		
Imaging (CT/PET Scans, MRIs)	0					
Nonemergency ambulance transportation	0					
Outpatient rehabilitation services	0					
Outpatient habilitation services	0					
Home health	0					
Hospice	0					
Durable medical equipment, including in-home DME	0					
Medical supplies	0					
Prosthetic and orthotic services and devices	0					
Diabetes equipment and supply services	0					
Contact lenses for aniridia or aphakia	0					
Infusion therapy	0					
Child eye glasses/contact lenses	0					
Child dental: basic services	N/A					
Child dental: major services	N/A					
Child medically necessary orthodontics	N/A					
E. Outpatient, Out-of-Network: Office Visits	**List Copayment/Coinsurance for Each Benefit**		**E. Outpatient, Out-of-Network: Office Visits**	**List Copayment/Coinsurance for Each Benefit**	**E. Outpatient, Out-of-Network: Office Visits**	
					N/A	N/A
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	**List Copayment/Coinsurance for Each Benefit**		**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each Benefit**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	

					N/A	N/A
G. Emergency	**List Copayment/Coinsurance for Each Benefit**		**G. Emergency**	**List Copayment/Coinsurance for Each Benefit**	**G. Emergency**	
Emergency room facility fee (waived if admitted)	0		Emergency room facility fee (waived if admitted)	0	Emergency Room Services	$0
Emergency room physician fee (waived if admitted)	0		Emergency room physician fee (waived if admitted)	0	Emergency Transportation/Ambulance	$0
Emergency medical transportation	0		Emergency medical/psychiatric transportation	0	Out-of-State Emergency Behavioral Health Services	$0
Urgent care	0		Urgent care	0		
H. Prescription Drugs	**List Copayment/Coinsurance for Each Benefit**			**List Copayment/Coinsurance for Each Benefit**		
Tier One	0		Tier One	0	Generic Brand	$0
Tier Two	0		Tier Two	0	Preferred Brand	$0
Tier Three	0		Tier Three	0	Prescription OTC	$0
Tier Four	0		Tier Four	0		

Table 4: Quantitative Treatment Limitations, including, but not limited to, limits on inpatient days per admission/episode or per year, outpatient visits per episode/year, outpatient services per episode/year.

Medical/Surgical Benefits			Mental Health/Substance Use Disorder			
Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Subclassification Below	**Quantitative Treatment Limits that Apply to Each**		**Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Subclassification Below**	**Quantitative Treatment Limits that Apply to Each**	**CCS**	
A. Inpatient, In-Network			**A. Inpatient, In-Network**		**A. Inpatient, In-Network**	**QTLs**
Hospital facility fee (e.g., hospital room)--acute inpatient	None		Hospital facility fee (e.g., hospital room)--acute MH inpatient	None	Inpatient Alcohol & Chemical Dependency Services	None
Physician/surgeon fee--acute inpatient	None		Physician/surgeon fee--acute MH inpatient	None	Inpatient Detoxification Only	None
Hospital facility fee (e.g., hospital room)--female sterilization	None		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	None	Inpatient Detoxification Only & Labs	None
Physician/surgeon fee--female sterilization	None		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	None	Inpatient Emergency Care	None
Hospital facility fee (e.g., hospital room)--maternity delivery	None		Hospital facility fee (e.g., hospital room)--SUD detoxification	None	Inpatient Psychiatric Services	None
Professional fees--maternity delivery	None		Physician/surgeon fee--SUD detoxification	None		
Inpatient hospice facility fee (e.g., hospital room)	None		Short-term mental health crisis residential treatment	None		
Skilled nursing facility fee (e.g., hospital room)	None		SUD transitional residential recovery services	None		
			Residential treatment services for SMI and SED	None		
B. Inpatient, Out-of-Network	**List all QTLs**		**B. Inpatient, Out-of-Network**	**List all QTLs**	**B. Inpatient, Out-of-Network**	**QTLs**
					N/A	N/A

C. Outpatient, In-Network: Office Visits	**List all QTLs**		**C. Outpatient, In-Network: Office Visits**	**List all QTLs**	**C. Outpatient, In-Network: Office Visits**	**QTLs**
Primary care visit to treat an injury, illness, or condition	None		Individual and group mental health evaluation and treatment	None	Air Transportation	None
Other practitioner office visit	None		Outpatient services for monitoring drug therapy	None	Alcohol & Chemical Dependency Services	None
Specialist physician visit	None		Individual and group chemical dependency evaluation and counseling	None	Ambulatory Behavioral Health Services & Crisis Mgt	None
Preventive care/screening/immunization	None		Medical treatment for withdrawal symptoms	None	Combined Therapy	None
Family planning	None		Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	None	Consultation	None
Prenatal care and preconception visits	None				Diagnostic Services	None
Acupuncture	N/A				Electro-Convulsive Therapy (ECT)	None
Health education	None				Group Therapy	None
Child dental: diagnostic and preventive	N/A				Intensive Case Management	None
Child eye exam	One (1) exam every 12 months	NON BH			Interpretation Services	None
					Maintenance Therapy	None
					Medication Management	None
					Member Education	None
					Methadone Management Services	None
					Non-Emergent Transportation	None
					Nurses Hotline	None
					Partial Hospitalization or Intensive Outpatient Hospitalization	None
					Practitioner Services	None
					Psychological Testing	None
					Psychotherapy	None
					Supported Employment Services	None
					Therapeutic Living Supports-Specialized Residential	None
					Treatment Facilities	None
					Transitional Housing	None
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)	**List all QTLs**		**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List all QTLs**	**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**QTLs**
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	None		Short-term partial hospitalization	None	See above Section C.	See above Section C.
Outpatient surgery --physician/surgeon fee	None		Short-term intensive outpatient psychiatric treatment	None		
Outpatient surgery facility fee--female sterilization	None		Outpatient psychiatric observation for an acute psychiatric crisis	None		
Outpatieint surgery--physician/surgeon fee--female sterilization	None		Psychological testing to evaluate a mental disorder	None		
Outpatient visit regarding outpatient surgery	None		Day treatment program for substance use disorder	None		
BRCA testing and related genetic counseling	None		Intensive outpatient treatment for substance use disorder	None		
Laboratory tests	None		Behavioral health therapy delivered in the home for autism and PDD	None		
X-rays and diagnostic imaging	None		Nonemergency psychiatric transportation	None		
Imaging (CT/PET Scans, MRIs)	None					
Nonemergency medical transportation	None					
Outpatient rehabilitation services	None					

Outpatient habilitation services	None					
Home health	None					
Hospice	None					
Durable medical equipment, including in-home DME	None					
Medical supplies	None					
Prosthetic and orthotic services and devices	None					
Diabetes equipment and supply services	None					
Contact lenses for aniridia or aphakia	None					
Infusion therapy	None					
Child eye glasses/contact lenses	Frames & lenses limited to one every twelve months	NON BH				
Child dental: basic services	N/A					
Child dental: major services	N/A					
Child medically necessary orthodontics	N/A					
E. Outpatient, Out-of-Network: Office Visits	**List all QTLs**		**E. Outpatient, Out-of-Network: Office Visits**	**List all QTLs**	**E. Outpatient, Out-of-Network: Office Visits**	**QTLs**
					N/A	N/A
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	**List all QTLs**		**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**List all QTLs**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**QTLs**
					N/A	N/A
G. Emergency	**List all QTLs**		**G. Emergency**	**List all QTLs**	**G. Emergency**	**QTLs**
Emergency room facility fee (waived if admitted)	None		Emergency room facility fee (waived if admitted)	None	Emergency Room Services	None
Emergency room physician fee (waived if admitted)	None		Emergency room physician fee (waived if admitted)	None	Emergency Transportation/Ambulance	None
Emergency medical transportation	None		Emergency medical/psychiatric transportation	None	Out-of-State Emergency Behavioral Health Services	None
Urgent care	None		Urgent care	None		
H. Prescription Drugs	**List all QTLs**		**H. Prescription Drugs**	**List all QTLs**	**H. Prescription Drugs**	**QTLs**
Tier One	None		Tier One	None	Tier One	None
Tier Two	None		Tier Two	None	Tier Two	None
Tier Three	None		Tier Three	None	Tier Three	None
Tier Four	None		Tier Four	None	Tier Four	None

Benefit Plan Design #1: HMSA QUEST Integration

Add or delete rows in each Classification/Subclassification, as needed

Table 1: Financial Requirements - Deductibles

A. Are there any deductibles? (Y/N)	N
B. Identify the amount(s) of the deductible(s). If the product has different deductible amounts for different coverage units (e.g., individual and family deductibles) and/or for benefits separate from the overall deductible (e.g., a separate pharmacy deductible), clearly identify those amounts. Identify any benefits that are not subject to the deductible(s).	N/A
C. Does the deductible, or do the deductibles, apply to "substantially all" M/S benefits in each classification or subclassification to which the deductible applies? (See 45 C.F.R.§ 146.136(c)(3)(v)(B) Example 4.) Show proof in the Exhibit 2.	N/A

Table 2: Financial Requirements - Out-of-Pocket Maximums

A. Identify the amount(s) of the out-of-pocket maximum(s). If there are different out-of-pocket maximums for different coverage units (e.g., individual and family out-of-pocket maximums), clearly identify these amounts.	N/A
B. Identify any benefits that are not subject to the out-of-pocket maximum(s).	N/A

Table 3: Financial Requirements - Copayments and Coinsurance

Medical/Surgical Benefits			Mental Health/Substance Use Disorder Benefits			
List All Benefits in Each Classification /Subclassification	**List Copayment/Coinsurance for Each Benefit**		**List Benefits in Each Classification /Subclassification**	**List Copayment/Coinsurance for Each Benefit**	**CCS**	
A. Inpatient, In-Network			**A. Inpatient, In-Network**		**A. Inpatient, In-Network**	
Hospital facility fee (e.g., hospital room)--acute inpatient	0		Hospital facility fee (e.g., hospital room)--acute MH inpatient	0	Inpatient Alcohol & Chemical Dependency Services	$0
Physician/surgeon fee--acute inpatient	0		Physician/surgeon fee--acute MH inpatient	0	Inpatient Detoxification Only	$0
Hospital facility fee (e.g., hospital room)--female sterilization	0		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	0	Inpatient Detoxification Only & Labs	$0
Physician/surgeon fee--female sterilization	0		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	0	Inpatient Emergency Care	$0
Hospital facility fee (e.g., hospital room)--maternity delivery	0		Hospital facility fee (e.g., hospital room)--SUD detoxification	0	Inpatient Psychiatric Services	$0
Professional fees--maternity delivery	0		Physician/surgeon fee--SUD detoxification	0		
Inpatient hospice facility fee (e.g., hospital room)	0		Short-term mental health crisis residential treatment	0		
Skilled nursing facility fee (e.g., hospital room)	0		SUD transitional residential recovery services	0		
			Residential treatment services for SMI and SED	0		
B. Inpatient, Out-of-Network	**List Copayment/Coinsurance for Each Benefit**		**B. Inpatient, Out-of-Network**	**List Copayment/Coinsurance for Each Benefit**	**B. Inpatient, Out-of-Network**	
					N/A	N/A

C. Outpatient, In-Network: Office Visits	**List Copayment/Coinsurance for Each Benefit**		**C. Outpatient, In-Network: Office Visits**	**List Copayment/Coinsurance for Each Benefit**	**C. Outpatient, In-Network: Office Visits**	
Primary care visit to treat an injury, illness, or condition	0		Individual and group mental health evaluation and treatment	0	Air Transportation	$0
Other practitioner office visit	0		Outpatient services for monitoring drug therapy	0	Alcohol & Chemical Dependency Services	$0
Specialist physician visit	0		Individual and group chemical dependency evaluation and counseling	0	Ambulatory Behavioral Health Services & Crisis Mgt	$0
Preventive care/screening/immunization	0		Medical treatment for withdrawal symptoms	0	Combined Therapy	$0
Family planning	0		Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	0	Consultation	$0
Prenatal care and preconception visits	0				Diagnostic Services	$0
Acupuncture	0				Electro-Convulsive Therapy (ECT)	$0
Health education	0				Group Therapy	$0
Child dental: diagnostic and preventive	0				Intensive Case Management	$0
Child eye exam	0				Interpretation Services	$0
					Maintenance Therapy	$0
					Medication Management	$0
					Member Education	$0
					Methadone Management Services	$0
					Non-Emergent Transportation	$0
					Nurses Hotline	$0
					Partial Hospitalization or Intensive Outpatient Hospitalization	$0
					Practitioner Services	$0
					Psychological Testing	$0
					Psychotherapy	$0
					Supported Employment Services	$0
					Therapeutic Living Supports-Specialized Residential	$0
					Treatment Facilities	$0
					Transitional Housing	$0
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)	**List Copayment/Coinsurance for Each Benefit**		**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each Benefit**	**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	0		Short-term partial hospitalization	0	See above Section C.	See above Section C.
Outpatient surgery--physician/surgeon fee	0		Short-term intensive outpatient psychiatric treatment	0		
Outpatient surgery facility fee--female sterilization	0		Outpatient psychiatric observation for an acute psychiatric crisis	0		
Outpatient surgery--physician/surgeon fee--female sterilization	0		Psychological testing to evaluate a mental disorder	0		
Outpatient visit regarding outpatient surgery	0		Day treatment program for substance use disorder	0		
BRCA testing and related genetic counseling	0		Intensive outpatient treatment for substance use disorder	0		
Laboratory tests	0		Behavioral health treatment delivered in the home for autism or PDD	0		
X-rays and diagnostic imaging	0		Nonemergency psychiatric transportation	0		
Imaging (CT/PET Scans, MRIs)	0					
Nonemergency ambulance transportation	0					
Outpatient rehabilitation services	0					
Outpatient habilitation services	0					
Home health	0					
Hospice	0					
Durable medical equipment, including in-home DME	0					

Medical supplies	0					
Prosthetic and orthotic services and devices	0					
Diabetes equipment and supply services	0					
Contact lenses for aniridia or aphakia	0					
Infusion therapy	0					
Child eye glasses/contact lenses	0					
Child dental: basic services	0					
Child dental: major services	0					
Child medically necessary orthodontics	0					
E. Outpatient, Out-of-Network: Office Visits	**List Copayment/Coinsurance for Each Benefit**		**E. Outpatient, Out-of-Network: Office Visits**	**List Copayment/Coinsurance for Each Benefit**	**E. Outpatient, Out-of-Network: Office Visits**	**List Copayment/Coinsurance for Each Benefit**
					N/A	N/A
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	**List Copayment/Coinsurance for Each Benefit**		**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each Benefit**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each Benefit**
					N/A	N/A
G. Emergency	**List Copayment/Coinsurance for Each Benefit**		**G. Emergency**	**List Copayment/Coinsurance for Each Benefit**	**G. Emergency**	
Emergency room facility fee (waived if admitted)	0		Emergency room facility fee (waived if admitted)	0	Emergency Room Services	$0
Emergency room physician fee (waived if admitted)	0		Emergency room physician fee (waived if admitted)	0	Emergency Transportation/Ambulance	$0
Emergency medical transportation	0		Emergency medical/psychiatric transportation	0	Out-of-State Emergency Behavioral Health Services	$0
Urgent care	0		Urgent care	0		
H. Prescription Drugs	**List Copayment/Coinsurance for Each Benefit**			**List Copayment/Coinsurance for Each Benefit**		**List Copayment/Coinsurance for Each Benefit**
Tier One	0		Tier One	0	Generic Brand	$0
Tier Two	0		Tier Two	0	Preferred Brand	$0
Tier Three	0		Tier Three	0	Prescription OTC	$0
Tier Four	0		Tier Four	0		
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Table 4: Quantitative Treatment Limitations, including, but not limited to, limits on inpatient days per admission/episode or per year, outpatient visits per episode/year, outpatient services per episode/year.						
Medical/Surgical Benefits			**Mental Health/Substance Use Disorder**			

Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Subclassification Below	Quantitative Treatment Limits that Apply to Each		Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Subclassification Below	Quantitative Treatment Limits that Apply to Each Benefit		
A. Inpatient, In-Network			**A. Inpatient, In-Network**		**A. Inpatient, In-Network**	**QTLs**
Hospital facility fee (e.g., hospital room)--acute inpatient	None		Hospital facility fee (e.g., hospital room)--acute MH inpatient	None	Inpatient Alcohol & Chemical Dependency Services	None
Physician/surgeon fee--acute inpatient	None		Physician/surgeon fee--acute MH inpatient	None	Inpatient Detoxification Only	None
Hospital facility fee (e.g., hospital room)--female sterilization	None		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	None	Inpatient Detoxification Only & Labs	None
Physician/surgeon fee--female sterilization	None		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	None	Inpatient Emergency Care	None
Hospital facility fee (e.g., hospital room)--maternity delivery	None		Hospital facility fee (e.g., hospital room)--SUD detoxification	None	Inpatient Psychiatric Services	None
Professional fees--maternity delivery	None		Physician/surgeon fee--SUD detoxification	None		
Inpatient hospice facility fee (e.g., hospital room)	None		Short-term mental health crisis residential treatment	None		
Skilled nursing facility fee (e.g., hospital room)	None		SUD transitional residential recovery services	None		
			Residential treatment services for SMI and SED	None		
B. Inpatient, Out-of-Network	**List all QTLs**		**B. Inpatient, Out-of-Network**	**List all QTLs**	**B. Inpatient, Out-of-Network**	**QTLs**
				None	N/A	N/A
C. Outpatient, In-Network: Office Visits	**List all QTLs**		**C. Outpatient, In-Network: Office Visits**	**List all QTLs**	**C. Outpatient, In-Network: Office Visits**	**QTLs**
Primary care visit to treat an injury, illness, or condition	None		Individual and group mental health evaluation and treatment	None	Air Transportation	None
Other practitioner office visit	None		Outpatient services for monitoring drug therapy	None	Alcohol & Chemical Dependency Services	None
Specialist physician visit	None		Individual and group chemical dependency evaluation and counseling	None	Ambulatory Behavioral Health Services & Crisis Mgt	None
Preventive care/screening/immunization	None		Medical treatment for withdrawal symptoms	None	Combined Therapy	None
Family planning	None		Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	None	Consultation	None
Prenatal care and preconception visits	None			None	Diagnostic Services	None
Acupuncture	None			None	Electro-Convulsive Therapy (ECT)	None
Health education	None			None	Group Therapy	None
Child dental: diagnostic and preventive	N/A			None	Intensive Case Management	None
Child eye exam	None				Interpretation Services	None
					Maintenance Therapy	None
					Medication Management	None
					Member Education	None
					Methadone Management Services	None
					Non-Emergent Transportation	None
					Nurses Hotline	None
					Partial Hospitalization or Intensive Outpatient Hospitalization	None
					Practitioner Services	None
					Psychological Testing	None
					Psychotherapy	None
					Supported Employment Services	None
					Therapeutic Living Supports-Specialized Residential	None
					Treatment Facilities	None
					Transitional Housing	None
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)	**List all QTLs**		**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List all QTLs**	**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**QTLs**
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	None		Short-term partial hospitalization	None	See above Section C.	See above Section C.
Outpatient surgery --physician/surgeon fee	None		Short-term intensive outpatient psychiatric treatment	None		
Outpatient surgery facility fee--female sterilization	None		Outpatient psychiatric observation for an acute psychiatric crisis	None		

Outpatieint surgery--physician/surgeon fee--female sterilization	None		Psychological testing to evaluate a mental disorder	None		
Outpatient visit regarding outpatient surgery	None		Day treatment program for substance use disorder	None		
BRCA testing and related genetic counseling	1 Per Lifetime	NON BH	Intensive outpatient treatment for substance use disorder	None		
Laboratory tests	Varied		Behavioral health therapy delivered in the home for autism and PDD	None		
X-rays and diagnostic imaging	None		Nonemergency psychiatric transportation	None		
Imaging (CT/PET Scans, MRIs)	None					
Nonemergency medical transportation	None					
Outpatient rehabilitation services	Auditory Therapy Limits	NON BH				
Outpatient habilitation services	None					
Home health	None					
Hospice	6 Month Life Expectation	NON BH				
Durable medical equipment, including in-home DME	None					
Medical supplies	None					
Prosthetic and orthotic services and devices	None					
Diabetes equipment and supply services	None					
Contact lenses for aniridia or aphakia	24 Month Period > Age 21 12 Month Period for < Age 21	NON BH				
Infusion therapy	None					
Child eye glasses/contact lenses	1 pair in 12 month period	NON BH				
Child dental: basic services	N/A					
Child dental: major services	N/A					
Child medically necessary orthodontics	N/A					
E. Outpatient, Out-of-Network: Office Visits	**List all QTLs**		**E. Outpatient, Out-of-Network: Office Visits**	**List all QTLs**	**E. Outpatient, Out-of-Network: Office Visits**	**QTLs**
				None	N/A	N/A
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	**List all QTLs**		**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**List all QTLs**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**QTLs**
				None	N/A	N/A
G. Emergency	**List all QTLs**		**G. Emergency**	**List all QTLs**	**G. Emergency**	**QTLs**
Emergency room facility fee (waived if admitted)	None		Emergency room facility fee (waived if admitted)	None	Emergency Room Services	None
Emergency room physician fee (waived if admitted)	None		Emergency room physician fee (waived if admitted)	None	Emergency Transportation/Ambulance	None
Emergency medical transportation	None		Emergency medical/psychiatric transportation	None	Out-of-State Emergency Behavioral Health Services	None
Urgent care	None		Urgent care	None		
H. Prescription Drugs	**List all QTLs**		**H. Prescription Drugs**	**List all QTLs**	**H. Prescription Drugs**	**QTLs**
Tier One	None		Tier One	None	Tier One	None
Tier Two	None		Tier Two	None	Tier Two	None
Tier Three	None		Tier Three	None	Tier Three	None
Tier Four	None		Tier Four	None	Tier Four	None
*The HMSA QUEST Integration Formulary is a one-tiered closed formulary. HMSA QUEST Integration members can fill up to a 30 day supply of mental health drugs (i.e. antipsychotics, antidepressants, and anti-anxiety medications) without being subject to any formulary edits (i.e. prior authorization, step therapy, and quantity limits).						

Table 2: Financial Requirements - Out-of-Pocket Maximums

A. Identify the amount(s) of the out-of-pocket maximum(s). If there are different out-of-pocket maximums for different coverage units (e.g., individual and family out-of-pocket maximums), clearly identify these amounts.	member cost share is $0 for all benefits, there is no out-of-pocket
B. Identify any benefits that are not subject to the out-of-pocket maximum(s).	N/A

Table 3: Financial Requirements - Copayments and Coinsurance

Medical/Surgical Benefits			Mental Health/Substance Use Disorder Benefits			
List All Benefits in Each Classification /Subclassification	**Copayment/Coinsurance for Each Benefit**		**List Benefits in Each Classification /Subclassification**	**Copayment/Coinsurance for Each Benefit**	**CCS**	
A. Inpatient, In-Network			**A. Inpatient, In-Network**		**A. Inpatient, In-Network**	
Hospital facility fee (e.g., hospital room)--acute inpatient	$0		Hospital facility fee (e.g., hospital room)--acute MH inpatient	$0	Inpatient Alcohol & Chemical Dependency Services	$0
Physician/surgeon fee--acute inpatient	$0		Physician/surgeon fee--acute MH inpatient	$0	Inpatient Detoxification Only	$0
Hospital facility fee (e.g., hospital room)--female sterilization	$0		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	$0	Inpatient Detoxification Only & Labs	$0
Physician/surgeon fee--female sterilization	$0		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	$0	Inpatient Emergency Care	$0
Hospital facility fee (e.g., hospital room)--maternity delivery	$0		Hospital facility fee (e.g., hospital room)--SUD detoxification	$0	Inpatient Psychiatric Services	$0
Professional fees--maternity delivery	$0		Physician/surgeon fee--SUD detoxification	$0		
Inpatient hospice facility fee (e.g., hospital room)	$0		Short-term mental health crisis residential treatment	$0		
Skilled nursing facility fee (e.g., hospital room)	$0		SUD transitional residential recovery services	$0		
			Residential treatment services for SMI and SED	$0		
B. Inpatient, Out-of-Network	**List Copayment/Coinsurance for Each Benefit**		**B. Inpatient, Out-of-Network**	**List Copayment/Coinsurance for Each Benefit**	**B. Inpatient, Out-of-Network**	
					N/A	N/A
C. Outpatient, In-Network: Office Visits	**List Copayment/Coinsurance for Each Benefit**		**C. Outpatient, In-Network: Office Visits**	**List Copayment/Coinsurance for Each Benefit**	**C. Outpatient, In-Network: Office Visits**	
Primary care visit to treat an injury, illness, or condition	$0		Individual and group mental health evaluation and treatment	$0	Air Transportation	$0
Other practitioner office visit	$0		Outpatient services for monitoring drug therapy	$0	Alcohol & Chemical Dependency Services	$0
Specialist physician visit	$0		Individual and group chemical dependency evaluation and counseling	$0	Ambulatory Behavioral Health Services & Crisis Mgt	$0
Preventive care/screening/immunization	$0		Medical treatment for withdrawal symptoms	$0	Combined Therapy	$0
Family planning	$0		Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	$0	Consultation	$0
Prenatal care and preconception visits	$0				Diagnostic Services	$0
Acupuncture	$0				Electro-Convulsive Therapy (ECT)	$0
Health education	$0				Group Therapy	$0
Child dental: diagnostic and preventive	$0				Intensive Case Management	$0

Child eye exam	$0				Interpretation Services	$0
					Maintenance Therapy	$0
					Medication Management	$0
					Member Education	$0
					Methadone Management Services	$0
					Non-Emergent Transportation	$0
					Nurses Hotline	$0
					Partial Hospitalization or Intensive Outpatient Hospitalization	$0
					Practitioner Services	$0
					Psychological Testing	$0
					Psychotherapy	$0
					Supported Employment Services	$0
					Therapeutic Living Supports-Specialized Residential	$0
					Treatment Facilities	$0
					Transitional Housing	$0
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)	**List Copayment/Coinsurance for Each Benefit**		**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each Benefit**	**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	$0		Short-term partial hospitalization	$0	See above Section C.	See above Section C.
Outpatient surgery--physician/surgeon fee	$0		Short-term intensive outpatient psychiatric treatment	$0		
Outpatient surgery facility fee--female sterilization	$0		Outpatient psychiatric observation for an acute psychiatric crisis	$0		
Outpatient surgery--physician/surgeon fee--female sterilization	$0		Psychological testing to evaluate a mental disorder	$0		
Outpatient visit regarding outpatient surgery	$0		Day treatment program for substance use disorder	$0		
BRCA testing and related genetic counseling	$0		Intensive outpatient treatment for substance use disorder	$0		
Laboratory tests	$0		Behavioral health treatment delivered in the home for autism or PDD	$0		
X-rays and diagnostic imaging	$0		Nonemergency psychiatric transportation	$0		
Imaging (CT/PET Scans, MRIs)	$0					
Nonemergency ambulance transportation	$0					
Outpatient rehabilitation services	$0					
Outpatient habilitation services	$0					
Home health	$0					
Hospice	$0					
Durable medical equipment, including in-home DME	$0					
Medical supplies	$0					
Prosthetic and orthotic services and devices	$0					
Diabetes equipment and supply services	$0					
Contact lenses for aniridia or aphakia	$0					
Infusion therapy	$0					
Child eye glasses/contact lenses	$0					
Child dental: basic services	N/A					
Child dental: major services	N/A					
Child medically necessary orthodontics	N/A					
Other Outpatient Services	$0					

E. Outpatient, Out-of-Network: Office Visits	List Copayment/Coinsurance for Each Benefit		E. Outpatient, Out-of-Network: Office Visits	List Copayment/Coinsurance for Each Benefit	E. Outpatient, Out-of-Network: Office Visits	
					N/A	N/A
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	**List Copayment/Coinsurance for Each Benefit**		**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each Benefit**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	
					N/A	N/A
G. Emergency	**List Copayment/Coinsurance for Each Benefit**		**G. Emergency**	**List Copayment/Coinsurance for Each Benefit**	**G. Emergency**	
Emergency room facility fee (waived if admitted)	$0		Emergency room facility fee (waived if admitted)	$0	Emergency Room Services	$0
Emergency room physician fee (waived if admitted)	$0		Emergency room physician fee (waived if admitted)	$0	Emergency Transportation/Ambulance	$0
Emergency medical transportation	$0		Emergency medical/psychiatric transportation	$0	Out-of-State Emergency Behavioral Health Services	$0
Urgent care	$0		Urgent care	$0		
H. Prescription Drugs	**List Copayment/Coinsurance for Each Benefit**			**List Copayment/Coinsurance for Each Benefit**		
Tier One	$0		Tier One	$0	Generic Brand	$0
Tier Two	$0		Tier Two	$0	Preferred Brand	$0
Tier Three	N/A		Tier Three	N/A	Prescription OTC	$0
Tier Four	N/A		Tier Four	N/A		

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Table 4: Quantitative Treatment Limitations, including, but not limited to, limits on inpatient days per admission/episode or per year, outpatient visits per episode/year, outpatient services per episode/year.						
Medical/Surgical Benefits			**Mental Health/Substance Use Disorder**			
Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Subclassification Below	**List all QTLs**		**Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Subclassification Below**	**List all QTLs**		**QTLs**
A. Inpatient, In-Network			**A. Inpatient, In-Network**		**A. Inpatient, In-Network**	
Hospital facility fee (e.g., hospital room)--acute inpatient	None		Hospital facility fee (e.g., hospital room)--acute MH inpatient	None	Inpatient Alcohol & Chemical Dependency Services	None
Physician/surgeon fee--acute inpatient	None		Physician/surgeon fee--acute MH inpatient	None	Inpatient Detoxification Only	None
Hospital facility fee (e.g., hospital room)--female sterilization	None		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	None	Inpatient Detoxification Only & Labs	None
Physician/surgeon fee--female sterilization	None		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	None	Inpatient Emergency Care	None
Hospital facility fee (e.g., hospital room)--maternity delivery	None		Hospital facility fee (e.g., hospital room)--SUD detoxification	None	Inpatient Psychiatric Services	None
Professional fees--maternity delivery	None		Physician/surgeon fee--SUD detoxification	None		
Inpatient hospice facility fee (e.g., hospital room)	None		Short-term mental health crisis residential treatment	None		

Skilled nursing facility fee (e.g., hospital room)	None		SUD transitional residential recovery services	None		
			Residential treatment services for SMI and SED	None		
B. Inpatient, Out-of-Network	**List all QTLs**		**B. Inpatient, Out-of-Network**	**List all QTLs**	**B. Inpatient, Out-of-Network**	**QTLs**
					N/A	N/A
C. Outpatient, In-Network: Office Visits	**List all QTLs**		**C. Outpatient, In-Network: Office Visits**	**List all QTLs**	**C. Outpatient, In-Network: Office Visits**	**QTLs**
Primary care visit to treat an injury, illness, or condition	None		Individual and group mental health evaluation and treatment	None	Air Transportation	None
Other practitioner office visit	None		Outpatient services for monitoring drug therapy	None	Alcohol & Chemical Dependency Services	None
Specialist physician visit	None		Individual and group chemical dependency evaluation and counseling	None	Ambulatory Behavioral Health Services & Crisis Mgt	None
Preventive care/screening/immunization	None		Medical treatment for withdrawal symptoms	None	Combined Therapy	None
Family planning	None		Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	None	Consultation	None
Prenatal care and preconception visits	None				Diagnostic Services	None
Acupuncture	None				Electro-Convulsive Therapy (ECT)	None
Health education	None				Group Therapy	None
Child dental: diagnostic and preventive	None				Intensive Case Management	None
Child eye exam	one per 12 months	NON BH			Interpretation Services	None
					Maintenance Therapy	None
					Medication Management	None
					Member Education	None
					Methadone Management Services	None
					Non-Emergent Transportation	None
					Nurses Hotline	None
					Partial Hospitalization or Intensive Outpatient Hospitalization	None
					Practitioner Services	None
					Psychological Testing	None
					Psychotherapy	None
					Supported Employment Services	None
					Therapeutic Living Supports-Specialized Residential	None
					Treatment Facilities	None
					Transitional Housing	None
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)	**List all QTLs**		**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List all QTLs**	**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**QTLs**
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	None		Short-term partial hospitalization	None	See above Section C.	See above Section C.
Outpatient surgery --physician/surgeon fee	None		Short-term intensive outpatient psychiatric treatment	None		
Outpatient surgery facility fee--female sterilization	None		Outpatient psychiatric observation for an acute psychiatric crisis	None		
Outpatieint surgery--physician/surgeon fee--female sterilization	None		Psychological testing to evaluate a mental disorder	None		
Outpatient visit regarding outpatient surgery	None		Day treatment program for substance use disorder	None		
BRCA testing and related genetic counseling	None		Intensive outpatient treatment for substance use disorder	None		
Laboratory tests	None		Behavioral health therapy delivered in the home for autism and PDD	None		
X-rays and diagnostic imaging	None		Nonemergency psychiatric transportation	None		
Imaging (CT/PET Scans, MRIs)	None					
Nonemergency medical transportation	None					
Outpatient rehabilitation services	None					
Outpatient habilitation services	None					

Home health	None					
Hospice	None					
Durable medical equipment, including in-home DME	None					
Medical supplies	None					
Prosthetic and orthotic services and devices	None					
Diabetes equipment and supply services	None					
Contact lenses for aniridia or aphakia	None					
Infusion therapy	None					
Child eye glasses/contact lenses	one pair of eyeglasses per 24 months	NON BH				
Child dental: basic services	N/A					
Child dental: major services	N/A					
Child medically necessary orthodontics	N/A					
E. Outpatient, Out-of-Network: Office Visits	**List all QTLs**		**E. Outpatient, Out-of-Network: Office Visits**	**List all QTLs**	**E. Outpatient, Out-of-Network: Office Visits**	**QTLs**
					N/A	N/A
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	**List all QTLs**		**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**List all QTLs**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**QTLs**
					N/A	N/A
G. Emergency	**List all QTLs**		**G. Emergency**	**List all QTLs**	**G. Emergency**	**QTLs**
Emergency room facility fee (waived if admitted)	None		Emergency room facility fee (waived if admitted)	None	Emergency Room Services	None
Emergency room physician fee (waived if admitted)	None		Emergency room physician fee (waived if admitted)	None	Emergency Transportation/Ambulance	None
Emergency medical transportation	None		Emergency medical/psychiatric transportation	None	Out-of-State Emergency Behavioral Health Services	None
Urgent care	None		Urgent care	None		
H. Prescription Drugs	**List all QTLs**		**H. Prescription Drugs**	**List all QTLs**	**H. Prescription Drugs**	**QTLs**
Tier One	None		Tier One	None	Tier One	None
Tier Two	None		Tier Two	None	Tier Two	None
Tier Three	N/A		Tier Three	N/A	Tier Three	None
Tier Four	N/A		Tier Four	N/A	Tier Four	None

Benefit Plan Design #1: QUEST Integration

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Add or delete rows in each Classification/Subclassification, as needed

Table 1: Financial Requirements - Deductibles

A. Are there any deductibles? (Y/N)	No
B. Identify the amount(s) of the deductible(s). If the product has different deductible amounts for different coverage units (e.g., individual and family deductibles) and/or for benefits separate from the overall deductible (e.g., a separate pharmacy deductible), clearly identify those amounts. Identify any benefits that are not subject to the deductible(s).	NA
C. Does the deductible, or do the deductibles, apply to "substantially all" M/S benefits in each classification or subclassification to which the deductible applies? (See 45 C.F.R.§ 146.136(c)(3)(v)(B) Example 4.) Show proof in the Exhibit 2.	NA

Table 2: Financial Requirements - Out-of-Pocket Maximums

A. Identify the amount(s) of the out-of-pocket maximum(s). If there are different out-of-pocket maximums for different coverage units (e.g., individual and family out-of-pocket maximums), clearly identify these amounts.	NA
B. Identify any benefits that are not subject to the out-of-pocket maximum(s).	NA

Table 3: Financial Requirements - Copayments and Coinsurance

Medical/Surgical Benefits			Mental Health/Substance Use Disorder Benefits			
List All Benefits in Each Classification /Subclassification	**List Copayment/Coinsurance for Each Benefit**		**List Benefits in Each Classification /Subclassification**	**List Copayment/Coinsurance for Each Benefit**	**CCS**	
A. Inpatient, In-Network			**A. Inpatient, In-Network**		**A. Inpatient, In-Network**	
Hospice	$0		Mental Health Hospital Inpatient	$0	Inpatient Alcohol & Chemical Dependency Services	$0
Hospital Services	$0		Substance Abuse	$0	Inpatient Detoxification Only	$0
Long Term Care Facility	$0				Inpatient Detoxification Only & Labs	$0
Maternity Services	$0				Inpatient Emergency Care	$0
Nursing Home Care	$0				Inpatient Psychiatric Services	$0
Physician Services	$0					
Skilled Nursing Facility	$0					
Surgical Services	$0					
B. Inpatient, Out-of-Network	**List Copayment/Coinsurance**		**B. Inpatient, Out-of-Network**	**List Copayment/Coinsurance**	**B. Inpatient, Out-of-Network**	**List Copayment/Coinsu**
N/A	N/A		N/A	N/A	N/A	N/A
C. Outpatient, In-Network: Office Visits	**List Copayment/Coinsurance**		**C. Outpatient, In-Network: Office Visits**	**List Copayment/Coinsurance**	**C. Outpatient, In-Network: Office Visits**	**List Copayment/Coinsu**
Ambulatory Surgery Center	$0		Ambulatory Mental Health	$0	Air Transportation	$0

Dental Services	$0		Behavioral Health Services for Children	$0	Alcohol & Chemical Dependency Services	$0
Diagnostic Services	$0		Support for Emotional & Behavioral Development (SEBD) Program	$0	Ambulatory Behavioral Health Services & Crisis Mgt	$0
Durable Medical Equipment	$0		Additional Behavioral Health Services	$0	Combined Therapy	$0
Family Planning Services	$0		Children 3 - 20	$0	Consultation	$0
Hearing Services	$0		Community Mental Health Services	$0	Diagnostic Services	$0
Home and Community Based Services	$0				Electro-Convulsive Therapy (ECT)	$0
Home Health	$0		Comprehensive Behavioral Health Services	$0	Group Therapy	$0
Hospice	$0		Community Care Services	$0	Intensive Case Management	$0
Hospital Services	$0		Adults 21>	$0	Interpretation Services	$0
Laboratory Services	$0		Mental Health Outpatient Services	$0	Maintenance Therapy	$0
Maternity Services	$0		Methadone Treatment Services	$0	Medication Management	$0
Non-Emergency Transportation (NET)	$0		Psychiatric / Psychological	$0	Member Education	$0
Physician Services	$0		Evaluation & Treatment	$0	Methadone Management Services	$0
Podiatry Care Services	$0		Psychotherapy	$0	Non-Emergent Transportation	$0
Preventive Services	$0		Psychotropic Medications	$0	Nurses Hotline	$0
Private Duty Nursing	$0		Medication Management	$0	Partial Hospitalization or Intensive Outpatient Hospitalization	$0
Prosthetic & Orthotic Devices	$0		Substance Abuse	$0	Practitioner Services	$0
Radiology Services	$0				Psychological Testing	$0
Rehabilitative Services (PT, OT, ST)	$0				Psychotherapy	$0
Skilled Nursing/Private Duty Nursing	$0				Supported Employment Services	$0
Smoking Cessation	$0				Therapeutic Living Supports-Specialized Residential	$0
Telemedicine	$0				Treatment Facilities	$0
Therapy Services	$0				Transitional Housing	$0
Vision Services	$0					
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)	**List Copayment/Coinsurance for Each Benefit**		**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each Benefit**	**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	
See above Section C.	See above Section C.		See above Section C.	See above Section C.	See above Section C.	See above Section C.
E. Outpatient, Out-of-Network: Office Visits	**List Copayment/Coinsurance**		**E. Outpatient, Out-of-Network: Office Visits**	**List Copayment/Coinsurance**	**E. Outpatient, Out-of-Network: Office Visits**	
N/A	N/A		N/A	N/A	N/A	N/A
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	**List Copayment/Coinsurance for Each Benefit**		**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each Benefit**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	
See above Section C.	See above Section C.		See above Section C.	See above Section C.	N/A	N/A
G. Emergency	**Copayment/Coinsurance**		**G. Emergency**	**Copayment/Coinsurance**	**G. Emergency**	**Copayment/Coinsu**
Emergency Room Services	$0		Emergency Room Services	$0	Emergency Room Services	$0
Emergency Transportation/Ambulance	$0		Emergency Transportation/Ambulance	$0	Emergency Transportation/Ambulance	$0
Urgent Care	$0		Urgent Care	$0	Out-of-State Emergency Behavioral Health Services	$0
H. Prescription Drugs	**List Copayment/Coinsurance for Each Benefit**			**List Copayment/Coinsurance for Each Benefit**		**List Copayment/Coinsurance for Each Benefit**

Generic Brand	$0		Generic Brand	$0	Generic Brand	$0
Preferred Brand	$0		Preferred Brand	$0	Preferred Brand	$0
Prescription OTC	$0		Prescription OTC	$0	Prescription OTC	$0
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Table 4: Quantitative Treatment Limitations, including, but not limited to, limits on inpatient days per admission/episode or per year, outpatient visits per episode/year, outpatient services per episode/year.						
Medical/Surgical Benefits		**quantitative**	**Mental Health/Substance Use Disorder**			
Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Subclassification Below	**List all QTLs**		**Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Subclassification Below**	**List all QTLs**		
A. Inpatient, In-Network			**A. Inpatient, In-Network**		**A. Inpatient, In-Network**	**QTLs**
Hospice	None		Mental Health Hospital Inpatient	None	Inpatient Alcohol & Chemical Dependency Services	None
Hospital Services	None		Substance Abuse	None	Inpatient Detoxification Only	None
Long Term Care Facility	None				Inpatient Detoxification Only & Labs	None
Maternity Services	None				Inpatient Emergency Care	None
Nursing Home Care	None				Inpatient Psychiatric Services	None
Physician Services	None					
Skilled Nursing Facility	None					
Surgical Services	None					
B. Inpatient, Out-of-Network	**List all QTLs**		**B. Inpatient, Out-of-Network**	**List all QTLs**	**B. Inpatient, Out-of-Network**	**QTLs**
N/A	N/A		N/A	N/A	N/A	N/A
C. Outpatient, In-Network: Office Visits	**List all QTLs**		**C. Outpatient, In-Network: Office Visits**	**List all QTLs**	**C. Outpatient, In-Network: Office Visits**	**QTLs**
Ambulatory Surgery Center	None		Ambulatory Mental Health	None	Air Transportation	None
Dental Services	None		Behavioral Health Services for Children, Support for Emotional & Behavioral Development (SEBD) Program, Additional Behavioral Health Service for Childrent 3-20	None	Alcohol & Chemical Dependency Services	None
Diagnostic Services	None		Community Mental Health Services		Ambulatory Behavioral Health Services & Crisis Mgt	None
Durable Medical Equipment	None		Comprehensive Behavioral Health Services Community Care Services Adults 21>	None	Combined Therapy	None
Family Planning Services	None		Mental Health Outpatient Services	None	Consultation	None
Hearing Services	**Adults-** 1 per 3 years for adults ages 21 and older. **Hearing Exam Adults-** 1 per year **Hearing Exam Children** -1 Hearing Initial Evaluation/Selection per year **Electroacoustic Evaluation** - 4 per year for children ages 3yrs and under	NON BH	Methadone Treatment Services	None	Diagnostic Services	None

Home and Communtiy Base Services	**Meals** -No more than 2 meals per day **Personal Assistance Services Level I -** Limited to 10	NON BH	Psychiatric / Psychological	None	Electro-Convulsive Therapy (ECT)	None
Home Health Services	• Daily visits permitted for home health aid and nursing services in the first two weeks of patient care if part of the written plan of care; • No more than three visits per week for each service in the thirds to seventh week of care; • No more than one visit per week for each service in the eight to fifteenth week of care; and, • No more than one visit every other month for each service	NON BH	Evaluation & Treatment	None	Group Therapy	None
Hospice	None		Psychotherapy	None	Intensive Case Management	None
Hospital Services	None		Psychotropic Medications	None	Interpretation Services	None
Laboratory Services	None		Medication Management	None	Maintenance Therapy	None
			Substance Abuse	None	Medication Management	None
Maternity Services	None				Member Education	None
Non-Emergency Transportation (NET)	None				Methadone Management Services	None
Physician Services	None				Non-Emergent Transportation	None
Podiatry Care Services	None				Nurses Hotline	None
Preventive Services	Limitst based on procedure and recommended guidelines	NON BH			Partial Hospitalization or Intensive Outpatient Hospitalization	None
Private Duty Nursing	None				Practitioner Services	None
Prosthetic & Orthotic Devices	None				Psychological Testing	None
Radiology Services	None				Psychotherapy	None
Rehabilitative Services (PT, OT, ST)	None				Supported Employment Services	None
Skilled Nursing/Private Duty Nursing	None				Therapeutic Living Supports-Specialized Residential	None
Smoking Cessation	Limited to 2 quit attempts per	NON BH			Treatment Facilities	None
Telemedicine	None				Transitional Housing	None
Therapy Services	None					

Vision Services	**Eye Exam Adult**- 1 every 24 months for adults 21 years of age and older. **Eyewear Adult**-1 every 24 months New lenses if medically necessary: **Eye Exam Child-1 every 12 months Eyewear Child**- 1 every 24 months	NON BH				
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)	**List all QTLs**		**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List all QTLs**	**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**QTLs**
See above Section C.	See above section C.		See above Section C.	See above Section C.	See above Section C.	See above Section C.
E. Outpatient, Out-of-Network: Office Visits	**List all QTLs**		**E. Outpatient, Out-of-Network: Office Visits**	**List all QTLs**	**E. Outpatient, Out-of-Network: Office Visits**	**QTLs**
N/A	N/A		N/A	N/A	N/A	N/A
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	**List all QTLs**		**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**List all QTLs**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**QTLs**
See above ection C.	See above Section C.		See above Section C.	See above Section C.	N/A	N/A
G. Emergency	**List all QTLs**		**G. Emergency**	**List all QTLs**	**G. Emergency**	**QTLs**
Emergency Room Services	None		Emergency Room Services	None	Emergency Room Services	None
Emergency Transportation/Ambulance	None		Emergency Transportation/Ambulance	None	Emergency Transportation/Ambulance	None
Urgent Care	None		Urgent Care	None	Out-of-State Emergency Behavioral Health Services	None
H. Prescription Drugs	**List all QTLs**		**H. Prescription Drugs**	**List all QTLs**	**H. Prescription Drugs**	**QTLs**
Tier 1	None		Tier 1	None	Tier 1	None
Tier 2	None		Tier 2	None	Tier 2	None
Tier 3	None		Tier 3	None	Tier 3	None
Tier 4	None		Tier 4	None	Tier 4	None

Benefit Plan Design #1: UnitedHealthcare Community Plan QUEST Integration	**DISCLAIMER:** Some of the services/procedures listed within this document may require a prior authorization with the ***exception*** of emergency services that are needed to evaluate or stabilize an emergency condition as well as direct access to women's health services. Members are held harmless for services/procedures that require a prior authorization by a participating provider (in-network) in the event the provider does not obtain a prior authorization. Members may be held liable for services/procedures that require a prior authorization provided by a non-participating provider	
Add or delete rows in each Classification/Subclassification, as needed		
Table 1: Financial Requirements - Deductibles		
A. Are there any deductibles? (Y/N)	No	
B. Identify the amount(s) of the deductible(s). If the product has different deductible amounts for different coverage units (e.g., individual and family deductibles) and/or for benefits separate from the overall deductible (e.g., a separate pharmacy deductible), clearly identify those amounts. Identify any benefits that are not subject to the deductible(s).	None	
C. Does the deductible, or do the deductibles, apply to "substantially all" M/S benefits in each classification or subclassification to which the deductible applies? (See 45 C.F.R.§ 146.136(c)(3)(v)(B) Example 4.) Show proof in the Exhibit 2.	None	
Table 2: Financial Requirements - Out-of-Pocket Maximums		
A. Identify the amount(s) of the out-of-pocket maximum(s). If there are different out-of-pocket maximums for different coverage units (e.g., individual and family out-of-pocket maximums), clearly identify these amounts.	None	
B. Identify any benefits that are not subject to the out-of-pocket maximum(s).	None	

Table 3: Financial Requirements - Copayments and

Medical/Surgical Benefits			Mental Health/Substance Use Disorder Benefits			
List All Benefits in Each Classification /Subclassification	**List Copayment/Coinsurance**		**List Benefits in Each Classification /Subclassification**	**List Copayment/Coinsurance**	**CCS**	
A. Inpatient, In-Network			**A. Inpatient, In-Network**		**A. Inpatient, In-Network**	
Hospital facility fee (e.g., hospital room)--acute inpatient	$0		Hospital facility fee (e.g., hospital room)--acute MH inpatient	$0	Inpatient Alcohol & Chemical Dependency Services	$0
Physician/surgeon fee--acute inpatient	$0		Physician/surgeon fee--acute MH inpatient	$0	Inpatient Detoxification Only	$0
Hospital facility fee (e.g., hospital room)--female sterilization	$0		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	$0	Inpatient Detoxification Only & Labs	$0
Physician/surgeon fee--female sterilization	$0		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	$0	Inpatient Emergency Care	$0
Hospital facility fee (e.g., hospital room)--maternity delivery	$0		Hospital facility fee (e.g., hospital room)--SUD detoxification	$0	Inpatient Psychiatric Services	$0
Professional fees--maternity delivery	$0		Physician/surgeon fee--SUD detoxification	$0		
Inpatient hospice facility fee (e.g., hospital room)	$0		Short-term mental health crisis residential treatment	$0		
Skilled nursing facility fee (e.g., hospital room)	$0		SUD transitional residential recovery services	$0		
			Residential treatment services for SMI and SED	$0		
B. Inpatient, Out-of-Network	**List Copayment/Coinsurance for Each Benefit**		**B. Inpatient, Out-of-Network**	**List Copayment/Coinsurance for Each Benefit**	**B. Inpatient, Out-of-Network**	**List Copayment/Coinsurance for Each Benefit**
Hospital facility fee (e.g., hospital room)--acute inpatient	$0		Hospital facility fee (e.g., hospital room)--acute MH inpatient	$0	N/A	N/A
Physician/surgeon fee--acute inpatient	$0		Physician/surgeon fee--acute MH inpatient	$0		
Hospital facility fee (e.g., hospital room)--female sterilization	$0		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	$0		
Physician/surgeon fee--female sterilization	$0		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	$0		

Hospital facility fee (e.g., hospital room)--maternity delivery	$0		Hospital facility fee (e.g., hospital room)--SUD detoxification	$0		
Professional fees--maternity delivery	$0		Physician/surgeon fee--SUD detoxification	$0		
Inpatient hospice facility fee (e.g., hospital room)	$0		Short-term mental health crisis residential treatment	$0		
Skilled nursing facility fee (e.g., hospital room)	$0		SUD transitional residential recovery services	$0		
			Residential treatment services for SMI and SED	$0		
C. Outpatient, In-Network: Office Visits	**List Copayment/Coinsurance for Each Benefit**		**C. Outpatient, In-Network: Office Visits**	**List Copayment/ Coinsurance for Each Benefit**	**C. Outpatient, In-Network: Office Visits**	
Primary care visit to treat an injury, illness, or condition	$0		Individual and group mental health evaluation and treatment	$0	Air Transportation	$0
Other practitioner office visit	$0		Outpatient services for monitoring drug therapy	$0	Alcohol & Chemical Dependency Services	$0
Specialist physician visit	$0		Individual and group chemical dependency evaluation and counseling	$0	Ambulatory Behavioral Health Services & Crisis Mgt	$0
Preventive care/screening/immunization	$0		Medical treatment for withdrawal symptoms	$0	Combined Therapy	$0
Family planning	$0		Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	$0	Consultation	$0
Prenatal care and preconception visits	$0				Diagnostic Services	$0
Acupuncture	Not a covered benefit.				Electro-Convulsive Therapy (ECT)	$0
Health education	$0				Group Therapy	$0
Child dental: diagnostic and preventive	Services are carved out to the State.				Intensive Case Management	$0
Child eye exam	$0				Interpretation Services	$0
					Maintenance Therapy	$0
					Medication Management	$0
					Member Education	$0
					Methadone Management Services	$0
					Non-Emergent Transportation	$0
					Nurses Hotline	$0

					Partial Hospitalization or Intensive Outpatient Hospitalization	$0
					Practitioner Services	$0
					Psychological Testing	$0
					Psychotherapy	$0
					Supported Employment Services	$0
					Therapeutic Living Supports-Specialized Residential	$0
					Treatment Facilities	$0
					Transitional Housing	$0
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)	**List Copayment/Coinsurance for Each Benefit**		**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List Copayment/ Coinsurance for Each Benefit**	**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List Copayment/Coinsurance for Each Benefit**
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	$0		Short-term partial hospitalization	$0	See above Section C.	See above Section C.
Outpatient surgery--physician/surgeon fee	$0		Short-term intensive outpatient psychiatric treatment	$0		
Outpatient surgery facility fee--female sterilization	$0		Outpatient psychiatric observation for an acute psychiatric crisis	$0		
Outpatient surgery--physician/surgeon fee--female sterilization	$0		Psychological testing to evaluate a mental disorder	$0		
Outpatient visit regarding outpatient surgery	$0		Day treatment program for substance use disorder	$0		
BRCA testing and related genetic counseling	$0		Intensive outpatient treatment for substance use disorder	$0		
Laboratory tests	$0		Behavioral health treatment delivered in the home for autism or PDD	$0		
X-rays and diagnostic imaging	$0		Nonemergency psychiatric transportation	$0		
Imaging (CT/PET Scans, MRIs)	$0					
Nonemergency ambulance transportation	$0					
Outpatient rehabilitation services	$0					
Outpatient habilitation services	$0					
Home health	$0					
Hospice	$0					

Durable medical equipment, including in-home DME	$0					
Medical supplies	$0					
Prosthetic and orthotic services and devices	$0					
Diabetes equipment and supply services	$0					
Contact lenses for aniridia or aphakia	$0					
Infusion therapy	$0					
Child eye glasses/contact lenses	$0					
Child dental: basic services	Services are carved out to the State.					
Child dental: major services	Carve out					
Child medically necessary orthodontics	Carve out					
E. Outpatient, Out-of-Network: Office Visits	**List Copayment/Coinsurance for Each Benefit**		**E. Outpatient, Out-of-Network: Office Visits**	**List Copayment/ Coinsurance for Each Benefit**	**E. Outpatient, Out-of-Network: Office Visits**	**List Copayment/Coinsurance for Each Benefit**
Primary care visit to treat an injury, illness, or condition	$0		Individual and group mental health evaluation and treatment	$0	N/A	N/A
Other practitioner office visit	$0		Outpatient services for monitoring drug therapy	$0		
Specialist physician visit	$0		Individual and group chemical dependency evaluation and counseling	$0		
Preventive care/screening/immunization	$0		Medical treatment for withdrawal symptoms	$0		
Family planning	$0		Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	$0		
Prenatal care and preconception visits	$0					
Acupuncture	Not a covered benefit.					
Health education	$0					
Child dental: diagnostic and preventive	Carve out					
Child eye exam	$0					

F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	Copayment/Coinsurance for Each Benefit		F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	Copayment/ Coinsurance for Each Benefit	F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	Copayment/Coinsurance for Each
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	$0		Short-term partial hospitalization	$0	N/A	N/A
Outpatient surgery--physician/surgeon fee	$0		Short-term intensive outpatient psychiatric treatment	$0		
Outpatient surgery facility fee--female sterilization	$0		Outpatient psychiatric observation for an acute psychiatric crisis	$0		
Outpatient surgery--physician/surgeon fee--female sterilization	$0		Psychological testing to evaluate a mental disorder	$0		
Outpatient visit regarding outpatient surgery	$0		Day treatment program for substance use disorder	$0		
BRCA testing and related genetic counseling	$0		Intensive outpatient treatment for substance use disorder	$0		
Laboratory tests	$0		Behavioral health treatment delivered in the home for autism or PDD	$0		
X-rays and diagnostic imaging	$0		Nonemergency psychiatric transportation	$0		
Imaging (CT/PET Scans, MRIs)	$0					
Nonemergency ambulance transportation	$0					
Outpatient rehabilitation services	$0					
Outpatient habilitation services	$0					
Home health	$0					
Hospice	$0					
Durable medical equipment, including in-home DME	$0					
Medical supplies	$0					
Prosthetic and orthotic services and devices	$0					
Diabetes equipment and supply services	$0					
Contact lenses for aniridia or aphakia	$0					
Infusion therapy	$0					
Child eye glasses/contact lenses	$0					
Child dental: basic services	Carve out	NON BH				
Child dental: major services	Carve out	NON BH				
Child medically necessary orthodontics	Carve out	NON BH				

G. Emergency	List Copayment/Coinsurance for Each Benefit		G. Emergency	List Copayment/Coinsurance for Each Benefit	G. Emergency	List Copayment/Coinsurance for Each Benefit
Emergency room facility fee (waived if admitted)	$0		Emergency room facility fee (waived if admitted)	$0	Emergency Room Services	$0
Emergency room physician fee (waived if admitted)	$0		Emergency room physician fee (waived if admitted)	$0	Emergency Transportation/Ambulance	$0
Emergency medical transportation	$0		Emergency medical/psychiatric transportation	$0	Out-of-State Emergency Behavioral Health Services	$0
Urgent care	$0		Urgent care	$0		
H. Prescription Drugs	**List Copayment/Coinsurance for Each Benefit**			**List Copayment/Coinsurance for Each Benefit**		**List Copayment/Coinsurance for Each Benefit**
Tier One	$0		Tier One	$0	Generic Brand	$0
Tier Two	$0		Tier Two	$0	Preferred Brand	$0
Tier Three	$0		Tier Three	$0	Prescription OTC	$0
Tier Four	$0		Tier Four	$0		
United Healthcare						
UHC						
Table 4: Quantitative Treatment Limitations, including, but not limited to, limits on inpatient days per admission/episode						
Medical/Surgical Benefits			**Mental Health/Substance Use Disorder**			
Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Subclassification Below	**List all QTLs**		**Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Subclassification Below**	**List all QTLs**		
A. Inpatient, In-Network			**A. Inpatient, In-Network**		**A. Inpatient, In-Network**	
Hospital facility fee (e.g., hospital room)--acute inpatient	None		Hospital facility fee (e.g., hospital room)--acute MH inpatient	None	Inpatient Alcohol & Chemical Dependency Services	None

Physician/surgeon fee--acute inpatient	None		Physician/surgeon fee--acute MH inpatient	None	Inpatient Detoxification Only	None
Hospital facility fee (e.g., hospital room)--female sterilization	None		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	None	Inpatient Detoxification Only & Labs	None
Physician/surgeon fee--female sterilization	None		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	None	Inpatient Emergency Care	None
Hospital facility fee (e.g., hospital room)--maternity delivery	None		Hospital facility fee (e.g., hospital room)--SUD detoxification	None	Inpatient Psychiatric Services	None
Professional fees--maternity delivery	None		Physician/surgeon fee--SUD detoxification	None		
Inpatient hospice facility fee (e.g., hospital room)	None		Short-term mental health crisis residential treatment	None		
Skilled nursing facility fee (e.g., hospital room)	None		SUD transitional residential recovery services	None		
			Residential treatment services for SMI and SED	CCS		
B. Inpatient, Out-of-Network	**List all QTLs**		**B. Inpatient, Out-of-Network**	**List all QTLs**	**B. Inpatient, Out-of-Network**	
Hospital facility fee (e.g., hospital room)--acute inpatient	None		Hospital facility fee (e.g., hospital room)--acute MH inpatient	None	N/A	N/A
Physician/surgeon fee--acute inpatient	None		Physician/surgeon fee--acute MH inpatient	None		
Hospital facility fee (e.g., hospital room)--female sterilization	None		Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	None		
Physician/surgeon fee--female sterilization	None		Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	None		
Hospital facility fee (e.g., hospital room)--maternity delivery	None		Hospital facility fee (e.g., hospital room)--SUD detoxification	None		
Professional fees--maternity delivery	None		Physician/surgeon fee--SUD detoxification	None		
Inpatient hospice facility fee (e.g., hospital room)	None		Short-term mental health crisis residential treatment	None		
Skilled nursing facility fee (e.g., hospital room)	None		SUD transitional residential recovery services	None		
			Residential treatment services for SMI and SED	CCS		
C. Outpatient, In-Network: Office Visits	**List all QTLs**		**C. Outpatient, In-Network: Office Visits**	**List all QTLs**	**C. Outpatient, In-Network: Office Visits**	
Primary care visit to treat an injury, illness, or condition	None		Individual and group mental health evaluation and treatment	None	Air Transportation	None
Other practitioner office visit	None		Outpatient services for monitoring drug therapy	None	Alcohol & Chemical Dependency Services	None
Specialist physician visit	None		Individual and group chemical dependency evaluation and counseling	None	Ambulatory Behavioral Health Services & Crisis Mgt	None
Preventive care/screening/immunization	None		Medical treatment for withdrawal symptoms	None	Combined Therapy	None
Family planning	None		Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	None	Consultation	None

Prenatal care and preconception visits	None				Diagnostic Services	None
Acupuncture	N/A				Electro-Convulsive Therapy (ECT)	None
Health education	None				Group Therapy	None
Child dental: diagnostic and preventive	N/A				Intensive Case Management	None
Child eye exam	One every 12 months.	NON BH			Interpretation Services	None
					Maintenance Therapy	None
					Medication Management	None
					Member Education	None
					Methadone Management Services	None
					Non-Emergent Transportation	None
					Nurses Hotline	None
					Partial Hospitalization or Intensive Outpatient Hospitalization	None
					Practitioner Services	None
					Psychological Testing	None
					Psychotherapy	None
					Supported Employment Services	None
					Therapeutic Living Supports-Specialized Residential	None
					Treatment Facilities	None
					Transitional Housing	None
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)	**List all QTLs**		**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	**List all QTLs**	**D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown separately here.)**	
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	None		Short-term partial hospitalization	None	See above Section C.	See above Section C.
Outpatient surgery --physician/surgeon fee	None		Short-term intensive outpatient psychiatric treatment	None		
Outpatient surgery facility fee--female sterilization	None		Outpatient psychiatric observation for an acute psychiatric crisis	None		
Outpatieint surgery--physician/surgeon fee--female sterilization	None		Psychological testing to evaluate a mental disorder	None		

Outpatient visit regarding outpatient surgery	None		Day treatment program for substance use disorder	None		
BRCA testing and related genetic counseling	None		Intensive outpatient treatment for substance use disorder	None		
Laboratory tests	None		Behavioral health therapy delivered in the home for autism and PDD	None		
X-rays and diagnostic imaging	None		Nonemergency psychiatric transportation	None		
Imaging (CT/PET Scans, MRIs)	None					
Nonemergency medical transportation	None					
Outpatient rehabilitation services	None					
Outpatient habilitation services	None					
Home health	None					
Hospice	None					
Durable medical equipment, including in-home DME	None					
Medical supplies	None					
Prosthetic and orthotic services and devices	None					
Diabetes equipment and supply services	None					
Contact lenses for aniridia or aphakia	None					
Infusion therapy	None					
Child eye glasses/contact lenses	Limit	NON BH				
Child dental: basic services	N/A					
Child dental: major services	N/A					
Child medically necessary orthodontics	N/A					
E. Outpatient, Out-of-Network: Office Visits	**List all QTLs**		**E. Outpatient, Out-of-Network: Office Visits**	**List all QTLs**	**E. Outpatient, Out-of-Network: Office Visits**	
Primary care visit to treat an injury, illness, or condition	None		Individual and group mental health evaluation and treatment	None	N/A	N/A
Other practitioner office visit	None		Outpatient services for monitoring drug therapy	None		
Specialist physician visit	None		Individual and group chemical dependency evaluation and counseling	None		
Preventive care/screening/immunization	None		Medical treatment for withdrawal symptoms	None		
Family planning	None		Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	None		
Prenatal care and preconception visits	None					
Acupuncture	N/A					
Health education	None					
Child dental: diagnostic and preventive	N/A					

Child eye exam	One every 12 months.	NON BH				
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	**List all QTLs**		**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	**List all QTLs**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)**	
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	None		Short-term partial hospitalization	None	N/A	N/A
Outpatient surgery --physician/surgeon fee	None		Short-term intensive outpatient psychiatric treatment	None		
Outpatient surgery facility fee--female sterilization	None		Outpatient psychiatric observation for an acute psychiatric crisis	None		
Outpatieint surgery--physician/surgeon fee--female sterilization	None		Psychological testing to evaluate a mental disorder	None		
Outpatient visit regarding outpatient surgery	None		Day treatment program for substance use disorder	None		
BRCA testing and related genetic counseling	None		Intensive outpatient treatment for substance use disorder	None		
Laboratory tests	None		Behavioral health therapy delivered in the home for autism and PDD	None		
X-rays and diagnostic imaging	None		Nonemergency psychiatric transportation	None		
Imaging (CT/PET Scans, MRIs)	None					
Nonemergency medical transportation	None					
Outpatient rehabilitation services	None					
Outpatient habilitation services	None					
Home health	None					
Hospice	None					
Durable medical equipment, including in-home DME	None					
Medical supplies	None					
Prosthetic and orthotic services and devices	None					
Diabetes equipment and supply services	None					
Contact lenses for aniridia or aphakia	None					
Infusion therapy	None					
Child eye glasses/contact lenses	Limit	NON BH				
Child dental: basic services	N/A					
Child dental: major services	N/A					
Child medically necessary orthodontics	N/A					
G. Emergency	**List all QTLs**		**G. Emergency**	**List all QTLs**	**G. Emergency**	

Emergency room facility fee (waived if admitted)	None		Emergency room facility fee (waived if admitted)	None	Emergency Room Services	None
Emergency room physician fee (waived if admitted)	None		Emergency room physician fee (waived if admitted)	None	Emergency Transportation/Ambulance	None
Emergency medical transportation	None		Emergency medical/psychiatric transportation	None	Out-of-State Emergency Behavioral Health	None
Urgent care	None		Urgent care	None		
H. Prescription Drugs	**List all QTLs**		**H. Prescription Drugs**	**List all QTLs**	**H. Prescription Drugs**	
Tier One	None		Tier One	None	Tier One	None
Tier Two	None		Tier Two	None	Tier Two	None
Tier Three	None		Tier Three	None	Tier Three	None
Tier Four	None		Tier Four	None	Tier Four	None

ATTACHMENT (B)

NQTL ANALYSIS

Individual MCOs

EMERGENCY CARE

Health Plan: AlohaCare Date: August 3, 2018
Contact Person: Don Ross, Dir Medicaid Product Email: dross@AlohaCare.org #: 808.976.1467

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prior authorization is not required for urgent care, emergency services and/or post-stabilization care and services. AlohaCare members are encouraged to communicate with their PCP prior to the development of an emergency situation. Members are informed that they may seek emergency services at the nearest hospital's Emergency Room. If an emergency situation occurs, members are advised to seek emergency services through the EMS 911 system or through the local emergency system. The PCP is encouraged to coordinate appropriate follow-up care with the attending physician and the member. Emergency Services may include: • Emergency eye and hearing exams • Emergency room services • Pathology/lab services, diagnostic tests, radiology	Prior authorization is not required for urgent care, emergency services and/or post-stabilization care and services. AlohaCare members are encouraged to communicate with their PCP prior to the development of an emergency situation. Members are informed that they may seek emergency services at the nearest hospital's Emergency Room. If an emergency situation occurs, members are advised to seek emergency services through the EMS 911 system or through the local emergency system. The PCP is encouraged to coordinate appropriate follow-up care with the attending physician and the member. Emergency Services may include: • Emergency room services • Pathology/lab services, diagnostic tests, radiology services, medical supplies and drugs within the ER visit	Emergency services for Medical/BH is not subject to prior authorization review regardless whether or not the provider is within the plan's network.	No issues found. **BH parity requirements met.**

services, medical supplies and drugs within the ER visit • Physician services provided during the • ER visit • Surgery and anesthesiology services • provided during the ER visit Emergency dental care for adults 21 years old and older. Members must get dental care from a dentist who sees Medicaid patients. Benefits include: • Acute injuries to the teeth and supporting structures • Treatment of elimination of acute dental infection • Relief of dental pain An Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part • With respect to a pregnant woman having contractions:	• Physician services provided during the ER visit An Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious harm to self or others due to an alcohol or drug abuse emergency • Injury to self or bodily harm to others The AlohaCare Member Handbook lists examples of when a member should go to the emergency room including but not limited to active labor, seizures, broken bones, and head injury.		

• that there is not adequate time to effect a safe transfer to another hospital before delivery • that transfer may pose a threat to the health or safety or the woman or her unborn child The AlohaCare Member Handbook lists examples of when a member should go to the emergency room including but not limited to active labor, seizures, broken bones, and head injury.			

2. 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

3. 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

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

N/A	N/A	N/A	N/A

Concurrent Review

5. 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?

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

Prescription Drugs

8. 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.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No tiers	No tiers	Prescription drug coverage for urgent and emergent needs is handled using the same policy for both MH/SUD conditions and M/S conditions.	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

10. 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.

List of documents: Provider selection, Network Development, Provider credentialing policies and procedures			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Per Credentialing policies and licensing regulations, providers must provide services within the scope of their license. AlohaCare will cover emergency services provided by any provider practicing and providing care within the scope of the provider's license and accreditation.	Per Credentialing policies and licensing regulations, providers must provide services within the scope of their license. AlohaCare will cover emergency services provided by any provider practicing and providing care within the scope of the provider's license and accreditation.	AlohaCare policy covers emergency services provided by providers providing care within scope of licensure and accreditation, regardless of whether the services are MH/SUD services or M/S services.	No issues found. **BH parity requirements met.**

11. 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.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	Emergency services are covered everywhere in or out of network.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	Emergency services are covered everywhere in or out of network.	No issues found. **BH parity requirements met.**

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
All provider contracts are negotiated rates and vary according to terms reached in negotiation. Most begin with the state's FFS fee schedule, or are a percentage of Medicare FFS fee schedule. This is true for physicians, PhDs and MAs.	All provider contracts are negotiated rates and vary according to terms reached in negotiation. Most begin with the state's FFS fee schedule, or are a percentage of Medicare FFS fee schedule. This is true for physicians, PhDs and MAs.	No difference between M/S and MH/SUD provider reimbursement approaches.	No issues found. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review

Medicare reimbursement, and service demand/network adequacy and capacity are the primary drivers for both M/S and MH/SUD providers. Some medical and mental health specialties are in a workforce shortage situation.	Medicare reimbursement, and service demand/network adequacy and capacity are the primary drivers for both M/S and MH/SUD providers. Some medical and mental health specialties are in a workforce shortage situation.	No difference between M/S and MH/SUD provider reimbursement approaches.	No issues found. **BH parity requirements met.**

INPATIENT

Health Plan: AlohaCare Date: August 3, 2018
Contact Person: Don Ross, Dir Medicaid Product Email: dross@alohacare.org #: 808.973.1467

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: Procedures for conducting UM review for inpatient LOC, Concurrent review workflow, Provider manual excerpts,			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Inpatient H, Maternity/Newborn Care, and Sub-acute Short/Long Term Rehabilitation services include: • Room and board • nursing care • medical supplies • equipment and drugs • diagnostic services • physical therapy • occupational therapy • audiology • speech- language pathology service • other medically necessary services. Concurrent Review process:	Inpatient Psychiatric Hospitalizations services include: • room/board • nursing care • medical supplies and equipment • medications and medication management • diagnostic services • psychiatric and other practitioner services • ancillary services • other medically necessary services Concurrent Review process: • Notification facesheet received from facility within 24 hours of member's admission.	Criteria/Guidelines used to make a determination of Medical Necessity for BH/Medical inpatient hospitalizations: • Interqual • Medical Necessity A notification from the facility within 24 hours of the member's acute admission is required to initiate an authorization to be created for review of the member's inpatient stay. For Acute inpatient stays, a concurrent review is conducted every 2 days for both BH/Medical hospitalizations. Rehabilitation/Long term residential stays are reviewed every 7 days for both BH/Medical hospitalizations. **Comparability:** Comparable criteria are utilized for review for coverage determinations of both M/S and MH/SUD	No issues found. **BH parity requirements met.**

• Notification facesheet received from facility within 24 hours of member's admission. • Intake (TCSS) receives notification facesheet and creates authorization and pends them to the UM clinician for review • UM clinician accepts the authorization and request clinical notes from facility. • Based on clinical notes reviewed, clinician will approve length of stay (LOS) and level of care (LOC) based on InterQual Criteria. Every 2 days for Acute Inpatient Every 7 days for SNF level of care • If criteria is not met, concurrent review nurse will contact facility UM review nurse to discuss level of care. • If both the concurrent and facility nurses agree, continue with review • If there is a disagreement and level of care/length of stay is potentially denied, authorization is pended to Medical Director for a Secondary review. • After the MD completes the secondary review, the MD returns the authorization to the UM clinician. • UM Clinician will process the denial and provide a verbal/written notification to	• Intake (TCSS) receives notification facesheet and creates authorization and pends them to the UM clinician for review • UM clinician accepts the authorization and request clinical notes from facility. • Based on clinical notes reviewed, clinician will approve length of stay (LOS) and level of care (LOC) based on InterQual Criteria. Every 2 days for Acute Inpatient Every 7 days for long term residential • If criteria is not met, concurrent review nurse will contact facility UM review nurse to discuss level of care. • If both the concurrent and facility nurses agree, continue with review • If there is a disagreement and level of care/length of stay is potentially denied, authorization is pended to Medical Director for a Secondary review. • After the MD completes the secondary review, the MD returns the authorization to the UM clinician. • UM Clinician will process the denial and provide a verbal/written notification to facility and written notification to member.	facility inpatient stays. Interqual criteria are developed by medical experts in a variety of specialties and is one of the several accepted national standards for medical necessity criteria. AlohaCare uses current revisions and updates criteria when changes are made. **Stringency:** MH/SUD criteria and application are no more stringent than for comparable stays and settings for M/S facility stays. Interqual criteria are used for both. Frequency of review for concurrent review are the same for both types of services.	

facility and written notification to member. • If member is still inpatient, concurrent review will resume until member is discharged home.	• If member is still inpatient, concurrent review will resume until member is discharged home.		

2. 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.

List of documents: Documents submitted for this item are included with Item #1 above			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Clinician will receive notification of the admission and request clinical notes to initiate Concurrent review. Once the clinical notes is received, the hospital stay is reviewed beginning on the day of admission. The clinical notes are reviewed against Interqual guidelines starting with the day of acute admission. If the length of stay (LOS)or the level of care (LOC) is not appropriate due to inadequate interventions/services being performed during the member's inpatient confinement, the clinician will notify the facility's CM/SW regarding the failed requirements to continue the LOS or to remain in the LOC the member is currently at. If the facility does not agree with the clinician's review, the authorization is sent to the Medical Director. The Medical Director will conduct a secondary review. If necessary a peer to peer with the facility's hospitalist may be conducted to determine the Medical Necessity of a continued stay or level	Clinician will receive notification of the admission and request clinical notes to initiate Concurrent review. Once the clinical notes is received, the hospital stay is reviewed beginning on the day of admission. The clinical notes are reviewed against Interqual guidelines starting with the day of BH acute admission. If the length of stay (LOS) or the level of care (LOC) is not appropriate due to inadequate interventions/services being performed during the member's inpatient confinement, the clinician will notify the facility's CM/SW regarding the failed requirements to continue the LOS or to remain in the LOC the member is currently at. If the facility does not agree with the clinician's review, the authorization is sent to the Medical Director. The Medical Director will conduct a secondary review. If necessary a peer to peer with the facility's hospitalist may be conducted to determine the Medical Necessity of a continued stay or level	For Medical/BH inpatient authorizations the process for making a determination to authorize and/or deny the services are the same.	No issues found. **BH parity requirements met.**

of care. Based on all available information a determination is made regarding LOC or LOS and pend the authorization back to the clinician to complete the authorization process or continue the concurrent review.	of care. Based on all available information a determination is made regarding LOC or LOS and pend the authorization back to the clinician to complete the authorization process or continue the concurrent review.		

3. 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

List of documents: Documents submitted for this item are included with Item #1 above			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
During a concurrent review of a member's acute/rehab inpatient stay, our guidelines (Interqual) require a series of tests, course of treatment, imaging, and intensity of rehab services to be conducted for each inpatient day. If the member is unwilling or unable to receive the appropriate interventions a Medical Necessity review will be conducted based on the Interqual guidelines. If the guidelines are not met due to failure to complete a course of treatment and the member's clinical state is not stable for discharge, the Level of care may be denied, but not the length of stay. Decisions are always based on our guidelines and Medical Necessity. Failure to complete a course of treatment is not a determining factor for a denial.	During a concurrent review of a member's BH acute/long term inpatient stay, our guidelines (Interqual) require a series of tests, course of treatment, imaging, and intensity of BH services to be conducted for each inpatient day. If the member is unwilling or unable to receive the appropriate interventions a Medical Necessity review will be conducted based on the Interqual guidelines. If the guidelines are not met due to failure to complete a course of treatment and the member's clinical state is not stable for discharge, the Level of care may be denied, but not the length of stay. Decisions are always based on our guidelines and Medical Necessity. Failure to complete a course of treatment is not a determining factor for a denial.	For Medical/BH services the process for making a determination to authorize and/or deny the services are the same.	No issues found. **BH parity requirements met.**

<u>Prior Authorization</u>

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: Documents submitted for this item are included with Item #1 above			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
For stabilization services post-acute hospitalization such as inpatient rehabilitation, a Prior authorization is not required. A notification from the facility is required within 24 hours of admission to initiate the creation of an authorization for concurrent review. Authorization of continued stay will be reviewd using Interqual guidelines	For post-acute BH hospitalization such as long term residential treatment, a Prior authorization is not required. A notification from the facility is required within 24 hours of admission to initiate the creation of an authorization for concurrent review. Authorization of continued stay will be reviewed using Interqual guidelines every 7 days.	For Medical/BH services the process for making a determination to authorize and/or deny the services, and the types of services requiring prior authorization or concurrent review are the same (see also the list of services requiring prior authorization for M/S and MH/SUD services included in Outpatient template narrative.	No issues found. **BH parity requirements met.**

Concurrent Review

5. 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?

List of documents: Documents submitted for this item are included with Item #1 above			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
During a concurrent review of a member's acute/rehab inpatient stay, our guidelines (Interqual) require a series of tests, course of treatment, imaging, and intensity of rehab services to be conducted for each inpatient day. Medical Necessity reviews are conducted based on the Interqual guidelines. If the guidelines are not met but the member's clinical state is not stable for discharge, the Level of care may be denied, but not the length of stay. If the guidelines are not met, continued stay may be denied. All denials regarding LOS/LOC are pended	During a concurrent review of a member's acute BH hospitalization or long term residential stay, our guidelines (Interqual) require a series of tests, course of treatment, imaging, and intensity of BH services to be conducted for each inpatient day. Medical Necessity reviews are conducted based on the Interqual guidelines. If the guidelines are not met but the member's clinical state is not stable for discharge, the Level of care may be denied, but not the length of stay. If the guidelines are not met, continued stay may be denied. All	For Medical/BH concurrent review the process for making a determination to authorize and/or deny the services are the same. The decisions about which services need to meet coverage criteria to be approved are made, for both MH/SUD services and for M/S services by reviewing denial rates, rates of overturn on appeal, and rates of requests for services that meet criteria versus those that do not. AlohaCare recently removed PA requirements from more than half of the services that previously required PA because the denial rates were so low, reducing the number of services requiring	No issues found. **BH parity requirements met.**

to Medical Directors for a secondary review and decision determination. Decisions are always based on our guidelines and Medical Necessity. The cost of the hospitalization/services is not a factor used to make a decision determination.	denials regarding LOS/LOC are pended to Medical Directors for a secondary review and decision determination. Decisions are always based on our guidelines and Medical Necessity. The cost of the hospitalization/services is not a factor used to make a decision determination.	PA by nearly half, effective January, 2018.	

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: Documents submitted for this item are included with Item #1 above			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
All process for concurrent review have been addressed in the above columns. From Jan 2018 – June 2018 there were no appeals that was requested from UM for inpatient denials. From Jan 2018-June 2018 there were 1904 authorizations for acute and LTC inpatient authorizations out of which 26 (1.37%) were denied.	All process for concurrent review have been addressed in the above columns. From Jan 2018 – June 2018 there were no appeals that were requested from UM for inpatient BH denials. From Jan 2018-June 2018 there were 196 authorizations for Acute BH inpatient 2 (1.02%) which were partially approved.	Based on the number of authorizations received for Medical/BH inpatient acute and long term. The percent of cases that are denied are comparable.	No issues found. **BH parity requirements met.**

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
• Every 2 days for Acute Inpatient • Every 7 days for Long term rehab	• Every 2 days for Acute Inpatient • Every 7 days for long term inpatient residential	Frequency of reviews for both Medical and MH/SUD inpatient reviews are the same.	No issues found. **BH parity requirements met.**

Prescription Drugs

8. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No tiers	No tiers	No difference between patient populations. Both MS and MH/SUD populations utilize the same criteria for medication coverage determinations	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: Selection and Retention of Providers			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
For M/S services, AlohaCare conducts annual and ad hoc assessments of our provider network delivery system to determine if it is meeting our standards for network adequacy, capacity, and member access. See attached Selections and Retention of Providers Policy. AlohaCare's Policy includes provider exclusion per federal and state requirements for government funded programs. Credentialing requirements include common, state-wide and national standards such as licensed, certified, accredited, and in good standing, with Appropriate	For MH/SUD services, AlohaCare conducts annual and ad hoc assessments of our provider network delivery system to determine if it is meeting our standards for network adequacy, capacity, and member access. See attached Selections and Retention of Providers Policy. . AlohaCare's Policy includes provider exclusion per federal and state requirements for government funded programs. Credentialing requirements include common, state-wide and national standards such as licensed, certified, accredited, and in good	No difference between patient populations. Both M/S and MH/SUD Practitioners and Facilities undergo the same credentialing and network selection requirements for participation in AlohaCare's network.	No issues found. **BH parity requirements met.**

medical liability, DEA, peer references, and other common credentialing and privileging verifications.	standing, with Appropriate medical liability, DEA, peer references, and other common credentialing and privileging verifications.		

10. 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.

List of documents: Provider Recruitment and retention policy			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No exclusions, except for those excluded from participation in government healthcare programs	No exclusions, except for those excluded from participation in government healthcare programs	No difference in approach to provider exclusion between M/S and MH/SUD providers.	No issues found. **BH parity requirements met.**

11. 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.

List of documents: Provider Recruitment and retention policy			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No such limitations	No such limitations		No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
AlohaCare members receive medically necessary care. OON care must be prior authorized and coverage determinations are made based on clinical review considering patient history with providers, and comparison	AlohaCare members receive medically necessary care. OON care must be prior authorized and coverage determinations are made based on clinical review considering patient history with providers, and comparison	There is no difference in the policies or procedures for review of requests for OON care whether services are M/S or MH/SUD services.	No issues found. **BH parity requirements met.**

of provider specialties, training, expertise, credentials, and on geography and proximity. If in-network providers of comparable credentials and specialties are available in the medical service area, care is re-directed to the network. If not, then OON care is authorized. This is also true for out of state non-emergency care.	of provider specialties, training, expertise, credentials, and on geography and proximity. If in-network providers of comparable credentials and specialties are available in the medical service area, care is re-directed to the network. If not, then OON care is authorized. This is also true for out of state non-emergency care.		

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
All provider contracts are negotiated rates and vary according to terms reached in negotiation. Most begin with the state's FFS fee schedule, or are a percentage of Medicare FFS fee schedule. This is true for physicians, PhDs and MAs.	All provider contracts are negotiated rates and vary according to terms reached in negotiation. Most begin with the state's FFS fee schedule, or are a percentage of Medicare FFS fee schedule. This is true for physicians, PhDs and MAs.	No difference between M/S and MH/SUD provider reimbursement approaches.	No issues found. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Medicare reimbursement, and service demand/network adequacy and capacity are the primary drivers for both M/S and MH/SUD providers. Some medical and mental health specialties are in a workforce shortage situation.	Medicare reimbursement, and service demand/network adequacy and capacity are the primary drivers for both M/S and MH/SUD providers. Some medical and mental health specialties are in a workforce shortage situation.	No difference between M/S and MH/SUD provider reimbursement approaches.	No issues found. **BH parity requirements met.**

OUTPATIENT

Health Plan: AlohaCare Date: August 3, 2018
Contact Person: Don Ross, Dir Medicaid Product Email: dross@alohacare.org #: 808.973.1467

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: Procedure documents for conducting UM review of services requiring prior authorization, Coverage criteria for ABA, Workflow for denials, Workflow for prior authorizations, Workflow for Denial letters, Links to medical necessity criteria			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
AlohaCare's Utilization Management Program (UMP) incorporates the functions of utilization review/management (e.g., prospective, concurrent and retrospective reviews) of medical, behavioral health, long term services and supports, pharmacy/drug services. The UMP monitors for over- or under-utilization, and inappropriate use of services. The AlohaCare UMP also includes services that promote the continuity and coordination of care through assistance and support during care transitions, disease management, and collaborative care and service coordination internally and externally. It objectively monitors and evaluates the cost of care based on medical or functional appropriateness. The AlohaCare UMP assesses not just clinical aspects of care, but also factors that impact how care is delivered/provided, such	AlohaCare's Utilization Management Program (UMP) incorporates the functions of utilization review/management (e.g., prospective, concurrent and retrospective reviews) of medical, behavioral health, long term services and supports, pharmacy/drug services. The UMP monitors for over- or under-utilization, and inappropriate use of services. The AlohaCare UMP also includes services that promote the continuity and coordination of care through assistance and support during care transitions, disease management, and collaborative care and service coordination internally and externally. It objectively monitors and evaluates the cost of care based on medical or functional appropriateness. The AlohaCare UMP assesses not just clinical aspects of care, but also factors that impact how care is delivered/provided, such	**Comparability:** Criteria applied to make medical necessity/appropriateness determination are selected from criteria available as national standard systems and based on the best available medical evidence reviewed by physicians, Psychologists, Pharmacists, and other clinical experts who serve on their committees and review boards. They include Interqual, Noridian (Medicare), ASAM, and AlohaCare policies and procedures based on NCQA requirements, and MQD rules, contract requirements, guidance and definitions. This is the same approach whether they are M/S or MH/SUD services. Services are selected for review based on	No issues found. **BH parity requirements met.**

as cultural and linguistic awareness and sensitivity, enabling services, and continuous monitoring of quality of service. The UMP creation and decisions are developed by various committees comprised internal and external clinicians, non-clinicians, and subject matter experts. Such committees are: The Board Quality Committee (BOC), Medical Management Committee (MCC), Practitioners Advisory Committee (PAC), LTSS Quality Advisory Committee, Pharmacy & Therapeutics Committee (P&T), as well as direct director oversight by the Chief Medical Officer (CMO). Medical necessity is based on review using the criteria guidelines as outlined in the Medical Necessity Criteria policy and procedure, medical coverage policies, or using Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) guidance as applicable. The UM policies and procedures are reviewed annually and are updated as necessary. AlohaCare reviews and updates, on an annual basis, all AlohaCare medical policies related to medical necessity of the following services: specific diagnostics and treatments, new technologies, and DME/supplies; pharmaceuticals; clinical practice guidelines, based on national recommendations; and inter-rater reliability among UM nurses, pharmacists and physician directors. New medical policies related to medical necessity are vetted through a process that involves the following:	as cultural and linguistic awareness and sensitivity, enabling services, and continuous monitoring of quality of service. The UMP creation and decisions are developed by various committees comprised internal and external clinicians, non-clinicians, and subject matter experts. Such committees are: The Board Quality Committee (BOC), Medical Management Committee (MCC), Practitioners Advisory Committee (PAC), LTSS Quality Advisory Committee, Pharmacy & Therapeutics Committee (P&T), as well as direct director oversight by the Chief Medical Officer (CMO). Medical necessity is based on review using the criteria guidelines as outlined in the Medical Necessity Criteria policy and procedure, medical coverage policies, or using Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) guidance as applicable. The UM policies and procedures are reviewed annually and are updated as necessary. AlohaCare reviews and updates, on an annual basis, all AlohaCare medical policies related to medical necessity of the following services: specific diagnostics and treatments, new technologies, and DME/supplies; pharmaceuticals; clinical practice guidelines, based on national recommendations; and inter-rater reliability among UM nurses, pharmacists and physician directors. New medical policies related to medical necessity are vetted through a process that involves the following:	the frequency with which AlohaCare observes that requests for services are not supported by the medical records submitted for review. As a result, AlohaCare reduced the number of services requiring PA by nearly half, effective January, 2018. Those services for which PA requirements were removed were services that most often met criteria and those that remained were those that most frequently were denied for not meeting criteria. So, for both M/S services and MH/SUD services, denial rates and rates of overturn on appeal are also considered. **Stringency:** AlohaCare MH/SUD coverage criteria are no more stringent than coverage criteria for M/S services. For both benefits, inpatient and other facility stays must meet criteria, as well as common types of diagnostic testing and specialized, intensive, or long-term treatments and therapies. The evidentiary standards for peer review and scientific literature are comparable and the consequences are equal (denial of authorization, coverage, and payment for services). Criteria are updated at AlohaCare whenever the entities who provide the criteria and guidelines make revisions or updates.	

• Research of available clinical information, coding, and national trends regarding medical necessity for the specific service by a medical policy analyst. • Vetting of the proposed medical policy among internal staff: o Chief Medical Officer, Medical Director, and Associate Medical Directors. o Senior Director of Long Term Services and Support (Service Coordination). o Director of Utilization Management. o Director of Health Plan Operations. o Pharmacy Manager. o Others as relevant. • Feedback from Practitioners Advisory Committee. Approval of Medical Management Committee. The following M/S services must meet criteria for coverage: Ambulatory/Outpatient surgery Durable Medical Equipment (DME) Prosthetics and Orthotics Eye surgery Adult Strabismus Home and Community Based Services Home Health Home IV and infusion therapy/drugs Hyperbaric Oxygen therapy Hysterectomy Housing and meals when traveling to approved services Incontinence supplies Mastectomy (prophylactic/gynecomastia)	• Research of available clinical information, coding, and national trends regarding medical necessity for the specific service by a medical policy analyst. • Vetting of the proposed medical policy among internal staff: o Chief Medical Officer, Medical Director, and Associate Medical Directors. o Senior Director of Long Term Services and Support (Service Coordination). o Director of Utilization Management. o Director of Health Plan Operations. o Pharmacy Manager. o Others as relevant. • Feedback from Practitioners Advisory Committee. Approval of Medical Management Committee. The following Mental Health and SUD services must meet criteria for coverage: MH/SUD/Psychiatric inpatient stays Chemical Dependency Treatment Electroconvulsive therapy Applied Behavioral Analysis (ABA) Facility-based IOP/LIOP/Day treatment Individual psychotherapy sessions > 1 hour/day Neuropsychological testing Psychological testing Substance Abuse Treatment Criteria/Guidelines used to make a determination of Medical Necessity for		

MRI/MRA scans below the neck Elective inpatient stays and surgery Inpatient rehab Non-Formulary Medication OB Ultrasound beyond 3x Occupational Therapy Out of State non-emergency services PET scans of the brain Physical Therapy PUVA therapy Sleep Studies Speech therapy Sterilization procedures Non-Emergent Medical Transportation (NEMT) Criteria/Guidelines used to make a determination of Medical Necessity for Medical Outpatient requests which require Prior Authorization: • Interqual • Noridian • AlohaCare Policies • Medical Necessity Outpatient medical services covered by AlohaCare. A prior auth look-up tool is available (http://www.alohacare.org/Providers/Authorization) to assist providers in determining prior authorization requirements for each of the listed services. For Outpatient services that are not covered such as ITOP, providers are referred to Xerox/ACS for information and claims submission. Members are directed to Medicaid's FFS program.	MH/SUD Outpatient requests which require Prior Authorization: • Interqual • ASAM • MQD Guidelines • AlohaCare Policies • Medical Necessity Outpatient MH/SUD services covered by AlohaCare. A prior auth look-up tool is available (http://www.alohacare.org/Providers/Authorization) to assist providers in determining prior authorization requirements for each of the listed services. Members covered under the QI Community Care Services (CCS) behavioral health program with a diagnosis that is indicative of a Serious and Persistent Mental Illness (SPMI) will have all of their MH services covered by the CCS program, which is currently being administered by Ohana Health Plan as the MQD contracted plan. Their QI benefit plan will include 'CCS' in the plan name. Providers should bill the CCS program administrator for the MH services l, along with the enhanced MH services that are covered under the CCS program. For these members, AC remains responsible for their medical (non-MH) services.		

For non-covered soft tissue/organ transplants members are referred to the State of Hawaii Organ Tissue Transplant program (SHOTT).			

2. 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.

List of documents: The same documents included with this submission for item #1 above.			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
As mentioned above, the UMP outlines the various committees and groups which collaborate on writing our medical and pharmacy policies. The requirements, such as initial trials, step therapies, criteria, and other UM edits placed on these therapies are developed from guidelines in Medical Necessity policy and procedure, and by using Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs). Clinician reviews services using appropriate guidelines based on the requested service using clinical notes that have been submitted by the requesting provider. During the review, if the guidelines are not met due to “failed first requirements or step therapies”, clinician will contact member’s requesting PCP/Specialist to request additional information to confirm that the member did fail “first requirements or step-therapies”. If provider has additional information, review will continue using the available information. If the allotted timeframe for review is coming to a close, clinician can inform the	As mentioned above, the UMP outlines the various committees and groups which collaborate on writing our medical and pharmacy policies. The requirements, such as initial trials, step therapies, criteria, and other UM edits placed on these therapies are developed from guidelines in Medical Necessity policy and procedure, and by using Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs). Clinician reviews services using appropriate guidelines based on the requested service using clinical notes that have been submitted by the requesting provider. During the review, if the guidelines are not met due to “failed first requirements or step therapies”, clinician will contact member’s requesting PCP/Specialist to request additional information to confirm that the member did fail “first requirements or step-therapies”. If provider has additional information, review will continue using the available information. If the allotted timeframe for review is coming to a close, clinician can inform the provider	For Medical/BH services which require prior authorization, the process for making a determination to authorize and/or deny the services are the same. (see above description of auth process)	No issues found. **BH parity requirements met.**

provider that the timeframe is near and provide the option of an extension if an extension of the review timeframe will not have any adverse effects on the member's health. Once all of the information is received and if it still does not meet the appropriate guidelines, a telephone call is made to the requesting provider to inform them that the request is being sent to Medical Director for secondary review. Should the provider wish to conduct a peer to peer with the Medical Director prior to the determination of the decision, clinician will arrange the peer to peer. Once all of the information has been obtained and peer to peer has been conducted the Medical Director will make a determination based on guidelines, and Medical Necessity. Medical Director will pend the authorization to the UM clinician to complete the authorization process based on the Medical Directors decision.	that the timeframe is near and provide the option of an extension if an extension of the review timeframe will not have any adverse effects on the member's health. Once all of the information is received and if it still does not meet the appropriate guidelines, a telephone call is made to the requesting provider to inform them that the request is being sent to Medical Director for secondary review. Should the provider wish to conduct a peer to peer with the Medical Director prior to the determination of the decision, clinician will arrange the peer to peer. Once all of the information has been obtained and peer to peer has been conducted the Medical Director will make a determination based on guidelines and Medical Necessity. Medical Director will pend the authorization to the UM clinician to complete the authorization process based on the Medical Directors decision.		

3. 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

List of documents: The same documents included with this submission for item #1 above.			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No, however non-compliant to a course of treatment can be used as a determining factor during a review should additional units be requested. These cases will be sent to Medical Director for review and continuation of services is based on meeting the appropriate guidelines and Medical Necessity.	No, however non-compliant to a course of treatment can be used as a determining factor during a review should additional units be requested. These cases will be sent to Medical Director for review and continuation of services is based on meeting the appropriate guidelines and Medical Necessity.	For Medical/BH services which require prior authorization, the process for making a determination to authorize and/or deny the services are the same. (See PA process)	No issues found. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: The same list of documents included with this submission for item #1 above.			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prior Authorization Review Process • PA Outpatient Medical services made • Intake (TCSS) accepts request and creates authorization and pends them to the UM clinician for review • UM BH/Medical clinician accepts the authorization and applies the appropriate guidelines based on the request • If guidelines are met, clinician approves the request and written notification of the decision is sent to the requesting and treating provider • If guidelines are not met, the authorization is sent to a Medical Director for a secondary review. Medical Directors will review for Medical Necessity and if necessary may request a third party reviewer (Alicare) if necessary and/or conduct a Peer to Peer with requesting/treating provider. • The Medical Director will make a determination to approve or deny and pend the authorization back to the UM BH/Medical clinician	**Prior Authorization Review Process** • PA Outpatient BH services made • Intake (TCSS) accepts request and creates authorization and pends them to the UM clinician for review • UM BH/Medical clinician accepts the authorization and applies the appropriate guidelines based on the request • If guidelines are met, clinician approves the request and written notification of the decision is sent to the requesting and treating provider • If guidelines are not met, the authorization is sent to a Medical Director for a secondary review. Medical Directors will review for Medical Necessity and if necessary may request a third party reviewer (Alicare) if necessary and/or conduct a Peer to Peer with requesting/treating provider. • The Medical Director will make a determination to approve or deny and pend the authorization back to the UM BH/Medical clinician	For Medical/BH services which require prior authorization, the process for making a determination to authorize and/or deny the services are the same. See item 1 above for how criteria are established or selected and what the evidentiary standards are.	No issues found. **BH parity requirements met.**

• Based on the Medical Director's decision, the UM BH/Medical clinician will either approve or deny the request. • If decision is approved, written notification will be provided to the requesting/treating provider • If denied, written and verbal notification will be provided to the requesting/treating provider. Written notification will be given to member in simple language explaining reason for the decision and their appeal rights. • All adverse decisions are made by AlohaCare's Medical Directors	• Based on the Medical Director's decision, the UM BH/Medical clinician will either approve or deny the request. • If decision is approved, written notification will be provided to the requesting/treating provider • If denied, written and verbal notification will be provided to the requesting/treating provider. Written notification will be given to member in simple language explaining reason for the decision and their appeal rights. • All adverse decisions are made by AlohaCare's Medical Directors		

Concurrent Review

5. 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?

List of documents: None. Concurrent review is not performed on outpatient services for M/S nor for MH/SUD services.			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent reviews are not conducted during the course of treatment for outpatient medical services.	Concurrent reviews are not conducted during the course of treatment for outpatient medical services.	The determination of continued services, should it be requested, is based on the efficacy of the prior service and whether or not additional units of the same service is Medically Necessary. This is determined by the review of the clinical notes obtained from the first course of treatment and using the appropriate guidelines under the continuation subset of the requested service and will follow the process for a prior authorization review.	No issues found. **BH parity requirements met.**

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: N/A			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents: N/A			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

Prescription Drugs

8. 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.

List of documents: 2018 QI ACAP Benefit Grid			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No tiers	No tiers	• No difference between patient populations. Both MS and MH/SUD populations utilize the same criteria for medication coverage determinations	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: Selection and Retention of Providers			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
For M/S services, AlohaCare conducts annual and ad hoc assessments of our provider network delivery system to determine if it is meeting our standards for network adequacy, capacity, and member access. See attached Selections and Retention of Providers Policy. AlohaCare's Policy includes provider exclusion per federal and state requirements for government funded programs. Credentialing requirements include common, state-wide and national standards such as licensed, certified, accredited, and in good standing, with Appropriate medical liability, DEA, peer references, and other common credentialing and privileging verifications.	For MH/SUD services, AlohaCare conducts annual and ad hoc assessments of our provider network delivery system to determine if it is meeting our standards for network adequacy, capacity, and member access. See attached Selections and Retention of Providers Policy. . AlohaCare's Policy includes provider exclusion per federal and state requirements for government funded programs. Credentialing requirements include common, state-wide and national standards such as licensed, certified, accredited, and in good standing, with Appropriate medical liability, DEA, peer references, and other common credentialing and privileging verifications.	No difference between patient populations. Both M/S and MH/SUD Practitioners and Facilities undergo the same credentialing and network selection requirements for participation in AlohaCare's network.	No issues found. **BH parity requirements met.**

10. 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.

List of documents: Provider Recruitment and retention policy			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No exclusions, except for those excluded from participation in government healthcare programs.	No exclusions, except for those excluded from participation in government healthcare programs.	No difference in approach to provider exclusion between M/S and MH/SUD providers.	No issues found. **BH parity requirements met.**

11. 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.

List of documents: Provider Recruitment and retention policy

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No such limitations	No such limitations		No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
AlohaCare members receive medically necessary care. OON care must be prior authorized and coverage determinations are made based on clinical review considering patient history with providers, and comparison of provider specialties, training, expertise, credentials, and on geography and proximity. If in-network providers of comparable credentials and specialties are available in the medical service area, care is re-directed to the network. If not, then OON care is authorized. This is also true for out of state non-emergency care.	AlohaCare members receive medically necessary care. OON care must be prior authorized and coverage determinations are made based on clinical review considering patient history with providers, and comparison of provider specialties, training, expertise, credentials, and on geography and proximity. If in-network providers of comparable credentials and specialties are available in the medical service area, care is re-directed to the network. If not, then OON care is authorized. This is also true for out of state non-emergency care.	There is no difference in the policies or procedures for review of requests for OON care whether services are M/S or MH/SUD services.	No issues found. **BH parity requirements met.**

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents: Provider Recruitment and retention policy			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
All provider contracts are negotiated rates and vary according to terms	All provider contracts are negotiated rates and vary according to terms	No difference between M/S and MH/SUD provider reimbursement approaches.	No issues found.

reached in negotiation. Most begin with the state's FFS fee schedule, or are a percentage of Medicare FFS fee schedule. This is true for physicians, PhDs and MAs.	reached in negotiation. Most begin with the state's FFS fee schedule, or are a percentage of Medicare FFS fee schedule. This is true for physicians, PhDs and MAs.		**BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Medicare reimbursement, and service demand/network adequacy and capacity are the primary drivers for both M/S and MH/SUD providers. Some medical and mental health specialties are in a workforce shortage situation.	Medicare reimbursement, and service demand/network adequacy and capacity are the primary drivers for both M/S and MH/SUD providers. Some medical and mental health specialties are in a workforce shortage situation	No difference between M/S and MH/SUD provider reimbursement approaches.	No issues found. **BH parity requirements met.**

PRESCRIPTION DRUGS

Health Plan: AlohaCare Date: August 3, 2018
Contact Person: Don Ross, Dir Medicaid Product Email: dross@alohacare.org #: 808.973.1467

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: Medical Management Prior Authorizations and Pre-Service Organization Determinations (MM-04); AlohaCare Utilization Management Program

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
AlohaCare's Utilization Management Program (UMP) incorporates the functions of utilization review/management (e.g., prospective, concurrent and retrospective reviews) of medical, behavioral health, long term services and supports, pharmacy/drug services. The UMP monitors for over- or under-utilization, and inappropriate use of services. The AlohaCare UMP also includes services that promote the continuity and coordination of care through assistance and support during care transitions, disease management, and collaborative care and service coordination internally and externally. It objectively monitors and evaluates the cost of care based	AlohaCare's Utilization Management Program (UMP) incorporates the functions of utilization review/management (e.g., prospective, concurrent and retrospective reviews) of medical, behavioral health, long term services and supports, pharmacy/drug services. The UMP monitors for over- or under-utilization, and inappropriate use of services. The AlohaCare UMP also includes services that promote the continuity and coordination of care through assistance and support during care transitions, disease management, and collaborative care and service coordination internally and externally. It objectively monitors and evaluates the cost of care based	• No difference between patient populations. • Both MS and MH/SUD populations utilize the same standards of criteria for medication coverage determinations.	No issues found. **BH parity requirements met.**

on medical or functional appropriateness. The AlohaCare UMP assesses not just clinical aspects of care, but also factors that impact how care is delivered/provided, such as cultural and linguistic awareness and sensitivity, enabling services, and continuous monitoring of quality of service. The UMP creation and decisions are developed by various committees comprised internal and external clinicians, non-clinicians, and subject matter experts. Such committees are: The Board Quality Committee (BOC), Medical Management Committee (MCC), Practitioners Advisory Committee (PAC), LTSS Quality Advisory Committee, Pharmacy & Therapeutics Committee (P&T), as well as direct director oversight by the Chief Medical Officer (CMO). Medical necessity is based on review using the criteria guidelines as outlined in the Medical Necessity Criteria policy and procedure, medical coverage policies, or using Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) guidance as applicable. The UM policies and procedures are reviewed annually and are updated as	on medical or functional appropriateness. The AlohaCare UMP assesses not just clinical aspects of care, but also factors that impact how care is delivered/provided, such as cultural and linguistic awareness and sensitivity, enabling services, and continuous monitoring of quality of service. The UMP creation and decisions are developed by various committees comprised internal and external clinicians, non-clinicians, and subject matter experts. Such committees are: The Board Quality Committee (BOC), Medical Management Committee (MCC), Practitioners Advisory Committee (PAC), LTSS Quality Advisory Committee, Pharmacy & Therapeutics Committee (P&T), as well as direct director oversight by the Chief Medical Officer (CMO). Medical necessity is based on review using the criteria guidelines as outlined in the Medical Necessity Criteria policy and procedure, medical coverage policies, or using Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) guidance as applicable. The UM policies and procedures are reviewed annually and are updated as		

necessary. AlohaCare reviews and updates, on an annual basis, all AlohaCare medical policies related to medical necessity of the following services: specific diagnostics and treatments, new technologies, and DME/supplies; pharmaceuticals; clinical practice guidelines, based on national recommendations; and inter-rater reliability among UM nurses, pharmacists and physician directors. New medical policies related to medical necessity are vetted through a process that involves the following: • Research of available clinical information, coding, and national trends regarding medical necessity for the specific service by a medical policy analyst. • Vetting of the proposed medical policy among internal staff: o Chief Medical Officer, Medical Director, and Associate Medical Directors. o Senior Director of Long Term Services and Support (Service Coordination). o Director of Utilization Management. o Director of Health Plan Operations. o Pharmacy Manager. o Others as relevant. • Feedback from Practitioners Advisory Committee.	necessary. AlohaCare reviews and updates, on an annual basis, all AlohaCare medical policies related to medical necessity of the following services: specific diagnostics and treatments, new technologies, and DME/supplies; pharmaceuticals; clinical practice guidelines, based on national recommendations; and inter-rater reliability among UM nurses, pharmacists and physician directors. New medical policies related to medical necessity are vetted through a process that involves the following: • Research of available clinical information, coding, and national trends regarding medical necessity for the specific service by a medical policy analyst. • Vetting of the proposed medical policy among internal staff: o Chief Medical Officer, Medical Director, and Associate Medical Directors. o Senior Director of Long Term Services and Support (Service Coordination). o Director of Utilization Management. o Director of Health Plan Operations. o Pharmacy Manager. o Others as relevant. • Feedback from Practitioners Advisory Committee.		

• Approval of Medical Management Committee.	Approval of Medical Management Committee.		

2. 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.

List of documents: Medical Management Prior Authorizations and Pre-Service Organization Determinations (MM-04); AlohaCare Utilization Management Program			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
As mentioned above, the UMP outlines the various committees and groups which collaborate on writing our medical and pharmacy policies. The requirements such has initial trials, step-therapies, and other various UM edits places on these therapies are created based on guidelines as outlined the Medical Necessity Criteria policy and procedure, medical coverage policies, or using Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) guidance as applicable.	As mentioned above, the UMP outlines the various committees and groups which collaborate on writing our medical and pharmacy policies. The requirements such has initial trials, step-therapies, and other various UM edits places on these therapies are created based on guidelines as outlined the Medical Necessity Criteria policy and procedure, medical coverage policies, or using Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) guidance as applicable.	• No difference between patient populations. • Both MS and MH/SUD populations utilize the same criteria for medication coverage determinations.	No issues found. **BH parity requirements met.**

3. 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

List of documents: Medical Management Prior Authorizations and Pre-Service Organization Determinations (MM-04); AlohaCare Utilization Management Program			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Just as the previously answered questions. Exclusions based on failure to complete a course of treatment and other exclusions are also taken into account in the writing of our UMP and individual UM edits on medications and procedures. These are developed	Just as the previously answered questions. Exclusions based on failure to complete a course of treatment and other exclusions are also taken into account in the writing of our UMP and individual UM edits on medications and procedures. These are developed	• No difference between patient populations. • Both MS and MH/SUD populations utilize the same criteria for medication coverage determinations.	No issues found. **BH parity requirements met.**

using the same criteria as outlined above.	using the same criteria as outlined above.		

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
For M/S services, based on LCDs and NCDs, manufacturers labeling information and other components of the UMP described in item #1 above, medications that require a PA, have quantity limits, or require step therapy are loaded into the Pharmacy Point Of Sale (POS) system by AlohaCare's Pharmacy Benefits Manager (Express Scripts, Inc so that they will not pay unless the PA is approved. Except for urgent and emergent needs during non-business hours, these are reviewed by AlohaCare Pharmacists before dispensing of medications and payment through the POS occurs. Interaction with the prescribing physician and review of the medical record may be utilized to consider for meeting criteria.	For M/S services, based on LCDs and NCDs, manufacturers labeling information and other components of the UMP described in item #1 above, medications that require a PA, have quantity limits, or require step therapy are loaded into the Pharmacy Point Of Sale (POS) system by AlohaCare's Pharmacy Benefits Manager (Express Scripts, Inc so that they will not pay unless the PA is approved. Except for urgent and emergent needs during non-business hours, these are reviewed by AlohaCare Pharmacists before dispensing of medications and payment through the POS occurs. Interaction with the prescribing physician and review of the medical record may be utilized to consider for meeting criteria.	• No difference between patient populations. Both MS and MH/SUD populations utilize the same processes for medication coverage determinations.	No issues found. **BH parity requirements met.**

Concurrent Review

5. 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?

List of documents: AlohaCare Utilization Management Program			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Medical and Utilization Management which includes: timely processing of referrals and prior authorization of medical, surgical, or behavioral health services in terms of specialty care, diagnostics, treatments; prospective, concurrent and retrospective reviews related to appropriate utilization; and medical policy development where coverage determination tools such as InterQual, Medicare NCD or LCD, DMERC do not adequately address specific requests for services; The AlohaCare Medical Director and Associate Medical Directors, under the direction of and in concert with the Chief Medical Officer, participate in medical management/utilization review decision making operations over the full scope of plan benefits through prospective, concurrent and retrospective review. AlohaCare's Pharmacy Manager provides day-to-day supervision and direction to staff within the Pharmacy Department and works collaboratively with the Chief Medical Officer, who has oversight	Medical and Utilization Management which includes: timely processing of referrals and prior authorization of medical, surgical, or behavioral health services in terms of specialty care, diagnostics, treatments; prospective, concurrent and retrospective reviews related to appropriate utilization; and medical policy development where coverage determination tools such as InterQual, Medicare NCD or LCD, DMERC do not adequately address specific requests for services; The AlohaCare Medical Director and Associate Medical Directors, under the direction of and in concert with the Chief Medical Officer, participate in medical management/utilization review decision making operations over the full scope of plan benefits through prospective, concurrent and retrospective review. AlohaCare's Pharmacy Manager provides day-to-day supervision and direction to staff within the Pharmacy Department and works collaboratively with the Chief Medical Officer, who has oversight	• No difference between patient populations. • Both MS and MH/SUD populations utilize the same criteria for medication soverage determinations.	No issues found. **BH parity requirements met.**

responsibility, as well as the Medical Director and Associate Medical Directors on UM initiatives, issues and decisions relating to utilization management of medications, and administration of AlohaCare's formulary. Behavioral health expertise is necessary among the Medical Director and Associate Medical Directors.	responsibility, as well as the Medical Director and Associate Medical Directors on UM initiatives, issues and decisions relating to utilization management of medications, and administration of AlohaCare's formulary. Behavioral health expertise is necessary among the Medical Director and Associate Medical Directors.		

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: AlohaCare Utilization Management Program			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Medical and Utilization Management which includes: timely processing of referrals and prior authorization of medical, surgical, or behavioral health services in terms of specialty care, diagnostics, treatments; prospective, concurrent and retrospective reviews related to appropriate utilization; and medical policy development where coverage determination tools such as InterQual, Medicare NCD or LCD, DMERC do not adequately address specific requests for services; We currently do not perform any concurrent reviews for outpatient or	Medical and Utilization Management which includes: timely processing of referrals and prior authorization of medical, surgical, or behavioral health services in terms of specialty care, diagnostics, treatments; prospective, concurrent and retrospective reviews related to appropriate utilization; and medical policy development where coverage determination tools such as InterQual, Medicare NCD or LCD, DMERC do not adequately address specific requests for services; We currently do not perform any concurrent reviews for outpatient or	• No difference between patient populations. • Both MS and MH/SUD populations utilize the same criteria for medication and medical service determinations	No issues found. **BH parity requirements met.**

pharmacy medications. Requests for post services are treated as Retrospective reviews. These are treated the same as regular or prospective reviews.	pharmacy medications. Requests for post services are treated as Retrospective reviews. These are treated the same as regular or prospective reviews.		

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents: AlohaCare Utilization Management Program			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
We currently do not perform any concurrent reviews for outpatient or pharmacy medications. Requests for post services are treated as Retrospective reviews. These are treated the same as regular or prospective reviews.	We currently do not perform any concurrent reviews for outpatient or pharmacy medications. Requests for post services are treated as Retrospective reviews. These are treated the same as regular or prospective reviews.	• No difference between patient populations. • Both MS and MH/SUD populations utilize the same criteria for medication and medical service determinations	No issues found. **BH parity requirements met.**

Prescription Drugs

8. 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.

List of documents: 2018 QI ACAP Benefit Grid			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
• No Tiers • Formulary or Non-Formulary Status Only • Closed Formulary • PA required for selected medications and situations, including non-formulary, step therapy, and quantity limits	• No Tiers • Formulary or Non-Formulary Status Only • Closed Formulary • PA required for selected medications and situations, including non-formulary, step therapy, and quantity limits	• No difference between patient populations. • Both MS and MH/SUD populations utilize the same criteria for medication coverage determinations.	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals (RFP-MQD); Selection and Retention of Providers			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The health plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. The health plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as: (1) requiring that the health plan contract with providers beyond the number necessary to meet the needs of its members; (2) precluding the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (3) precluding the health plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to	The health plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. The health plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as: (1) requiring that the health plan contract with providers beyond the number necessary to meet the needs of its members; (2) precluding the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (3) precluding the health plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to	• No difference between patient populations. • Both MS and MH/SUD populations utilize the same criteria for medication and medical service determinations	No issues found. **BH parity requirements met.**

members. The health plan is not required to contract with every willing provider. If the health plan does not or will not include individuals or groups of providers of a specialty grouping in its network, it shall provide that information in its proposal. AlohaCare's provider network team maintains the Selection and Retention of Providers policy which outlines the development, maintenance, assessment, and other aspects of the provider network.	members. The health plan is not required to contract with every willing provider. If the health plan does not or will not include individuals or groups of providers of a specialty grouping in its network, it shall provide that information in its proposal. AlohaCare's provider network team maintains the Selection and Retention of Providers policy which outlines the development, maintenance, assessment, and other aspects of the provider network.		

10. 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.

List of documents: QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals (RFP-MQD)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The health plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. The health plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as: (1) requiring that the	The health plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. The health plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as: (1) requiring that the	• No difference between patient populations. • Both MS and MH/SUD populations utilize the same criteria for medication and medical service determinations	No issues found. **BH parity requirements met.**

health plan contract with providers beyond the number necessary to meet the needs of its members; (2) precluding the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (3) precluding the health plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. The health plan is not required to contract with every willing provider. If the health plan does not or will not include individuals or groups of providers of a specialty grouping in its network, it shall provide that information in its proposal.	health plan contract with providers beyond the number necessary to meet the needs of its members; (2) precluding the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (3) precluding the health plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. The health plan is not required to contract with every willing provider. If the health plan does not or will not include individuals or groups of providers of a specialty grouping in its network, it shall provide that information in its proposal.		

11. 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.

List of documents: QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals (RFP-MQD)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
• No geographic limitations	• No geographic limitations	• No difference between patient populations. • Both MS and MH/SUD populations utilize the same criteria for medication and medical service determinations	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
OON dispensing of prescription medications is less frequently necessary than for professional and facility services, since the PBM's pharmacy network is extensive and includes all major national chains. If an OON pharmacy must be utilized, then a contract or letter of agreement must be obtained and the OON dispensing authorized. AlohaCare will approve dispensing of at least a 3 day supply of necessary medication at whatever rates the OON pharmacy may charge until a LOA can be signed.	OON dispensing of prescription medications is less frequently necessary than for professional and facility services, since the PBM's pharmacy network is extensive and includes all major national chains. If an OON pharmacy must be utilized, then a contract or letter of agreement must be obtained and the OON dispensing authorized. AlohaCare will approve dispensing of at least a 3 day supply of necessary medication at whatever rates the OON pharmacy may charge until a LOA can be signed.	There is no difference between MH/SUD and M/S services regarding the handling of OON pharmacy dispensing and coverage determinations.	No issues found. **BH parity requirements met.**

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
PBM drug ingredient pricing is obtained based on national volumes for Medicaid and made available to AlohaCare by the PBM.	PBM drug ingredient pricing is obtained based on national volumes for Medicaid and made available to AlohaCare by the PBM.	There is no difference between MH/SUD and M/S services regarding the reimbursement approaches for prescription drugs. AlohaCare's PBM obtains the best net drug pricing they can achieve for all medications.	No issues found. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review

	(MH/SUD)		
PBM professional dispensing fee pricing is obtained based on national volumes for Medicaid and made available to AlohaCare by the PBM.	PBM professional dispensing fee pricing is obtained based on national volumes for Medicaid and made available to AlohaCare by the PBM.	There is no difference between MH/SUD and M/S services regarding the reimbursement approaches for professional dispensing fees. AlohaCare's PBM obtains the best terms on professional dispensing fees they can achieve for all locations and medications.	No issues found. **BH parity requirements met.**

EMERGENCY CARE

Health Plan: HMSA Date: August 3, 2018
Contact Person: Micah Hu Email: Micah_hu@hmsa.com #: (808) 948-6587

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents:

1. Hawaii Revised Statute HRS 432E-1.4
2. HMSA Policy & Procedure – Clinical Review Criteria
3. HMSA Policy & Procedure – New Technology Evaluation
4. Beacon Policy & Procedure –Medical Necessity
5. Beacon Policy & Procedure –Objectivity in Clinical Decision Making
6. Beacon Policy & Procedure – New Medical Technologies
7. MCG Guidelines for Inpatient and Surgical Care (available online under HMSA's license)
8. MCG Guidelines for Behavioral Health Care (available online under Beacon's license)

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
In developing medical necessity standards for Medical/Surgical services, HMSA considers scientific evidence/peer reviewed literature, professional standards of care, expert opinion and community input and utilizes multiple sources including: • Hawaii Revised Statutes (HRS §432E-1.4) • Blue Cross Blue Shield Association guidelines and medical policies • Milliman Care Guidelines (MCG)	Beacon Health Options (Beacon) is HMSA's delegate for Mental Health/Substance Use Disorder utilization management function. For services that are subject to medical necessity, Beacon utilized evidence-based criteria that are either nationally recognized criteria sets, such as those developed by the American Society of Addiction Medicine (ASAM) or are developed by Beacon from the comparison of national, scientific and evidenced based criteria sets, including	Both MS and MH/SUD services are subject to comparable and no more stringent applications of medical necessity. In general, health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms are evaluated by HMSA and Beacon using comparable criteria. At a high level, these criteria ensure such services are: • In accordance with Generally Accepted Standards of Medical Practice	No issues found. **BH parity requirements met.**

Along with the available medical evidence, additional consideration is given to factors such as a treatment's cost-effectiveness, most appropriate delivery of level of service, and potential benefits and harms to the patient to determine medical necessary of medical/surgical treatments and services. Medical necessity criteria (aka policies) are developed by HMSA Medical Directors with input from medical practitioners in the community. Once policies are developed, reviews of the medical necessity criteria are conducted at least annually and more frequently as new evidences become available.	but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). 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. Beacon's medical necessity criteria are reviewed on an annual basis, or more frequently, as necessary by the Corporate Medical Management Committee (CMMC) and updated as needed when new treatment applications and technologies are adopted as generally accepted professional medical practice.	• Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's sickness, injury, mental illness, substance use disorder, disease or its symptoms • Not mainly for the member's convenience or that of the member's doctor or other health care provider 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. After a review of this comparative analysis, it is concluded that the medical necessity criteria development processes for treatments and services between Medical/Surgical and Mental Health/Substance Abuse Disorder benefits are comparable and deemed to be in compliance with mental health parity provisions.	

2. 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable	Not applicable	Not applicable	N/A

3. 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

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable	Not applicable	Not applicable	N/A

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable	Not applicable	Not applicable	N/A

Concurrent Review

5. 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?

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable	Not applicable	Not applicable	N/A

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable	Not applicable	Not applicable	N/A

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable	Not applicable	Not applicable	N/A

Prescription Drugs

8. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable	Not applicable	Not applicable	N/A

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: 1. HMSA-HSD001.pdf 2. HMSA Facility_Ancillary_CRED_REQ 2018 HMSA QUEST Integration LTSS Cred Req.pdf			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Providers must be appropriately licensed or certified in accordance with state and national guidelines, meet all standard educational and credentialing criteria for their	Providers must be appropriately licensed or certified in accordance with state and national guidelines, meet all standard educational and credentialing criteria for their	The processes and standards used in contracting and credentialing both MS and MH/SUD for Emergency providers are comparable and equally stringent.	No issues found. **BH parity requirements met.**

specialty, not be an excluded entity with Medicare or Medicaid programs, and have met all continuing educational requirements specific to their provider type Provider must be willing to contract at sustainable rates and to submit all required documentation for both credentialing process and for system configuration for adjudication of provider claims. Provider onboarding process can be initiated either by the health Plan or Provider followed by execution of a contract between Plan and Provider for participation in one or more products. Plan monitors network needs on a regular basis in accordance with its practitioner availability policies and will initiate outreach to non-par Providers if network analysis shows a need in a specific geography. Also, non-par Providers frequently initiate a request for participation. Plan will either respond and begin contracting process or politely decline if credentialing requirements are not met. Plan retains all rights to determine which providers it adds to its provider networks. HMSA has formal credentialing criteria and a Credentialing Committee.	specialty, not be an excluded entity with Medicare or Medicaid programs, and have met all continuing educational requirements specific to their provider type Provider must be willing to contract at sustainable rates and to submit all required documentation for both credentialing process and for system configuration for adjudication of provider claims. Provider onboarding process can be initiated either by the health Plan or Provider followed by execution of a contract between Plan and Provider for participation in one or more products. Plan monitors network needs on a regular basis in accordance with its practitioner availability policies and will initiate outreach to non-par Providers if network analysis shows a need in a specific geography. Also, non-par Providers frequently initiate a request for participation. Plan will either respond and begin contracting process or politely decline if credentialing requirements are not met. Plan retains all rights to determine which providers it adds to its provider networks. HMSA has formal credentialing criteria and a Credentialing Committee.		

10. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
HMSA does not have any exclusions pertaining to provider types, facility types, or specialty providers.	HMSA does not have any exclusions pertaining to provider types, facility types, or specialty providers.	Both sides do not have exclusions based on provider type, facility type, or specialty providers and are therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

11. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no geographic limitations	There are no geographic limitations	Both sides do not have geographic limitations and are therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
QUEST Integration members have no out-of-network benefits except for emergencies. If a member is admitted for an emergent condition, no prior authorization or concurrent reviews are required until the time the member's condition is stabilized.	QUEST Integration members have no out-of-network benefits except for emergencies. If a member is admitted for an emergent condition, no prior authorization or concurrent reviews are required until the time the member's condition is stabilized.	The process determining access to out of network emergency services is equally applied to both M/S and MH/SUD and are therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Please refer to the NQTL- Outpatient document.			No issues found. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Emergency Care follows professional fee schedule rates and hospitals are individually negotiated. All rates are based on budget availability. Rural areas may play a factor due to access issues.	Emergency Care follows professional fee schedule rates and hospitals are individually negotiated. All rates are based on budget availability. Rural areas may play a factor due to access issues..	The processes and standards used in determining appropriate rates for emergency services are the same for both MS and MH/SUD and are therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

INPATIENT

Health Plan: HMSA Date: August 3, 2018
Contact Person: Micah Hu Email: Micah_hu@hmsa.com #: (808) 948-6587

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents:

1. Hawaii Revised Statute HRS 432E-1.4
2. HMSA Policy & Procedure – Clinical Review Criteria
3. HMSA Policy & Procedure – New Technology Evaluation
4. Beacon Policy & Procedure –Medical Necessity
5. Beacon Policy & Procedure –Objectivity in Clinical Decision Making
6. Beacon Policy & Procedure – New Medical Technologies
7. MCG Guidelines for Inpatient and Surgical Care (available online under HMSA's license)
8. MCG Guidelines for Behavioral Health Care (available online under Beacon's license)

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
In developing medical necessity standards for Medical/Surgical services, HMSA considers scientific evidence/peer reviewed literature, professional standards of care, expert opinion and community input and utilizes multiple sources including: • Hawaii Revised Statutes (HRS §432E-1.4) • Blue Cross Blue Shield Association guidelines and medical policies • Milliman Care Guidelines (MCG)	Beacon Health Options (Beacon) is HMSA's delegate for Mental Health/Substance Use Disorder utilization management function. For services that are subject to medical necessity, Beacon utilized evidence-based criteria that are either nationally recognized criteria sets, such as those developed by the American Society of Addiction Medicine (ASAM) or are developed by Beacon from the comparison of national, scientific and evidenced based criteria sets, including	Both MS and MH/SUD services are subject to comparable and no more stringent applications of medical necessity. In general, health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms are evaluated by HMSA and Beacon using comparable criteria. At a high level, these criteria ensure such services are: • In accordance with Generally Accepted Standards of Medical Practice	No issues found. **BH parity requirements met.**

Along with the available medical evidence, additional consideration is given to factors such as a treatment's cost-effectiveness, most appropriate delivery of level of service, and potential benefits and harms to the patient to determine medical necessary of medical/surgical treatments and services. Medical necessity criteria (aka policies) are developed by HMSA Medical Directors with input from medical practitioners in the community. Once policies are developed, reviews of the medical necessity criteria are conducted at least annually and more frequently as new evidences become available.	but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). 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. Beacon's medical necessity criteria are reviewed on an annual basis, or more frequently, as necessary by the Corporate Medical Management Committee (CMMC) and updated as needed when new treatment applications and technologies are adopted as generally accepted professional medical practice.	• Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's sickness, injury, mental illness, substance use disorder, disease or its symptoms • Not mainly for the member's convenience or that of the member's doctor or other health care provider 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. After a review of this comparative analysis, it is concluded that the medical necessity criteria development processes for treatments and services between Medical/Surgical and Mental Health/Substance Abuse Disorder benefits are comparable and deemed to be in compliance with mental health parity provisions.	

2. 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no fail first requirements for Inpatient treatments under Medical/Surgical benefits.	There are no fail first requirements for Inpatient treatments under Mental Health/Substance Use Disorder benefits.	Fail first requirements are not part of the utilization management process for both Medical/Surgical and Mental	No issues found. **BH parity requirements met.**

Fail first requirements or step-therapies for prescription drugs are not applicable in the Inpatient document. Please refer to the NQTL- Prescription Drugs document.	Fail first requirements or step-therapies for prescription drugs are not applicable in the Inpatient document. Please refer to the NQTL- Prescription Drugs document.	Health/Substance Use Disorder inpatient treatments.	

3. 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

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no exclusions based on failure to complete a course of treatment under Inpatient Medical/Surgical benefits.	There are no exclusions based on failure to complete a course of treatment under Inpatient Mental Health/Substance Use Disorder benefits.	Both MS and MH/SUD are treated the same way by not requiring any exclusion based on failure to complete a course of treatment and therefore are comparable.	No issues found. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: 1. HMSA Policy on Post-acute, Residential Treatment Facility and Community Care Foster Family Home Care HMSA Policy on MH/SUD Residential Treatment			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prior authorization is not required for M/S acute Inpatient hospital admissions. However prior authorization is required for post-acute care services such as skilled nursing facilities admissions. The rationale for requiring	Prior authorization is not required for MH/SUD acute Inpatient hospital admissions. Prior authorization is required for residential treatment centers admission for treatment of mental health/substance use disorders. The	Although there are no prior authorization requirements for acute inpatient admissions, prior authorization is required for coverage of rehabilitative services under medical/surgical benefits and residential treatment under mental health/substance use disorder benefits. Processes, standards and objective used in	No issues found. **BH parity requirements met.**

prior authorization is to ensure that the admissions for post-acute care are medically necessary and not for the sole purpose of custodial care. In developing prior authorization requirements for skilled nursing facility admissions, HMSA utilizes a medical policy – Post acute, Residential Treatment Facility and Community Care Foster Family Home Care which is consistent with current standards of care and is based on the State of Hawaii Level of Care Criteria.	process used in developing prior authorization requirement for residential treatment facilities is similar to and no more stringent than the process used for skilled nursing facilities. Beacon Health uses a set of medical necessity criteria based on the Milliman Care Guidelines – Behavioral Health Care and various medical literature and professional society guidelines.	developing both types of prior authorization requirements are comparable and applied in equally stringent manners.	

Concurrent Review

5. 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?

List of documents:

1. MCG Guidelines for Inpatient and Surgical Care (available online under HMSA's license)
2. MCG Guidelines for Behavioral Health Care (available online under Beacon's license)
3. Beacon Level of Care Criteria on Mental Health/Substance Use Inpatient Treatment
4. American Society for Addiction Medicine Criteria

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
State of Hawaii Med-QUEST RFP requirements are the primary drivers in the development of our concurrent review process. Other factors considered in requiring concurrent reviews are the cost of treatment, potential high utilization relative to benchmark, variability in the level of care and the length of treatment, and the availability of alternative treatments with different costs. In	The determining factors for concurrent reviews for Mental Health/Substance Use Disorders treatments are similar to and no more stringent than those of Medical/Surgical treatments.	The same factors are utilized in determining concurrent review requirements for both Medical/Surgical and Mental Health/Substance Use Disorder treatments. The manner in which concurrent reviews are conducted are equally stringent for M/S and MH/SUD inpatient services. During the course of concurrent review for both MS and MH/SUD inpatient	No issues found. **BH parity requirements met.**

addition, the reviews enable health plan and provider utilization reviewers, service coordinators, and social workers to collaborate on a regular basis on discharge planning and transition of care for members receiving acute inpatient care. Concurrent review process is evidence-based and takes into account individual patient's circumstances and the local delivery system when determining medical appropriateness of health care services. The decision-making also takes into consideration the medical necessity criteria under Hawaii's Patients' Bill of Rights and Responsibilities Act, generally accepted standards of medical practice and review of medical literature.		services, if the level of care, length of stay, quality concerns, discharge planning or other issues arise, the health plan utilization reviewers collaborate with the facility's utilization review/case management staff for a peer to peer discussion. If consensus is not reached, then it is elevated to peer to peer discussions between the attending physician and the health plan's medical director. If there is no consensus between the physicians with regard to the level of care or the length of stay, the health plan issues a denial letter or notification of action letter to the provider and to the member as appropriate.	

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:

1. HMSA Utilization Management Program Description

Beacon Policy on Objectivity in Clinical Decision Making

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent reviews are performed for all inpatient confinements under medical/surgical benefits. The purpose of concurrent reviews is to ensure the appropriateness of level of care and duration of treatment. The concurrent review process requires that the admissions are reviewed within 1-2 working days of receiving	The concurrent review process for inpatient treatments under mental health/substance use disorder treatment is similar to that of medical/surgical inpatient treatments. Notification of admission comes via electronic census from inpatient facilities and concurrent reviews are performed using remote access to the electronic medical records	The processes and evidentiary standards used in performing concurrent reviews for both medical/surgical and mental health/substance use disorders are comparable. The denial rate for MH/SUD inpatient services is comparable to that of M/S which indicates that concurrent review	No issues found. **BH parity requirements met.**

notification. Notification of admission is done via electronic census data transmitted to the health plan. Using electronic medical records, reviews are performed periodically thereafter dependent on diagnosis and treatment. Nurse reviewers with acute inpatient care experience and who are licensed to practice in the state of Hawaii conduct concurrent reviews in consultation with our medical directors. Medical directors are also available to provide peer-to-peer reviews with treating physician(s) as needed. Clinical reviewers utilize nationally recognized MCG – Inpatient & Surgical Care and General Recovery Care Guidelines as decision support tools to evaluate appropriateness and cost effectiveness of care provided to our members. Nurse reviewers collaborate with various hospital Utilization Review staff/case managers on a daily basis to ensure that the inpatient level of care conforms to the established clinical guidelines and the length of stay remains within the goal recommended in the guidelines. Continued hospital stays are reviewed concurrently by nurse reviewers via remote access to the hospitals' electronic medical records, records transmitted to HMSA via secure fax, or telephonically. Concurrent reviews are done at regular intervals (generally every 2-3 days) appropriate for the patient's specific clinical conditions and intensity of services required.	or records transmitted via fax. Inpatient - Psychiatric/Substance Use and Residential Treatment – Psychiatric/Substance Use clinical criteria are utilized in making medical necessity determinations in collaboration with utilization reviewers at the treatment facilities. The denial rates for mental health/substance use disorder inpatient treatments is 0-0.25% per quarter for the QUEST Integration Plan. Similar to M/S, the collaboration between the plan and provider UR staff results in low denials during MH/SUD concurrent reviews. Due to the low volume of denials and our process there have been no instances of a provider appeal. Thus we are unable to provide an appeal overturn rate.	process for MH/SUD services is no more stringent than that of MS services.	

The denial rate for M/S inpatient services is less than 1%. Low denial rate is attributed to the discussions and consensus between the health plan and the provider utilization reviewers. Through this collaboration process, facility providers lower level of care or discharge timely therefore not requiring the plan to issue denials. Due to the low volume of denials and our process there have been no instances of a provider appeal. Thus we are unable to provide an appeal overturn rate.			

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The average frequency of concurrent reviews for acute inpatient medical/surgical treatment is once every 2-3 days but varies depending on a patient's medical/surgical condition and response to the treatment and the current level of care. The optimal frequency of concurrent review is agreed upon between the health plan and the inpatient facility's utilization reviewers.	Similar to that of the medical/surgical concurrent reviews, MH/SUD reviews vary depending on a patient's condition and response to the treatment and level of care. Generally, MH/SUD is reviewed less frequently than 2-3 days, but follows the same process. The optimal frequency of concurrent review is agreed upon between the health plan and the inpatient facility's utilization reviewers.	The intensity and frequency of concurrent reviews for inpatient services are comparable between medical/surgical and mental health/substance use disorder treatments. The reviews are conducted in a manner that is agreed upon between the health plan and the facility providers and do not create undue burden on the provider.	No issues found. **BH parity requirements met.**

Prescription Drugs

8. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Please refer to the NQTL- Prescription Drugs document.			No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents:
1. HMSA-HSD001.pdf
2. HMSA Facility_Ancillary_CRED_REQ

2018 HMSA QUEST Integration LTSS Cred Req.pdf

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Providers must be appropriately licensed or certified in accordance with state and national guidelines, meet all standard educational and credentialing criteria for their specialty, not be an excluded entity with Medicare or Medicaid programs, and have met all continuing educational requirements specific to their provider type Provider must be willing to contract at sustainable rates and to submit all required documentation for both credentialing process and for system configuration for adjudication of provider claims. Provider onboarding process can be initiated either by the health Plan or Provider followed by execution of a	Providers must be appropriately licensed or certified in accordance with state and national guidelines, meet all standard educational and credentialing criteria for their specialty, not be an excluded entity with Medicare or Medicaid programs, and have met all continuing educational requirements specific to their provider type Provider must be willing to contract at sustainable rates and to submit all required documentation for both credentialing process and for system configuration for adjudication of provider claims. Provider onboarding process can be initiated either by the health Plan or Provider followed by execution of a	The processes and standards used in contracting and credentialing both MS and MH/SUD for inpatient providers are comparable and equally stringent.	No issues found. **BH parity requirements met.**

contract between Plan and Provider for participation in one or more products. Plan monitors network needs on a regular basis in accordance with its practitioner availability policies and will initiate outreach to non-par Providers if network analysis shows a need in a specific geography. Also, non-par Providers frequently initiate a request for participation. Plan will either respond and begin contracting process or politely decline if credentialing requirements are not met. Plan retains all rights to determine which providers it adds to its provider networks. HMSA has formal credentialing criteria and a Credentialing Committee.	contract between Plan and Provider for participation in one or more products. Plan monitors network needs on a regular basis in accordance with its practitioner availability policies and will initiate outreach to non-par Providers if network analysis shows a need in a specific geography. Also, non-par Providers frequently initiate a request for participation. Plan will either respond and begin contracting process or politely decline if credentialing requirements are not met. Plan retains all rights to determine which providers it adds to its provider networks. HMSA has formal credentialing criteria and a Credentialing Committee.		

10. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
HMSA does not have any exclusions pertaining to provider types, facility types, or specialty providers.	HMSA does not have any exclusions pertaining to provider types, facility types, or specialty providers.	Both sides do not have exclusions based on provider type, facility type, or specialty providers and are therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

11. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

There are no geographic limitations	There are no geographic limitations	Both sides do not have geographic limitations and are therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: 1. QUEST Integration Member Handbook			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
QUEST Integration members have no out-of-network benefits except for emergencies. If a member is admitted for an emergent condition, no prior authorization or concurrent reviews are required until the time the member's condition is stabilized. If a member needs a treatment or service that is not available from network providers, exception can be made after a medical necessity review and verifying availability of comparable services within the network. If the out of network treatment is warranted, HMSA will contract with the out-of-network provider for a single case agreement.	QUEST Integration members have no out-of-network benefits except for emergencies. If a member is admitted for an emergent condition, no prior authorization or concurrent reviews are required until the time the member's condition is stabilized. If a member needs a treatment or service that is not available from network providers, exception can be made after a medical necessity review and verifying availability of comparable services within the network. If the out of network treatment is warranted, HMSA will contract with the out-of-network provider for a single case agreement.	The process determining access to out of network services is equally applied to both M/S and MH/SUD benefits. Once an exception is made, the same process is used in paying for M/S and MH/SUD out-of-network providers.	No issues found. **BH parity requirements met.**

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Please refer to the NQTL- Outpatient document.			No issues found. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Inpatient Facilities are individually negotiated. All rates are based on budget availability. Rural areas may play a factor due to access issues. Rates could be matching Medicare or the commercial business.	Inpatient Facilities are individually negotiated. All rates are based on budget availability. Rural areas may play a factor due to access issues. Rates could be matching Medicare or the commercial business.	The processes and standards used in determining appropriate rates for inpatient services are the same for both MS and MH/SUD and are therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

OUTPATIENT

Health Plan: HMSA Date: August 3, 2018
Contact Person: Micah Hu Email: Micah_hu@hmsa.com #: (808) 948-6587

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents:

1. Hawaii Revised Statute HRS 432E-1.4
2. HMSA Policy & Procedure – Clinical Review Criteria
3. HMSA Policy & Procedure – New Technology Evaluation
4. Beacon Policy & Procedure –Medical Necessity
5. Beacon Policy & Procedure –Objectivity in Clinical Decision Making
6. Beacon Policy & Procedure – New Medical Technologies
7. MCG Guidelines for Inpatient and Surgical Care (available online under HMSA's license)
8. MCG Guidelines for Behavioral Health Care (available online under Beacon's license)

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
In developing medical necessity standards for Medical/Surgical outpatient services, HMSA considers scientific evidence/peer reviewed literature, professional standards of care, expert opinion and community input and utilizes multiple sources including: • Hawaii Revised Statutes (HRS §432E-1.4) • Blue Cross Blue Shield Association guidelines and medical policies • Milliman Care Guidelines (MCG)	Beacon Health Options (Beacon) is HMSA's delegate for Mental Health/Substance Use Disorder utilization management function. For services that are subject to medical necessity, Beacon utilized evidence-based criteria that are either nationally recognized criteria sets, such as those developed by the American Society of Addiction Medicine (ASAM) or are developed by Beacon from the comparison of national, scientific and evidenced based criteria sets, including	Both MS and MH/SUD services are subject to comparable and no more stringent applications of medical necessity. In general, health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms are evaluated by HMSA and Beacon using comparable criteria.. At a high level, these criteria ensure such services are: • In accordance with Generally Accepted Standards of Medical Practice	No issues found. **BH parity requirements met.**

Along with the available medical evidence, additional consideration is given to factors such as a treatment's cost-effectiveness, most appropriate delivery of level of service, and potential benefits and harms to the patient to determine medical necessary of medical/surgical treatments and services. Medical necessity criteria (aka policies) are developed by HMSA Medical Directors with input from medical practitioners in the community. Once policies are developed, reviews of the medical necessity criteria are conducted at least annually and more frequently as new evidences become available.	but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), and the American Society of Addiction Medicine (ASAM). 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. Beacon's medical necessity criteria are reviewed on an annual basis, or more frequently, as necessary by the Corporate Medical Management Committee (CMMC) and updated as needed when new treatment applications and technologies are adopted as generally accepted professional medical practice.	• Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's sickness, injury, mental illness, substance use disorder, disease or its symptoms • Not mainly for the member's convenience or that of the member's doctor or other health care provider 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. After a review of this comparative analysis, it is concluded that the medical necessity criteria development processes for treatments and services between Medical/Surgical and Mental Health/Substance Abuse Disorder benefits are comparable and deemed to be in compliance with mental health parity provisions.	

2. 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.

List of documents:

1. HMSA Policy on Kyphoplasty and Vertebroplasty

HMSA Policy on Transcranial Magnetic Stimulation

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Although there are no exclusions based on failure to complete a course of treatment, there are requirements to	Similar to M/S benefits, although there are no exclusions based on failure to complete a course of treatment, there	The comparison indicates that the first-fail requirements for both M/S and MH/SUD	No issues found. **BH parity requirements met.**

attempt certain conservative or non-operative treatments prior to receiving certain surgical procedures. For example, to qualify for certain spinal procedures, a patient must have failed an adequate trial of conservative therapy. These requirements are outlined in the respective medical policies. Rationale for such requirements is based on the review of published medical literature, professional society guidelines, and medical necessity criteria in determining the most appropriate delivery or the level of service. Please refer to NQTL – Prescription Drugs document for information on fail first or step therapy requirements for prescription drugs.	are requirements to attempt certain conservative options prior to receiving some MH/SUD treatments. For example, to be able to receive Transcranial Magnetic Stimulation (TMS), a patient must have had four trials of pharmacologic therapy for major depressive disorder. The rationale for requiring adequate trials of medications before the TMS procedure is due to its potentially serious adverse effects. An equally robust collection of medical evidence (as cited in the medical policy's references section) forms the basis of fail first requirements in MH/SUD treatments as in MS treatments. Please refer to NQTL – Prescription Drugs document for information on fail first or step therapy requirements for prescription drugs.	treatments are applied in a comparable manner.	

3. 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

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no exclusions based on failure to complete a course of treatment under Outpatient Medical/Surgical benefits.	There are no exclusions based on failure to complete a course of treatment under Outpatient Mental Health/Substance Use Disorder benefits.	Both MS and MH/SUD are treated the same way by not requiring any exclusion based on failure to complete a course of treatment and therefore are comparable.	No issues found. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents:

1. HMSA Policy on Precertification Review Activities
2. HMSA Policy on Clinical Review Criteria
3. HMSA Utilization Management Program Description

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prior authorization is required for rehabilitative services such as Physical Therapy, Occupational Therapy, and Speech Therapy and for certain outpatient medical/surgical procedures. HMSA performs prior authorization reviews to evaluate health care services for medical necessity in the following general categories: • Services for which aberrant or potential inappropriate patterns of care are identified • New technology or new uses of existing technology • Services with the potential for non-covered purposes (e.g., lifestyle enhancement, cosmetic services, surgery or supplies) • Transplants or other complex treatments that can be triaged to ensure quality and prevent unexpected member out-of-pocket expenses HMSA utilizes medical policies for review of prior authorization requests. Medical policies are developed using the clinical evidence found in published medical literature, standards of care, professional society	The majority of outpatient services such as partial hospitalization, intensive outpatient therapy and other office-based outpatient treatments do not require prior authorization. The only few MH/SUD services that require prior authorization are the Transcranial Magnetic Stimulation therapy and methadone maintenance treatment. Prior authorization is administered for the afore-mentioned MH/SUD treatments based on the medical evidence in published literatures, nationally recognized treatment guidelines or recommendations by various professional societies. Rationale for prior authorization requirement for the outpatient therapy is to ensure that patients meet the medical necessity, treatment duration is appropriate, risk of relapse is minimized, and the appropriate care coordination or case management services are provided.	The decision to apply prior authorization requirement for a particular medical/surgical or behavioral health outpatient service is based on factors identified in the industry standard utilization management standards. These factors include but are not limited to cost of treatment, procedures with extraordinary expense, variability in cost and quality, clinical efficacy of any proposed treatment or service, inconsistent adherence to practice guideline, care deemed experimental or investigational, and availability of alternative treatments with different costs. These factors apply to both M/S and MH/SUD outpatient treatments in a comparable manner in developing prior authorization requirements.	No issues found. **BH parity requirements met.**

guidelines, and community practitioners' input.			

Concurrent Review

5. 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?

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent reviews are not required once a prior authorization has been obtained for an outpatient M/S treatments. If continued treatment is medically necessary, HMSA conducts prior authorization reviews for subsequent treatment period(s).	Concurrent reviews are not required once a prior authorization has been obtained for outpatient MH/SUD treatments. If continued treatment is medically necessary, Beacon conducts prior authorization reviews for subsequent treatment period(s).	Concurrent reviews are not required for both M/S and MH/SUD services for treatment periods that have been approved by prior authorization reviews.	No issues found. **BH parity requirements met.**

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent reviews are not required once a prior authorization has been obtained for outpatient M/S services. If continued treatment is medically necessary, HMSA conducts prior authorization reviews for subsequent treatment period(s).	Concurrent reviews are not required once a prior authorization has been obtained for outpatient MH/SUD services. If continued treatment is medically necessary, Beacon conducts prior authorization reviews for subsequent treatment period(s).	Concurrent reviews are not required for both M/S and MH/SUD services for treatment periods that have been approved by prior authorization reviews.	No issues found. **BH parity requirements met.**

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable	Not applicable	Not applicable	N/A

Prescription Drugs

8. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Please refer to the NQTL – Prescription Drugs document			No issues found **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents:

1. HMSA-HSD001
2. 2018 Professional Cred Req_Physicians
3. 2018 Professional Cred Req_PT_Opt_Psychologists
4. 2018 Professional Cred Req_MFT_MHC
5. 2018 Professional Cred Req_LCSW

2018 Professional Cred Req_BCBA

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Providers must be appropriately licensed or certified in accordance with state and national guidelines, meet all standard educational and credentialing criteria for their specialty, not be an excluded entity with Medicare or Medicaid programs, and have met all continuing educational requirements specific to their provider type Provider must be willing to contract at sustainable rates and to submit all required documentation for both credentialing process and for system configuration for adjudication of provider claims. Provider onboarding process can be initiated either by the health Plan or Provider followed by execution of a contract between Plan and Provider for participation in one or more products. Plan monitors network needs on a regular basis in accordance with its practitioner availability policies and will initiate outreach to non-par Providers if network analysis shows a need in a specific geography. Also,	Providers must be appropriately licensed or certified in accordance with state and national guidelines, meet all standard educational and credentialing criteria for their specialty, not be an excluded entity with Medicare or Medicaid programs, and have met all continuing educational requirements specific to their provider type Provider must be willing to contract at sustainable rates and to submit all required documentation for both credentialing process and for system configuration for adjudication of provider claims. Provider onboarding process can be initiated either by the health Plan or Provider followed by execution of a contract between Plan and Provider for participation in one or more products. Plan monitors network needs on a regular basis in accordance with its practitioner availability policies and will initiate outreach to non-par Providers if network analysis shows a need in a specific geography. Also,	The processes and standards used in contracting and credentialing both medical/surgical and mental health/substance for outpatient providers are comparable and equally stringent.	No issues found. **BH parity requirements met.**

non-par Providers frequently initiate a request for participation. Plan will either respond and begin contracting process or politely decline if credentialing requirements are not met. Plan retains all rights to determine which providers it adds to its provider networks. HMSA has formal credentialing criteria and a Credentialing Committee. See the attached requirements documents: • Physicians (Medical Doctors, Osteopaths, Podiatrists and Oral Surgeons) 2018 HMSA Professional Credentialing Requirements • Physical Therapists, Optometrists, and Clinical Psychologists 2018 HMSA Professional Credentialing Requirements	non-par Providers frequently initiate a request for participation. Plan will either respond and begin contracting process or politely decline if credentialing requirements are not met. Plan retains all rights to determine which providers it adds to its provider networks. HMSA has formal credentialing criteria and a Credentialing Committee. See the attached requirements documents: • Marriage and Family Therapists and Mental Health Counselors 2017 HMSA Professional Credentialing Requirements • Clinical Social Workers 2018 HMSA Professional Credentialing Requirements • Physical Therapists, Optometrists, and Clinical Psychologists 2018 HMSA • Behavior Analysts 2018 HMSA Professional Credentialing Requirements		

10. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
HMSA does not have any exclusions pertaining to provider types, facility types, or specialty providers.	HMSA does not have any exclusions pertaining to provider types, facility types, or specialty providers.	Both sides do not have exclusions based on provider type, facility type, or specialty	No issues found. **BH parity requirements met.**

		providers and is therefore comparable and equally stringent.	

11. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no geographic limitations	There are no geographic limitations	Both sides do not have geographic limitations and is therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: QUEST Integration Member Handbook			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
QUEST Integration members have no out-of-network benefits except for emergencies. If a member is admitted for an emergent condition, no prior authorization or concurrent reviews are required until the time the member's condition is stabilized. If a member needs a treatment or service that is not available from network providers, exception can be made after a medical necessity review and verifying availability of comparable services within the network. If the out of network treatment is warranted, HMSA will contract with the out-of-network provider for a single case agreement.	QUEST Integration members have no out-of-network benefits except for emergencies. If a member is admitted for an emergent condition, no prior authorization or concurrent reviews are required until the time the member's condition is stabilized. If a member needs a treatment or service that is not available from network providers, exception can be made after a medical necessity review and verifying availability of comparable services within the network. If the out of network treatment is warranted, HMSA will contract with the out-of-network provider for a single case agreement.	The process determining access to out of network services is equally applied to both M/S and MH/SUD benefits. Once an exception is made, the same process is used in paying for M/S and MH/SUD out of network providers.	No issues found. **BH parity requirements met.**

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Initial fees were established at the beginning of the QUEST program in 1994. At that time, fees were established based on the Medicaid FFS schedule at that time. Since then increases or decreases were based on the reimbursement rates set by the state to the Insurance plans. Adjustments are made to the changes in coding that occur nationally. For ABD and Non-ABD, we primarily follow the Medicaid fee schedule. Some providers fees are individually negotiated. Psychiatrists and Psychologists are paid the same rate. Child Psychiatrists are paid 110% of the Psychiatrist fee. Social workers, Marriage Family Therapists, Mental health counselors, and APRNs are paid 85% of the psychiatrist rate.	Initial fees were established at the beginning of the QUEST program in 1994. At that time, fees were established based on the Medicaid FFS schedule at that time. Since then increases or decreases were based on the reimbursement rates set by the state to the Insurance plans. Adjustments are made to the changes in coding that occur nationally. For ABD and Non-ABD, we primarily follow the Medicaid fee schedule. Some providers fees are individually negotiated. Psychiatrists and Psychologists are paid the same rate. Child Psychiatrists are paid 110% of the Psychiatrist fee. Social workers, Marriage Family Therapists, Mental health counselors, and APRNs are paid 85% of the psychiatrist rate.	The processes and standards used in determining appropriate rates for Professional services for both medical/surgical and mental health/substance for outpatient providers are comparable and equally stringent.	No issues found. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Due to access issues, provider rates may be negotiated to help the rural	Due to access issues, provider rates may be negotiated to help the rural	The processes and standards used in determining appropriate rates for	No issues found.

areas. Individually negotiated rates are reviewed on a case-by-case basis and could match Medicare or commercial business.	areas. Individually negotiated rates are reviewed on a case-by-case basis and could match Medicare or commercial business.	professional services for both medical/surgical and mental health/substance for outpatient providers are comparable and equally stringent.	**BH parity requirements met.**

PRESCRIPTION DRUGS

Health Plan: HMSA Date: August 3, 2018
Contact Person: Micah Hu Email: Micah_hu@hmsa.com #: (808) 948-6587

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents:
1. CVS 2018 UM Program Description

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
HMSA's QUEST Integration formulary is based on the CVS Caremark National Managed Medicaid Template Formulary. The CVS Caremark National P&T Committee manages this formulary and reviews the safety and efficacy of each drug to determine formulary inclusion or exclusion. Decisions are based on evidenced-based medicine principles, well established clinical practice guidelines, scientific evidence, peer-reviewed medical literature, and standards of practice.	HMSA's QUEST Integration formulary is based on the CVS Caremark National Managed Medicaid Template Formulary. The CVS Caremark National P&T Committee manages this formulary and reviews the safety and efficacy of each drug to determine formulary inclusion or exclusion. Decisions are based on evidenced-based medicine principles, well established clinical practice guidelines, scientific evidence, peer-reviewed medical literature, and standards of practice.	The processes and standards used for formulary inclusion for both medical/surgical and mental health/substance are the same and therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

2. 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.

List of documents:
1. CVS 2018 UM Program Description

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

Fail first requirements or step therapy (ST) criteria are based on standards of medical practice, current clinical principles and processes of pharmacotherapy, evidence-based drug information, expert opinion, drug labeling, randomized clinical trials, pharmacoeconomic studies, and outcomes research data. All ST requirements are reviewed and approved by the CVS Caremark National P&T Committee. ST requirements are reviewed annually or more frequently when new indications or information become available.	Currently, there are no fail first requirements or ST on all MH/SUD drugs.	The processes and standards used for setting up fail first requirements or step therapies for both medical/surgical and mental health/substance are the same and therefore comparable and equally stringent. Currently, there are no fail first requirements or step therapies on any MH/SUD drugs and is therefore less stringent than MS. Parity is met.	No issues found. **BH parity requirements met.**

3. 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

List of documents:
1. MM.04.036_Hepatitis C
2. QI-1721 FFS 17-10_DAA drugs Hep C

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
According to HMSA's Hepatitis C Policy, a repeat treatment for hepatitis C medication will not be covered if a member had inadequate compliance resulting in failure to achieve a sustained viral response. HMSA's Hepatitis C Policy is based on QI-172, which requires a member to have 100% medication compliance with hepatitis C medications.	Currently, there are no exclusions based on failure to complete a course of treatment for MH/SUD drugs.	Currently, there are no exclusions based on failure to complete a course of treatment on any MH/SUD drugs and is therefore less stringent than MS. Parity is met.	No issues found. **BH parity requirements met.**

<u>Prior Authorization</u>

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: 1. CVS 2018 UM Program Description			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prior authorization (PA) helps promote safe and appropriate medication utilization. The goal is to ensure that the drug, dosing, and treatment duration are appropriate for the member. The CVS Caremark PA Center will collect information (e.g. diagnosis, previous medications, allergies, contraindications, etc) from the provider to determine whether the member meets the established criteria for the drug. PA criteria are based on standards of medical practice, current clinical principles and processes of pharmacotherapy, evidence-based drug information, expert opinion, drug labeling, randomized clinical trials, pharmacoeconomic studies, and outcomes research data. All PA requirements are reviewed and approved by the CVS Caremark National P&T Committee. PA requirements are reviewed annually or more frequently when new indications or information become available.	Currently, there are no PA requirements on all MH/SUD drugs.	Currently, there are no PA requirements on any MH/SUD drugs and is therefore less stringent than MS. Parity is met.	No issues found. **BH parity requirements met.**

Concurrent Review

5. 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?

List of documents: N/A			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation and/or Plan	State Review

	(MH/SUD)		
N/A	N/A	N/A	N/A

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: N/A			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents: N/A			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

Prescription Drugs

8. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
HMSA's QUEST Integration Formulary is not a tiered formulary.	HMSA's QUEST Integration Formulary is not a tiered formulary.	HMSA's QUEST Integration Formulary is not a tiered formulary.	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Every pharmacy must supply documentation, pass enrollment, and meet certification requirements prior to joining the pharmacy network. Enrollment requirements: - Provider Agreement (base contract) - Credentialing forms/answers to enrollment application questions - Copies of current state license(s) - Copy of DEA certificate - Copy of Liability policy - FWA training attestation - NCPDP and NPI - Network enrollment forms Credentialing verification process: - State Pharmacy and Pharmacist-In-Charge licenses (must be active, in-date, and in good standing) - Pharmacy's DEA license (must be active, in-date, and in good standing) - Pharmacy's NCPDP and NPI numbers - Liability policy (must be active and meet minimum coverage requirements)	Every pharmacy must supply documentation, pass enrollment, and meet certification requirements prior to joining the pharmacy network. Enrollment requirements: - Provider Agreement (base contract) - Credentialing forms/answers to enrollment application questions - Copies of current state license(s) - Copy of DEA certificate - Copy of Liability policy - FWA training attestation - NCPDP and NPI - Network enrollment forms Credentialing verification process: - State Pharmacy and Pharmacist-In-Charge licenses (must be active, in-date, and in good standing) - Pharmacy's DEA license (must be active, in-date, and in good standing) - Pharmacy's NCPDP and NPI numbers - Liability policy (must be active and meet minimum coverage requirements)	The processes and standards used for network admission for both medical/surgical and mental health/substance are the same and therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

- Pharmacy address - Exclusion searches (all officers, owners, entities, and managing employees are checked against the Federal OIG/SAM databases and State Medicaid exclusion lists - FWA training attestation (must be in-date and not set to expire within the next 30 days)	- Pharmacy address - Exclusion searches (all officers, owners, entities, and managing employees are checked against the Federal OIG/SAM databases and State Medicaid exclusion lists - FWA training attestation (must be in-date and not set to expire within the next 30 days)		

10. 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.

List of documents: N/A			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	No issues found. **BH parity requirements met.**

11. 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.

List of documents: [Please include most current version of the QI RFP].			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no geographic limitations HMSA has a sufficient network of pharmacies to ensure geographic pharmacy access standards (Section 40.240 of the Quest Integration RFP) are met.	There are no geographic limitations HMSA has a sufficient network of pharmacies to ensure geographic pharmacy access standards (Section 40.240 of the Quest Integration RFP) are met.	Both sides do not have geographic limitations and is therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Out-of-network pharmacy exceptions may occur if a member is on a trip out of state and needs access to medications or if a drug has limited distribution.	Out-of-network pharmacy exceptions may occur if a member is on a trip out of state and needs access to medications or if a drug has limited distribution.	The processes and standards used to determine out-of-network pharmacy exceptions for both medical/surgical and mental health/substance are the same and therefore comparable and equally stringent.	No issues found. **BH parity requirements met.**

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents: N/A			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents: N/A			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
N/A	N/A	N/A	N/A

EMERGENCY CARE

Health Plan: Kaiser Foundation Health Plan (Hawaii Region) Date: 3/2018
Contact Person: Cathy M. Makishima Email: kpqi@kp.org #:

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: -0-			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No medical necessity review is performed for emergency care.	No medical necessity review is performed for emergency care.	No medical necessity review is performed for emergency care for MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

2. 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.

List of documents: -0-			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed annually.	No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed annually	No step-therapy (aka "fail first") protocols are in place for both MS and MH/SUD coverage. There is one Kaiser Permanente Hawaii policy on Drug Formulary (#65-61-2.11) which uniformly applies to step-therapy (aka "fail first") requirements for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

3. 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

List of documents:-0-			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable for emergency care.	Not applicable for emergency care.	Not applicable for emergency care.	N/A

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents:-0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Pre-service authorization is not required for emergency care.	Pre-service authorization is not required for emergency care.	Pre-service authorization is not required for emergency care related to MS and MH/SUD coverage. The Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) applies to prior authorization for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

Concurrent Review

5. 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?

List of documents:-0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review is not required for emergency care.	Concurrent review is not required for emergency care.	Concurrent review is not required for emergency care related to MS and MH/SUD coverage.	No issues found **BH parity requirements met.**

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review is not required for emergency care.	Concurrent review is not required for emergency care.	Concurrent review is not required for emergency care related to MS and MH/SUD coverage.	No issues found **BH parity requirements met.**

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review is not required for emergency care.	Concurrent review is not required for emergency care.	Concurrent review is not required for emergency care related to MS and MH/SUD coverage.	No issues found **BH parity requirements met.**

Prescription Drugs

8. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prescription drug benefits are not tiered for Medicaid members.	Prescription drug benefits are not tiered for Medicaid members.	Prescription drug benefits are not tiered for Medicaid members.	No issues found **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable for emergency care.	Not applicable for emergency care.	Not applicable for emergency care.	N/A

10. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable for emergency care.	Not applicable for emergency care.	Not applicable for emergency care.	N/A

11. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable for emergency care.	Not applicable for emergency care.	Not applicable for emergency care.	N/A

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable for emergency care.	Not applicable for emergency care.	Not applicable for emergency care.	N/A

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable for emergency care.	Not applicable for emergency care.	Not applicable for emergency care.	N/A

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Professional provider reimbursement rates for emergency care are determined by Medicaid and Medicare fee schedules.	Professional provider reimbursement rates for emergency care are determined by Medicaid and Medicare fee schedules.	Professional provider reimbursement rates for M/S and MH/SUD emergency care providers are determined by Medicaid and Medicare fee schedules.	No issues found. **BH parity requirements met.**

INPATIENT

Health Plan: Kaiser Foundation Health Plan (Hawaii Region) Date: 3/2018
Contact Person: Cathy M Makishima Email: kpqi@kp.org #:

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502)			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Medical necessity/appropriateness determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Criteria for Adult and Pediatric; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502).	Medical necessity/appropriateness determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Level of Care Criteria (behavior health volumes); - ASAM (American Society of Addiction Medicine) Criteria; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-	There is one Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) with guidance which applies to medical necessity/appropriateness determinations for both MS and MH/SUD coverage. Relevant InterQual Criteria, Medicare guidelines and Medicaid guidelines are referenced as medical necessity and appropriateness criteria for both MS and MH/SUD coverage. Frequency of inpatient concurrent review is very similar for MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

Concurrent review and authorization for continued coverage during inpatient acute hospitalization is performed every 1-3 days. (Note: When member is confined to an out-of-state inpatient facility, there may be occasional concurrent review delays pending receipt of requested concurrent medical information. Concurrent reviews will be performed when information is received.) Concurrent review and authorization for continued coverage in an alternate inpatient setting (e.g., SNF) is performed every 7-14 days. Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness.	502). Concurrent review and authorization for continued coverage during inpatient acute hospitalization is performed every 2 days. (Note: When member is confined to an out-of-state inpatient facility, there may be occasional concurrent review delays pending receipt of requested concurrent medical information. Concurrent reviews will be performed when information is received.) Concurrent review and authorization for continued coverage in an alternate inpatient setting (e.g., residential treatment) is performed every 14 days. Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness. A psychiatrist reviews any denial of behavioral health care that is based on medical necessity.		

2. 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.

List of documents: Kaiser Permanente Hawaii policy on Drug Formulary (#65-61-2.11)-0-			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed	No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed annually.	No step-therapy (aka "fail first") protocols are in place for both MS and MH/SUD coverage. There is one Kaiser Permanente Hawaii policy on Drug Formulary	No issues found. **BH parity requirements met.**

annually.		(#65-61-2.11) which uniformly applies to step-therapy (aka "fail first") requirements for both MS and MH/SUD coverage.	

3. 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

List of documents: -0-			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no health plan exclusions based on failure to complete a course of treatment.	There are no exclusions based on failure to complete a course of treatment.	There are no exclusions based on failure to complete a course of treatment for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Pre-service authorization is not required for emergent inpatient hospitalizations. Pre-service authorization is required for inpatient rehabilitative treatment. Urgent pre-service decisions for Medicaid members are communicated within 3 business days of request receipt. Non-urgent pre-service decisions are	Pre-service authorization is not required for emergent inpatient hospitalizations. Pre-service authorization is required for residential/inpatient rehabilitative treatment. Urgent pre-service decisions for Medicaid members are communicated within 3 business days of request receipt. Non-urgent	There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance applies to prior authorization and medical necessity determinations for both MS and MH/SUD coverage. Essentially the same processes, decision-making accountabilities, and timelines are applied for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

communicated within 14 calendar days of request receipt. Medicaid members are allowed up to a 14-calendar day extension if they, or the provider, requests the extension or if the health plan justifies the need for an extension and it's in the member's interest. Members are informed of the right to file a grievance if they disagree with the need for an extension. Approvals are the responsibility of the Clinical Chief (or designee). Board certified physicians from appropriate specialty areas assist in making determination of medical and clinical appropriateness. Only licensed physicians can make medical necessity denial determinations. Determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Criteria for Adult and Pediatric; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes also guided by the Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and	pre-service decisions are communicated within 14 calendar days of request receipt. Medicaid members are allowed up to a 14-calendar day extension if they, or the provider, requests the extension or if the health plan justifies the need for an extension and it's in the member's interest. Members are informed of the right to file a grievance if they disagree with the need for an extension. Approvals are the responsibility of the Clinical Chief (or designee). Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness. Only licensed physicians can make medical necessity denial determinations. A psychiatrist reviews any denial of behavioral health care that is based on medical necessity. Determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Level of Care Criteria (behavior health volumes); - ASAM (American Society of Addiction Medicine) Criteria; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated	Relevant InterQual Criteria, Medicare guidelines and Medicaid guidelines are referenced as medical necessity and appropriateness criteria for both MS and MH/SUD coverage.	

Out-of-Plan Requests for Care and Services (#5054-01-A).	within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. There are no requirements for treatment plans before a member receives MH/SUD services. Processes also guided by the Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A).		

Concurrent Review

5. 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?

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Selection of services designated for concurrent review are determined after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Criteria for Adult and Pediatric; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii	Selection of services designated for concurrent review are determined after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Level of Care Criteria (behavior health volumes); - ASAM (American Society of Addiction Medicine) Criteria; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and	Relevant InterQual Criteria, Medicare guidelines and Medicaid guidelines are referenced as medical necessity and appropriateness criteria related to concurrent review for both MS and MH/SUD coverage. There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance applies to concurrent review for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A).	- Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A).		

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review processes are determined for each case after evaluation of clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Criteria for Adult and Pediatric; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy	Concurrent review processes are determined for each case after evaluation of clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Level of Care Criteria (behavior health volumes); - ASAM (American Society of Addiction Medicine) Criteria; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review	Relevant InterQual Criteria, Medicare guidelines and Medicaid guidelines are referenced as medical necessity and appropriateness criteria related to concurrent review for both MS and MH/SUD coverage. There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance applies to concurrent review for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Concurrent review denial rate and appeal overturn rate were 0% during annual period ending June 2018.	are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Concurrent review denial rate was 0.008% and appeal overturn rate was 0% during annual period ending June 2018.		

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review during inpatient acute hospitalization is performed every 1-3 days. (Note: When member is confined to an out-of-state inpatient facility, there may be occasional concurrent review delays pending receipt of requested concurrent medical information. Concurrent reviews will be performed when information is received.) Concurrent review in an alternate inpatient setting (e.g., SNF) is performed every 7-14 days. Processes and frequency of review are guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A).	Concurrent review and authorization for continued coverage during inpatient acute hospitalization is performed every 2 days. (Note: When member is confined to an out-of-state inpatient facility, there may be occasional concurrent review delays pending receipt of requested concurrent medical information. Concurrent reviews will be performed when information is received.) Concurrent review and authorization for continued coverage in an alternate inpatient setting (e.g., residential treatment) is performed every 14 days. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy	There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance applies to concurrent review for both MS and MH/SUD coverage. Frequency of inpatient concurrent review is very similar for MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

	on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A).		

Prescription Drugs

8. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prescription drug benefits are not tiered for Medicaid members.	Prescription drug benefits are not tiered for Medicaid members.	Prescription drug benefits are not tiered for Medicaid members.	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Kaiser Permanente Hawaii Region (KP) is an integrated model of care which provides 97% of KP member care via its employed providers and facilities. To augment KP's internal care delivery system, KP contracts with specialized service providers, both within and outside the State of Hawaii. Network admission requirements are comprised of several factors which	Kaiser Permanente Hawaii Region (KP) is an integrated model of care which provides 97% of KP member care via its employed providers and facilities. To augment KP's internal care delivery system, KP contracts with specialized service providers, both within and outside the State of Hawaii. Network admission requirements are comprised of several factors which	Network admission requirements and processes are comparable for M/S and MH/SUD providers.	No issues found. **BH parity requirements met.**

vary according to the service provider. These factors include appropriate licensing, accreditation, good standing against government agency listings of excluded individuals/entities, education, training, board qualification, certification, reference checks, background checks, interviews with relevant departments, agreement to maintain compliance with requirements and code of ethics, acceptance of offered compensation, and other factors. Initial evaluation of a provider is performed by the Provider Relations and Contracting representative and/or physician/provider recruiter and/or department physician chief who reviews the application, checks references, and interviews the applicant provider. Further interviews are conducted and recommendations to leadership are made. Credentialing occurs thereafter with National Provider Identification confirmation, primary source verification, background checks, and a Medicare/Medicaid status query to ensure avoidance of providers who have been excluded from participation by the U.S. Department of Health and Human Services Office of Inspector General, Section 1128 (including Section 1128A) of the Social Security Act, and/or by the State Department of Human Services (DHS) from participating in the Medicaid program. Findings are evaluated by credentialing staff and committee prior to hiring/contracting.	vary according to the service provider. These factors include appropriate licensing, accreditation, good standing against government agency listings of excluded individuals/entities, education, training, board qualification, certification, reference checks, background checks, interviews with relevant departments, agreement to maintain compliance with requirements and code of ethics, acceptance of offered compensation, and other factors. Initial evaluation of a provider is performed by the Provider Relations and Contracting representative and/or physician/provider recruiter and/or department physician chief who reviews the application, checks references, and interviews the applicant provider. Further interviews are conducted and recommendations to leadership are made. Credentialing occurs thereafter with National Provider Identification confirmation, primary source verification, background checks, and a Medicare/Medicaid status query to ensure avoidance of providers who have been excluded from participation by the U.S. Department of Health and Human Services Office of Inspector General, Section 1128 (including Section 1128A) of the Social Security Act, and/or by the State Department of Human Services (DHS) from participating in the Medicaid program. Findings are evaluated by credentialing staff and committee prior to hiring/contracting.		

KP refers to the Medicaid network adequacy requirements within the State of Hawaii Department of Human Services RFP-MQD-2014-005: 	Minutes of drive time	Urban	Rural
---	---	---
PCP	30	60
Specialist	30	60
Hospital	30	60
Emergency Facility	30	60
Mental Health	30	60
Pharmacy	15	60
24-Hour Pharmacy	60	N/A		KP refers to the Medicaid network adequacy requirements within the State of Hawaii Department of Human Services RFP-MQD-2014-005: | Minutes of drive time	Urban	Rural
---	---	---
PCP	30	60
Specialist	30	60
Hospital	30	60
Emergency Facility	30	60
Mental Health	30	60
Pharmacy	15	60
24-Hour Pharmacy	60	N/A		

10. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No practitioner types, facility types, or specialty providers are specifically excluded from eligibility to enter into contracting consideration toward providing covered benefit services.	No practitioner types, facility types, or specialty providers are specifically excluded from eligibility to enter into contracting consideration toward providing covered benefit services.	No practitioner types, facility types, or specialty providers are specifically excluded from eligibility to enter into contracting consideration toward providing M/S and MH/SUD covered benefit services.	No issues found. **BH parity requirements met.**

11. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

Assuming the provider is within the U.S.A., there are no geographic limitations on provider inclusion. Each provider candidate's geographic area is considered in relation to the needs of the health plan's membership within that geographic area and Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005.	Assuming the provider is within the U.S.A., there are no geographic limitations on provider inclusion. Each provider candidate's geographic area is considered in relation to the needs of the health plan's membership within that geographic area and Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005.	Assuming the provider is within the U.S.A., there are no geographic limitations on M/S and MH/SUD provider inclusion.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Physician evaluates member. If out-of-plan referral appears appropriate, physician completes an order for the request. Department Chief receives referral request and performs evaluation/determination. Medical necessity approval from the Outside Medical Services Medical Director or other appropriate Department Chief /Designee is required for the following types of referral requests: • Requests for services from non-credentialed providers; • Requests for mainland/out of	Integrated Behavioral Health (IBH) Call Center receives calls and conducts initial screening and triage according to established IBH protocol which may result in the following action: • Appoint member with plan provider within established timeframe guidelines; • Direct member to a Treatment Team (Adult, Child or Chemical Dependency) for an assessment if member requests out-of-plan (OOP) service or meets criteria for OOP referral; • Direct member to IBH UM Coordinator if IBH services are not appropriate for	There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance applies to both MS and MH/SUD coverage. Process flow of evaluation and out-of-plan referral approval/denial tasks are generally the same for M/S and MH/SUD coverage. Specific operational routing of referral request varies between M/S and MH/SUD due to the respective member care needs, required specialty expertise and differing organizational structure within the M/S and MH/SUD departments. Referral criteria used in the utilization management of behavioral health out-of-plan referrals are no more restrictive	No issues found. **BH parity requirements met.**

area services; • Experimental treatments/therapies; • Requests for services where there is internal capability; • Requests for transplantation services. Medical necessity determination is referred to Authorizations and Referral Management (ARM). If medical necessity is approved, ARM reviews request to ensure that referral guidelines and criteria are met: • The requested service is certified as medically necessary by Chief/Designee; • The service is a covered Health Plan benefit; • The requested service is not available within Plan; • The patient is an eligible Health Plan member; • The patient has benefits available • Referral parameters (frequency/ duration) are clearly defined; and • Selected provider/ practitioner is credentialed or has Letter of Agreement with health plan. If criteria met, ARM will generate the authorization, notify the receiving provider, notify the	member; or • If IBH lacks capacity and waiting period for an intake is excessive as determined by prudent medical care, the IBH Call Center practitioner will request an OOP referral approval from an IBH physician. IBH physician will make medical necessity determination and refer case to IBH Utilization Management (UM). If approved, IBH UM reviews referral request to ensure that referral guidelines and criteria are met: • The requested service is medically necessary; • The requested service is a covered Health Plan benefit; • The requested service is not available within Plan; • The service is available within plan but the waiting period is excessive as defined by prudent medical care or established regional access standards; • The patient is an eligible Health Plan member; • The patient has benefits available • Referral parameters (frequency/duration/ intensity) are clearly defined; • Selected provider/practitioner is credentialed by	than the criteria applied to medical/surgical benefits per Federal Mental Health Parity Law	

requesting practitioner of the approval, and generate a notification letter to the member. Only licensed physicians can make medical necessity denial determinations.	Plan; • Selected provider is available to see the patient. If criteria met, IBH UM will generate the authorization, notify the receiving provider, notify the requesting practitioner of the approval, and generate a notification letter to the member. A psychiatrist reviews any denial of behavioral health care that is based on medical necessity.		

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable for inpatient.	Not applicable for inpatient.	Not applicable for inpatient.	N/A

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
In this island State of Hawaii, provider supply and demand in target geographic areas of need is a primary influencer of professional provider reimbursement rates. While the Medicaid fee schedule is considered, the actual provider reimbursement rates may be higher.	In this island State of Hawaii, provider supply and demand in target geographic areas of need is a primary influencer of professional provider reimbursement rates. While the Medicaid fee schedule is considered, the actual provider reimbursement rates may be higher.	Provider reimbursement rate determination is comparable for M/S and MH/SUD providers.	No issues found. **BH parity requirements met.**

Beyond the issues related to supply and demand, professional provider reimbursement rates are not specifically impacted by service type, practice size, and licensure.	Beyond the issues related to supply and demand, professional provider reimbursement rates are not specifically impacted by service type, practice size, and licensure.		

OUTPATIENT

Health Plan: Kaiser Foundation Health Plan (Hawaii Region) Date: 3/2018
Contact Person: Cathy M Makishima Email: kpqi@kp.org #:

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) KPHI Clinical Practice Guidelines and Clinical Practice Recommendation (#6403-20)			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Medical necessity/appropriateness determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502).	Medical necessity/appropriateness determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Level of Care Criteria (behavior health volumes); - ASAM (American Society of Addiction Medicine) Criteria; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente	There is one Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) with guidance which applies to medical necessity/appropriateness determinations for both MS and MH/SUD coverage. Relevant InterQual Criteria, Medicare guidelines, Medicaid guidelines and clinical guidelines are referenced as medical necessity and appropriateness criteria for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

Concurrent review and authorization is not generally performed for outpatient services. A case may be reviewed if an extension is requested for pre-authorized services. Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness.	Hawaii Region policy on Utilization Decisions (#6425-502). Concurrent review and authorization for continued coverage is performed every 12 sessions. Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness. A psychiatrist reviews any denial of behavioral health care that is based on medical necessity.		

2. 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.

List of documents: Kaiser Permanente Hawaii policy on Drug Formulary (#65-61-2.11)			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed annually.	No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed annually.	No step-therapy (aka "fail first") protocols are in place for both MS and MH/SUD coverage. There is one Kaiser Permanente Hawaii policy on Drug Formulary (#65-61-2.11) which uniformly applies to step-therapy (aka "fail first") requirements for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

3. 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

List of documents: -0-			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no exclusions based on failure to complete a course of treatment.	There are no exclusions based on failure to complete a course of treatment.	There are no exclusions based on failure to complete a course of treatment for both MS	No issues found.

		and MH/SUD coverage.	**BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Pre-service authorization is not required for in-plan outpatient rehabilitative service. Pre-service authorization is required for out-of-plan outpatient rehabilitative service. Urgent pre-service decisions for Medicaid members are communicated within 3 business days of request receipt. Non-urgent pre-service decisions are communicated within 14 calendar days of request receipt. Medicaid members are allowed up to a 14-calendar day extension if they, or the provider, requests the extension or if the health plan justifies the need for an extension and it's in the member's interest. Members are informed of the right to file a grievance if they disagree with the need for an extension. Approvals are the responsibility of the Clinical Chief (or designee). Board certified physicians from appropriate specialty areas assist in making determination of medical and clinical	Pre-service authorization is not required for in-plan outpatient rehabilitative service. Pre-service authorization is required for out-of-plan outpatient rehabilitative service. Urgent pre-service decisions for Medicaid members are communicated within 3 business days of request receipt. Non-urgent pre-service decisions are communicated within 14 calendar days of request receipt. Medicaid members are allowed up to a 14-calendar day extension if they, or the provider, requests the extension or if the health plan justifies the need for an extension and it's in the member's interest. Members are informed of the right to file a grievance if they disagree with the need for an extension. Approvals are the responsibility of the Clinical Chief (or designee). Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and	There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance applies to prior authorization and medical necessity determinations for both MS and MH/SUD coverage. Essentially the same processes, decision-making accountabilities, and timelines are applied for both MS and MH/SUD coverage. Relevant InterQual Criteria, Medicare guidelines and Medicaid guidelines are referenced as medical necessity and appropriateness criteria for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

appropriateness. Only licensed physicians can make medical necessity denial determinations. Determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes also guided by the Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). There are no requirements for written treatment plans before a member receives services.	clinical appropriateness. Only licensed physicians can make medical necessity denial determinations. A psychiatrist reviews any denial of behavioral health care that is based on medical necessity. Determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Level of Care Criteria (behavior health volumes); - ASAM (American Society of Addiction Medicine) Criteria; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes also guided by the Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). There are no requirements for written treatment plans before a member receives MH/SUD services.		

Concurrent Review

5. 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?

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review and authorization is not generally performed for outpatient services. A case may be reviewed if an extension is requested for pre-authorized services. Reviews consider clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502). Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness.	Concurrent review and authorization for continued coverage is performed every 12 sessions Reviews consider clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Level of Care Criteria (behavior health volumes); - ASAM (American Society of Addiction Medicine) Criteria; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502). Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness. A psychiatrist reviews any denial of behavioral health care that is based on medical necessity.	Relevant criteria, Medicare guidelines and Medicaid guidelines are referenced during concurrent review for MS and MH/SUD coverage. There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance applies to concurrent review for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review processes are determined for each case after evaluation of clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD-2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decision Requests for Care and Services (#5054-01-A).s (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness. Concurrent review denial rate was 0.016% and appeal overturn rate was	Concurrent review and authorization for continued coverage is performed every 12 sessions Reviews consider clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Level of Care Criteria (behavior health volumes); - ASAM (American Society of Addiction Medicine) Criteria; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502). Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty	Relevant criteria, Medicare guidelines and Medicaid guidelines are referenced during concurrent review for MS and MH/SUD coverage. There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance applies to concurrent review for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

0% during annual period ending June 2018.	areas are used to assist in making determination of medical and clinical appropriateness. A psychiatrist reviews any denial of behavioral health care that is based on medical necessity.		

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents: Kaiser Permanente Hawaii Region Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review and authorization is not generally performed for outpatient services. A case may be reviewed if an extension is requested for pre-authorized services.	Concurrent review and authorization for continued coverage is performed every 12 sessions	There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance applies to concurrent review for both MS and MH/SUD coverage. Frequency of concurrent review for MS and MH/SUD coverage is guided by the policies and appropriate for care delivered under each specialty.	No issues found. **BH parity requirements met.**

Prescription Drugs

8. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prescription drug benefits are not tiered for Medicaid members.	Prescription drug benefits are not tiered for Medicaid members.	Prescription drug benefits are not tiered for Medicaid members.	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: Kaiser Permanente Hawaii Region policies on Selecting and Contracting Affiliated Health Delivery Organizations and Licensed Independent Practitioners (#5054-02A); and Credentialing and Privileging Policy and Procedure (#6226-02-P)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Kaiser Permanente Hawaii Region (KP) is an integrated model of care which provides 97% of KP member care via its employed providers and facilities. To augment KP's internal care delivery system, KP contracts with specialized service providers, both within and outside the State of Hawaii. Network admission requirements are comprised of several factors which vary according to the service provider. These factors include appropriate licensing, accreditation, good standing against government agency listings of excluded individuals/entities, education, training, board qualification, certification, reference checks, background checks, interviews with relevant departments, agreement to maintain compliance with requirements and code of ethics, acceptance of offered compensation, and other factors. Initial evaluation of a provider is performed by the Provider Relations and Contracting representative	Kaiser Permanente Hawaii Region (KP) is an integrated model of care which provides 97% of KP member care via its employed providers and facilities. To augment KP's internal care delivery system, KP contracts with specialized service providers, both within and outside the State of Hawaii. Network admission requirements are comprised of several factors which vary according to the service provider. These factors include appropriate licensing, accreditation, good standing against government agency listings of excluded individuals/entities, education, training, board qualification, certification, reference checks, background checks, interviews with relevant departments, agreement to maintain compliance with requirements and code of ethics, acceptance of offered compensation, and other factors. Initial evaluation of a provider is performed by the Provider Relations and Contracting representative and/or physician/provider recruiter and/or department physician chief who reviews the application, checks	Network admission requirements and processes are comparable for M/S and MH/SUD providers.	No issues found. **BH parity requirements met.**

and/or physician/provider recruiter and/or department physician chief who reviews the application, checks references, and interviews the applicant provider. Further interviews are conducted and recommendations to leadership are made. Credentialing occurs thereafter with National Provider Identification confirmation, primary source verification, background checks, and a Medicare/Medicaid status query to ensure avoidance of providers who have been excluded from participation by the U.S. Department of Health and Human Services Office of Inspector General, Section 1128 (including Section 1128A) of the Social Security Act, and/or by the State Department of Human Services (DHS) from participating in the Medicaid program. Findings are evaluated by credentialing staff and committee prior to hiring/contracting. KP refers to the Medicaid network adequacy requirements within the State of Hawaii Department of Human Services RFP-MQD-2014-005: Minutes of drive time / Urban / Rural PCP 30 60 Specialist 30 60 Hospital 30 60 Emergency Facility 30 60 Mental Health 30 60	references, and interviews the applicant provider. Further interviews are conducted and recommendations to leadership are made. Credentialing occurs thereafter with National Provider Identification confirmation, primary source verification, background checks, and a Medicare/Medicaid status query to ensure avoidance of providers who have been excluded from participation by the U.S. Department of Health and Human Services Office of Inspector General, Section 1128 (including Section 1128A) of the Social Security Act, and/or by the State Department of Human Services (DHS) from participating in the Medicaid program. Findings are evaluated by credentialing staff and committee prior to hiring/contracting. KP refers to the Medicaid network adequacy requirements within the State of Hawaii Department of Human Services RFP-MQD-2014- 005: Minutes of drive time / Urban / Rural PCP 30 60 Specialist 30 60 Hospital 30 60 Emergency Facility 30 60 Mental Health 30 60		

10. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No practitioner types, facility types, or specialty providers are specifically excluded from eligibility to enter into contracting consideration toward providing covered benefit services.	No practitioner types, facility types, or specialty providers are specifically excluded from eligibility to enter into contracting consideration toward providing covered benefit services.	No practitioner types, facility types, or specialty providers are specifically excluded from eligibility to enter into contracting consideration toward providing M/S and MH/SUD covered benefit services.	No issues found. **BH parity requirements met.**

11. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Assuming the provider is within the U.S.A., there are no geographic limitations on provider inclusion. Each provider candidate's geographic area is considered in relation to the needs of the health plan's membership within that geographic area and Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005.	Assuming the provider is within the U.S.A., there are no geographic limitations on provider inclusion. Each provider candidate's geographic area is considered in relation to the needs of the health plan's membership within that geographic area and Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005.	Assuming the provider is within the U.S.A., there are no geographic limitations on M/S and MH/SUD provider inclusion.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Physician evaluates member. If out-of-plan referral appears appropriate, physician completes an order for the request. Department Chief receives referral request and performs evaluation/determination. Medical necessity approval from the Outside Medical Services Medical Director or other appropriate Department Chief /Designee is required for the following types of referral requests: • Requests for services from non-credentialed providers; • Requests for mainland/out of area services; • Experimental treatments/therapies; • Requests for services where there is internal capability; • Requests for transplantation services. Medical necessity determination is referred to Authorizations and Referral Management (ARM). If medical necessity is approved, ARM reviews request to ensure that referral guidelines and criteria are met: • The requested service is certified as medically necessary by Chief/Designee; • The service is a covered Health Plan benefit; • The requested service is not available within Plan;	Integrated Behavioral Health (IBH) Call Center receives calls and conducts initial screening and triage according to established IBH protocol which may result in the following action: Appoint member with plan provider within established timeframe guidelines; Direct member to a Treatment Team (Adult, Child or Chemical Dependency) for an assessment if member requests out-of-plan (OOP) service or meets criteria for OOP referral; Direct member to IBH UM Coordinator if IBH services are not appropriate for member; or If IBH lacks capacity and waiting period for an intake is excessive as determined by prudent medical care, the IBH Call Center practitioner will request an OOP referral approval from an IBH physician. IBH physician will make medical necessity determination and refer case to IBH Utilization Management (UM). If approved, IBH UM reviews referral request to ensure that referral guidelines and criteria are met: • The requested service is medically necessary; • The requested service is a covered Health Plan benefit; • The requested service is not available within Plan; • The service is available within plan but the waiting period is excessive as defined by	There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance applies to both MS and MH/SUD coverage. Process flow of evaluation and out-of-plan referral approval/denial tasks are generally the same for M/S and MH/SUD coverage. Specific operational routing of referral request varies between M/S and MH/SUD due to the respective member care needs, required specialty expertise and differing organizational structure within the M/S and MH/SUD departments. Referral criteria used in the utilization management of behavioral health out-of- plan referrals are no more restrictive than the criteria applied to medical/surgical benefits per Federal Mental Health Parity Law.	No issues found. **BH parity requirements met.**

• The patient is an eligible Health Plan member; • The patient has benefits available • Referral parameters (frequency/ duration) are clearly defined; and • Selected provider/ practitioner is credentialed or has Letter of Agreement with health plan. If criteria met, ARM will generate the authorization, notify the receiving provider, notify the requesting practitioner of the approval, and generate a notification letter to the member. Only licensed physicians can make medical necessity denial determinations.	prudent medical care or established regional access standards; • The patient is an eligible Health Plan member; • The patient has benefits available • Referral parameters (frequency/duration/ intensity) are clearly defined; • Selected provider/practitioner is credentialed by Plan; • Selected provider is available to see the patient. If criteria met, IBH UM will generate the authorization, notify the receiving provider, notify the requesting practitioner of the approval, and generate a notification letter to the member. A psychiatrist reviews any denial of behavioral health care that is based on medical necessity		

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
In this island State of Hawaii, provider supply and demand in target geographic areas of need is a primary influencer of professional provider reimbursement rates for physicians,	In this island State of Hawaii, provider supply and demand in target geographic areas of need is a primary influencer of professional provider reimbursement rates for physicians,	Provider reimbursement rate determination is comparable for M/S and MH/SUD providers.	No issues found. **BH parity requirements met.**

PhD, MA and other professionals. While the Medicaid fee schedule is considered, the actual provider reimbursement rates may be higher. Beyond the issues related to supply and demand, professional provider reimbursement rates are not specifically impacted by service type, practice size, and licensure.	PhD, MA and other professionals. While the Medicaid fee schedule is considered, the actual provider reimbursement rates may be higher. Beyond the issues related to supply and demand, professional provider reimbursement rates are not specifically impacted by service type, practice size, and licensure.		

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
In this island State of Hawaii, provider supply and demand in target geographic areas of need is a primary influencer of professional provider reimbursement rates. While the Medicaid fee schedule is considered, the actual provider reimbursement rates may be higher. Beyond the issues related to supply and demand, professional provider reimbursement rates are not specifically impacted by service type, practice size, and licensure.	In this island State of Hawaii, provider supply and demand in target geographic areas of need is a primary influencer of professional provider reimbursement rates. While the Medicaid fee schedule is considered, the actual provider reimbursement rates may be higher. Beyond the issues related to supply and demand, professional provider reimbursement rates are not specifically impacted by service type, practice size, and licensure.	Provider reimbursement rate determination is comparable for M/S and MH/SUD providers.	No issues found. **BH parity requirements met.**

PRESCRIPTION DRUGS

Health Plan: Kaiser Foundation Health Plan (Hawaii Region) Date: 3/2018
Contact Person: Cathy M Makishima Email: kpqi@kp.org #:

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: Kaiser Permanente Hawaii Region policies on Drug Formulary (#65-61-2.11) and Drug Formulary Exception Process (#65-61-2.11a)			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The health plan does not establish medical necessity criteria for prescription drugs. The prescriber makes the final decision regarding what drug is medically necessary and appropriate for the member. If that drug is not on the formulary, the prescriber submits the prescription/order for the non-formulary drug to a Kaiser Permanente (KP) pharmacy. The pharmacist and prescriber may collaborate on evaluating the circumstances for considering the non-formulary drug, assessing the member's need for the non-formulary drug, and determining if a comparable formulary drug or over the counter drug can be considered for use. If the prescriber determines that a non-formulary drug must be utilized, then the health plan covers the non-formulary drug per the member's benefit plan.	The health plan does not establish medical necessity criteria for prescription drugs. The prescriber makes the final decision regarding what drug is medically necessary and appropriate for the member. If that drug is not on the formulary, the prescriber submits the prescription/order for the non-formulary drug to a Kaiser Permanente (KP) pharmacy. The pharmacist and prescriber may collaborate on evaluating the circumstances for considering the non-formulary drug, assessing the member's need for the non-formulary drug, and determining if a comparable formulary drug or over the counter drug can be considered for use. If the prescriber determines that a non-formulary drug must be utilized, then the health plan covers the non-formulary drug per the member's benefit plan.	There are two Kaiser Permanente Hawaii Region policies on Drug Formulary (#65-61-2.11) and Drug Formulary Exception Process (#65-61-2.11a). Policy guidance applies to medical necessity determinations related to prescription drugs for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

2. 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.

List of documents: Kaiser Permanente Hawaii policy on Drug Formulary (#65-61-2.11)			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed annually.	No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed annually.	No step-therapy (aka "fail first") protocols are in place for both MS and MH/SUD coverage. There is one Kaiser Permanente Hawaii policy on Drug Formulary (#65-61-2.11) which uniformly applies to step-therapy (aka "fail first") requirements for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

3. 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

List of documents: -0-			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no exclusions based on failure to complete a course of treatment.	There are no exclusions based on failure to complete a course of treatment.	There are no exclusions based on failure to complete a course of treatment for both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prior authorization is not required for prescription drug coverage by health	Prior authorization is not required for prescription drug coverage by health	Health plan does not require prior authorization for prescription drug	No issues found.

plan.	plan.	coverage related to MS and MH/SUD drug therapy.	**BH parity requirements met.**

Concurrent Review

5. 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?

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review of prescribed drugs is not required for continued health plan coverage.	Concurrent review of prescribed drugs is not required for continued health plan coverage.	Concurrent review of prescribed drugs is not required for continued health plan coverage related to MS and MH/SUD drug therapy.	No issues found. **BH parity requirements met.**

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review of prescribed drugs is not required for continued health plan coverage.	Concurrent review of prescribed drugs is not required for continued health plan coverage.	Concurrent review of prescribed drugs is not required for continued health plan coverage related to MS and MH/SUD drug therapy.	No issues found. **BH parity requirements met.**

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review of prescribed drugs is not required for continued health plan coverage.	Concurrent review of prescribed drugs is not required for continued health plan coverage.	Concurrent review of prescribed drugs is not required for continued health plan coverage related to MS and MH/SUD drug	No issues found. **BH parity requirements met.**

		therapy.	

Prescription Drugs

8. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prescription drug benefits are not tiered for Medicaid members.	Prescription drug benefits are not tiered for Medicaid members.	Prescription drug benefits are not tiered for Medicaid members.	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable for prescription drugs.	Not applicable for prescription drugs.	Not applicable for prescription drugs.	N/A

10. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable for prescription drugs.	Not applicable for prescription drugs.	Not applicable for prescription drugs.	N/A

11. 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.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Assuming the pharmacy provider is within the U.S.A., there are no geographic limitations on provider inclusion.	Assuming the pharmacy provider is within the U.S.A., there are no geographic limitations on provider inclusion.	Assuming the pharmacy provider is within the U.S.A., there are no geographic limitations on M/S and MH/SUD provider inclusion.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A)			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Physician prescriber evaluates member. If out-of- plan referral appears appropriate, physician completes an order for the request. Department Chief receives referral request and performs evaluation/determination. Medical necessity approval from the Outside Medical Services Medical Director or other appropriate Department Chief /Designee is required for the following types of referral requests: • Requests for services from non- credentialed providers; • Requests for mainland/out of area services; • Experimental treatments/therapies; • Requests for services where there is internal capability;	Physician prescriber evaluates member. If out-of- plan referral appears appropriate, physician completes an order for the request. Department Chief receives referral request and performs evaluation/determination. Medical necessity approval from the Outside Medical Services Medical Director or other appropriate Department Chief /Designee is required for the following types of referral requests: • Requests for services from non- credentialed providers; • Requests for mainland/out of area services; • Experimental treatments/therapies; • Requests for services where there is internal capability;	There are two Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Policy guidance for out-of-plan pharmacy utilization applies to both MS and MH/SUD coverage.	No issues found. **BH parity requirements met.**

• Requests for transplantation services. Medical necessity determination is referred to Authorizations and Referral Management (ARM). If medical necessity is approved, ARM reviews request to ensure that referral guidelines and criteria are met: • The requested service is certified as medically necessary by Chief/Designee; • The service is a covered Health Plan benefit; • The requested service is not available within Plan; • The patient is an eligible Health Plan member; • The patient has benefits available • Referral parameters (frequency/ duration) are clearly defined; and • Selected provider/ practitioner is credentialed or has Letter of Agreement with health plan. If criteria met, ARM will generate the authorization, notify the receiving provider, notify the requesting practitioner of the approval, and generate a notification letter to the member. Only licensed physicians can make medical necessity denial determinations.	• Requests for transplantation services. Medical necessity determination is referred to Authorizations and Referral Management (ARM). If medical necessity is approved, ARM reviews request to ensure that referral guidelines and criteria are met: • The requested service is certified as medically necessary by Chief/Designee; • The service is a covered Health Plan benefit; • The requested service is not available within Plan; • The patient is an eligible Health Plan member; • The patient has benefits available • Referral parameters (frequency/ duration) are clearly defined; and • Selected provider/ practitioner is credentialed or has Letter of Agreement with health plan. If criteria met, ARM will generate the authorization, notify the receiving provider, notify the requesting practitioner of the approval, and generate a notification letter to the member. Only licensed physicians can make medical necessity denial determinations.		

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents: -0-

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Not applicable for prescription drugs.	Not applicable for prescription drugs.	Not applicable for prescription drugs.	N/A

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents: -0-			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Not applicable for prescription drugs.	Not applicable for prescription drugs.	Not applicable for prescription drugs.	N/A

EMERGENCY CARE

Health Plan: CCS Date: 8/3/2018
Contact Person: Lauren Toro Email: Lauren.toro@wellcare.com #: 675-7630

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Since medical necessity review is not applicable to emergency care, this section is not applicable	Since medical necessity review is not applicable to emergency care, this section is not applicable	Since medical necessity review is not applicable to emergency care, this section is not applicable	N/A

2. 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no fail first requirements for emergency care, thus, this section is not applicable	There are no fail first requirements for emergency care, thus, this section is not applicable	There are no fail first requirements for emergency care, thus, this section is not applicable	N/A

3. 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

List of documents: Medicaid Step Therapy Protocols, Medicaid PA Protocols			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain	No issues found. Comparison was not done; however, the

drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	process for both M/S and MH/SUD are identical. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are not prior authorization requirements for Emergency Care	There are not prior authorization requirements for Emergency Care	There are not prior authorization requirements for Emergency Care	N/A

Concurrent Review

5. 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?

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	N/A

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	N/A

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	N/A

<u>Prescription Drugs</u>

8. 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.

List of documents: Policy C20RX-136 Preferred Drug List; Policy C20RX-134 Corporate Pharmacy committee.			
Medical/Surgical (M/S)	Medical/Surgical (M/S)	Medical/Surgical (M/S)	State Review
The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee.	The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee.	The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee.	No issues found. **BH parity requirements met.**

a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

10. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

11. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

INPATIENT

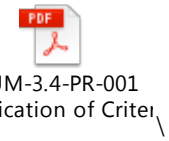
Health Plan: CCS Date: 8/3/18
Contact Person: Lauren Toro Email: Lauren.toro@wellcare.com #: 675-7630

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. What criteria is 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 benefits within each classification? 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.

List of documents: C7 UM-3.4, C7UM-3.4-PR-001



Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Depending on the pre-service procedure, Industry accepted Medical Criteria and approved `Ohana Clinical Coverage Guidelines are utilized to assess medical necessity and appropriateness. If none is available based on service requested, or criteria is not met, a request is sent for a secondary Medical Director review Industry accepted medical necessity criteria in this classification and authorization rules include but are not limited to: • Clinical complexity, • Place of service appropriateness, • Financial and utilization data, and	Industry accepted Medical Necessity Criteria (in addition to `Ohana's Clinical Coverage Guidelines are utilized to assess medical necessity (MN) and appropriateness. Authorizations are given based on MN. If there is a concern that an authorization does not meet MN, we offer a peer to peer review. Industry accepted medical necessity criteria in this classification routinely include: • Level of clinical need that cannot be met in an outpatient environment. • Safety of the patient regarding danger to self or others, • current mental status,	Since industry accepted medical necessity criteria is used for both M/S and MH/SUD the comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

• Benefit restrictions, such as cosmetic procedures. • Diagnosis and clinical must be supplied by the facility. • Number of days approved are based on diagnosis and member co-morbidities. • Concurrent reviews are every 3 days • Discharge planning begins on admission Authorization is nearly always required for inpatient settings, with some exceptions on the claims side for newborn deliveries. Inpatient hospital services are considered and treated as an emergency service. We request the provider to notify us within 24 hours of admission. If there is a concern that an authorization does not meet MN, we offer a peer to peer review and we will send for a secondary review.	• compliance with medication and • duration of the current psychiatric event. Inpatient Psychiatric hospital services are considered and treated as an emergency service. As such, we request the provider to notify us within 24 hours of admission and while an authorization is required, prior authorization is not required. Inpatient hospital services are considered and treated as an emergency service. We request the provider to notify us within 24 hours of admission. If there is a concern that an authorization does not meet MN, we offer a peer to peer review and we will send for a secondary review.		

2. 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.

List of documents: Policy C20RX-136 Policy C20RX-150 Preferred Drug List			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred	Fail first requirements or step-therapy processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	Same process used for both M/S & MH/SUD – no issues with parity. May have to have them clarify use of QLs? Will do overall comparison with all health plans first. **BH parity requirements met.**

Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria	Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the DER process and will receive the ST medication. An example of ST criteria would be for Saphris tablet. The patient would have had to complete a trial and failure of a preferred alternative within the last 100 days or have a contraindication before the Saphris tablet would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific		

that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).	diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).		

3. 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

List of documents: Medicaid Step Therapy Protocols, Medicaid PA Protocols			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
\`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	\`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	\`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	No issues found. Comparison was not done; however, the process for both M/S and MH/SUD are identical. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: C7UM 4.12; C7UM-4.12 PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Pre-service, planned Inpatient surgeries, require prior authorization. Services are requested via fax, web portal, phone from the provider. Inpatient services are reviewed for medical necessity dependent on code. \`Ohana utilizes the following criteria to conduct a medical necessity review:	Residential substance abuse is an example of non-acute inpatient level of care that requires prior authorization. Psychiatric Residential Treatment Facilities for youth is another example of non-acute inpatient level of care. Prior authorization is required in order	Comparing non-acute M/S inpatient stays (planned inpatient surgeries) to non-acute MH/SUD inpatient stays (residential substance abuse), industry accepted medical necessity criteria is used for both M/S and MH/SUD non-acute inpatient admissions. Comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

For Inpatient Prior Authorization review we use the industry standard criteria or `Ohana Clinical coverage guidelines to review diagnosis and symptoms depending on the services requested. All Inpatient pre-planned surgeries require an authorization The industry standard criteria or `Ohana Clinical coverage guidelines applied in this classification routinely include: • Injuries in need of repair, • progression of diseases which require surgical intervention such as mastectomy and breast reconstruction, • possibly arthritis in joints which may require a repair. • Hernia repairs Specific clinical information must meet the standards and guidelines presented in the criteria review. Criteria points are reviewed according to the diagnosis presented and services requested. UM will outreach to the provider three times, to obtain any additional clinical information required to make a determination or send the review to the Medical Director if the medical necessity does not meet criteria and outreach has been unsuccessful. The prior authorization nurse will review the System for Award Management (SAM) website and Office of Inspector general website for provider and facility sanctions. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer review and we will send for a secondary review by a Medical Director.	for a member to be admitted into a program. Authorizations are based on Industry Accepted Medical Criteria to assess medical necessity, which can include: • The presenting problems, • How long they have been having difficulties, • Interventions previously attempted, • Social support, • Physical health, and • School performance Specific clinical information must meet the standards and guidelines presented in the criteria review. Criteria points are reviewed according to the diagnosis presented and services requested. UM will outreach to the provider three times, to obtain any additional clinical information required to make a determination or send the review to the Medical Director if the medical necessity does not meet criteria and outreach has been unsuccessful.		

Once the member is admitted to the hospital a concurrent review will be conducted by the Inpatient nurse every 3 – 5 days depending on diagnosis, co-morbidities and treatment plan.			

Concurrent Review

5. 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?

List of documents: C7UM-5.4; C7UM- 5.4-PR-001; C7UM-5.4- PR-002			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review is not done selectively; it is performed for all inpatient stays to determine medical necessity of continued length of stay in addition to prepare for discharge planning. Continued stays are reviewed every 3 – 5 days using Industry accepted Medical criteria and based on clinical complexity for the services requested. Each service requires clinical information to review for medical necessity for the continued stay. Examples include: • Inpatient Hospital stay: What is the treatment plan currently for the Inpatient stay? • Skilled Nursing Facility: What was the Prior level of function prior to the Inpatient hospital stay? • Inpatient Rehabilitation: Is the Member capable of tolerating 3 hours of skilled therapy, at least 5 days a week? • Long Acute Care: Member requires 6.5 hours/24 hours of	For facility contracts on a per diem (contracted by the day for all diagnoses), concurrent reviews are not done selectively. They are performed for BH Inpatient admissions to determine the medical necessity of continued stay, in addition to ensuring safe transitions upon completion of treatment for our member. Due to the per diem nature of these contracts, concurrent reviews for BH Inpatient admissions are completed, *on average*, every 2-3 days and are based on medical necessity. Additional days are approved based on medical necessity. Many of medical necessity criteria points reflect symptomatology and treatment within the last 24 to 72 hours. The criteria in this classification is used to assess • Presenting problems, • How long the patient has been having difficulties, • Interventions previously attempted, • Social support	Concurrent review is done for all M/S and MH/SUD inpatient stays. Concurrent review is done to ensure medical necessity for continued stays is met. The frequency of the review is based on the contract type: DRG (every 3-5 days) vs. per diem contracts (every 2-3 days). Comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

skilled nursing services and medical practitioner assessment daily. Additional days are approved based on medical necessity. Discharge planning begins on admission for all Inpatient stays. Discharge planning is reviewed as an individual plan for each member by reviewing the following for the next level of care: member age, diagnosis, co-morbidities, prior level of function, home environment. The nurse reviewer will arrange discharge planning for the member prior to discharge. Setting up services such as Skilled nursing facility, home health, durable equipment needs, care management referrals and follow-ups with their primary care provider or Specialist will assist a safe discharge and to prevent re-admissions.	• Physical health, and • School performance Discharge planning that includes follow up appointments to the member's primary care physician (PCP) and therapist(s), community resources needed is also discussed at concurrent reviews to ensure safe transitions upon completion of treatment.		

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review?

List of documents: C7UM-5.4; C7UM- 5.4-PR-001; C7UM-5.4- PR-002			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
61.54% denial rate; Zero appeals so no appeal overturn rate to report (1/1/16-12/31/16)	.69% denial rate; Zero appeals so no appeal overturn rate to report (1/1/16-12/31/16)	The reason the medical denial rate appears so high is there were only 8 denials out of 13 requested; whereas there were a total of 722 requests for behavioral. The "n" for medical is much lower making the % much for volatile and higher.	No issues found. **BH parity requirements met.**

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents: C7UM-5.4; C7UM- 5.4-PR-001; C7UM-5.4- PR-002			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

Continued stays are reviewed every 3 – 5 days using Industry accepted Medical criteria and based on clinical complexity for the services requested. Each service requires clinical information to review for medical necessity for the continued stay. Examples include: • Inpatient Hospital stay: What is the treatment plan currently for the Inpatient stay? • Skilled Nursing Facility: What was the Prior level of function prior to the Inpatient hospital stay? • Inpatient Rehabilitation: Is the Member capable of tolerating 3 hours of skilled therapy, at least 5 days a week? • Long Acute Care: Member requires 6.5 hours/24 hours of skilled nursing services and medical practitioner assessment daily. Additional days are approved based on medical necessity.	Due to the per diem nature of these contracts, concurrent reviews for BH Inpatient admissions are completed, *on average*, every 2-3 days and are based on medical necessity. Additional days are approved based on medical necessity. Many of medical necessity criteria points reflect symptomatology and treatment within the last 24 to 72 hours. The criteria in this classification is used to assess • Presenting problems, • How long the patient has been having difficulties, • Interventions previously attempted, • Social support • Physical health, and • School performance	Frequency of the review is based on the contract type: DRG (every 3-5 days) vs. per diem contracts (every 2-3 days). Comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

Prescription Drugs

8. 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.

List of documents: Policy C20RX-136 Preferred Drug List; Policy C20RX-134 Corporate Pharmacy committee.			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process:	The selections of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process:	Benefit plan construction processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL		

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: C6CR-009, C6CR-001, C6CR-004, C6CR-009-PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana provides contracted networks of qualified organizational health care providers, and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in	`Ohana provides contracted networks of qualified organizational health care providers, and community based case management providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in	Network admission processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

order to achieve a decision to approve or deny network participation.	order to achieve a decision to approve or deny network participation.		

10. 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.

List of documents: C6CR-009, C6CR-001 C6CR-004, C6CR-009-PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above.	Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above	Practitioner types, facility types, or specialty providers are not excluded whether M/S or MH/SUD providers. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

11. 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.

List of documents: C6CR-009			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is).	The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is).	There are no differences between geographic limitations between M/S or MH/SUD providers. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: State benefit plan documentation			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's	The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's	There is no differences in how out-of-network benefits are accessed whether M/S or MH/SUD. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

benefit plan design dictates how members can access out of network benefits.	benefit plan design dictates how members can access out of network benefits.		

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents: State Medicaid Fee Schedule			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	Reimbursement rate amounts are set by the State. Thus, comparability between M/S and MH/SUD meets parity requirements	No issues found. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents: State Medicaid Fee Schedule			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue	None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue	The factors listed do not affect how professional provider reimbursement rates are determined whether the provider is M/S or MH/SUD. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

that requires a higher percentage of the State's fee schedule.	that requires a higher percentage of the State's fee schedule.		

OUTPATIENT

Health Plan: CCS Date: 8/3/2018
Contact Person: Lauren Toro Email: Lauren.toro@wellcare.com #: 675-7630

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: C7UM-3.4; C7UM-3.4-PR-001			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Outpatient services are reviewed by the services requested, dependent on codes and place of service. Medical necessity is reviewed using clinical criteria, including industry accepted medical criteria and `Ohana Clinical Coverage guidelines, to make a determination. The industry accepted and `Ohana criteria reviewed in this classification for services ranging from Speech, Physical and Occupational therapy services to pre-planned surgeries routinely include but are not limited to the following: • Imaging results • Members age • Past medical history or co-morbidities • Symptoms and diagnosis • Prior level of function	In reviewing medical necessity and appropriateness, industry accepted Medical criteria are utilized which routinely include: • Risk of Harm, • Functional Status, • Co-Morbidity, • Recovery Environment, Acceptance, • Engagement in treatment, and • Level of Support. • Level Care Assessment tools These criteria are utilized for Psych testing, ECT, Substance Abuse services, Day Rehabilitation, Community Support, and Psychiatric Residential Rehabilitation. Providers submit an Outpatient Services request form via web portal or fax to Utilization review and any clinical information that they feel is appropriate for initial and recurrent review.	Since industry accepted medical necessity criteria is used for both M/S and MH/SUD the comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

Providers submit outpatient service requests. Outpatient services are requested via fax, web portal, phone or/and state portals from the provider. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer review and we will send for a secondary review by a Medical Director.	Utilization Management sends a fax regarding authorization or calls the provider to request further information. For substance abuse outpatient services, `Ohana uses industry accepted medical criteria and `Ohana Clinical Coverage guidelines for criteria review. Examples of applied criteria include: • Acute Intoxication and Withdrawal • Potential, Biochemical complications, • Emotional, Behavioral and Cognitive Conditions. • Readiness to Change, • Relapse and Continued Problem Potential and Living and Recovery. Authorizations are given based on MN. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer		

2. 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.

List of documents: Policy C20RX-136 Policy C20RX-150 Preferred Drug List			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred	Fail first requirements or step-therapy processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	Same process used for both M/S & MH/SUD – no issues with parity. May have to have them clarify use of QLs? Will do overall comparison with all health plans first. **BH parity requirements met.**

Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria	Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the DER process and will receive the ST medication. An example of ST criteria would be for Saphris tablet. The patient would have had to complete a trial and failure of a preferred alternative within the last 100 days or have a contraindication before the Saphris tablet would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug		

that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).	to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).		

1. 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

List of documents: Medicaid Step Therapy Protocols, Medicaid PA Protocols			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
\`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	\`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	\`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	No issues found. Comparison was not done; however, the process for both M/S and MH/SUD are identical. **BH parity requirements met.**

<u>Prior Authorization</u>

2. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: C7UM 4.12; C7UM-4.12 PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prior authorization is required for certain outpatient services. Medical necessity and appropriateness are required for prior authorization. Medical necessity is determined using Industry accepted Medical criteria. Outpatient services are requested via fax, web portal, phone or state portals from the provider. Services are	Industry accepted Medical Criteria are utilized to determine the appropriate medical necessity ("MN") per member. The aforementioned criteria provide assessment tools used to support accurate level of care recommendations. The assessment determines clinical need based on multiple levels, including: • Mental,	Comparing outpatient M/S services to outpatient MH/SUD services, industry accepted medical necessity criteria is used for both M/S and MH/SUD outpatient services. Comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

reviewed dependent on code, place of service and clinical information received from the provider. Industry accepted medical criteria, `Ohana Clinical Coverage Guidelines and Benefit limits that are applied in this classification routinely include but are not necessarily limited to the following: • Determination of prior level of function • Members age and previous services • Clinical information which must include assessments, tools and non-standardized testing • Plan of Care • Review of benefit limits using the Benefit Master list. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer review and we will send for a secondary review by a Medical Director.	• Social, • Physical, and • Current functioning levels. Based on the results obtained from these assessment tools, the appropriate amount of units based on medical necessity and services are authorized for 20 sessions. The session limit is to ensure that members are getting their needs met, treatment plans are being followed and that community resources are being connected to the member. If there is a concern that an authorization does not meet MN, we offer a peer to peer review and we will send for a secondary review by a Medical Director. Outpatient therapies such as individual, family and group do not have to have prior authorization for the first 20 sessions. After 20 sessions the provider can submit a request for additional services through web portal or fax. UM then determines the number of additional sessions and sends a fax informing the provider.		
	There is substantial research in the area of outcomes and treatment effectiveness for outpatient psychotherapy. Psychotherapy has been demonstrated to be an effective treatment intervention. However, there is data that suggests that the effectiveness of treatment occurs early in care and better outcomes are not produced by long term		

	treatment. A 2001 study published in the Journal of Counseling Psychology found that patients improved most dramatically between their seventh and tenth sessions. Another study, published in 2006 in the Journal of Consulting and Clinical Psychology, looked at nearly 2,000 people who underwent counseling for 1 to 12 sessions and found that while 88 percent improved after one session, the rate fell to 62 percent after 12. Yet, according to research conducted at the University of Pennsylvania, therapists who practice more traditional psychotherapy treat patients for an average of 22 sessions before concluding that progress isn't being made. Only 12 percent of those therapists choose to refer their stagnant patients to another therapist. Even though extended therapy is not always beneficial, many therapists persist in leading patients on an open-ended, potentially endless, therapeutic course. The review starting at session 21 is to help identify providers who have become "stuck" with members or where care is not progressing as expected to help facilitate a care plan review with the provider.		

Concurrent Review

3. 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?

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

Concurrent Review is not applicable to outpatient Services	Concurrent Review is not applicable to outpatient Services	N/A	N/A

4. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent Review is not applicable to outpatient Services	Concurrent Review is not applicable to outpatient Services	N/A	N/A

5. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent Review is not applicable to outpatient Services	Concurrent Review is not applicable to outpatient Services	N/A	N/A

<u>Prescription Drugs</u>

6. 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.

List of documents: Policy C20RX-136 Preferred Drug List; Policy C20RX-134 Corporate Pharmacy committee.			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard	The selections of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard	Benefit plan construction processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL		

NETWORK ADMISSION REQUIREMENTS

3. 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.

List of documents: C6CR-009, C6CR-001, C6CR-004, C6CR-009-PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana provides contracted networks of qualified organizational health care providers, and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	`Ohana provides contracted networks of qualified organizational health care providers, and community based case management providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	Network admission processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

4. 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.

List of documents: C6CR-009, C6CR-001 C6CR-004, C6CR-009-PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above.	Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above	Practitioner types, facility types, or specialty providers are not excluded whether M/S or MH/SUD providers. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

5. 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.

List of documents: C6CR-009			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is).	The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is).	There are no differences between geographic limitations between M/S or MH/SUD providers. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

6. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: State benefit plan documentation			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's benefit plan design dictates how members can access out of network benefits.	The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's benefit plan design dictates how members can access out of network benefits.	There is no differences in how out-of-network benefits are accessed whether M/S or MH/SUD. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

7. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents: State Medicaid Fee Schedule			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	Reimbursement rate amounts are set by the State. Thus, comparability between M/S and MH/SUD meets parity requirements	No issues found. **BH parity requirements met.**

8. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents: State Medicaid Fee Schedule			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	The factors listed do not affect how professional provider reimbursement rates are determined whether the provider is M/S or MH/SUD. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

PRESCRIPTION DRUGS

Health Plan: CCS Date: 8/3/2018
Contact Person: Lauren Toro Email: Lauren.toro@wellcare.com #: 675-7630

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Medical Necessity Criteria Development is not applicable to Prescription Drugs	Medical Necessity Criteria Development is not applicable to Prescription Drugs	N/A	N/A

2. 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.

List of documents: Policy C20RX-136 Policy C20RX-150 Preferred Drug List			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available	Same process used for both M/S & MH/SUD – no issues with parity. May have to have them clarify use of QLs? Will do overall comparison with all health plans first. **BH parity requirements met.**

there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure	there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the DER process and will receive the ST medication. An example of ST criteria would be for Saphris tablet. The patient would have had to complete a trial and failure of a preferred alternative within the last 100 days or have a contraindication before the Saphris tablet would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).	on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).	

of alternative drug(s), allergic reaction to preferred product, etc.).			

3. 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

List of documents: Medicaid Step Therapy Protocols, Medicaid PA Protocols			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
\`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	\`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	\`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	No issues found. Comparison was not done; however, the process for both M/S and MH/SUD are identical. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

Concurrent Review

5. 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?

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

Prescription Drugs

8. 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.

List of documents: Policy C20RX-136 Preferred Drug List; Policy C20RX-134 Corporate Pharmacy committee.			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee.	The selections of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee.	Benefit plan construction processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL		

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

10. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

11. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

EMERGENCY CARE

Health Plan: QI Date: 8/3/2018
Contact Person: Lauren Toro Email: Lauren.toro@wellcare.com #: 675-7630

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Since medical necessity review is not applicable to emergency care, this section is not applicable	Since medical necessity review is not applicable to emergency care, this section is not applicable	Since medical necessity review is not applicable to emergency care, this section is not applicable	N/A

2. 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no fail first requirements for emergency care, thus, this section is not applicable	There are no fail first requirements for emergency care, thus, this section is not applicable	There are no fail first requirements for emergency care, thus, this section is not applicable	N/A

3. 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

List of documents: Medicaid Step Therapy Protocols, Medicaid PA Protocols			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain	No issues found. Comparison was not done; however, the

drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	process for both M/S and MH/SUD are identical. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are not prior authorization requirements for Emergency Care	There are not prior authorization requirements for Emergency Care	There are not prior authorization requirements for Emergency Care	N/A

Concurrent Review

5. 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?

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	N/A

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	N/A

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	There is no concurrent review for Emergency Care	N/A

Prescription Drugs

8. 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.

List of documents: Policy C20RX-136 Preferred Drug List; Policy C20RX-134 Corporate Pharmacy committee.			
Medical/Surgical (M/S)	Medical/Surgical (M/S)	Medical/Surgical (M/S)	State Review
The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee.	The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee.	The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee.	No issues found. **BH parity requirements met.**

a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

10. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

11. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	There are no network requirements for Emergency Care	N/A

INPATIENT

Health Plan: QI Date: 8/3/18
Contact Person: Lauren Toro Email: Lauren.toro@wellcare.com #: 675-7630

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. What criteria is 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 benefits within each classification? 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.

List of documents: C7 UM-3.4, C7UM-3.4-PR-001			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Depending on the pre-service procedure, Industry accepted Medical Criteria and approved `Ohana Clinical Coverage Guidelines are utilized to assess medical necessity and appropriateness. If none is available based on service requested, or criteria is not met, a request is sent for a secondary Medical Director review Industry accepted medical necessity criteria in this classification and authorization rules include but are not limited to: • Clinical complexity, • Place of service appropriateness, • Financial and utilization data, and • Benefit restrictions, such as cosmetic procedures. • Diagnosis and clinical must be supplied by the facility.	Industry accepted Medical Necessity Criteria (in addition to `Ohana's Clinical Coverage Guidelines are utilized to assess medical necessity (MN) and appropriateness. Authorizations are given based on MN. If there is a concern that an authorization does not meet MN, we offer a peer to peer review. Industry accepted medical necessity criteria in this classification routinely include: • Level of clinical need that cannot be met in an outpatient environment. • Safety of the patient regarding danger to self or others, • current mental status, • compliance with medication and • duration of the current psychiatric event.	Since industry accepted medical necessity criteria is used for both M/S and MH/SUD the comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

• Number of days approved are based on diagnosis and member co-morbidities. • Concurrent reviews are every 3 days • Discharge planning begins on admission Authorization is nearly always required for inpatient settings, with some exceptions on the claims side for newborn deliveries. Inpatient hospital services are considered and treated as an emergency service. We request the provider to notify us within 24 hours of admission. If there is a concern that an authorization does not meet MN, we offer a peer to peer review and we will send for a secondary review.	Inpatient Psychiatric hospital services are considered and treated as an emergency service. As such, we request the provider to notify us within 24 hours of admission and while an authorization is required, prior authorization is not required. Inpatient hospital services are considered and treated as an emergency service. We request the provider to notify us within 24 hours of admission. If there is a concern that an authorization does not meet MN, we offer a peer to peer review and we will send for a secondary review.		

2. 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.

List of documents: Policy C20RX-136 Policy C20RX-150 Preferred Drug List			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when	Fail first requirements or step-therapy processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	Same process used for both M/S & MH/SUD – no issues with parity. May have to have them clarify use of QLs? Will do overall comparison with all health plans first. **BH parity requirements met.**

there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure	there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the DER process and will receive the ST medication. An example of ST criteria would be for Saphris tablet. The patient would have had to complete a trial and failure of a preferred alternative within the last 100 days or have a contraindication before the Saphris tablet would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).		

of alternative drug(s), allergic reaction to preferred product, etc.).			

3. 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

List of documents: Medicaid Step Therapy Protocols, Medicaid PA Protocols			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	No issues found. Comparison was not done; however, the process for both M/S and MH/SUD are identical. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: C7UM 4.12; C7UM-4.12 PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Pre-service, planned Inpatient surgeries, require prior authorization. Services are requested via fax, web portal, phone from the provider. Inpatient services are reviewed for medical necessity dependent on code. `Ohana utilizes the following criteria to conduct a medical necessity review: For Inpatient Prior Authorization review we use the industry standard criteria or `Ohana Clinical coverage guidelines to	Residential substance abuse is an example of non-acute inpatient level of care that requires prior authorization. Psychiatric Residential Treatment Facilities for youth is another example of non-acute inpatient level of care. Prior authorization is required in order for a member to be admitted into a program. Authorizations are based on Industry Accepted Medical Criteria to	Comparing non-acute M/S inpatient stays (planned inpatient surgeries) to non-acute MH/SUD inpatient stays (residential substance abuse), industry accepted medical necessity criteria is used for both M/S and MH/SUD non-acute inpatient admissions. Comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

review diagnosis and symptoms depending on the services requested. All Inpatient pre-planned surgeries require an authorization The industry standard criteria or `Ohana Clinical coverage guidelines applied in this classification routinely include: • Injuries in need of repair, • progression of diseases which require surgical intervention such as mastectomy and breast reconstruction, • possibly arthritis in joints which may require a repair. • Hernia repairs Specific clinical information must meet the standards and guidelines presented in the criteria review. Criteria points are reviewed according to the diagnosis presented and services requested. UM will outreach to the provider three times, to obtain any additional clinical information required to make a determination or send the review to the Medical Director if the medical necessity does not meet criteria and outreach has been unsuccessful. The prior authorization nurse will review the System for Award Management (SAM) website and Office of Inspector general website for provider and facility sanctions. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer review and we will send for a secondary review by a Medical Director. Once the member is admitted to the hospital a concurrent review will be conducted by the Inpatient nurse every	assess medical necessity, which can include: • The presenting problems, • How long they have been having difficulties, • Interventions previously attempted, • Social support, • Physical health, and • School performance Specific clinical information must meet the standards and guidelines presented in the criteria review. Criteria points are reviewed according to the diagnosis presented and services requested. UM will outreach to the provider three times, to obtain any additional clinical information required to make a determination or send the review to the Medical Director if the medical necessity does not meet criteria and outreach has been unsuccessful.		

3 – 5 days depending on diagnosis, co-morbidities and treatment plan.			

Concurrent Review

5. 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?

List of documents: C7UM-5.4; C7UM- 5.4-PR-001; C7UM-5.4- PR-002			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent review is not done selectively; it is performed for all inpatient stays to determine medical necessity of continued length of stay in addition to prepare for discharge planning. Continued stays are reviewed every 3 – 5 days using Industry accepted Medical criteria and based on clinical complexity for the services requested. Each service requires clinical information to review for medical necessity for the continued stay. Examples include: • Inpatient Hospital stay: What is the treatment plan currently for the Inpatient stay? • Skilled Nursing Facility: What was the Prior level of function prior to the Inpatient hospital stay? • Inpatient Rehabilitation: Is the Member capable of tolerating 3 hours of skilled therapy, at least 5 days a week? • Long Acute Care: Member requires 6.5 hours/24 hours of skilled nursing services and medical practitioner assessment daily.	For facility contracts on a per diem (contracted by the day for all diagnoses), concurrent reviews are not done selectively. They are performed for BH Inpatient admissions to determine the medical necessity of continued stay, in addition to ensuring safe transitions upon completion of treatment for our member. Due to the per diem nature of these contracts, concurrent reviews for BH Inpatient admissions are completed, *on average*, every 2-3 days and are based on medical necessity. Additional days are approved based on medical necessity. Many of medical necessity criteria points reflect symptomatology and treatment within the last 24 to 72 hours. The criteria in this classification is used to assess • Presenting problems, • How long the patient has been having difficulties, • Interventions previously attempted, • Social support • Physical health, and • School performance	Concurrent review is done for all M/S and MH/SUD inpatient stays. Concurrent review is done to ensure medical necessity for continued stays is met. The frequency of the review is based on the contract type: DRG (every 3-5 days) vs. per diem contracts (every 2-3 days). Comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

Additional days are approved based on medical necessity. Discharge planning begins on admission for all Inpatient stays. Discharge planning is reviewed as an individual plan for each member by reviewing the following for the next level of care: member age, diagnosis, co-morbidities, prior level of function, home environment. The nurse reviewer will arrange discharge planning for the member prior to discharge. Setting up services such as Skilled nursing facility, home health, durable equipment needs, care management referrals and follow-ups with their primary care provider or Specialist will assist a safe discharge and to prevent re-admissions.	Discharge planning that includes follow up appointments to the member's primary care physician (PCP) and therapist(s), community resources needed is also discussed at concurrent reviews to ensure safe transitions upon completion of treatment.		

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review?

List of documents: C7UM-5.4; C7UM- 5.4-PR-001; C7UM-5.4- PR-002			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
61.54% denial rate; Zero appeals so no appeal overturn rate to report (1/1/16-12/31/16)	.69% denial rate; Zero appeals so no appeal overturn rate to report (1/1/16-12/31/16)	The reason the medical denial rate appears so high is there were only 8 denials out of 13 requested; whereas there were a total of 722 requests for behavioral. The "n" for medical is much lower making the % much for volatile and higher.	No issues found. **BH parity requirements met.**

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents: C7UM-5.4; C7UM- 5.4-PR-001; C7UM-5.4- PR-002			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Continued stays are reviewed every 3 – 5 days using Industry accepted Medical criteria and based on clinical	Due to the per diem nature of these contracts, concurrent reviews for BH Inpatient admissions are completed, *on*	Frequency of the review is based on the contract type: DRG (every 3-5 days) vs. per diem contracts (every 2-3 days).	No issues found. **BH parity requirements met.**

complexity for the services requested. Each service requires clinical information to review for medical necessity for the continued stay. Examples include: • Inpatient Hospital stay: What is the treatment plan currently for the Inpatient stay? • Skilled Nursing Facility: What was the Prior level of function prior to the Inpatient hospital stay? • Inpatient Rehabilitation: Is the Member capable of tolerating 3 hours of skilled therapy, at least 5 days a week? • Long Acute Care: Member requires 6.5 hours/24 hours of skilled nursing services and medical practitioner assessment daily. Additional days are approved based on medical necessity.	*average*, every 2-3 days and are based on medical necessity. Additional days are approved based on medical necessity. Many of medical necessity criteria points reflect symptomatology and treatment within the last 24 to 72 hours. The criteria in this classification is used to assess • Presenting problems, • How long the patient has been having difficulties, • Interventions previously attempted, • Social support • Physical health, and • School performance	Comparability between M/S and MH/SUD meets parity requirements.	

Prescription Drugs

8. 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.

List of documents: Policy C20RX-136 Preferred Drug List; Policy C20RX-134 Corporate Pharmacy committee.			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following	The selections of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following	Benefit plan construction processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL		

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: C6CR-009, C6CR-001, C6CR-004, C6CR-009-PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana provides contracted networks of qualified organizational health care providers, and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	`Ohana provides contracted networks of qualified organizational health care providers, and community based case management providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	Network admission processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

10. 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.

List of documents: C6CR-009, C6CR-001 C6CR-004, C6CR-009-PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above.	Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above	Practitioner types, facility types, or specialty providers are not excluded whether M/S or MH/SUD providers. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

11. 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.

List of documents: C6CR-009			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is).	The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is).	There are no differences between geographic limitations between M/S or MH/SUD providers. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: State benefit plan documentation			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's benefit plan design dictates how	The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's benefit plan design dictates how	There is no differences in how out-of-network benefits are accessed whether M/S or MH/SUD. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

members can access out of network benefits.	members can access out of network benefits.		

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents: State Medicaid Fee Schedule			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	Reimbursement rate amounts are set by the State. Thus, comparability between M/S and MH/SUD meets parity requirements	No issues found. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents: State Medicaid Fee Schedule			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue	None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue	The factors listed do not affect how professional provider reimbursement rates are determined whether the provider is M/S or MH/SUD. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

that requires a higher percentage of the State's fee schedule.	that requires a higher percentage of the State's fee schedule.		

OUTPATIENT

Health Plan: QI Date: 8/3/2018
Contact Person: Lauren Toro Email: Lauren.toro@wellcare.com #: 675-7630

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: C7UM-3.4; C7UM-3.4-PR-001			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Outpatient services are reviewed by the services requested, dependent on codes and place of service. Medical necessity is reviewed using clinical criteria, including industry accepted medical criteria and `Ohana Clinical Coverage guidelines, to make a determination. The industry accepted and `Ohana criteria reviewed in this classification for services ranging from Speech, Physical and Occupational therapy services to pre-planned surgeries routinely include but are not limited to the following: • Imaging results • Members age • Past medical history or co-morbidities • Symptoms and diagnosis • Prior level of function	In reviewing medical necessity and appropriateness, industry accepted Medical criteria are utilized which routinely include: • Risk of Harm, • Functional Status, • Co-Morbidity, • Recovery Environment, Acceptance, • Engagement in treatment, and • Level of Support. • Level Care Assessment tools These criteria are utilized for Psych testing, ECT, Substance Abuse services, Day Rehabilitation, Community Support, and Psychiatric Residential Rehabilitation. Providers submit an Outpatient Services request form via web portal or fax to Utilization review and any clinical information that they feel is appropriate for initial and recurrent review.	Since industry accepted medical necessity criteria is used for both M/S and MH/SUD the comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

Providers submit outpatient service requests. Outpatient services are requested via fax, web portal, phone or/and state portals from the provider. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer review and we will send for a secondary review by a Medical Director.	Utilization Management sends a fax regarding authorization or calls the provider to request further information. For substance abuse outpatient services, `Ohana uses industry accepted medical criteria and `Ohana Clinical Coverage guidelines for criteria review. Examples of applied criteria include: • Acute Intoxication and Withdrawal • Potential, Biochemical complications, • Emotional, Behavioral and Cognitive Conditions. • Readiness to Change, • Relapse and Continued Problem Potential and Living and Recovery. Authorizations are given based on MN. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer		

2. 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.

List of documents: Policy C20RX-136 Policy C20RX-150 Preferred Drug List			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred	Fail first requirements or step-therapy processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	Same process used for both M/S & MH/SUD – no issues with parity. May have to have them clarify use of QLs? Will do overall comparison with all health plans first. **BH parity requirements met.**

Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria	Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the DER process and will receive the ST medication. An example of ST criteria would be for Saphris tablet. The patient would have had to complete a trial and failure of a preferred alternative within the last 100 days or have a contraindication before the Saphris tablet would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug		

that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).	to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).		

1. 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

List of documents: Medicaid Step Therapy Protocols, Medicaid PA Protocols			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	No issues found. Comparison was not done; however, the process for both M/S and MH/SUD are identical. **BH parity requirements met.**

<u>Prior Authorization</u>

2. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: C7UM 4.12; C7UM-4.12 PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prior authorization is required for certain outpatient services. Medical necessity and appropriateness are required for prior authorization. Medical necessity is determined using Industry accepted Medical criteria. Outpatient services are requested via fax, web portal, phone or state portals from the provider. Services are	Industry accepted Medical Criteria are utilized to determine the appropriate medical necessity ("MN") per member. The aforementioned criteria provide assessment tools used to support accurate level of care recommendations. The assessment determines clinical need based on multiple levels, including: • Mental,	Comparing outpatient M/S services to outpatient MH/SUD services, industry accepted medical necessity criteria is used for both M/S and MH/SUD outpatient services. Comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

reviewed dependent on code, place of service and clinical information received from the provider. Industry accepted medical criteria, `Ohana Clinical Coverage Guidelines and Benefit limits that are applied in this classification routinely include but are not necessarily limited to the following: • Determination of prior level of function • Members age and previous services • Clinical information which must include assessments, tools and non-standardized testing • Plan of Care • Review of benefit limits using the Benefit Master list. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer review and we will send for a secondary review by a Medical Director.	• Social, • Physical, and • Current functioning levels. Based on the results obtained from these assessment tools, the appropriate amount of units based on medical necessity and services are authorized for 20 sessions. The session limit is to ensure that members are getting their needs met, treatment plans are being followed and that community resources are being connected to the member. If there is a concern that an authorization does not meet MN, we offer a peer to peer review and we will send for a secondary review by a Medical Director. Outpatient therapies such as individual, family and group do not have to have prior authorization for the first 20 sessions. After 20 sessions the provider can submit a request for additional services through web portal or fax. UM then determines the number of additional sessions and sends a fax informing the provider.		
	There is substantial research in the area of outcomes and treatment effectiveness for outpatient psychotherapy. Psychotherapy has been demonstrated to be an effective treatment intervention. However, there is data that suggests that the effectiveness of treatment occurs early in care and better outcomes are not produced by long term		

	treatment. A 2001 study published in the Journal of Counseling Psychology found that patients improved most dramatically between their seventh and tenth sessions. Another study, published in 2006 in the Journal of Consulting and Clinical Psychology, looked at nearly 2,000 people who underwent counseling for 1 to 12 sessions and found that while 88 percent improved after one session, the rate fell to 62 percent after 12. Yet, according to research conducted at the University of Pennsylvania, therapists who practice more traditional psychotherapy treat patients for an average of 22 sessions before concluding that progress isn't being made. Only 12 percent of those therapists choose to refer their stagnant patients to another therapist. Even though extended therapy is not always beneficial, many therapists persist in leading patients on an open-ended, potentially endless, therapeutic course. The review starting at session 21 is to help identify providers who have become "stuck" with members or where care is not progressing as expected to help facilitate a care plan review with the provider.		

Concurrent Review

3. 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?

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

Concurrent Review is not applicable to outpatient Services	Concurrent Review is not applicable to outpatient Services	N/A	N/A

4. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent Review is not applicable to outpatient Services	Concurrent Review is not applicable to outpatient Services	N/A	N/A

5. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Concurrent Review is not applicable to outpatient Services	Concurrent Review is not applicable to outpatient Services	N/A	N/A

<u>Prescription Drugs</u>

6. 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.

List of documents: Policy C20RX-136 Preferred Drug List; Policy C20RX-134 Corporate Pharmacy committee.			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard	The selections of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard	Benefit plan construction processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL		

NETWORK ADMISSION REQUIREMENTS

3. 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.

List of documents: C6CR-009, C6CR-001, C6CR-004, C6CR-009-PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana provides contracted networks of qualified organizational health care providers, and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	`Ohana provides contracted networks of qualified organizational health care providers, and community based case management providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	Network admission processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

4. 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.

List of documents: C6CR-009, C6CR-001 C6CR-004, C6CR-009-PR-001			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above.	Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above	Practitioner types, facility types, or specialty providers are not excluded whether M/S or MH/SUD providers. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

5. 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.

List of documents: C6CR-009			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is).	The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is).	There are no differences between geographic limitations between M/S or MH/SUD providers. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

6. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: State benefit plan documentation			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's benefit plan design dictates how members can access out of network benefits.	The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's benefit plan design dictates how members can access out of network benefits.	There is no differences in how out-of-network benefits are accessed whether M/S or MH/SUD. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

7. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents: State Medicaid Fee Schedule			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	Reimbursement rate amounts are set by the State. Thus, comparability between M/S and MH/SUD meets parity requirements	No issues found. **BH parity requirements met.**

8. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents: State Medicaid Fee Schedule			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	The factors listed do not affect how professional provider reimbursement rates are determined whether the provider is M/S or MH/SUD. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

PRESCRIPTION DRUGS

Health Plan: QI Date: 8/3/2018
Contact Person: Lauren Toro Email: Lauren.toro@wellcare.com #: 675-7630

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Medical Necessity Criteria Development is not applicable to Prescription Drugs	Medical Necessity Criteria Development is not applicable to Prescription Drugs	N/A	N/A

2. 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.

List of documents: Policy C20RX-136 Policy C20RX-150 Preferred Drug List			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available	Same process used for both M/S & MH/SUD – no issues with parity. May have to have them clarify use of QLs? Will do overall comparison with all health plans first. **BH parity requirements met.**

there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure	there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the DER process and will receive the ST medication. An example of ST criteria would be for Saphris tablet. The patient would have had to complete a trial and failure of a preferred alternative within the last 100 days or have a contraindication before the Saphris tablet would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).	on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).	

of alternative drug(s), allergic reaction to preferred product, etc.).			

3. 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

List of documents: Medicaid Step Therapy Protocols, Medicaid PA Protocols			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting.	No issues found. Comparison was not done; however, the process for both M/S and MH/SUD are identical. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

Concurrent Review

5. 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?

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

Prescription Drugs

8. 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.

List of documents: Policy C20RX-136 Preferred Drug List; Policy C20RX-134 Corporate Pharmacy committee.			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee.	The selections of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee.	Benefit plan construction processes between M/S and MH/SUD are identical. Thus, comparability between M/S and MH/SUD meets parity requirements.	No issues found. **BH parity requirements met.**

a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL		

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

10. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

11. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A

EMERGENCY CARE

Health Plan: UnitedHealthcare Community Plan Date: August 2, 2018
Contact Person: Jocelyn Tafao Email: Jocelyn_tafao@uhc.com #: 808-535-1058

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: UM-1061-Policy-Clinical-Review-Criteria

UM-1061-Policy-Clinic
al_Review_Criteria.pdf

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the following components are taken into consideration: "A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is: (1) For the purpose of treating a medical condition; (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient; (3) Known to be effective in improving health outcomes; provided that:	As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the following components are taken into consideration: "A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is: (1) For the purpose of treating a medical condition; (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient; (3) Known to be effective in improving health outcomes; provided that:	UnitedHealthcare uses evidenced based, peer reviewed, industry standards to determine the criteria for medical necessity for both M/S and MH/SUD and therefore the medical necessity criteria used for M/S and MH/SUD are effectively comparable.	No issues found. **BH parity requirements met.**

(A) Effectiveness is determined first by scientific evidence; (B) If no scientific evidence exists, then by professional standards of care; and (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost effective shall not necessarily mean the lowest price."	(A) Effectiveness is determined first by scientific evidence; (B) If no scientific evidence exists, then by professional standards of care; and (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost effective shall not necessarily mean the lowest price."		

2. 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
NA for emergency services	NA for emergency services	NA	N/A

3. 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

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
NA for emergency services	NA for emergency services	NA	N/A

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Emergency Services do not require Prior Authorization.	Emergency Services do not require Prior Authorization.	NA	N/A

Concurrent Review

5. 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?

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Emergency Services do not require concurrent review.	Emergency Services do not require concurrent review.	NA	N/A

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
NA for emergency services	NA for emergency services	NA	N/A

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
NA for emergency services	NA for emergency services	NA	N/A

Prescription Drugs

8. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare does not restrict or set limits on prescription drugs provided in an emergency setting or take home drugs.	UnitedHealthcare does not restrict or set limits on prescription drugs provided in an emergency setting or take home drugs.	Same rules apply for both S/M and MH/SUD therefore comparable.	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: CR-0001 Credentialing Process Policy, PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy


CR-0001 Credentialing Process.


PN-1003-Policy-Availability GeoAccess_1122


PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, provider disclosures, and licensure/certification. All applicable providers go through the credentialing process that is based on NCQA requirements. Credentialing of a provider is initiated prior to contracting with the provider. Once a provider has completed the credentialing process and approved by	The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, provider disclosures, and licensure/certification. All applicable providers go through the credentialing process that is based on NCQA requirements. Credentialing of a provider is initiated prior to contracting with the provider. Once a provider has completed the credentialing process and approved by	Same rules apply for both S/M and MH/SUD therefore comparable.	No issues found. **BH parity requirements met.**

the Credentialing Committee, they are offered a contract with UnitedHealthcare. Participation criteria for practitioners include information about the provider, such as: 1. Education 2. Licensing 3. Applicant must have full hospital admitting privileges, without Material Restrictions, conditions or other disciplinary actions, at a minimum of one participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Credentialing Entity determines that Applicant's practice requires such privileges. 4. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant. 5. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS. 6. Work History 7. Mal-practice Insurance or state approved alternative 8. Network participation	the Credentialing Committee, they are offered a contract with UnitedHealthcare. Participation criteria for practitioners include information about the provider, such as: 1. Education 2. Licensing 3. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant practices. 4. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS. 5. Work History - must provide a 5 year employment history. Gaps longer than 6 months must be explained by the applicant and found acceptable by the credentialing committee. 6. Mal-practice Insurance or state approved alternative 7. Network participation UnitedHealthcare ensures that it has the network capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive, primary, acute, behavioral health services, and long-term services and supports (LTSS) and it maintains a sufficient number,		

UnitedHealthcare ensures that it has the network capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive, primary, acute, behavioral health services, and long-term services and supports (LTSS) and it maintains a sufficient number, mix, and geographic distribution of providers of covered services. UnitedHealthcare network providers must meet availability standards for Medicaid members. Our Medicaid members and providers are notified of the plan's policies for immediate care and for scheduling urgent, pediatric sick, adult sick and routine appointments. UnitedHealthcare monitors provider performance against the standards at a minimum on a quarterly basis. UnitedHealthcare ensures it's network has the capacity and is adequate to serve the expected enrollment in the service area to maintain a sufficient number, mix, and geographic distribution of providers for services; taking in consideration the distance that it takes the member to travel in normal traffic conditions, using usual travel means in a direct route from his/her home to the provider based on the GeoAccess Standards.	mix, and geographic distribution of providers of covered services. UnitedHealthcare network providers must meet availability standards for Medicaid members. Our Medicaid members and providers are notified of the plan's policies for immediate care and for scheduling urgent, pediatric sick, adult sick and routine appointments. UnitedHealthcare monitors provider performance against the standards at a minimum on a quarterly basis. UnitedHealthcare ensures it's network has the capacity and is adequate to serve the expected enrollment in the service area to maintain a sufficient number, mix, and geographic distribution of providers for services; taking in consideration the distance that it takes the member to travel in normal traffic conditions, using usual travel means in a direct route from his/her home to the provider based on the GeoAccess Standards.		

10. 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.

List of documents: CR-0001 Credentialing Process Policy, PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy


CR-0001 Credentialing Process.


PN-1003-Policy-Availability GeoAccess_1122


PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare does not exclude any provider types however we may exclude a provider based on the credentialing criteria. UnitedHealthcare complies with state licensing requirements and if there is a practitioner type who is eligible a contract will be offered. All applicable providers must meet the requirements of our credentialing requirements.	UnitedHealthcare does not exclude any provider types however we may exclude a provider based on the credentialing criteria. UnitedHealthcare complies with state licensing requirements and if there is a practitioner type who is eligible a contract will be offered. All applicable providers must meet the requirements of our credentialing requirements.	Same rules apply for both S/M and MH/SUD therefore comparable.	No issues found. **BH parity requirements met.**

11. 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.

List of documents: PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy


PN-1003-Policy-Availability GeoAccess_1122


PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare does not impose or have any geographic limitations on provider inclusions.	UnitedHealthcare does not impose or have any geographic limitations on provider inclusions.	Same rules apply for both S/M and MH/SUD therefore comparable.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

Lists of documents: PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy

PN-1003-Policy-Availability GeoAccess_1122 PN-1078-Policy-Selection and Retention_112			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare provides access to Out of Network (OON) providers (non-contracted providers) if an in-network provider is unable to provide medically necessary services in an adequate and timely manner to a member and continue to authorize the use of non-contract providers for as long as UnitedHealthcare is unable to provide services through network providers. UnitedHealthcare requires prior authorization approval for OON providers prior to rendering the service.	UnitedHealthcare provides access to Out of Network (OON) providers (non-contracted providers) if an in-network provider is unable to provide medically necessary services in an adequate and timely manner to a member and continue to authorize the use of non-contract providers for as long as UnitedHealthcare is unable to provide services through network providers. UnitedHealthcare requires prior authorization approval for OON providers prior to rendering the service.	Same rules apply for both S/M and MH/SUD therefore comparable.	No issues found. **BH parity requirements met.**

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare's Medicaid Fee Schedule is developed using the State's Medicaid Fee Schedule with alignment using Medicare relatively. Where the fee source does not publish a specific fee amount, UnitedHealthcare will use the CMS Gap fill using a % of prevailing Medicare. UnitedHealthcare will use reasonable commercial efforts to implement the	UnitedHealthcare's Medicaid Fee Schedule is developed using the State's Medicaid Fee Schedule with alignment using Medicare relatively. Where the fee source does not publish a specific fee amount, UnitedHealthcare will use the CMS Gap fill using a % of prevailing Medicare. UnitedHealthcare will use reasonable commercial efforts to implement the	Same process is applied for both M/S and MH/SUD therefore comparable.	No issues found. **BH parity requirements met.**

updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). UnitedHealthcare will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by UnitedHealthcare will not be reprocessed unless otherwise required by law.	updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). UnitedHealthcare will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by UnitedHealthcare will not be reprocessed unless otherwise required by law.		

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Professional provider reimbursement rates do not vary based on the factors listed above. In limited instances variations can occur based on availability of certain limited specialty services in Hawaii.	Professional provider reimbursement rates do not vary based on the factors listed above. In limited instances variations can occur based on availability of certain limited specialty services in Hawaii.	Same process is applied for both M/S and MH/SUD therefore comparable.	No issues found. **BH parity requirements met.**

INPATIENT

Health Plan: UnitedHealthcare Community Plan Date: August 2, 2018
Contact Person: Jocelyn Tafao Email: Jocelyn_tafao@uhc.com #: 808-535-1058

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: UM-1061-Policy-Clinical-Review-Criteria; UM-1011-Policy-Prior-Authorization; BH Standard Level of Care Guidelines; 2018 Optum Behavioral UM Program Description

UM-1061-Policy-Clinical_Review_Criteria.pdf
UM-1011-Policy-Prior-Authorization.pdf
BH Standard Level of Care Guidelines (0518
2018 Optum Behavioral UM Prograr

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the following components are taken into consideration: "A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is: (1) For the purpose of treating a medical condition; (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient; (3) Known to be effective in improving health outcomes; provided that: (A) Effectiveness is determined first by scientific evidence;	As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the following components are taken into consideration: "A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is: (1) For the purpose of treating a medical condition; (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient; (3) Known to be effective in improving health outcomes; provided that: (A) Effectiveness is determined first by scientific evidence;	UnitedHealthcare uses evidenced based, peer reviewed, industry standards to determine the criteria for medical necessity for both M/S and MH/SUD and therefore the medical necessity criteria used for M/S and MH/SUD are effectively comparable.	No issues found. **BH parity requirements met.**

(B) If no scientific evidence exists, then by professional standards of care; and (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost effective shall not necessarily mean the lowest price." UnitedHealthcare uses Milliman Care Guidelines (MCG) evidenced based criteria to determine the most appropriate level of inpatient care with care guidelines specific to the member's admitting diagnosis. MCG supports the nurse's approval decisions and those cases that may not meet the evidenced based criteria. When the member's clinical does not appear to meet MCG inpatient guidelines, a higher level of review is required. The case is then escalated to the receiving medical director to review for potential adverse determination (see Inpatient Medical Necessity document above). Medical review frequency is based off of UnitedHealthcare Priority Review Process (see document name and number above). Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms, which are all of the following as determined by	(B) If no scientific evidence exists, then by professional standards of care; and (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost effective shall not necessarily mean the lowest price." UnitedHealthcare uses the *Level of Care Guidelines* a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum. This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. The clinical standards used by Optum were devised in conjunction with the best clinical practices established through the following professional and clinical organizations: American Association of Community Psychiatrists, American Psychiatric Association, Centers for Medicare and Medicaid Services, and the Association for Ambulatory Behavioral Healthcare. The factor(s) used to identify the conditions/services and/or procedure(s) to be targeted in the Utilization Management process are identified through comparable methodologies used by the medical-		

UnitedHealthcare or our designee, within our sole discretion. • In accordance with *Generally Accepted Standards of Medical Practice* • Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's sickness, injury, mental illness, substance use disorder, disease or its symptoms • Not mainly for the member's convenience or that of the member's doctor or other health care provider • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's sickness, injury, disease or symptoms. 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	surgical portion of the plan and generally include the following: • Significant practice variation/variability that indicate over, under, misuse and/or ineffective use of services. Areas monitored for variability and variation are: o Level of care o Specific service/procedure o Geographic region o Diagnosis/condition o Provider/facility and/or • Significant drivers of changes in cost and use pattern trend such as: o High unit cost o High cost episode of care/services o Significant inexplicable clinically-based shifts in patterns of use and/or • Outlier performance against established benchmarks o Optum's national benchmarks o Third party benchmarks and/or • Benefits where there is disproportionate utilization by a subset of the population where targeted interventions increase effectiveness of care delivery and/or • Benefits that are unfavorably affected by preference/arbitrary system driven care • Benefits where there are significant gaps in care that negatively impact cost, quality and/or result in over or wasteful utilization • The potential for meaningful results from the UM activity relative to the administrative cost. The scope of methodologies, (e.g., benchmarking against national norms, statistical modeling, distribution curves, co-efficient of variance) used to determine when utilization management techniques should be best applied is based on the		

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. 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.	scope of methodologies that are used by the medical portion of the plan.		

2. 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
MCG would be used to identify any criteria that would correlate between the member's diagnoses and failure of outpatient treatment. Application of a "fail first" or "step therapy" requirement is based on use of nationally recognized clinical standards, which may be incorporated into the plan's review guidelines. Based on, and consistent with, these nationally recognized clinical standards, some of the plan's medical/surgical review guidelines have what may be considered to be "fail first" or "step therapy" protocols.	There are no first requirements or step therapies for inpatient hospitalization. Member must meet the medical necessity criteria for inpatient admission.	The MH/SUD process is not more stringent than the M/S.	No issues found. **BH parity requirements met.**

3. 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

List of documents:

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The medical/surgical inpatient benefit does not include exclusions based on a failure to complete a course of treatment. As noted in response to #1 above, inpatient coverage is determined by medical necessity.	There are no exclusions based on failure to complete a course of treatment. As noted in response to #1 above, inpatient coverage is determined by medical necessity.	There are no exclusions based on failure to complete a course of treatment for either M/S or MH/SUD.	No issues found. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: UM-1011-Policy-Prior-Authorization

UM-1011-Policy-Prior-Authorization.pdf

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Prior authorization is not required for emergent admissions into an inpatient facility. Notification of the admission (emergent/non-emergent) is required. Subsequent concurrent reviews are conducted. Prior authorization is required for non-emergent admissions with subsequent concurrent reviews conducted by UnitedHealthcare.	Prior authorization is not required for emergent admissions into an inpatient facility. Notification of the admission (emergent/non-emergent) is required. Subsequent concurrent reviews are conducted. Prior authorization is required for non-emergent admissions with subsequent concurrent reviews conducted by UnitedHealthcare.	UnitedHealthcare applies the same prior authorization process for both M/S and MH/SUD.	No issues found. **BH parity requirements met.**

Concurrent Review

5. 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?

List of documents: UM-1061-Policy-Clinical-Review-Criteria; 2018 Optum UM Program Description; BH Standard Level of Care Guidelines


UM-1061-Policy-Clinic al_Review_Criteria.pd


2018 Optum Behavioral UM Prograr


BH Standard Level of Care Guidelines (0518

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Inpatient review is a component of the medical plan's utilization management activities. The Medical Director and other 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. Reviews usually begin on the first business day following admission. If a nurse reviewer believes that an admission or continued stay is not an appropriate use of benefit coverage, the facility will be asked for more information concerning the treatment and case management plan. The nurse may also refer the case to our Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or	Concurrent Review is conducted on all acute inpatient admissions following the initial authorization periods for admissions which require extension beyond those initial covered days. The factors that are explored in the decision, in addition to establishing that the member continues to meet the medical necessity criteria established in the level of care guidelines, is that the member continues to benefit from treatment, that treatment is progressive and cannot be provided at a lower level of care, and that the treatment is appropriate to the member's clinical needs and necessary for continued improvement.	The same process is applied for both the M/S and MH/SUD when performing concurrent reviews that focuses on promoting delivery of care that will promote efficient execution of the member's treatment plan based on medical necessity. As such, the factors considered for concurrent review and standards used are similar and therefore the M/S and MH/SUD inpatient processes are comparable.	No issues found. **BH parity requirements met.**

continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. Non-reimbursable charges are not billable to the member. The facility and the attending physician have sole authority and responsibility for the medical care of patients. The plan's medical management decisions do not override those obligations. We do not ever direct an attending physician to discharge a patient. We simply inform the member of our determination. • Participating facilities are required to cooperate with all medical plan requests for information, documents or discussions for purposes of concurrent review and discharge planning including, but not limited to: primary and secondary diagnosis, clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date. • Initial and concurrent review can be conducted by telephone, on- site and when available, facilities can provide clinical information via access to Electronic Medical Records (EMR). •Participating facilities must cooperate with all medical plan requests from the inpatient care management team and/or medical director to engage our members directly face-to-face or telephonically. All national inpatient care managers are Registered Nurses with an unencumbered license in the state that they are conducting medical necessity review.			

Any potential fraud or quality occurrence identified while reviewing for medical necessity is reported to the United Health Care Clinical Services Medical Management Program. The rest must be entered by the Medical Director.			

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: UM-1061-Policy-Clinical-Review-Criteria; 2018 Optum UM Program Description


UM-1061-Policy-Clinic al_Review_Criteria.pd


2018 Optum Behavioral UM Prograr

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. The medical plan clinical criteria can be requested from the Case Reviewer. Criteria other than MCG™ Care Guidelines 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 Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay.	Concurrent reviews are conducted via review of faxed clinical documentation for medical necessity. Notification to providers regarding authorization determinations are provided verbally and in writing consistent with federal and state timeline requirements. The number of days authorized for acute inpatient admissions are tailored to the age of the client, reason for admission, presenting issues, type of and efficacy of current treatment and past treatment history. Denial determinations are made by a licensed psychiatrist with at least 5 years of experience in psychiatry. The denial rate was 0.01% and the appeal overturn rate for concurrent reviews was zero (0).	The same process is exercised for both the M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

% of Cases With Adverse Determination	% of Total Cases Appealed	% of Adverse Determination Cases with at Least One Day Overturned on appeal	% of Appealed Cases Overturned on Appeal
7.40%	0.50%	1.80%	29.40%

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The Inpatient Care Manager prioritizes and reviews criteria for all inpatient admissions based on medical necessity and non-medical necessity agreements. The ICM reviews the clinical associated with the inpatient case and uses the priority review guide as guidance for frequency of review. Level of care for medical necessity approved facilities is reviewed on hospital day one. DRG contracted facilities are concurrently reviewed every 4 days until discharge unless otherwise medically indicated. Non-DRG contracted facilities are concurrently reviewed every 2 days until discharge unless otherwise medically indicated. For any acute non-medical necessity agreements, the inpatient cases are reviewed on hospital day fourteen and then subsequently every 4 days until discharge. The Acute Inpatient Rehab is reviewed for medical necessity upon request. Non-DRG agreements are reviewed on hospital day 14. DRG agreements are reviewed on hospital	Concurrent reviews are conducted approximately every 3 days on average for this level of care.	The M/S and MH/SUD processes for concurrent review including frequency are very similar and therefore considered comparable. Given the nature of some M/S inpatient stays (e.g. ICU/CCU/NICU/PICU) a more frequent concurrent review may occur than the average review frequency in a MH/SUD inpatient stay.	No issues found. **BH parity requirements met.**

day 7 and then every 4 days until discharge unless otherwise medically indicated.			

Prescription Drugs

8. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare does not restrict or set limits on prescription drugs provided in an inpatient setting or take home drugs.	UnitedHealthcare does not restrict or set limits on prescription drugs provided in an inpatient setting or take home drugs.	Same rules apply for both M/S and MH/SUD and therefore are comparable.	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: CR-0001 Credentialing Process Policy, PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy

CR-0001 Credentialing Process.

PN-1003-Policy-Availability GeoAccess_1122

PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, provider disclosures, and licensure/certification.	The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, provider disclosures, and licensure/certification.	Network requirements for both M/S and MH/SUD are comparable.	No issues found. **BH parity requirements met.**

All applicable providers go through the credentialing process that is based on NCQA requirements. Credentialing of a provider is initiated prior to contracting with the provider. Once a provider has completed the credentialing process and approved by the Credentialing Committee, they are offered a contract with UnitedHealthcare. Participation criteria for practitioners include information about the provider, such as: 1. Education 2. Licensing 3. Applicant must have full hospital admitting privileges, without Material Restrictions, conditions or other disciplinary actions, at a minimum of one participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Credentialing Entity determines that Applicant's practice requires such privileges. 4. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant. 5. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other	All applicable providers go through the credentialing process that is based on NCQA requirements. Credentialing of a provider is initiated prior to contracting with the provider. Once a provider has completed the credentialing process and approved by the Credentialing Committee, they are offered a contract with UnitedHealthcare. Participation criteria for practitioners include information about the provider, such as: 1. Education 2. Licensing 3. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant practices. 4. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS. 5. Work History - must provide a 5 year employment history. Gaps longer than 6 months must be explained by the applicant and found acceptable by the credentialing committee. 6. Mal-practice Insurance or state approved alternative 7. Network participation		

disciplinary action by any federal or state entities identified by CMS. 6. Work History 7. Mal-practice Insurance or state approved alternative 8. Network participation UnitedHealthcare ensures that it has the network capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive, primary, acute, behavioral health services, and long-term services and supports (LTSS) and it maintains a sufficient number, mix, and geographic distribution of providers of covered services. UnitedHealthcare network providers must meet availability standards for Medicaid members. Our Medicaid members and providers are notified of the plan's policies for immediate care and for scheduling urgent, pediatric sick, adult sick and routine appointments. UnitedHealthcare monitors provider performance against the standards at a minimum on a quarterly basis. UnitedHealthcare ensures it's network has the capacity and is adequate to serve the expected enrollment in the service area to maintain a sufficient number, mix, and geographic distribution of providers for services; taking in consideration the distance that it takes the member to travel in normal traffic conditions, using usual travel means in a direct route from his/her	UnitedHealthcare ensures that it has the network capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive, primary, acute, behavioral health services, and long-term services and supports (LTSS) and it maintains a sufficient number, mix, and geographic distribution of providers of covered services. UnitedHealthcare network providers must meet availability standards for Medicaid members. Our Medicaid members and providers are notified of the plan's policies for immediate care and for scheduling urgent, pediatric sick, adult sick and routine appointments. UnitedHealthcare monitors provider performance against the standards at a minimum on a quarterly basis. UnitedHealthcare ensures it's network has the capacity and is adequate to serve the expected enrollment in the service area to maintain a sufficient number, mix, and geographic distribution of providers for services; taking in consideration the distance that it takes the member to travel in normal traffic conditions, using usual travel means in a direct route from his/her home to the provider based on the GeoAccess Standards.		

home to the provider based on the GeoAccess Standards.			

10. 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.

List of documents: CR-0001 Credentialing Process Policy, PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers


CR-0001 Credentialing Process.


PN-1003-Policy-Availability GeoAccess_1122


PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare does not exclude any provider types however we may exclude a provider based on the credentialing criteria. UnitedHealthcare complies with state licensing requirements and if there is a practitioner type who is eligible a contract will be offered. All applicable providers must meet the requirements of our credentialing requirements.	UnitedHealthcare does not exclude any provider types however we may exclude a provider based on the credentialing criteria. UnitedHealthcare complies with state licensing requirements and if there is a practitioner type who is eligible a contract will be offered. All applicable providers must meet the requirements of our credentialing requirements.	Same process is applied for both M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

11. 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.

List of documents: PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy


PN-1003-Policy-Availability GeoAccess_1122


PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation and/or Plan	State Review

	(MH/SUD)		
UnitedHealthcare does not impose or have any geographic limitations on provider inclusions.	UnitedHealthcare does not impose or have any geographic limitations on provider inclusions.	Same process is applied for both M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy

PN-1003-Policy-Availability GeoAccess_1122

PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare provides access to Out of Network (OON) providers (non-contracted providers) if an in-network provider is unable to provide medically necessary services in an adequate and timely manner to a member and continue to authorize the use of non-contract providers for as long as UnitedHealthcare is unable to provide services through network providers. UnitedHealthcare requires prior authorization approval for OON providers prior to rendering the service.	UnitedHealthcare provides access to Out of Network (OON) providers (non-contracted providers) if an in-network provider is unable to provide medically necessary services in an adequate and timely manner to a member and continue to authorize the use of non-contract providers for as long as UnitedHealthcare is unable to provide services through network providers. UnitedHealthcare requires prior authorization approval for OON providers prior to rendering the service.	Same process is applied for both M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

UnitedHealthcare's Medicaid Fee Schedule is developed using the State's Medicaid Fee Schedule with alignment using Medicare relatively. Where the fee source does not publish a specific fee amount, UnitedHealthcare will use the CMS Gap fill using a % of prevailing Medicare. UnitedHealthcare will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). UnitedHealthcare will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by UnitedHealthcare will not be reprocessed unless otherwise required by law.	UnitedHealthcare's Medicaid Fee Schedule is developed using the State's Medicaid Fee Schedule with alignment using Medicare relatively. Where the fee source does not publish a specific fee amount, UnitedHealthcare will use the CMS Gap fill using a % of prevailing Medicare. UnitedHealthcare will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). UnitedHealthcare will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by UnitedHealthcare will not be reprocessed unless otherwise required by law.	Same process is applied for both M/S and MH/SUD and therefore comparable. Note that this question (#13) is asking about "outpatient" but this document is specific to inpatient. UHC's Medicaid reimbursement rates (fee schedules) for professionals including physicians, PhDs, MAs and others is developed and maintained the same for professional services rendered on an outpatient basis as well as inpatient.	No issues found. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Professional provider reimbursement rates do not vary based on the factors listed above. In limited instances variations can occur based on	Professional provider reimbursement rates do not vary based on the factors listed above. In limited instances variations can occur based on	Same process is applied for both M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

availability of certain limited specialty services in Hawaii.	availability of certain limited specialty services in Hawaii.		

OUTPATIENT

Health Plan: UnitedHealthcare Community Plan Date: August 2, 2018
Contact Person: Jocelyn Tafao Email: Jocelyn_tafao@uhc.com #: 808-535-1058

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

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2018 Optum Behavioral UM Prograr

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the following components are taken into consideration: "A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is: (1) For the purpose of treating a medical condition; (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient; (3) Known to be effective in improving health outcomes; provided that:	As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the following components are taken into consideration: "A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is: (1) For the purpose of treating a medical condition; (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient; (3) Known to be effective in improving health outcomes; provided that: (A) Effectiveness is determined first by scientific evidence;	UnitedHealthcare uses evidenced based, peer reviewed, industry standards to determine the criteria for medical necessity for both M/S and MH/SUD and therefore the medical necessity criteria used for M/S and MH/SUD are effectively comparable.	No issues found. **BH parity requirements met.**

(A) Effectiveness is determined first by scientific evidence; (B) If no scientific evidence exists, then by professional standards of care; and (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost effective shall not necessarily mean the lowest price." UnitedHealthcare uses Milliman Care Guidelines (MCG) evidenced based criteria to determine the most appropriate level of inpatient care with care guidelines specific to the member's admitting diagnosis. MCG supports the nurse's approval decisions and those cases that may not meet the evidenced based criteria. When the member's clinical does not appear to meet MCG inpatient guidelines, a higher level of review is required. The case is then escalated to the receiving medical director to review for potential adverse determination (see Inpatient Medical Necessity document above). Medical review frequency is based off of UnitedHealthcare Priority Review Process (see document name and number above). Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental	(B) If no scientific evidence exists, then by professional standards of care; and (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost effective shall not necessarily mean the lowest price." UnitedHealthcare uses the *Level of Care Guidelines* a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum. This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. The clinical standards used by Optum were devised in conjunction with the best clinical practices established through the following professional and clinical organizations: American Association of Community Psychiatrists, American Psychiatric Association, Centers for Medicare and Medicaid Services, and the Association for Ambulatory Behavioral Healthcare. The factor(s) used to identify the conditions/services and/or procedure(s) to be targeted in the Utilization Management process are identified through comparable methodologies used		

illness, substance use disorder, condition, disease or its symptoms, which are all of the following as determined by UnitedHealthcare or our designee, within our sole discretion. • In accordance with *Generally Accepted Standards of Medical Practice* • Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's sickness, injury, mental illness, substance use disorder, disease or its symptoms • Not mainly for the member's convenience or that of the member's doctor or other health care provider • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's sickness, injury, disease or symptoms. 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	by the medical-surgical portion of the plan and generally include the following: • Significant practice variation/variability that indicate over, under, misuse and/or ineffective use of services. Areas monitored for variability and variation are: o Level of care o Specific service/procedure o Geographic region o Diagnosis/condition o Provider/facility and/or • Significant drivers of changes in cost and use pattern trend such as: o High unit cost o High cost episode of care/services o Significant inexplicable clinically-based shifts in patterns of use and/or • Outlier performance against established benchmarks o Optum's national benchmarks o Third party benchmarks and/or • Benefits where there is disproportionate utilization by a subset of the population where targeted interventions increase effectiveness of care delivery and/or • Benefits that are unfavorably affected by preference/arbitrary system driven care • Benefits where there are significant gaps in care that negatively impact cost, quality and/or result in over or wasteful utilization • The potential for meaningful results from the UM activity relative to the administrative cost. The scope of methodologies, (e.g., benchmarking against national norms, statistical modeling, distribution curves, co-efficient of variance) used to		

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. 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.	determine when utilization management techniques should be best applied is based on the scope of methodologies that are used by the medical portion of the plan.		

2. 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
MCG would be used to identify any criteria that would correlate between the member's diagnoses and failure of outpatient treatment. Application of a "fail first" or "step therapy" requirement is based on use of nationally recognized clinical standards, which may be incorporated into the plan's review guidelines. Based on, and consistent with, these nationally recognized clinical standards, some of the plan's medical/surgical review guidelines have what may be considered to be "fail first" or "step	There are no first requirements or step therapies for outpatient services. The member must meet the medical necessity criteria for the requested level of OP services.	The MH/SUD process is not more stringent than the M/S.	No issues found. **BH parity requirements met.**

therapy" protocols.			

3. 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

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The medical/surgical inpatient benefit does not include exclusions based on a failure to complete a course of treatment. As noted in response to #1 above, inpatient coverage is determined by medical necessity.	There are no exclusions based on failure to complete a course of treatment. As noted in response to #1 above, inpatient coverage is determined by medical necessity.	There are no exclusions based on failure to complete a course of treatment for either M/S or MH/SUD.	No issues found. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: UM-1011-Policy-Prior-Authorization  UM-1011-Policy-Prior-Authorization.pdf			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Certain outpatient services require a prior authorization with the exception of emergency services that are needed to evaluate or stabilize an emergency condition as well as direct access to women's health services. Members are held harmless for services/procedures that require a prior authorization by a participating provider (in-network) in the event the provider does not obtain a prior authorization. Members may be held liable	Certain outpatient services require a prior authorization with the exception of emergency services that are needed to evaluate or stabilize an emergency condition. Members are held harmless for services/procedures that require a prior authorization by a participating provider (in-network) in the event the provider does not obtain a prior authorization.	The prior authorization processes are similar between M/S and MH.SUD and overall the MH/SUD process is not more stringent than the M/S.	No issues found. **BH parity requirements met.**

for services/procedures that require a prior authorization provided by a non-participating provider without prior authorization (excluding as noted above emergent/stabilization/women's health services).	Prior authorization is required for non-routine OP services, OP methadone maintenance treatment, Intensive Outpatient Programming, and Partial Hospitalization. Prior authorization is also required for all out-of-network provider providing any type of OP services. All authorizations are managed by fax to improve accuracy and timeliness of processing and are based upon the Optum Level of Care Criteria and other factors identified in section 3 above. The frequency and duration of services is determined based on the clinical criteria presented to ensure effective services at that level of care for least amount of time necessary to effect positive change.		

Concurrent Review

5. 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?

List of documents: UM-1061-Policy-Clinical-Review-Criteria; 2018 Optum UM Program Description UM-1061-Policy-Clinical_Review_Criteria.pdf 2018 Optum Behavioral UM Program			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Outlier management algorithms are applied to outpatient services based on the following criteria: •Treatment plans ranging from 1-24+ visits, with the likelihood for treatment being medically unnecessary increasing with higher number of	Concurrent Review is conducted on all outpatient treatment services for which an initial authorization was provided, following the initial authorization period. The factors that are explored in the decision, in addition to establishing that the member continues	The MH/SUD concurrent process is similar in structure and is not more stringent than the M/S concurrent review process.	No issues found. **BH parity requirements met.**

visits •Treatment durations ranging from 1-365+ days, with the likelihood for treatment being medically unnecessary increasing with longer treatment durations •Visits including multiple units of services, with the likelihood for treatment being medically unnecessary increasing with higher number of services per visit •Potential to bill for the same service using multiple levels of coding •Relatively low/modest cost per service • Variable rates of patient progress during a treatment plan • Variable approaches to patient care among providers •Coverage up to and including the point of maximum therapeutic benefit being attained, after which additional improvement is no longer expected, and coverage for the same services may no longer exist • A portion of patients never having complete resolution of their condition resulting in ongoing management for a chronic condition Based on the above criteria, the medical/surgical plan has identified the following services in the outpatient classification: •Chiropractic •Occupational Therapy •Physical Therapy Outpatient medical/surgical services rendered using E/M codes are not included in this outlier program. In order to ensure members have access to services available to them through their COC/SPD and the sponsor does not pay for non-covered	to meet the medical necessity criteria established in the level of care guidelines, is that the member continues to benefit from treatment, that treatment is progressive and cannot be provided at a lower level of care, and that the treatment is appropriate to the member's clinical needs and necessary for continued improvement.		

services a utilization review program is then applied to the identified medical/surgical services. This utilization review program has the following attributes: •Differentiated UR process based on historical provider performance •Business rules identify attributes of cases with a high likelihood for medically unnecessary services currently or in the relatively near future • Identified cases are clinically reviewed • In cases with apparent medically unnecessary services, peer to peer telephonic contact is initiated to make sure complete information is available • In cases where ongoing services have been determined to be unnecessary an adverse benefit determination is made and member/provider communication, compliant with all state and federal regulatory requirements, is issued •Appeals process is available for adverse determination			

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: UM-1061-Policy-Clinical-Review-Criteria; UM-1011-Policy-Prior-Authorization; 2018 Optum UM Program Description


UM-1061-Policy-Clinical_Review_Criteria.pdf


UM-1011-Policy-Prior-Authorization.pdf


2018 Optum Behavioral UM Prograr

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
•Concurrent review is a component of the plan's utilization management activities and includes medical necessity reviews. The Medical	Concurrent reviews are conducted via review of faxed clinical documentation for medical necessity. Notification to providers regarding authorization	The same process is exercised for both the M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

Director and other independently licensed clinical staff review care to detect and better manage over- and under-utilization and to determine whether continued services are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. •If a service requires prior authorization and services require authorization beyond the initial. •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. •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. UnitedHealthcare reviews these documents to adhere to NCQA 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,	determinations are provided verbally and in writing consistent with federal and state timeline requirements. The number of days authorized for outpatient treatment is tailored to the age of the client, reason for admission, presenting issues, type of and efficacy of current treatment and past treatment history. Denial determinations are made by a licensed psychiatrist with at least 5 years of experience in psychiatry. The average OP denial rate for concurrent reviews for all OP levels of care is 1.6%. There were no overturned appeals for these LOC in 2017 to current.		

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 through review of current, new and emerging medical technologies. While "Concurrent" is a term that generally refers to management of inpatient cases over the course of an inpatient stay, the following is based on Prior Authorization requests for the period of January 2017 to June 2018.			

Total # Auths	Total #/% of Auths cases w/Initial Adverse Determination	Total #/% of Initial Adverse Determination Cases Appealed	Total #/% of Appealed Cases overturned on Appeal	Total #/% Adverse Determination Cases Reversed other than Appeal	Total #/% of Auth Cases w/Persistent Adverse Determination
9,559	2018/21.2%	48/0.5%	23/47.9%	1030/51.0%	965/10.2%

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
•If a service requires prior authorization and services require authorization beyond the initial. •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.	Concurrent reviews are conducted approximately every 10 days on average for Partial Hospitalization, every 14 days for Intensive Outpatient Program, and every 9-12 months for out-of–network and non-routine OP services.	The M/S and MH/SUD processes for concurrent review of outpatient services including frequency are considered comparable as they are based on medical necessity and evidenced based criteria. Given the nature of certain MH/SUD outpatient programs (e.g. Partial Hospitalization) with no comparable	No issues found. **BH parity requirements met.**

•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. UnitedHealthcare relies on the National Recognized Practice Guidelines and review and approve the use of these guidelines annually. UnitedHealthcare reviews these documents to adhere to NCQA standards.		services with M/S, there are unique concurrent reviews to within MH/SUD.	

Prescription Drugs

8. 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.

<table>
<tr><td colspan="4">List of documents:</td></tr>
<tr><td>Medical/Surgical
(M/S)</td><td>Mental Health/Substance Use Disorder
(MH/SUD)</td><td>Comparability/Stringency w/ Explanation and/or Plan</td><td>State Review</td></tr>
<tr><td>UnitedHealthcare does not restrict or set limits on prescription drugs provided in an outpatient setting.

Due to the CMS Final Rule, tiers related to brand vs. generic have been established. The tiers are not tied to copays. The conditions treated do not affect the tier assignment of a medication.

<table><tr><th>Tier Name</th><th>Drug Tier</th></tr><tr><td>Tier 1</td><td>Generic</td></tr><tr><td>Tier 2</td><td>Brand</td></tr></table></td><td>UnitedHealthcare does not restrict or set limits on prescription drugs provided in an outpatient setting.

Due to the CMS Final Rule, tiers related to brand vs. generic have been established. The tiers are not tied to copays. The conditions treated do not affect the tier assignment of a medication.

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BH parity requirements met.</td></tr>
</table>

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents: CR-0001 Credentialing Process Policy, PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy

CR-0001 Credentialing Process.

PN-1003-Policy-Availability GeoAccess_1122

PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, provider disclosures, and licensure/certification. All applicable providers go through the credentialing process that is based on NCQA requirements. Credentialing of a provider is initiated prior to contracting with the provider. Once a provider has completed the credentialing process and approved by the Credentialing Committee, they are offered a contract with UnitedHealthcare. Participation criteria for practitioners include information about the provider, such as: 1. Education 2. Licensing 3. Applicant must have full hospital admitting privileges, without Material Restrictions, conditions or other disciplinary actions, at a minimum of	The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, provider disclosures, and licensure/certification. All applicable providers go through the credentialing process that is based on NCQA requirements. Credentialing of a provider is initiated prior to contracting with the provider. Once a provider has completed the credentialing process and approved by the Credentialing Committee, they are offered a contract with UnitedHealthcare. Participation criteria for practitioners include information about the provider, such as: 1. Education 2. Licensing 3. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant practices.	Network requirements for both M/S and MH/SUD are comparable.	No issues found. **BH parity requirements met.**

one participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Credentialing Entity determines that Applicant's practice requires such privileges. 4. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant. 5. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS. 6. Work History 7. Mal-practice Insurance or state approved alternative 8. Network participation UnitedHealthcare ensures that it has the network capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive, primary, acute, behavioral health services, and long-term services and supports (LTSS) and it maintains a sufficient number, mix, and geographic distribution of providers of covered services. UnitedHealthcare network providers must meet availability standards for	4. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS. 5. Work History - must provide a 5 year employment history. Gaps longer than 6 months must be explained by the applicant and found acceptable by the credentialing committee. 6. Mal-practice Insurance or state approved alternative 7. Network participation UnitedHealthcare ensures that it has the network capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive, primary, acute, behavioral health services, and long-term services and supports (LTSS) and it maintains a sufficient number, mix, and geographic distribution of providers of covered services. UnitedHealthcare network providers must meet availability standards for Medicaid members. Our Medicaid members and providers are notified of the plan’s policies for immediate care and for scheduling urgent, pediatric sick, adult sick and routine appointments. UnitedHealthcare monitors provider performance against		

Medicaid members. Our Medicaid members and providers are notified of the plan's policies for immediate care and for scheduling urgent, pediatric sick, adult sick and routine appointments. UnitedHealthcare monitors provider performance against the standards at a minimum on a quarterly basis. UnitedHealthcare ensures it's network has the capacity and is adequate to serve the expected enrollment in the service area to maintain a sufficient number, mix, and geographic distribution of providers for services; taking in consideration the distance that it takes the member to travel in normal traffic conditions, using usual travel means in a direct route from his/her home to the provider based on the GeoAccess Standards.	the standards at a minimum on a quarterly basis. UnitedHealthcare ensures it's network has the capacity and is adequate to serve the expected enrollment in the service area to maintain a sufficient number, mix, and geographic distribution of providers for services; taking in consideration the distance that it takes the member to travel in normal traffic conditions, using usual travel means in a direct route from his/her home to the provider based on the GeoAccess Standards.		

10. 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.

List of documents: CR-0001 Credentialing Process Policy, PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy


CR-0001 Credentialing Process.


PN-1003-Policy-Availability GeoAccess_1122


PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare does not exclude any provider types however we may exclude a provider based on the credentialing criteria. UnitedHealthcare complies with state licensing requirements and if there is a	UnitedHealthcare does not exclude any provider types however we may exclude a provider based on the credentialing criteria. UnitedHealthcare complies with state licensing requirements and if there is a	Same process is applied for both M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

practitioner type who is eligible a contract will be offered. All applicable providers must meet the requirements of our credentialing requirements.	practitioner type who is eligible a contract will be offered. All applicable providers must meet the requirements of our credentialing requirements.		

11. 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.

List of documents: PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy


PN-1003-Policy-Availability GeoAccess_1122


PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare does not impose or have any geographic limitations on provider inclusions.	UnitedHealthcare does not impose or have any geographic limitations on provider inclusions.	Same process is applied for both M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents: PN-1003 Availability of Network Providers and GeoAccess Monitoring Policy, and PN-1078 Selection and Retention of Providers Policy


PN-1003-Policy-Availability GeoAccess_1122


PN-1078-Policy-Selection and Retention_112

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare provides access to Out of Network (OON) providers (non-contracted providers) if an in-network provider is unable to provide medically necessary services in an adequate and timely manner to a member and continue to authorize the	UnitedHealthcare provides access to Out of Network (OON) providers (non-contracted providers) if an in-network provider is unable to provide medically necessary services in an adequate and timely manner to a member and continue to authorize the	Same process is applied for both M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

use of non-contract providers for as long as UnitedHealthcare is unable to provide services through network providers. UnitedHealthcare requires prior authorization approval for OON providers prior to rendering the service.	use of non-contract providers for as long as UnitedHealthcare is unable to provide services through network providers. UnitedHealthcare requires prior authorization approval for OON providers prior to rendering the service.		

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
UnitedHealthcare's Medicaid Fee Schedule is developed using the State's Medicaid Fee Schedule with alignment using Medicare relatively. Where the fee source does not publish a specific fee amount, UnitedHealthcare will use the CMS Gap fill using a % of prevailing Medicare. UnitedHealthcare will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). UnitedHealthcare will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being	UnitedHealthcare's Medicaid Fee Schedule is developed using the State's Medicaid Fee Schedule with alignment using Medicare relatively. Where the fee source does not publish a specific fee amount, UnitedHealthcare will use the CMS Gap fill using a % of prevailing Medicare. UnitedHealthcare will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). UnitedHealthcare will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being	Same process is applied for both M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

implemented by UnitedHealthcare will not be reprocessed unless otherwise required by law.	implemented by UnitedHealthcare will not be reprocessed unless otherwise required by law.		

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Professional provider reimbursement rates do not vary based on the factors listed above. In limited instances variations can occur based on availability of certain limited specialty services in Hawaii.	Professional provider reimbursement rates do not vary based on the factors listed above. In limited instances variations can occur based on availability of certain limited specialty services in Hawaii.	Same process is applied for both M/S and MH/SUD and therefore comparable.	No issues found. **BH parity requirements met.**

PRESCRIPTION DRUGS

Health Plan: UnitedHealthcare Community Plan Date: August 2, 2018
Contact Person: Jocelyn Tafao Email: Jocelyn_tafao@uhc.com #: 808-535-1058

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

List of documents: PH-1004-PharmacyCoverageReviews

PH-1004-PharmacyCoverageReviews.pdf

Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the medical necessity/appropriateness criteria for drug therapy are developed by UnitedHealthcare Pharmacy (UHCP) Team. Once developed or modified by UHCP the criteria is directed to the Pharmacy and Therapeutics (P&T) Committee process for review and adoption. The P&T Committee meets quarterly. Issues pertaining to drug selection and pharmacy program management are communicated quarterly through a newsletter to providers and are also available on the UnitedHealthcare Community Plan internet site.. An overview of the process is as follows:	As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the medical necessity/appropriateness criteria for drug therapy are developed by UnitedHealthcare Pharmacy (UHCP) Team. Once developed or modified by UHCP the criteria is directed to the Pharmacy and Therapeutics (P&T) Committee process for review and adoption. The P&T Committee meets quarterly. Issues pertaining to drug selection and pharmacy program management are communicated quarterly through a newsletter to providers and are also available on the UnitedHealthcare Community Plan internet site.. An overview of the process is as follows:	The development, modification, and adoption of medical necessity/appropriateness criteria follow the same steps and processes for medical/surgical drugs as for behavioral health/substance use disorder drugs in the pharmacy benefit criteria therefore M/S and MH/SUD are comparable.	No issues found. **BH parity requirements met.**

1. Development of Criteria a. The process is generally initiated by the approval of a medication by the Food and Drug Administration (FDA). Once approved by the FDA the medication will be reviewed for inclusion in the preferred drug list (PDL). As part of the review medical necessity/appropriateness criteria for use may be drafted if deemed appropriate by the review. b. When drafting the medical necessity/appropriateness criteria the following are considered: review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. c. Criteria development will consider the likely impact of a drug product on patient compliance when compared to alternative products. d. The criteria will be presented to the UHC UM Committee and UHC P&T Committee 2. Modification of Criteria a. Annually UHCP will review clinical criteria to determine if the criteria need to be modified based on new evidence. b. Ad hoc reviews may be performed at any time when questions concerning a particular indication are raised by medical directors, pharmacy directors, managers, through the coverage review or appeal process. c. Any new FDA approved indication that would be considered a covered	1. Development of Criteria a. The process is generally initiated by the approval of a medication by the Food and Drug Administration (FDA). Once approved by the FDA the medication will be reviewed for inclusion in the preferred drug list (PDL). As part of the review medical necessity/appropriateness criteria for use may be drafted if deemed appropriate by the review. b. When drafting the medical necessity/appropriateness criteria the following are considered: review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. c. Criteria development will consider the likely impact of a drug product on patient compliance when compared to alternative products. d. The criteria will be presented to the UHC UM Committee and UHC P&T Committee 2. Modification of Criteria a. Annually UHCP will review clinical criteria to determine if the criteria need to be modified based on new evidence. b. Ad hoc reviews may be performed at any time when questions concerning a particular indication are raised by medical directors, pharmacy directors, managers, through the coverage review or appeal process. c. Any new FDA approved indication that would be considered a covered		

benefit will be considered for addition to the criteria. d. Modified criteria will be reviewed for approval/adoption via the UHC P&T Committee process. 3. Adoption of Criteria a. The criteria are reviewed and approved via the UHC P&T process. b. Once the criteria have been reviewed and accepted they will be adopted for use/implemented. The time period needed for implementation is 60 days.	benefit will be considered for addition to the criteria. d. Modified criteria will be reviewed for approval/adoption via the UHC P&T Committee process. 3. Adoption of Criteria a. The criteria are reviewed and approved via the UHC P&T process. b. Once the criteria have been reviewed and accepted they will be adopted for use/implemented. The time period needed for implementation is 60 days.		

2. 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.

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
The step-therapy drugs are routinely covered only after a sufficient trial of an indicated first-line agent has been adequately tried and failed. These medications may also be requested through the Prior authorization process. The provider must submit clinical notes along with the PA form to document what medications were attempted and failed. The factors that the P&T Committee use to determine step-therapy include the prescribing and delivery of quality cost effective care, monitoring of utilization, and enhanced PDL compliance. The purpose is to ensure safe, proper and cost effective medication use. Members are required to try and fail preferred agents prior to receiving non-preferred agents to encourage the	The step-therapy drugs are routinely covered only after a sufficient trial of an indicated first-line agent has been adequately tried and failed. These medications may also be requested through the Prior authorization process. The provider must submit clinical notes along with the PA form to document what medications were attempted and failed. The factors that the P&T Committee use to determine step-therapy include the prescribing and delivery of quality cost effective care, monitoring of utilization, and enhanced PDL compliance. The purpose is to ensure safe, proper and cost effective medication use. Members are required to try and fail preferred agents prior to receiving non-preferred agents to encourage the	The step-therapy policy applies to both M/S and MH/SUD therefore M/S and MH/SUD are comparable.	No issues found. **BH parity requirements met.**

use of cost-effective drug therapies (preferred agents) prior to being able to fill the more expensive drug therapies (non-preferred agents). Preferred agents are more cost-effective than non-preferred agents. Preferred agents typically account for nearly 80% of a program's total prescription fills, but only 20%-30% of the cost.	use of cost-effective drug therapies (preferred agents) prior to being able to fill the more expensive drug therapies (non-preferred agents). Preferred agents are more cost-effective than non-preferred agents. Preferred agents typically account for nearly 80% of a program's total prescription fills, but only 20%-30% of the cost.		

3. 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

List of documents:			
Medical/Surgical (MS)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
There are no exclusions based on failure to complete treatment.	There are no exclusions based on failure to complete treatment.	Same requirement for both M/S and MH/SUD.	No issues found. **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

List of documents: PH-1004-PharmacyCoverageReviews  PH-1004-PharmacyCoverageReviews.pdf			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Medications that are on the UnitedHealthcare Prescription Drug List (PDL) are selected because they are considered both clinically appropriate and cost-effective. When	Behavioral Health medications are carved out to Ohana Health if the member is enrolled in CCS (Community Care Services). We	The same standards are used for both M/S and MH/SUD and are derived from Food & Drug Administration (FDA) indications, clinical trial information, manufacturer's information, and other	No issues found. **BH parity requirements met.**

a drug not listed on the PDL is requested by a provider, it must go through the prior authorization review. Prior authorization is required when a provider prescribes non-formulary/non-PDL medication or certain formulary medications that have precursor therapies, specific indications, or not routinely covered due to plan Benefit Limitations or Exclusions. An overview of the prior authorization process is as follows: • The provider prescribes a medication for the member that is one of the following: non-formulary; or, formulary but requires precursor therapies or has specific indications; or, not routinely covered due to Plan Benefit Limitations or Exclusions. • If the provider has advance knowledge of the prior authorization process, they can submit a prior authorization request prior to the pharmacy running a claim for the medication. • If the provider is not aware of the prior authorization the requirement, when the pharmacy submits a claim for the medication it will be with a message that prior authorization is required. • Should the member urgently need the medication, the pharmacy can submit a dynamic override code which will allow a 5 day supply of medication to be dispensed. This will allow time for prior authorization submission and urgent review. • The provider completes and submits	receive a monthly roster of members enrolled in this program. Currently, Suboxone and Subutex require a prior authorization, but the criteria will be changing as of Sept. 1, 2018, where having the pharmacist entering the appropriate diagnosis in their computer system will allow the prescription to process without a prior authorization. Sublocade will be covered under the medical benefit with a required prior authorization. Medications that are on the UnitedHealthcare Prescription Drug List (PDL) are selected because they are considered both clinically appropriate and cost-effective. When a drug not listed on the PDL is requested by a provider, it must go through the prior authorization review. Prior authorization is required when a provider prescribes non-formulary/non-PDL medication or certain formulary medications that have precursor therapies, specific indications, or not routinely covered due to plan Benefit Limitations or Exclusions. An overview of the prior authorization process is as follows: • The provider prescribes a medication for the member that is one of the following: non-formulary; or, formulary but requires precursor therapies or has specific indications; or, not routinely covered due to Plan Benefit Limitations or Exclusions. • If the provider has advance	national treatment guidelines. Per the HI Medicaid contract, there is to be an open formulary for antidepressants and antipsychotics, thus making it less stringent to get this type MH/SUD medications when compared to M/S medications. Overall the strategy, evidentiary standards, and the processes and procedures used to apply this NQTL appear to be similar to both M/S and MH/SUD medications and are applied no more stringently to MH/SUD drugs.	

a prior authorization request form along with relevant clinical documentation to support medical necessity. The request can be submitted either over the phone or via fax form. • The prior authorization request is received by pharmacy prior authorization unit and a clinical review for medical necessity is conducted. The request is reviewed against the applicable clinical policy and must be completed in amount of time allotted based upon the urgency of the request. • Urgent requests must be completed in 3 business days. • Standard requests must be completed in 14 calendar days. • Once the review is complete notice of action is sent to both the member and provider. If the notice of action is a denial then the member and provider are advised other their options and Appeals Rights. Prior authorization requests are reviewed by the following staff: • Licensed Pharmacy Technicians • Licensed Clinical Pharmacists • Licensed Physicians Please note: Only a physician may deny a prior authorization request based upon lack of medical necessity. Assessing the approval denial rate for a particular drug and across the spectrum of drugs will indicate the rigor with which the authorization standards. An Inter-rater Reliability Process is used to measure and assess adherence to the approved clinical	knowledge of the prior authorization process, they can submit a prior authorization request prior to the pharmacy running a claim for the medication. • If the provider is not aware of the prior authorization the requirement, when the pharmacy submits a claim for the medication it will be with a message that prior authorization is required. • Should the member urgently need the medication, the pharmacy can submit a dynamic override code which will allow a 5 day supply of medication to be dispensed. This will allow time for prior authorization submission and urgent review. • The provider completes and submits a prior authorization request form along with relevant clinical documentation to support medical necessity. The request can be submitted either over the phone or via fax form. • The prior authorization request is received by pharmacy prior authorization unit and a clinical review for medical necessity is conducted. The request is reviewed against the applicable clinical policy and must be completed in amount of time allotted based upon the urgency of the request. • Urgent requests must be completed in 3 business days. • Standard requests must be completed in 14 calendar days. • Once the review is complete notice of action is sent to both the member and provider. If the notice of action is a denial then the member and provider are advised other their options and		

policies when reviewing prior authorization requests. Over application of prior authorization to a particular drug could be measured by the approval/denial rate. If the approval rate is very high, then the medication is being utilized appropriately and prior authorization could be unnecessary.	Appeals Rights. Prior authorization requests are reviewed by the following staff: • Licensed Pharmacy Technicians • Licensed Clinical Pharmacists • Licensed Physicians Please note: Only a physician may deny a prior authorization request based upon lack of medical necessity. Assessing the approval denial rate for a particular drug and across the spectrum of drugs will indicate the rigor with which the authorization standards. An Inter-rater Reliability Process is used to measure and assess adherence to the approved clinical policies when reviewing prior authorization requests. Over application of prior authorization to a particular drug could be measured by the approval/denial rate. If the approval rate is very high, then the medication is being utilized appropriately and prior authorization could be unnecessary.		

Concurrent Review

5. 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?

List of documents: PH-1010-DrugUtilizationReview

PH-1010-DrugUtilizationReview.pdf

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation and/or Plan	State Review

	(MH/SUD)		
Medispan database is used to assist retail and mail order pharmacists with therapeutic decisions with at least 9 system edits. Duration of treatment, drug-drug interactions, and therapeutic duplication are some of the edits that are used The screening edits that are utilized include: 1) Drug-Drug Interaction Screening 2) Diagnosis Caution Screening 3) Drug Inferred Screening 4) Drug-Age Contraindication Screening 5) Drug-Sex Contraindication Screening 6) Duplicate Prescription Screening 7) Drug Class Duplication Screening 8) Refill Too Soon 9) Therapeutic Dose Limits Screening	If member is not in Community Care Services (those members receive Mental Health meds from Ohana Insurance), meds are reviewed through our cDUR program which consists of various Point of Sale edits. Medispan database is used to assist retail and mail order pharmacists with therapeutic decisions with at least 9 system edits. Duration of treatment, drug-drug interactions, and therapeutic duplication are some of the edits that are used The screening edits that are utilized include: 1) Drug-Drug Interaction Screening 2) Diagnosis Caution Screening 3) Drug Inferred Screening 4) Drug-Age Contraindication Screening 5) Drug-Sex Contraindication Screening 6) Duplicate Prescription Screening 7) Drug Class Duplication Screening 8) Refill Too Soon Therapeutic Dose Limits Screening	Both M/S and MH/SUD are reviewed equally through the concurrent review process therefore M/S and MH/SUD are comparable.	No issues found. **BH parity requirements met.**

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

List of documents: PH-1010-DrugUtilizationReview

PH-1010-DrugUtilizationReview.pdf

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation and/or Plan	State Review

	(MH/SUD)		
A concurrent DUR program screens all retail and mail service prescription claims at the point of service before the drug is dispensed. The concurrent DUR system screens each prescription against the member's prescription drug history. The system checks for inappropriate drug prescribing and utilization, as well as potentially dangerous medical implications or drug interactions. The program includes communication avenues through claims edits and messaging to the dispensing pharmacy at point-of-service. Our concurrent reviews do not have appeal overturn rates but the average number of prescriptions that were screened through the cDUR program during 2017 had a 53.9% paid rate; 20.3% were rejected; and 54.3% were reversed; total of 42.2% prescriptions. The prior authorization figures are listed below and do include appeal overturn rates. Med/Surg meds had 22 cases appealed with a 27.3% overturn rate. The approval rate for PA's were 51.9% with a denial rate of 48.1%.*	A concurrent DUR program screens all retail and mail service prescription claims at the point of service before the drug is dispensed. The concurrent DUR system screens each prescription against the member's prescription drug history. The system checks for inappropriate drug prescribing and utilization, as well as potentially dangerous medical implications or drug interactions. The program includes communication avenues through claims edits and messaging to the dispensing pharmacy at point-of-service. Our concurrent reviews do not have appeal overturn rates but the average number of prescriptions that were screened through the cDUR program during 2017 had a 53.9% paid rate; 20.3% were rejected; and 54.3% were reversed; total of 42.2% prescriptions. The prior authorization figures are listed below and do include appeal overturn rates MH/SUD meds had 2 cases with a 50% overturn rate for appeals. The approval rate for PA's were 59.1 % with a denial rate of 41.9%*	Although the overturn rate was higher MH/SUD, the approval and denial rates for prior authorizations were similar for both M/S and MH/SUD. Both classes of medications are screened with the same criteria therefore M/S and MH/SUD are comparable.	No issues found. **BH parity requirements met.**

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

POS edits are conducted whenever a prescription is filled at point of service at a retail or mail order pharmacy. The UnitedHealthcare Pharmacy reviews the DUR summaries quarterly and they are then reviewed by the Quality Management Committee.	POS edits are conducted whenever a prescription is filled at point of service at a retail or mail order pharmacy. The UnitedHealthcare Pharmacy reviews the DUR summaries quarterly and they are then reviewed by the Quality Management Committee.	The POS edits are applied equally to M/S and MH/SUD medications therefore M/S and MH/SUD are comparable.	No issues found. **BH parity requirements met.**

Prescription Drugs

8. 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.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Due to the CMS Final Rule, tiers related to brand vs. generic have been established. The tiers are not tied to copays. The conditions treated do not affect the tier assignment of a medication. **Tier Name** / **Drug Tier** Tier 1 / Generic Tier 2 / Brand	Due to the CMS Final Rule, tiers related to brand vs. generic have been established. The tiers are not tied to copays. The conditions treated do not affect the tier assignment of a medication. **Tier Name** / **Drug Tier** Tier 1 / Generic Tier 2 / Brand	There are no differences in the drug benefits tiered for M/S or MH/SUD medications therefore M/S and MH/SUD are comparable.	No issues found. **BH parity requirements met.**

NETWORK ADMISSION REQUIREMENTS

9. 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.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review

The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. We contractually require each pharmacy to ensure credentials and compliance as well as Chain and PSAO organizations to maintain a credentialing program for itself and their member pharmacies. **Processes:** We contractually require each pharmacy to ensure credentials and compliance as well as Chain and PSAO organizations to maintain a credentialing program for itself and their member pharmacies. Credentialing requirements, but are not limited to: • Validation of state pharmacy licenses • Validation of the Pharmacist in Charge License • Validation of the DEA license • Insurance showing adequate coverage • Copy Wholesale Invoice/Drug Purchase Packing Slip • Ownerships and affiliations • Review of disciplinary actions, convictions, restrictions and	The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. We contractually require each pharmacy to ensure credentials and compliance as well as Chain and PSAO organizations to maintain a credentialing program for itself and their member pharmacies. **Processes:** We contractually require each pharmacy to ensure credentials and compliance as well as Chain and PSAO organizations to maintain a credentialing program for itself and their member pharmacies. Credentialing requirements, but are not limited to: • Validation of state pharmacy licenses • Validation of the Pharmacist in Charge License • Validation of the DEA license • Insurance showing adequate coverage • Copy Wholesale Invoice/Drug Purchase Packing Slip • Ownerships and affiliations • Review of disciplinary actions, convictions, restrictions and any other adverse actions	Provider enrollment requirements are the same for both M/S and MH/SUD providers therefore M/S and MH/SUD are comparable.	No issues found. **BH parity requirements met.**

any other adverse actions In addition, each month we validate our pharmacy network against the U.S. Department of Health and Human Services, Office of Inspector General (OIG) list of excluded individuals and entities (LEIE) to ensure no excluded pharmacy is on that LEIE. Pharmacies, if identified on that list, are immediately termed from the pharmacy network. Pharmacies are required to insure compliance with professional standards that include, but not limited to: • Have an NCPDP# • Ability to transmit 100% of claims via the point of service system (POS) • Maintain verifiable records and signature logs • Allow for on-site audits of records and prescriptions • Maintain adequate insurance coverage • Comply with the Agreement and Provider Manual • Agree to comply with all Drug Utilization Review (DUR)	In addition, each month we validate our pharmacy network against the U.S. Department of Health and Human Services, Office of Inspector General (OIG) list of excluded individuals and entities (LEIE) to ensure no excluded pharmacy is on that LEIE. Pharmacies, if identified on that list, are immediately termed from the pharmacy network. Pharmacies are required to insure compliance with professional standards that include, but not limited to: • Have an NCPDP# • Ability to transmit 100% of claims via the point of service system (POS) • Maintain verifiable records and signature logs • Allow for on-site audits of records and prescriptions • Maintain adequate insurance coverage • Comply with the Agreement and Provider Manual • Agree to comply with all Drug Utilization Review (DUR) and Client's plan design parameters		

and Client's plan design parameters • Comply with applicable State and Federal laws All pharmacies are fully re-credentialed at least every three years. Pharmacy's need to meet specific compound drug credentialing criteria, including but not limited to: • Accreditation from one of the following two accreditation organizations: 1) PCAB - Pharmacy Compounding Accreditation Board 2) NABP-VPP – National Association of Boards of Pharmacy Verified Pharmacy Program • Maintain a continuous quality improvement process (inclusive of validation testing for endotoxin, stability and sterility), Beyond Use Date (BUD) verifications, clean room certifications, review of FDA approved vendors for API purchases, Anticipatory compounding procedure review, NCPDP D.0 multi-ingredient claims submission compliance, daily calibration and routine maintenance verifications (e.g. autoclave, electronic balances, convention oven, incubator, automated compounding devices such as pumps), staff	• Comply with applicable State and Federal laws All pharmacies are fully re-credentialed at least every three years. Pharmacy's need to meet specific compound drug credentialing criteria, including but not limited to: • Accreditation from one of the following two accreditation organizations: 1) PCAB - Pharmacy Compounding Accreditation Board 2) NABP-VPP – National Association of Boards of Pharmacy Verified Pharmacy Program • Maintain a continuous quality improvement process (inclusive of validation testing for endotoxin, stability and sterility), Beyond Use Date (BUD) verifications, clean room certifications, review of FDA approved vendors for API purchases, Anticipatory compounding procedure review, NCPDP D.0 multi-ingredient claims submission compliance, daily calibration and routine maintenance verifications (e.g. autoclave, electronic balances, convention oven, incubator, automated compounding devices such as pumps), staff competency evaluations, Media fill process verification testing, clean room garb procedures and testing, an ethics management compliance		

competency evaluations, Media fill process verification testing, clean room garb procedures and testing, an ethics management compliance review to include business operations, compliance with Anti-Kickback and Stark law, state/federal pharmacy law, compliance with USP 795 and USP 797, defined allowable sales and marketing conduct, a defined compounding code of conduct and pharmacy manual, and an onsite credentialing review. UHC provides a consistent and standard credentialing approach for our network pharmacies. As is the industry standard, our network pharmacies must comply with national and industry standards as listed above in the Processes Section, including but not limited to NCPDP, PCAB-VPP, for claims submission, contractual compliance, legal and pharmacy board requirements.	review to include business operations, compliance with Anti-Kickback and Stark law, state/federal pharmacy law, compliance with USP 795 and USP 797, defined allowable sales and marketing conduct, a defined compounding code of conduct and pharmacy manual, and an onsite credentialing review. UHC provides a consistent and standard credentialing approach for our network pharmacies. As is the industry standard, our network pharmacies must comply with national and industry standards as listed above in the Processes Section, including but not limited to NCPDP, PCAB-VPP, for claims submission, contractual compliance, legal and pharmacy board requirements.		

10. 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.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
No	No	N/A Note: the only limitations on practitioner types for pharmacy are those imposed by	No issues found. **BH parity requirements met.**

		State/Federal requirements and regulations on which practitioners have prescriptive authority.	

11. 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.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or PlanS	State Review
On an annual basis as part of the PBA oversight audit, UnitedHealthcare will validate network access levels by the review of GeoAccess reports. In the event that a network deficiency is confirmed, and is deemed to be correctable, UnitedHealthcare Community & State or the PBA is obligated to correct the stated Deficiency. For urban pharmacies the requirements are: • 1 Pharmacy within 15 minutes driving time (Urban is defined as the Honolulu Metropolitan Statistical Area); • 24 Hour Pharmacy for within 60 minutes Urban[Honolulu CBSA (MSA)/Estimated Driving Time The requirements for non-urban pharmacies are:	On an annual basis as part of the PBA oversight audit, UnitedHealthcare will validate network access levels by the review of GeoAccess reports. In the event that a network deficiency is confirmed, and is deemed to be correctable, UnitedHealthcare Community & State or the PBA is obligated to correct the stated Deficiency. For urban pharmacies the requirements are: • 1 Pharmacy within 15 minutes driving time (Urban is defined as the Honolulu Metropolitan Statistical Area); • 24 Hour Pharmacy for within 60 minutes Urban[Honolulu CBSA (MSA)/Estimated Driving Time The requirements for non-urban pharmacies are:	The geographic access requirements for pharmacies are the same for both M/S and MH/SUD. UnitedHealthcare does not differentiate or otherwise limit pharmacies (or prescribers) based on geography for either M/S or MH/SUD providers.	No issues found. **BH parity requirements met.**

• 1 Pharmacy within 60 minutes driving time Rural [Non-Honolulu CBSA (MSA) [Estimated Driving Time]	• 1 Pharmacy within 60 minutes driving time Rural [Non-Honolulu CBSA (MSA) [Estimated Driving Time]		

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
If a member goes to an out of network pharmacy, the claim will reject at point of sale and the pharmacy can contact OptumRx to obtain info on how to apply to gain network pharmacy status. In order to become a Network Pharmacy Provider, a credentialing application must be obtained. The provider must meet the OptumRx credentialing requirements and be able to comply with the requirements of the Agreement and OptumRx Pharmacy Manual. All Network Pharmacy Providers shall be credentialed pursuant to the OptumRx credentialing policy prior to submitting any claims.	If a member goes to an out of network pharmacy, the claim will reject at point of sale and the pharmacy can contact OptumRx to obtain info on how to apply to gain network pharmacy status. In order to become a Network Pharmacy Provider, a credentialing application must be obtained. The provider must meet the OptumRx credentialing requirements and be able to comply with the requirements of the Agreement and OptumRx Pharmacy Manual. All Network Pharmacy Providers shall be credentialed pursuant to the OptumRx credentialing policy prior to submitting any claims.	The standards would be the same for M/S and MH/SUD prescriptions therefore comparable.	No issues found. **BH parity requirements met.**

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

List of documents:

Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
Reimbursement rates depend on the contract with the pharmacy. An equal	Reimbursement rates depend on the contract with the pharmacy. An equal	Although reimbursement prices are set at the drug level, the strategy, evidence used as resources, and the process to set drug	No issues found. **BH parity requirements met.**

percentage of the standard is applied to both M/S and MH/SUD.	percentage of the standard is applied to both M/S and MH/SUD.	reimbursement rates are generally the same for MH/SUD and M/S drugs and are therefore comparable.	

14. 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, practice size, Medicare reimbursement rates, licensure, other.

List of documents:			
Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency (y/n) w/ Explanation and/or Plan	State Review
Service type and geographic market affects reimbursement rates. Specialty pharmacies, for example, have a different reimbursement rate compared to a retail pharmacy. A small rural pharmacy can have a different rate of reimbursement than a retail chain pharmacy. 340B pharmacies have different reimbursement rates.	Service type and geographic market affects reimbursement rates. Specialty pharmacies, for example, have a different reimbursement rate compared to a retail pharmacy. A small rural pharmacy can have a different rate of reimbursement than a retail chain pharmacy. 340B pharmacies have different reimbursement rates.	The factors that determine pharmacy reimbursement can vary by pharmacy type (e.g. small, chain, 340B) but are the same for both M/S and MH/SUD situations and therefore comparable.	No issues found. **BH parity requirements met.**

ATTACHMENT (C)

NQTL ANALYSIS

Statewide Comparison

NQTL ANALYSIS FOR BH PARITY – EMERGENCY CARE

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Prior authorization is not required for urgent care, emergency services and/or post-stabilization care and services.	In developing medical necessity standards for Medical/Surgical services, HMSA considers scientific evidence/peer reviewed literature, professional standards of care, expert opinion and community input and utilizes multiple sources including: • Hawaii Revised Statutes (HRS §432E-1.4) • Blue Cross Blue Shield Association guidelines and medical policies • Milliman Care Guidelines (MCG) Along with the available medical evidence, additional consideration is given to factors such as a treatment's cost-effectiveness, most appropriate delivery of level of service, and potential benefits and harms to the patient to determine medical necessary of medical/surgical treatments and services. Medical necessity criteria (aka policies) are developed by HMSA Medical Directors with input from medical practitioners in the community. Once policies are developed, reviews of the medical necessity criteria are conducted at least annually and more frequently as new evidences become available.	No medical necessity review is performed for emergency care.	Since medical necessity review is not applicable to emergency care, this section is not applicable	As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the following components are taken into consideration: "A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is: (1) For the purpose of treating a medical condition; (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient; (3) Known to be effective in improving health outcomes; provided that: (A) Effectiveness is determined first by scientific evidence; (B) If no scientific evidence exists, then by professional standards of care; and (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost effective shall not necessarily mean the lowest price."	Since medical necessity review is not applicable to emergency care, this section is not applicable	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

2. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	Not applicable	No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the	There are no fail first requirements for emergency care, thus, this section is not applicable	NA for emergency services	There are no fail first requirements for emergency care, thus, this section is not applicable	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services.

		Pharmacy & Therapeutics Committee and reviewed annually				**BH parity requirements met.**

3. 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

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	Not applicable	Not applicable for emergency care.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting. Clarified response 10/31/18: No, this does not apply for emergency situations whether medical or behavioral. There is no protocol for emergent services that would include failure to complete a course of treatment since there would be no prescribed course of treatment predicating an emergency.	NA for emergency services	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting. Clarified response 10/31/18: No, this does not apply for emergency situations whether medical or behavioral. There is no protocol for emergent services that would include failure to complete a course of treatment since there would be no prescribed course of treatment predicating an emergency.	CCS is more stringent than AlohaCare, HMSA, Kaiser and United. **BH parity is in question.** **11/5/18:** **BH parity no longer in question.** **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	Not applicable	Pre-service authorization is not required for emergency care.	There are not prior authorization requirements for Emergency Care	Emergency Services do not require Prior Authorization.	There are not prior authorization requirements for Emergency Care	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

Concurrent Review

5. 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?

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	Not applicable	Concurrent review is not required for emergency care.	There is no concurrent review for Emergency Care	Emergency Services do not require concurrent review.	There is no concurrent review for Emergency Care	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services.

						BH parity requirements met.

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	Not applicable	Concurrent review is not required for emergency care.	There is no concurrent review for Emergency Care	NA for emergency services	There is no concurrent review for Emergency Care	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	Not applicable	Concurrent review is not required for emergency care.	There is no concurrent review for Emergency Care	NA for emergency services	There is no concurrent review for Emergency Care	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

<u>Prescription Drugs</u>

8. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
No tiers	Not applicable	Prescription drug benefits are not tiered for Medicaid members.	The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescriber's e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	UnitedHealthcare does not restrict or set limits on prescription drugs provided in an emergency setting or take home drugs.	The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescriber's e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	CCS is more stringent than AlohaCare, HMSA, Kaiser and United. **BH parity is in question.** **11/5/18:** **BH parity no longer in question.** **BH parity requirements met.**

			Clarified response 10/31/18: No, prescription drug benefits are not tiered for Medicaid beneficiaries. Since prescription drugs, by their very nature, are not emergent, this question does not really apply to this document. Emergent drugs would be administered by the facility where the emergency is being treated (i.e., an emergency room at the facility where the patient presents with their emergency) versus via a prescription.		Clarified response 10/31/18: No, prescription drug benefits are not tiered for Medicaid beneficiaries. Since prescription drugs, by their very nature, are not emergent, this question does not really apply to this document. Emergent drugs would be administered by the facility where the emergency is being treated (i.e., an emergency room at the facility where the patient presents with their emergency) versus via a prescription.	

NETWORK ADMISSION REQUIREMENTS

9. 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.

ALOHACARE	HMSA	KAISER	‘OHANA	UNITED	‘OHANA CCS	COMPARABILITY/STRINGENCY
N/A	Providers must be appropriately licensed or certified in accordance with state and national guidelines, meet all standard educational and credentialing criteria for their specialty, not be an excluded entity with Medicare or Medicaid programs, and have met all continuing educational requirements specific to their provider type Provider must be willing to contract at sustainable rates and to submit all required documentation for both credentialing process and for system configuration for adjudication of provider claims. Provider onboarding process can be initiated either by the health Plan or Provider followed by execution of a contract between Plan and Provider for participation in one or more products. Plan monitors network needs on a regular basis in accordance with its practitioner availability policies	Not applicable for emergency care.	There are no network requirements for Emergency Care	The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, provider disclosures, and licensure/certification. All applicable providers go through the credentialing process that is based on NCQA requirements. Credentialing of a provider is initiated prior to contracting with the provider. Once a provider has completed the credentialing process and approved by the Credentialing Committee, they are offered a contract with UnitedHealthcare. Participation criteria for practitioners include information about the provider, such as: 1. Education 2. Licensing 3. Applicant must have full hospital admitting privileges, without Material Restrictions, conditions or other disciplinary	There are no network requirements for Emergency Care	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

	and will initiate outreach to non-par Providers if network analysis shows a need in a specific geography. Also, non-par Providers frequently initiate a request for participation. Plan will either respond and begin contracting process or politely decline if credentialing requirements are not met. Plan retains all rights to determine which providers it adds to its provider networks. HMSA has formal credentialing criteria and a Credentialing Committee.			actions, at a minimum of one participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Credentialing Entity determines that Applicant's practice requires such privileges. 4. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant. 5. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS. 6. Work History 7. Mal-practice Insurance or state approved alternative 8. Network participation UnitedHealthcare ensures that it has the network capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive, primary, acute, behavioral health services, and long-term services and supports (LTSS) and it maintains a sufficient number, mix, and geographic distribution of providers of covered services. UnitedHealthcare network providers must meet availability standards for Medicaid members. Our Medicaid members and providers are notified of the plan’s policies for immediate care and for scheduling urgent, pediatric sick, adult sick and routine appointments. UnitedHealthcare		

				monitors provider performance against the standards at a minimum on a quarterly basis. UnitedHealthcare ensures it's network has the capacity and is adequate to serve the expected enrollment in the service area to maintain a sufficient number, mix, and geographic distribution of providers for services; taking in consideration the distance that it takes the member to travel in normal traffic conditions, using usual travel means in a direct route from his/her home to the provider based on the GeoAccess Standards.		

10. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Per Credentialing policies and licensing regulations, providers must provide services within the scope of their license. AlohaCare will cover emergency services provided by any provider practicing and providing care within the scope of the provider's license and accreditation.	HMSA does not have any exclusions pertaining to provider types, facility types, or specialty providers.	Not applicable for emergency care.	There are no network requirements for Emergency Care	UnitedHealthcare does not exclude any provider types however we may exclude a provider based on the credentialing criteria. UnitedHealthcare complies with state licensing requirements and if there is a practitioner type who is eligible a contract will be offered. All applicable providers must meet the requirements of our credentialing requirements.	There are no network requirements for Emergency Care	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

11. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	There are no geographic limitations	Not applicable for emergency care.	There are no network requirements for Emergency Care	UnitedHealthcare does not impose or have any geographic limitations on provider inclusions.	There are no network requirements for Emergency Care	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of- network benefits.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	QUEST Integration members have no out-of-network benefits except for emergencies. If a member is admitted for an emergent condition, no prior authorization or concurrent reviews are required	Not applicable for emergency care.	There are no network requirements for Emergency Care	UnitedHealthcare provides access to Out of Network (OON) providers (non-contracted providers) if an in-network provider is unable to provide medically necessary services in an adequate and timely manner to a	There are no network requirements for Emergency Care	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

	until the time the member's condition is stabilized.			member and continue to authorize the use of non-contract providers for as long as UnitedHealthcare is unable to provide services through network providers. UnitedHealthcare requires prior authorization approval for OON providers prior to rendering the service.		

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
All provider contracts are negotiated rates and vary according to terms reached in negotiation. Most begin with the state's FFS fee schedule, or are a percentage of Medicare FFS fee schedule. This is true for physicians, PhDs and MAs.	Initial fees were established at the beginning of the QUEST program in 1994. At that time, fees were established based on the Medicaid FFS schedule at that time. Since then increases or decreases were based on the reimbursement rates set by the state to the Insurance plans. Adjustments are made to the changes in coding that occur nationally. For ABD and Non-ABD, we primarily follow the Medicaid fee schedule. Some provider's fees are individually negotiated. Psychiatrists and Psychologists are paid the same rate. Child Psychiatrists are paid 110% of the Psychiatrist fee. Social workers, Marriage Family Therapists, Mental health counselors, and APRNs are paid 85% of the psychiatrist rate.	Not applicable for emergency care.	There are no network requirements for Emergency Care	UnitedHealthcare's Medicaid Fee Schedule is developed using the State's Medicaid Fee Schedule with alignment using Medicare relatively. Where the fee source does not publish a specific fee amount, UnitedHealthcare will use the CMS Gap fill using a % of prevailing Medicare. UnitedHealthcare will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). UnitedHealthcare will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by UnitedHealthcare will not be reprocessed unless otherwise required by law.	There are no network requirements for Emergency Care	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Medicare reimbursement, and service demand/network adequacy and capacity are the primary drivers for both M/S and MH/SUD providers. Some medical and mental health	Emergency Care follows professional fee schedule rates and hospitals are individually negotiated. All rates are based on budget availability. Rural areas may play a factor due to access issues.	Professional provider reimbursement rates for emergency care are determined by Medicaid and Medicare fee schedules.	There are no network requirements for Emergency Care	Professional provider reimbursement rates do not vary based on the factors listed above. In limited instances variations can occur based on availability of certain limited specialty services in Hawaii.	There are no network requirements for Emergency Care	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

specialties are in a workforce shortage situation.						

NQTL ANALYSIS FOR BH PARITY - INPATIENT

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Inpatient H, Maternity/Newborn Care, and Sub-acute Short/Long Term Rehabilitation services include: • Room and board • nursing care • medical supplies • equipment and drugs • diagnostic services • physical therapy • occupational therapy • audiology • speech- language pathology service • other medically necessary services. Concurrent Review process: • Notification facesheet received from facility within 24 hours of member's admission. • Intake (TCSS) receives notification facesheet and creates authorization and pends them to the UM clinician for review • UM clinician accepts the authorization and request clinical notes from facility. • Based on clinical notes reviewed, clinician will approve length of stay (LOS) and level of care (LOC) based on InterQual Criteria. Every 2 days for Acute Inpatient Every 7 days for SNF level of care	In developing medical necessity standards for Medical/Surgical services, HMSA considers scientific evidence/peer reviewed literature, professional standards of care, expert opinion and community input and utilizes multiple sources including: • Hawaii Revised Statutes (HRS §432E-1.4) • Blue Cross Blue Shield Association guidelines and medical policies • Milliman Care Guidelines (MCG) Along with the available medical evidence, additional consideration is given to factors such as a treatment's cost-effectiveness, most appropriate delivery of level of service, and potential benefits and harms to the patient to determine medical necessary of medical/surgical treatments and services. Medical necessity criteria (aka policies) are developed by HMSA Medical Directors with input from medical practitioners in the community. Once policies are developed, reviews of the medical necessity criteria are conducted at least annually and more frequently as new evidences become available.	Medical necessity/appropriateness determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Criteria for Adult and Pediatric; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502). Concurrent review and authorization for continued coverage during inpatient acute hospitalization is performed every 1-3 days. (Note: When member is confined to an out-of-state inpatient facility, there may be occasional concurrent review delays pending receipt of requested concurrent medical information. Concurrent reviews will be performed when information is received.) Concurrent review and authorization for continued coverage in an alternate inpatient setting (e.g., SNF) is performed every 7-14 days.	Depending on the pre-service procedure, Industry accepted Medical Criteria and approved `Ohana Clinical Coverage Guidelines are utilized to assess medical necessity and appropriateness. If none is available based on service requested, or criteria is not met, a request is sent for a secondary Medical Director review Industry accepted medical necessity criteria in this classification and authorization rules include but are not limited to: • Clinical complexity, • Place of service appropriateness, • Financial and utilization data, and • Benefit restrictions, such as cosmetic procedures. • Diagnosis and clinical must be supplied by the facility. • Number of days approved are based on diagnosis and member co-morbidities. • Concurrent reviews are every 3 days • Discharge planning begins on admission Authorization is nearly always required for inpatient settings, with some exceptions on the claims side for newborn deliveries. Inpatient hospital services are considered and treated as an	As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the following components are taken into consideration: "A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is: (1) For the purpose of treating a medical condition; (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient; (3) Known to be effective in improving health outcomes; provided that: (A) Effectiveness is determined first by scientific evidence; (B) If no scientific evidence exists, then by professional standards of care; and (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost effective shall not necessarily mean the lowest price." UnitedHealthcare uses Milliman Care Guidelines (MCG) evidenced based criteria to determine the most appropriate level of inpatient care with care guidelines specific to the member's admitting	Industry accepted Medical Necessity Criteria (in addition to `Ohana's Clinical Coverage Guidelines are utilized to assess medical necessity (MN) and appropriateness. Authorizations are given based on MN. If there is a concern that an authorization does not meet MN, we offer a peer to peer review. Industry accepted medical necessity criteria in this classification routinely include: • Level of clinical need that cannot be met in an outpatient environment. • Safety of the patient regarding danger to self or others, • current mental status, • compliance with medication and • duration of the current psychiatric event. Inpatient Psychiatric hospital services are considered and treated as an emergency service. As such, we request the provider to notify us within 24 hours of admission and while an authorization is required, prior authorization is not required. Inpatient hospital services are considered and treated as an emergency service. We request the provider to notify us within 24 hours of admission. If there is a concern that an authorization does not meet MN, we offer a peer to peer review and we will send for a secondary review.	All MCO's use federal and state guidelines to make determinations of medical necessity. All are comparable with CCS BH services. **BH parity requirements met.**

• If criteria is not met, concurrent review nurse will contact facility UM review nurse to discuss level of care. • If both the concurrent and facility nurses agree, continue with review • If there is a disagreement and level of care/length of stay is potentially denied, authorization is pended to Medical Director for a Secondary review. • After the MD completes the secondary review, the MD returns the authorization to the UM clinician. • UM Clinician will process the denial and provide a verbal/written notification to facility and written notification to member. • If member is still inpatient, concurrent review will resume until member is discharged home.		Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness.	emergency service. We request the provider to notify us within 24 hours of admission. If there is a concern that an authorization does not meet MN, we offer a peer to peer review and we will send for a secondary review.	diagnosis. MCG supports the nurse's approval decisions and those cases that may not meet the evidenced based criteria. When the member's clinical does not appear to meet MCG inpatient guidelines, a higher level of review is required. The case is then escalated to the receiving medical director to review for potential adverse determination (see Inpatient Medical Necessity document above). Medical review frequency is based off of UnitedHealthcare Priority Review Process (see document name and number above). Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms, which are all of the following as determined by UnitedHealthcare or our designee, within our sole discretion. • In accordance with *Generally Accepted Standards of Medical Practice* • Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's sickness, injury, mental illness, substance use disorder, disease or its symptoms • Not mainly for the member's convenience or that of the member's doctor or other health care provider • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's sickness, injury, disease or symptoms. 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. 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.		

2. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Clinician will receive notification of the admission and request clinical notes to initiate Concurrent review. Once the clinical notes is received, the hospital stay is reviewed beginning on the day of admission. The clinical notes are reviewed against Interqual guidelines starting with the day of acute admission. If the length of stay (LOS) or the level of care (LOC) is not appropriate due to inadequate interventions/services being performed during the member's inpatient confinement, the clinician will notify the facility's CM/SW regarding the failed requirements to continue the LOS or to remain in the LOC the member is currently at. If the	There are no fail first requirements for Inpatient treatments under Medical/Surgical benefits. Fail first requirements or step-therapies for prescription drugs are not applicable in the Inpatient document. Please refer to the NQTL- Prescription Drugs document	No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed annually.	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-	MCG would be used to identify any criteria that would correlate between the member's diagnoses and failure of outpatient treatment. Application of a "fail first" or "step therapy" requirement is based on use of nationally recognized clinical standards, which may be incorporated into the plan's review guidelines. Based on, and consistent with, these nationally recognized clinical standards, some of the plan's medical/surgical review guidelines have what may be considered to be "fail first" or "step therapy" protocols.	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-	AlohaCare: Need to clarify answer. Does not pertain to step-therapy. HMSA, KAISER: N/A OHANA HP & CCS: Both have ST protocols. Based on review of all MCO's it seems that Ohana CCS is more stringent in comparison to HMSA and Kaiser. **BH parity is in question.** **11/9/18:** **Discussion needed with 'Ohana about their protocols for step-therapy for INPATIENT settings. Also to inform them that it is the state's responsibility to bring all MCO's providing Medicaid to be in parity with each other across**

facility does not agree with the clinician's review, the authorization is sent to the Medical Director. The Medical Director will conduct a secondary review. If necessary a peer to peer with the facility's hospitalist may be conducted to determine the Medical Necessity of a continued stay or level of care. Based on all available information a determination is made regarding LOC or LOS and pend the authorization back to the clinician to complete the authorization process or continue the concurrent review. <u>Clarified response 10/31/18</u>: AlohaCare utilizes concurrent review of inpatient stays. We deploy step therapy using InterQual criteria to progress patients in a clinically appropriate way from IV meds to oral medications in anticipation of discharge.			cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.). <u>Clarified response 10/31/18:</u> The QL description was submitted in error due to a misinterpretation of the document line of questions. Quantity Limits (QL) rules and Step Therapy (ST) rules are two distinct methods of Utilization Management deployed to ensure proper use of medication therapies. There is no difference in how ST is applied between MH/SUD and M/S services. Our treatment of prescription drugs is in parity between MH/SUD and M/S services.		cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the DER process and will receive the ST medication. An example of ST criteria would be for Saphris tablet. The patient would have had to complete a trial and failure of a preferred alternative within the last 100 days or have a contraindication before the Saphris tablet would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.). <u>Clarified response 10/31/18:</u> The QL description was submitted in error due to a misinterpretation of the document line of questions. Quantity Limits (QL) rules and Step Therapy (ST) rules are two distinct methods of Utilization Management deployed to ensure proper use of medication therapies. There is no difference in how ST is applied between MH/SUD and M/S services. Our treatment of prescription drugs is in parity between MH/SUD and M/S services.	**the state. The state is in process w/CMS to add BH parity language to the current QI and CCS RFPs.** BH parity requirements NOT met. Meetings set up with 'Ohana to discuss options to remedy the parity issue. **12/17/18:** **After review/discussion of 'Ohana's revised response, with no step-therapy used in inpatient settings, there is NO question of parity.** **<u>As of 12/17/18</u>:** **BH parity requirements met.**

			Clarified response 12/4/18 No, we would not use step therapy rules in inpatient settings. This is only for outpatient settings.		Clarified response 12/4/18 No, we would not use step therapy rules in inpatient settings. This is only for outpatient settings.	

3. 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

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
During a concurrent review of a member's acute/rehab inpatient stay, our guidelines (Interqual) require a series of tests, course of treatment, imaging, and intensity of rehab services to be conducted for each inpatient day. If the member is unwilling or unable to receive the appropriate interventions a Medical Necessity review will be conducted based on the Interqual guidelines. If the guidelines are not met due to failure to complete a course of treatment and the member's clinical state is not stable for discharge, the Level of care may be denied, but not the length of stay. Decisions are always based on our guidelines and Medical Necessity. Failure to complete a course of treatment is not a determining factor for a denial.	There are no exclusions based on failure to complete a course of treatment under Inpatient Medical/Surgical benefits.	There are no health plan exclusions based on failure to complete a course of treatment.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting. Clarified response 10/31/18: The QL description was submitted in error due to a misinterpretation of the document line of questions. Quantity Limits (QL) rules and Step Therapy (ST) rules are two distinct methods of Utilization Management deployed to ensure proper use of medication therapies. There is no difference in how ST is applied between MH/SUD and M/S services. Our treatment of prescription drugs is in parity between MH/SUD and M/S services. Clarified response 12/4/18 No, we would not use step therapy rules in inpatient settings. This is only for outpatient settings.	The medical/surgical inpatient benefit does not include exclusions based on a failure to complete a course of treatment. As noted in response to #1 above, inpatient coverage is determined by medical necessity.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting. Clarified response 10/31/18: The QL description was submitted in error due to a misinterpretation of the document line of questions. Quantity Limits (QL) rules and Step Therapy (ST) rules are two distinct methods of Utilization Management deployed to ensure proper use of medication therapies. There is no difference in how ST is applied between MH/SUD and M/S services. Our treatment of prescription drugs is in parity between MH/SUD and M/S services. Clarified response 12/4/18 No, we would not use step therapy rules in inpatient settings. This is only for outpatient settings.	HMSA, Kaiser & UHC do not have exclusions. 'Ohana HP and CCS both have the same standard. Based on review of all MCO's it seems that Ohana CCS is more stringent in comparison to HMSA, Kaiser & UHC. **BH parity is in question.** **11/9/18:** **After discussion, the initial responses are comparable. 'Ohana documents "may contain exclusions", it is not a "yes". In addition, they do describe processes in the event there is an exclusion based on failure to complete a course of treatment.** **To be sure, will have 'Ohana re-visit to provide a definitive answer.** **12/17/18:** **After review/discussion of 'Ohana's revised response, with no step-therapy used in inpatient settings, there is NO question of parity.** **As of 12/17/18:** **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
For stabilization services post-acute hospitalization such as inpatient rehabilitation, a Prior authorization is not required. A	Prior authorization is not required for M/S acute Inpatient hospital admissions.	Pre-service authorization is not required for emergent inpatient	Pre-service, planned Inpatient surgeries, require prior authorization. Services are requested via fax, web portal,	Prior authorization is not required for emergent admissions into an inpatient facility. Notification of the admission (emergent/non-	Residential substance abuse is an example of non-acute inpatient level of care that requires prior authorization.	All non-emergent inpatient admissions require a prior authorization. All MCOs are comparable and there is no more stringency with CCS/BH services.

notification from the facility is required within 24 hours of admission to initiate the creation of an authorization for concurrent review. Authorization of continued stay will be reviewed using Interqual guidelines	However prior authorization is required for post-acute care services such as skilled nursing facilities admissions. The rationale for requiring prior authorization is to ensure that the admissions for post-acute care are medically necessary and not for the sole purpose of custodial care. In developing prior authorization requirements for skilled nursing facility admissions, HMSA utilizes a medical policy – Post acute, Residential Treatment Facility and Community Care Foster Family Home Care which is consistent with current standards of care and is based on the State of Hawaii Level of Care Criteria.	hospitalizations. Pre-service authorization is required for inpatient rehabilitative treatment. Urgent pre-service decisions for Medicaid members are communicated within 3 business days of request receipt. Non-urgent pre-service decisions are communicated within 14 calendar days of request receipt. Medicaid members are allowed up to a 14-calendar day extension if they, or the provider, requests the extension or if the health plan justifies the need for an extension and it's in the member's interest. Members are informed of the right to file a grievance if they disagree with the need for an extension. Approvals are the responsibility of the Clinical Chief (or designee). Board certified physicians from appropriate specialty areas assist in making determination of medical and clinical appropriateness. Only licensed physicians can make medical necessity denial determinations. Determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Criteria for Adult and Pediatric; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005.	phone from the provider. Inpatient services are reviewed for medical necessity dependent on code. `Ohana utilizes the following criteria to conduct a medical necessity review: For Inpatient Prior Authorization review we use the industry standard criteria or `Ohana Clinical coverage guidelines to review diagnosis and symptoms depending on the services requested. All Inpatient pre-planned surgeries require an authorization The industry standard criteria or `Ohana Clinical coverage guidelines applied in this classification routinely include: • Injuries in need of repair, • progression of diseases which require surgical intervention such as mastectomy and breast reconstruction, • possibly arthritis in joints which may require a repair. • Hernia repairs Specific clinical information must meet the standards and guidelines presented in the criteria review. Criteria points are reviewed according to the diagnosis presented and services requested. UM will outreach to the provider three times, to obtain any additional clinical information required to make a determination or send the review to the Medical Director if the medical necessity does not meet criteria and outreach has been unsuccessful. The prior authorization nurse will review the System for Award Management (SAM) website and Office of Inspector general website for provider and facility sanctions. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer review and we will send for a secondary review by a Medical Director.	emergent) is required. Subsequent concurrent reviews are conducted. Prior authorization is required for non-emergent admissions with subsequent concurrent reviews conducted by UnitedHealthcare.	Psychiatric Residential Treatment Facilities for youth is another example of non-acute inpatient level of care. Prior authorization is required in order for a member to be admitted into a program. Authorizations are based on Industry Accepted Medical Criteria to assess medical necessity, which can include: • The presenting problems, • How long they have been having difficulties, • Interventions previously attempted, • Social support, • Physical health, and • School performance Specific clinical information must meet the standards and guidelines presented in the criteria review. Criteria points are reviewed according to the diagnosis presented and services requested. UM will outreach to the provider three times, to obtain any additional clinical information required to make a determination or send the review to the Medical Director if the medical necessity does not meet criteria and outreach has been unsuccessful.	**BH parity requirements met**.

		Processes also guided by the Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A).	Once the member is admitted to the hospital a concurrent review will be conducted by the Inpatient nurse every 3 – 5 days depending on diagnosis, co-morbidities and treatment plan.			

Concurrent Review

5. 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?

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
During a concurrent review of a member's acute/rehab inpatient stay, our guidelines (Interqual) require a series of tests, course of treatment, imaging, and intensity of rehab services to be conducted for each inpatient day. Medical Necessity reviews are conducted based on the Interqual guidelines. If the guidelines are not met but the member's clinical state is not stable for discharge, the Level of care may be denied, but not the length of stay. If the guidelines are not met, continued stay may be denied. All denials regarding LOS/LOC are pended to Medical Directors for a secondary review and decision determination. Decisions are always based on our guidelines and Medical Necessity. The cost of the hospitalization/services is not a factor used to make a decision determination.	State of Hawaii Med-QUEST RFP requirements are the primary drivers in the development of our concurrent review process. Other factors considered in requiring concurrent reviews are the cost of treatment, potential high utilization relative to benchmark, variability in the level of care and the length of treatment, and the availability of alternative treatments with different costs. In addition, the reviews enable health plan and provider utilization reviewers, service coordinators, and social workers to collaborate on a regular basis on discharge planning and transition of care for members receiving acute inpatient care. Concurrent review process is evidence-based and takes into account individual patient's circumstances and the local delivery system when determining medical appropriateness of health care services. The decision-making also takes into consideration the medical necessity criteria under Hawaii's Patients' Bill of Rights and Responsibilities Act, generally accepted standards of medical practice and review of medical literature.	Selection of services designated for concurrent review are determined after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Criteria for Adult and Pediatric; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A).	Concurrent review is not done selectively; it is performed for all inpatient stays to determine medical necessity of continued length of stay in addition to prepare for discharge planning. Continued stays are reviewed every 3 – 5 days using Industry accepted Medical criteria and based on clinical complexity for the services requested. Each service requires clinical information to review for medical necessity for the continued stay. Examples include: • Inpatient Hospital stay: What is the treatment plan currently for the Inpatient stay? • Skilled Nursing Facility: What was the Prior level of function prior to the Inpatient hospital stay? • Inpatient Rehabilitation: Is the Member capable of tolerating 3 hours of skilled therapy, at least 5 days a week? • Long Acute Care: Member requires 6.5 hours/24 hours of skilled nursing services and medical practitioner assessment daily. Additional days are approved based on medical necessity. Discharge planning begins on admission for all Inpatient stays. Discharge planning is reviewed as an individual plan for each member by reviewing the	Inpatient review is a component of the medical plan's utilization management activities. The Medical Director and other 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. Reviews usually begin on the first business day following admission. If a nurse reviewer believes that an admission or continued stay is not an appropriate use of benefit coverage, the facility will be asked for more information concerning the treatment and case management plan. The nurse may also refer the case to our Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified.	For facility contracts on a per diem (contracted by the day for all diagnoses), concurrent reviews are not done selectively. They are performed for BH Inpatient admissions to determine the medical necessity of continued stay, in addition to ensuring safe transitions upon completion of treatment for our member. Due to the per diem nature of these contracts, concurrent reviews for BH Inpatient admissions are completed, *on average*, every 2-3 days and are based on medical necessity. Additional days are approved based on medical necessity. Many of medical necessity criteria points reflect symptomatology and treatment within the last 24 to 72 hours. The criteria in this classification is used to assess • Presenting problems, • How long the patient has been having difficulties, • Interventions previously attempted, • Social support • Physical health, and • School performance Discharge planning that includes follow up appointments to the member's primary care physician (PCP) and therapist(s), community resources needed is also discussed at concurrent reviews to ensure safe transitions upon completion of treatment.	All MCO's review the admission for medical necessity. All are comparable in terms of their review; however, quantitatively, CCS is more stringent in terms of review every 2-3 days in comparison to all of the other MCO's. **BH parity is in question.** **11/5/18:** **Based on the initial responses provided, all MCO's are comparable regarding their procedures/processes for concurrent reviews for inpatient settings.** **BH parity is no longer in question.** **BH parity requirements met.**

			following for the next level of care: member age, diagnosis, co-morbidities, prior level of function, home environment. The nurse reviewer will arrange discharge planning for the member prior to discharge. Setting up services such as Skilled nursing facility, home health, durable equipment needs, care management referrals and follow-ups with their primary care provider or Specialist will assist a safe discharge and to prevent re-admissions.	Non-reimbursable charges are not billable to the member. The facility and the attending physician have sole authority and responsibility for the medical care of patients. The plan's medical management decisions do not override those obligations. We do not ever direct an attending physician to discharge a patient. We simply inform the member of our determination. • Participating facilities are required to cooperate with all medical plan requests for information, documents or discussions for purposes of concurrent review and discharge planning including, but not limited to: primary and secondary diagnosis, clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date. • Initial and concurrent review can be conducted by telephone, on-site and when available, facilities can provide clinical information via access to Electronic Medical Records (EMR). •Participating facilities must cooperate with all medical plan requests from the inpatient care management team and/or medical director to engage our members directly face-to-face or telephonically. All national inpatient care managers are Registered Nurses with an unencumbered license in the state that they are conducting medical necessity review. Any potential fraud or quality occurrence identified while reviewing for medical necessity is reported to the United Health Care Clinical Services Medical Management Program. The rest must be entered by the Medical Director.		

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY

All process for concurrent review have been addressed in the above columns. From Jan 2018 – June 2018 there were no appeals that was requested from UM for inpatient denials. From Jan 2018-June 2018 there were 1904 authorizations for acute and LTC inpatient authorizations out of which 26 (1.37%) were denied.	Concurrent reviews are performed for all inpatient confinements under medical/surgical benefits. The purpose of concurrent reviews is to ensure the appropriateness of level of care and duration of treatment. The concurrent review process requires that the admissions are reviewed within 1-2 working days of receiving notification. Notification of admission is done via electronic census data transmitted to the health plan. Using electronic medical records, reviews are performed periodically thereafter dependent on diagnosis and treatment. Nurse reviewers with acute inpatient care experience and who are licensed to practice in the state of Hawaii conduct concurrent reviews in consultation with our medical directors. Medical directors are also available to provide peer-to-peer reviews with treating physician(s) as needed. Clinical reviewers utilize nationally recognized MCG – Inpatient & Surgical Care and General Recovery Care Guidelines as decision support tools to evaluate appropriateness and cost effectiveness of care provided to our members. Nurse reviewers collaborate with various hospital Utilization Review staff/case managers on a daily basis to ensure that the inpatient level of care conforms to the established clinical guidelines and the length of stay remains within the goal recommended in the guidelines. Continued hospital stays are reviewed concurrently by nurse reviewers via remote access to the hospitals' electronic medical records, records transmitted to HMSA via secure fax, or telephonically. Concurrent reviews are done at regular intervals (generally every 2-3 days) appropriate for the patient's	Concurrent review processes are determined for each case after evaluation of clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - InterQual Criteria for Adult and Pediatric; - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Concurrent review denial rate and appeal overturn rate were 0% during annual period ending June 2018.	2.18% denial rate; 78.26% appeal overturn rate. There were only 23 appeals during this time, 18 of which were overturned, so the % appears very high due to the small "n". (1/1/16-12/31/16)	UnitedHealthcare uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. The medical plan clinical criteria can be requested from the Case Reviewer. Criteria other than MCG™ Care Guidelines 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 Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. % of Cases with Adverse Determination: 7.40% % of Total Cases Appealed: 0.50% % of Adverse Determination Cases with at Least One Day Overturned on Appeal: 1.80% % of Appealed Cases Overturned on Appeal: 29.40%	.69% denial rate; Zero appeals so no appeal overturn rate to report (1/1/16-12/31/16)	Comparable results. **BH parity requirements met.**

	specific clinical conditions and intensity of services required. The denial rate for M/S inpatient services is less than 1%. Low denial rate is attributed to the discussions and consensus between the health plan and the provider utilization reviewers. Through this collaboration process, facility providers lower level of care or discharge timely therefore not requiring the plan to issue denials. Due to the low volume of denials and our process there have been no instances of a provider appeal. Thus we are unable to provide an appeal overturn rate.					

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
• Every 2 days for Acute Inpatient • Every 7 days for Long term rehab	The average frequency of concurrent reviews for acute inpatient medical/surgical treatment is once every 2-3 days but varies depending on a patient's medical/surgical condition and response to the treatment and the current level of care. The optimal frequency of concurrent review is agreed upon between the health plan and the inpatient facility's utilization reviewers.	Concurrent review during inpatient acute hospitalization is performed every 1-3 days. (Note: When member is confined to an out-of-state inpatient facility, there may be occasional concurrent review delays pending receipt of requested concurrent medical information. Concurrent reviews will be performed when information is received.) Concurrent review in an alternate inpatient setting (e.g., SNF) is performed every 7-14 days. Processes and frequency of review are guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A).	Continued stays are reviewed every 3 – 5 days using Industry accepted Medical criteria and based on clinical complexity for the services requested. Each service requires clinical information to review for medical necessity for the continued stay. Examples include: • Inpatient Hospital stay: What is the treatment plan currently for the Inpatient stay? • Skilled Nursing Facility: What was the Prior level of function prior to the Inpatient hospital stay? • Inpatient Rehabilitation: Is the Member capable of tolerating 3 hours of skilled therapy, at least 5 days a week? • Long Acute Care: Member requires 6.5 hours/24 hours of skilled nursing services and medical practitioner assessment daily. Additional days are approved based on medical necessity. <u>Clarified response 10/31/18</u>:	The Inpatient Care Manager prioritizes and reviews criteria for all inpatient admissions based on medical necessity and non-medical necessity agreements. The ICM reviews the clinical associated with the inpatient case and uses the priority review guide as guidance for frequency of review. Level of care for medical necessity approved facilities is reviewed on hospital day one. DRG contracted facilities are concurrently reviewed every 4 days until discharge unless otherwise medically indicated. Non-DRG contracted facilities are concurrently reviewed every 2 days until discharge unless otherwise medically indicated. For any acute non-medical necessity agreements, the inpatient cases are reviewed on hospital day fourteen and then subsequently every 4 days until discharge. The Acute Inpatient Rehab is reviewed for medical necessity upon request. Non-DRG agreements are reviewed on hospital day 14. DRG agreements are reviewed on hospital day 7 and then every 4 days until discharge unless otherwise medically indicated.	Due to the per diem nature of these contracts, concurrent reviews for BH Inpatient admissions are completed, *on average*, every 2-3 days and are based on medical necessity. Additional days are approved based on medical necessity. Many of medical necessity criteria points reflect symptomatology and treatment within the last 24 to 72 hours. The criteria in this classification is used to assess • Presenting problems, • How long the patient has been having difficulties, • Interventions previously attempted, • Social support • Physical health, and • School performance <u>Clarified response 10/31/18</u>: Parity requirements do not require that 'Ohana HP be in parity with other MCO's. However, 'Ohana is in parity between how we manage Concurrent Review between MH/SUD and M/S services. As stated in our original response, concurrent review timeframes are done on average based on the	AlohaCare: 2 days HMSA: 2-3 days Kaiser: 1-3 days 'Ohana HP: 3-5 United: 4 days CCS: 2-3 days CCS is more stringent than 'Ohana HP and United. **BH parity is in question.** **11/9/18:** **Based on the initial and clarified responses by 'Ohana, with utilization review being done every 2-3 days allows for a more efficient use of resources. More attention is focused on the BH admissions and therefore health and safety of the member is ensured. The timeframes of the MCO's across the state are comparable.** **BH parity is no longer in question.** **BH parity requirements met.**

			Parity requirements do not require that 'Ohana HP be in parity with other MCO's. However, 'Ohana is in parity between how we manage Concurrent Review between MH/SUD and M/S services. As stated in our original response, concurrent review timeframes are done on average based on the patient's condition and the treatment plan from the attending providers. On average, medical reviews are completed every 3-5 days and on average, behavioral reviews are completed every 2-3 days. All reviews are based on medical necessity. The P&P's we referenced for this include: C7UM-5.4 & C7UM- 5.4-PR-001, and have been sent with this submission		patient's condition and the treatment plan from the attending providers. On average, medical reviews are completed every 3-5 days and on average, behavioral reviews are completed every 2-3 days. All reviews are based on medical necessity. The P&P's we referenced for this include: C7UM-5.4 & C7UM- 5.4-PR-001, and have been sent with this submission	

Prescription Drugs

8. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
No tiers	HMSA's QUEST Integration Formulary is not a tiered formulary.	Prescription drug benefits are not tiered for Medicaid members.	The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	UnitedHealthcare does not restrict or set limits on prescription drugs provided in an inpatient setting or take home drugs.	The selections of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	CCS is more stringent than AlohaCare, HMSA, Kaiser and United. **BH parity is in question.** **As of 11/5/18:** **Based on clarification provided, BH parity is no longer in question.** **BH parity requirements met.**

			Clarified response 10/31/18: No, prescription drug benefits are not tiered for Medicaid beneficiaries.		Clarified response 10/31/18: No, prescription drug benefits are not tiered for Medicaid beneficiaries.	

NETWORK ADMISSION REQUIREMENTS

9. 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.

ALOHACARE	HMSA	KAISER	‘OHANA	UNITED	‘OHANA CCS	COMPARABILITY/STRINGENCY
For M/S services, AlohaCare conducts annual and ad hoc assessments of our provider network delivery system to determine if it is meeting our standards for network adequacy, capacity, and member access. See attached Selections and Retention of Providers Policy. AlohaCare’s Policy includes provider exclusion per federal and state requirements for government funded programs. Credentialing requirements include common, state-wide and national standards such as licensed, certified, accredited, and in good standing, with Appropriate medical liability, DEA, peer references, and other common credentialing and privileging verifications.	Providers must be appropriately licensed or certified in accordance with state and national guidelines, meet all standard educational and credentialing criteria for their specialty, not be an excluded entity with Medicare or Medicaid programs, and have met all continuing educational requirements specific to their provider type Provider must be willing to contract at sustainable rates and to submit all required documentation for both credentialing process and for system configuration for adjudication of provider claims. Provider onboarding process can be initiated either by the health Plan or Provider followed by execution of a contract between Plan and Provider for participation in one or more products. Plan monitors network needs on a regular basis in accordance with its practitioner availability policies and will initiate outreach to non-par Providers if network analysis shows a need in a specific geography. Also, non-par Providers frequently initiate a request for participation. Plan will either respond and begin contracting process or politely decline if credentialing requirements are not met. Plan retains all rights to determine which providers it adds to its provider networks. HMSA has formal credentialing criteria and a Credentialing Committee.	Kaiser Permanente Hawaii Region (KP) is an integrated model of care which provides 97% of KP member care via its employed providers and facilities. To augment KP’s internal care delivery system, KP contracts with specialized service providers, both within and outside the State of Hawaii. Network admission requirements are comprised of several factors which vary according to the service provider. These factors include appropriate licensing, accreditation, good standing against government agency listings of excluded individuals/entities, education, training, board qualification, certification, reference checks, background checks, interviews with relevant departments, agreement to maintain compliance with requirements and code of ethics, acceptance of offered compensation, and other factors. Initial evaluation of a provider is performed by the Provider Relations and Contracting representative and/or physician/provider recruiter and/or department physician chief who reviews the application, checks references, and interviews the applicant provider. Further interviews are conducted and recommendations to leadership are made. Credentialing occurs thereafter with National Provider	`Ohana provides contracted networks of qualified organizational health care providers, and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation	The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, provider disclosures, and licensure/certification. All applicable providers go through the credentialing process that is based on NCQA requirements. Credentialing of a provider is initiated prior to contracting with the provider. Once a provider has completed the credentialing process and approved by the Credentialing Committee, they are offered a contract with UnitedHealthcare. Participation criteria for practitioners include information about the provider, such as: 1. Education 2. Licensing 3. Applicant must have full hospital admitting privileges, without Material Restrictions, conditions or other disciplinary actions, at a minimum of one participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Credentialing Entity determines that Applicant's practice requires such privileges. 4. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant. 5. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare	`Ohana provides contracted networks of qualified organizational health care providers, and community based case management providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	All MCO’s are comparable for provider credentialing. **BH parity requirements met**.

		Identification confirmation, primary source verification, background checks, and a Medicare/Medicaid status query to ensure avoidance of providers who have been excluded from participation by the U.S. Department of Health and Human Services Office of Inspector General, Section 1128 (including Section 1128A) of the Social Security Act, and/or by the State Department of Human Services (DHS) from participating in the Medicaid program. Findings are evaluated by credentialing staff and committee prior to hiring/contracting. KP refers to the Medicaid network adequacy requirements within the State of Hawaii Department of Human Services RFP-MQD-2014-005: <table><tr><td>Min. of drive time</td><td>Urban</td><td>Rural</td></tr><tr><td>PCP</td><td>30</td><td>60</td></tr><tr><td>Specialist</td><td>30</td><td>60</td></tr><tr><td>Hospital</td><td>30</td><td>60</td></tr><tr><td>Emergency Facility</td><td>30</td><td>60</td></tr><tr><td>Mental Health</td><td>30</td><td>60</td></tr><tr><td>Pharmacy</td><td>15</td><td>60</td></tr><tr><td>24-Hr Pharmacy</td><td>60</td><td>NA</td></tr></table>		and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS. 6. Work History 7. Mal-practice Insurance or state approved alternative 8. Network participation UnitedHealthcare ensures that it has the network capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive, primary, acute, behavioral health services, and long-term services and supports (LTSS) and it maintains a sufficient number, mix, and geographic distribution of providers of covered services. UnitedHealthcare network providers must meet availability standards for Medicaid members. Our Medicaid members and providers are notified of the plan's policies for immediate care and for scheduling urgent, pediatric sick, adult sick and routine appointments. UnitedHealthcare monitors provider performance against the standards at a minimum on a quarterly basis. UnitedHealthcare ensures it's network has the capacity and is adequate to serve the expected enrollment in the service area to maintain a sufficient number, mix, and geographic distribution of providers for services; taking in consideration the distance that it takes the member to travel in normal traffic conditions, using usual travel means in a direct route from his/her home to the		

				provider based on the GeoAccess Standards.		

10. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
No exclusions, except for those excluded from participation in government healthcare programs	HMSA does not have any exclusions pertaining to provider types, facility types, or specialty providers.	No practitioner types, facility types, or specialty providers are specifically excluded from eligibility to enter into contracting consideration toward providing covered benefit services.	Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above	UnitedHealthcare does not exclude any provider types however we may exclude a provider based on the credentialing criteria. UnitedHealthcare complies with state licensing requirements and if there is a practitioner type who is eligible a contract will be offered. All applicable providers must meet the requirements of our credentialing requirements.	Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above	All MCO's are comparable as they do not exclude specialty providers. The only exclusions would be for those who do not meet credentialing criteria. **BH parity requirements met**.

11. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
No such limitations	There are no geographic limitations	Assuming the provider is within the U.S.A., there are no geographic limitations on provider inclusion. Each provider candidate's geographic area is considered in relation to the needs of the health plan's membership within that geographic area and Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD-2014-005.	The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is). <u>Clarified response 10/31/18:</u> This question deals with the geographic limitations of our contracting efforts to get providers within our network and whether we have more stringent contracting and credentialing requirements for BH providers than we do for medical providers. The answer is our contracting and credentialing requirements are the same regardless of provider specialty. Because the question asked about out-of-network providers, we stated that our only limitation re: contracting with providers was the boundaries of the geographic region defined by the State for their membership. We do not "contract" with providers outside the State's defined geographic service area. If a member requires care that is not available within our network of providers, we would identify the closest out of network provider available to provide the care and	UnitedHealthcare does not impose or have any geographic limitations on provider inclusions.	The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is). <u>Clarified response 10/31/18:</u> This question deals with the geographic limitations of our contracting efforts to get providers within our network and whether we have more stringent contracting and credentialing requirements for BH providers than we do for medical providers. The answer is our contracting and credentialing requirements are the same regardless of provider specialty. Because the question asked about out-of-network providers, we stated that our only limitation re: contracting with providers was the boundaries of the geographic region defined by the State for their membership. We do not "contract" with providers outside the State's defined geographic service area. If a member requires care that is not available within our network of providers, we would identify the closest out of network provider available to provide the care and	CCS is more stringent as they have geographic limitations to only the service area of the plan. AlohaCare, HMSA, Kaiser and United all have no geographic limitations. **BH parity is in question.** **11/9/18:** **After further discussion and review of the clarified response by 'Ohana, it is comparable to the rest of the MCO's in the state.** **BH parity is no longer in question.** **BH parity requirements met.**

			authorize via a Single Case Agreement. That, however, has nothing to do with our contracting requirements and the parity between how we contract for providers between medical and behavioral services.		authorize via a Single Case Agreement. That, however, has nothing to do with our contracting requirements and the parity between how we contract for providers between medical and behavioral services.	

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of- network benefits.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
AlohaCare members receive medically necessary care. OON care must be prior authorized and coverage determinations are made based on clinical review considering patient history with providers, and comparison of provider specialties, training, expertise, credentials, and on geography and proximity. If in-network providers of comparable credentials and specialties are available in the medical service area, care is re-directed to the network. If not, then OON care is authorized. This is also true for out of state non-emergency care.	QUEST Integration members have no out-of-network benefits except for emergencies. If a member is admitted for an emergent condition, no prior authorization or concurrent reviews are required until the time the member's condition is stabilized. If a member needs a treatment or service that is not available from network providers, exception can be made after a medical necessity review and verifying availability of comparable services within the network. If the out of network treatment is warranted, HMSA will contract with the out-of-network provider for a single case agreement.	Physician evaluates member. If out-of-plan referral appears appropriate, physician completes an order for the request. Department Chief receives referral request and performs evaluation/determination. Medical necessity approval from the Outside Medical Services Medical Director or other appropriate Department Chief /Designee is required for the following types of referral requests: • Requests for services from non-credentialed providers; • Requests for mainland/out of area services; • Experimental treatments/therapies; • Requests for services where there is internal capability; • Requests for transplantation services. Medical necessity determination is referred to Authorizations and Referral Management (ARM). If medical necessity is approved, ARM reviews request to ensure that referral guidelines and criteria are met: • The requested service is certified as medically necessary by	The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's benefit plan design dictates how members can access out of network benefits.	UnitedHealthcare provides access to Out of Network (OON) providers (non-contracted providers) if an in-network provider is unable to provide medically necessary services in an adequate and timely manner to a member and continue to authorize the use of non-contract providers for as long as UnitedHealthcare is unable to provide services through network providers. UnitedHealthcare requires prior authorization approval for OON providers prior to rendering the service.	The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's benefit plan design dictates how members can access out of network benefits.	Comparable responses. CCS is not more stringent than the other MCO's. **BH parity requirements met.**

		Chief/Designee; • The service is a covered Health Plan benefit; • The requested service is not available within Plan; • The patient is an eligible Health Plan member; • The patient has benefits available • Referral parameters (frequency/ duration) are clearly defined; and • Selected provider/ practitioner is credentialed or has Letter of Agreement with health plan. If criteria met, ARM will generate the authorization, notify the receiving provider, notify the requesting practitioner of the approval, and generate a notification letter to the member. Only licensed physicians can make medical necessity denial determinations				

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
All provider contracts are negotiated rates and vary according to terms reached in negotiation. Most begin with the state's FFS fee schedule, or are a percentage of Medicare FFS fee schedule. This is true for physicians, PhDs and MAs.	Initial fees were established at the beginning of the QUEST program in 1994. At that time, fees were established based on the Medicaid FFS schedule at that time. Since then increases or decreases were based on the reimbursement rates set by the state to the Insurance plans. Adjustments are made to the changes in coding that occur nationally. For ABD and Non-ABD, we primarily follow the Medicaid fee schedule. Some provider's fees are individually negotiated.	Not applicable for inpatient.	`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	UnitedHealthcare's Medicaid Fee Schedule is developed using the State's Medicaid Fee Schedule with alignment using Medicare relatively. Where the fee source does not publish a specific fee amount, UnitedHealthcare will use the CMS Gap fill using a % of prevailing Medicare. UnitedHealthcare will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source	`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	All MCO's are comparable. CCS is not more stringent. **BH parity requirements met.**

	Psychiatrists and Psychologists are paid the same rate. Child Psychiatrists are paid 110% of the Psychiatrist fee. Social workers, Marriage Family Therapists, Mental health counselors, and APRNs are paid 85% of the psychiatrist rate.			initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). UnitedHealthcare will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by UnitedHealthcare will not be reprocessed unless otherwise required by law.		

14. 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, practice size, Medicare reimbursement rates, licensure, other.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Medicare reimbursement, and service demand/network adequacy and capacity are the primary drivers for both M/S and MH/SUD providers. Some medical and mental health specialties are in a workforce shortage situation.	Inpatient Facilities are individually negotiated. All rates are based on budget availability. Rural areas may play a factor due to access issues. Rates could be matching Medicare or the commercial business.	In this island State of Hawaii, provider supply and demand in target geographic areas of need is a primary influencer of professional provider reimbursement rates. While the Medicaid fee schedule is considered, the actual provider reimbursement rates may be higher. Beyond the issues related to supply and demand, professional provider reimbursement rates are not specifically impacted by service type, practice size, and licensure.	None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	Professional provider reimbursement rates do not vary based on the factors listed above. In limited instances variations can occur based on availability of certain limited specialty services in Hawaii.	None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	All MCO's are comparable. CCS is not more stringent. **BH parity requirements met.**

NQTL ANALYSIS FOR BH PARITY – OUTPATIENT

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
AlohaCare's Utilization Management Program (UMP) incorporates the functions of utilization review/management (e.g., prospective, concurrent and retrospective reviews) of medical, behavioral health, long term services and supports, pharmacy/drug services. The UMP monitors for over- or under-utilization, and inappropriate use of services. The AlohaCare UMP also includes services that promote the continuity and coordination of care through assistance and support during care transitions, disease management, and collaborative care and service coordination internally and externally. It objectively monitors and evaluates the cost of care based on medical or functional appropriateness. The AlohaCare UMP assesses not just clinical aspects of care, but also factors that impact how care is delivered/provided, such as cultural and linguistic awareness and sensitivity, enabling services, and continuous monitoring of quality of service. The UMP creation and decisions are developed by various committees comprised internal and external clinicians, non-clinicians, and subject matter experts. Such committees are: The Board Quality Committee (BOC), Medical Management Committee (MCC), Practitioners	In developing medical necessity standards for Medical/Surgical outpatient services, HMSA considers scientific evidence/peer reviewed literature, professional standards of care, expert opinion and community input and utilizes multiple sources including: • Hawaii Revised Statutes (HRS §432E-1.4) • Blue Cross Blue Shield Association guidelines and medical policies • Milliman Care Guidelines (MCG) Along with the available medical evidence, additional consideration is given to factors such as a treatment's cost-effectiveness, most appropriate delivery of level of service, and potential benefits and harms to the patient to determine medical necessary of medical/surgical treatments and services. Medical necessity criteria (aka policies) are developed by HMSA Medical Directors with input from medical practitioners in the community. Once policies are developed, reviews of the medical necessity criteria are conducted at least annually and more frequently as new evidences become available	Medical necessity/appropriateness determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502). Concurrent review and authorization is not generally performed for outpatient services. A case may be reviewed if an extension is requested for pre-authorized services. Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness.	Outpatient services are reviewed by the services requested, dependent on codes and place of service. Medical necessity is reviewed using clinical criteria, including industry accepted medical criteria and `Ohana Clinical Coverage guidelines, to make a determination. The industry accepted and `Ohana criteria reviewed in this classification for services ranging from Speech, Physical and Occupational therapy services to pre-planned surgeries routinely include but are not limited to the following: • Imaging results • Members age • Past medical history or co-morbidities • Symptoms and diagnosis • Prior level of function Providers submit outpatient service requests. Outpatient services are requested via fax, web portal, phone or/and state portals from the provider. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer review and we will send for a secondary review by a Medical Director.	As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the following components are taken into consideration: "A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is: (1) For the purpose of treating a medical condition; (2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient; (3) Known to be effective in improving health outcomes; provided that: (A) Effectiveness is determined first by scientific evidence; (B) If no scientific evidence exists, then by professional standards of care; and (C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and (4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost effective shall not necessarily mean the lowest price." UnitedHealthcare uses Milliman Care Guidelines (MCG) evidenced based criteria to determine the most	In reviewing medical necessity and appropriateness, industry accepted Medical criteria are utilized which routinely include: • Risk of Harm, • Functional Status, • Co-Morbidity, • Recovery Environment, Acceptance, • Engagement in treatment, and • Level of Support. • Level Care Assessment tools These criteria are utilized for Psych testing, ECT, Substance Abuse services, Day Rehabilitation, Community Support, and Psychiatric Residential Rehabilitation. Providers submit an Outpatient Services request form via web portal or fax to Utilization review and any clinical information that they feel is appropriate for initial and recurrent review. Utilization Management sends a fax regarding authorization or calls the provider to request further information. For substance abuse outpatient services, `Ohana uses industry accepted medical criteria and `Ohana Clinical Coverage guidelines for criteria review. Examples of applied criteria include: • Acute Intoxication and Withdrawal • Potential, Biochemical complications,	All MCO medical necessity reviews are comparable. **BH parity requirements met.**

Advisory Committee (PAC), LTSS Quality Advisory Committee, Pharmacy & Therapeutics Committee (P&T), as well as direct director oversight by the Chief Medical Officer (CMO). Medical necessity is based on review using the criteria guidelines as outlined in the Medical Necessity Criteria policy and procedure, medical coverage policies, or using Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) guidance as applicable. The UM policies and procedures are reviewed annually and are updated as necessary. AlohaCare reviews and updates, on an annual basis, all AlohaCare medical policies related to medical necessity of the following services: specific diagnostics and treatments, new technologies, and DME/supplies; pharmaceuticals; clinical practice guidelines, based on national recommendations; and inter-rater reliability among UM nurses, pharmacists and physician directors. New medical policies related to medical necessity are vetted through a process that involves the following: • Research of available clinical information, coding, and national trends regarding medical necessity for the specific service by a medical policy analyst. • Vetting of the proposed medical policy among internal staff: o Chief Medical Officer, Medical Director, and Associate Medical Directors. o Senior Director of Long Term Services and Support (Service				appropriate level of inpatient care with care guidelines specific to the member's admitting diagnosis. MCG supports the nurse's approval decisions and those cases that may not meet the evidenced based criteria. When the member's clinical does not appear to meet MCG inpatient guidelines, a higher level of review is required. The case is then escalated to the receiving medical director to review for potential adverse determination (see Inpatient Medical Necessity document above). Medical review frequency is based off of UnitedHealthcare Priority Review Process (see document name and number above). Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms, which are all of the following as determined by UnitedHealthcare or our designee, within our sole discretion. • In accordance with *Generally Accepted Standards of Medical Practice* • Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's sickness, injury, mental illness, substance use disorder, disease or its symptoms • Not mainly for the member's convenience or that of the member's doctor or other health care provider • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's sickness, injury, disease or symptoms.	• Emotional, Behavioral and Cognitive Conditions. • Readiness to Change, • Relapse and Continued Problem Potential and Living and Recovery. Authorizations are given based on MN. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer	

Coordination). o Director of Utilization Management. o Director of Health Plan Operations. o Pharmacy Manager. o Others as relevant. • Feedback from Practitioners Advisory Committee. Approval of Medical Management Committee. The following M/S services must meet criteria for coverage: Ambulatory/Outpatient surgery Durable Medical Equipment (DME) Prosthetics and Orthotics Eye surgery Adult Strabismus Home and Community Based Services Home Health Home IV and infusion therapy/drugs Hyperbaric Oxygen therapy Hysterectomy Housing and meals when traveling to approved services Incontinence supplies Mastectomy (prophylactic/gynecomastia) MRI/MRA scans below the neck Elective inpatient stays and surgery Inpatient rehab Non-Formulary Medication OB Ultrasound beyond 3x Occupational Therapy Out of State non-emergency services PET scans of the brain Physical Therapy PUVA therapy Sleep Studies Speech therapy Sterilization procedures Non-Emergent Medical Transportation (NEMT) Criteria/Guidelines used to make a determination of Medical Necessity for Medical Outpatient				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. 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.		

requests which require Prior Authorization: • Interqual • Noridian • AlohaCare Policies • Medical Necessity Outpatient medical services covered by AlohaCare. A prior auth look-up tool is available (http://www.alohacare.org/Providers/Authorization) to assist providers in determining prior authorization requirements for each of the listed services. For Outpatient services that are not covered such as ITOP, providers are referred to Xerox/ACS for information and claims submission. Members are directed to Medicaid's FFS program. For non-covered soft tissue/organ transplants members are referred to the State of Hawaii Organ Tissue Transplant program (SHOTT).						

2. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
As mentioned above, the UMP outlines the various committees and groups which collaborate on writing our medical and pharmacy policies. The requirements, such as initial trials, step therapies, criteria, and other UM edits placed on these therapies are developed from guidelines in Medical Necessity policy and procedure, and by using Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs). Clinician reviews services using appropriate guidelines based on the requested service using clinical notes that have been submitted by the requesting provider. During the review, if the guidelines are not met due to "failed first requirements or step therapies", clinician will contact member's requesting	Although there are no exclusions based on failure to complete a course of treatment, there are requirements to attempt certain conservative or non-operative treatments prior to receiving certain surgical procedures. For example, to qualify for certain spinal procedures, a patient must have failed an adequate trial of conservative therapy. These requirements are outlined in the respective medical policies. Rationale for such requirements is based on the review of published medical literature, professional society guidelines, and medical necessity criteria in determining the most appropriate delivery or the level of service. Please refer to NQTL – Prescription Drugs document for information on fail first or step	No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed annually. <u>Clarified response 10/31/18</u>: Kaiser does not currently use step-therapy protocols for outpatient services/settings. See attached Drug Formulary policy (65-61-2.11), Section 4.2.4. *The Kaiser Permanente Hawaii Drug Formulary currently does not apply a traditional prior authorization (PA), step therapy, or treatment protocols and procedures, but in the event the P&T Committee decides to implement such utilization*	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives.	MCG would be used to identify any criteria that would correlate between the member's diagnoses and failure of outpatient treatment. Application of a "fail first" or "step therapy" requirement is based on use of nationally recognized clinical standards, which may be incorporated into the plan's review guidelines. Based on, and consistent with, these nationally recognized clinical standards, some of the plan's medical/surgical review guidelines have what may be considered to be "fail first" or "step therapy" protocols.	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives.	CCS: Use of QL? May need to clarify this. Also seems to be more stringent than Kaiser. Comparable to other MCO's. **BH parity is in question.** **11/9/18:** **Discussed with Medical Director and Psychiatrist, the issue may be the wording of the question. Being that Kaiser has a unique business/medical model/ approach to the rest of the MCO's in Hawaii, if the question is addressed in a different way, the issue may be resolved.** **BH parity requirements NOT met. Meetings set up with Kaiser to discuss options to remedy the parity issue.** **12/17/18:** **After review/discussion of Kaiser's response, it seems that**

PCP/Specialist to request additional information to confirm that the member did fail "first requirements or step-therapies". If provider has additional information, review will continue using the available information. If the allotted timeframe for review is coming to a close, clinician can inform the provider that the timeframe is near and provide the option of an extension if an extension of the review timeframe will not have any adverse effects on the member's health. Once all of the information is received and if it still does not meet the appropriate guidelines, a telephone call is made to the requesting provider to inform them that the request is being sent to Medical Director for secondary review. Should the provider wish to conduct a peer to peer with the Medical Director prior to the determination of the decision, clinician will arrange the peer to peer. Once all of the information has been obtained and peer to peer has been conducted the Medical Director will make a determination based on guidelines, and Medical Necessity. Medical Director will pend the authorization to the UM clinician to complete the authorization process based on the Medical Directors decision.	therapy requirements for prescription drugs.	*management programs, they will be reviewed at least annually.* <u>Clarified response 12/12/18</u>: Kaiser Permanente does not impose fail first or step-therapy requirements. There are formulary guidelines in place which recommend preferred formulary agents. However, it is the prescribing provider who maintains the authority and responsibility to determine medical necessity. Thus, if the provider determines that first line drugs are highly likely to fail or are not medically appropriate for the patient, the patient may obtain second line drugs without attempting use of first line drugs.	1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.) <u>Clarified response 10/31/18</u>: The QL description was submitted in error due to a misinterpretation of the document line of questions. Quantity Limits (QL) rules and Step Therapy (ST) rules are two distinct methods of Utilization Management deployed to ensure proper use of medication therapies. There is no difference in how ST is applied between MH/SUD and M/S services. Our treatment of prescription drugs is in parity between MH/SUD and M/S services.		1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the DER process and will receive the ST medication. An example of ST criteria would be for Saphris tablet. The patient would have had to complete a trial and failure of a preferred alternative within the last 100 days or have a contraindication before the Saphris tablet would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.). <u>Clarified response 10/31/18</u>: The QL description was submitted in error due to a misinterpretation of the document line of questions. Quantity Limits (QL) rules and Step Therapy (ST) rules are two distinct methods of Utilization Management deployed to ensure proper use of medication therapies. There is no difference in how ST is applied between MH/SUD and M/S services. Our treatment of prescription drugs is in parity between MH/SUD and M/S services.	**Kaiser does have a protocol that uses a formulary guidelines and will use drugs based on medical necessity or appropriateness as decided by the prescribing provider. As stated by Kaiser, "…if the provider determines that the first line drugs are highly likely to fail or are not medically appropriate for the patient, the patient may obtain second line drugs without attempting use of first line drugs."** **Based on Kaiser's response it has been determined that BH parity requirements have been fulfilled.** **<u>As of 12/17/18:</u>** **BH parity requirements met.**

3. 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

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
No, however non-compliant to a course of treatment can be used as a determining factor during a review should additional units be requested. These cases will be sent to Medical Director for review and continuation of services is based on meeting the appropriate guidelines and Medical Necessity.	There are no exclusions based on failure to complete a course of treatment under Outpatient Medical/Surgical benefits.	There are no exclusions based on failure to complete a course of treatment.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting. Clarified response 10/31/18: The QL description was submitted in error due to a misinterpretation of the document line of questions. Quantity Limits (QL) rules and Step Therapy (ST) rules are two distinct methods of Utilization Management deployed to ensure proper use of medication therapies.	The medical/surgical inpatient benefit does not include exclusions based on a failure to complete a course of treatment. As noted in response to #1 above, inpatient coverage is determined by medical necessity.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting. Clarified response 10/31/18: The QL description was submitted in error due to a misinterpretation of the document line of questions. Quantity Limits (QL) rules and Step Therapy (ST) rules are two distinct methods of Utilization Management deployed to ensure proper use of medication therapies.	HMSA, Kaiser and UHC do not have exclusions. 'Ohana HP and CCS have the same standard. Based on review of all MCO's it seems that Ohana CCS is more stringent in comparison to HMSA, Kaiser and UHC. **BH parity is in question.** **11/9/18:** **After discussion, the responses are comparable. 'Ohana documents "may contain exclusions", it is not a "yes".** **Based on this, BH parity requirements are no longer in question.** **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Prior Authorization Review Process • PA Outpatient Medical services made • Intake (TCSS) accepts request and creates authorization and pends them to the UM clinician for review • UM BH/Medical clinician accepts the authorization and applies the appropriate guidelines based on the request • If guidelines are met, clinician approves the request and written notification of the decision is sent to the requesting and treating provider • If guidelines are not met, the authorization is sent to a Medical Director for a secondary review. Medical Directors will review for	Prior authorization is required for rehabilitative services such as Physical Therapy, Occupational Therapy, and Speech Therapy and for certain outpatient medical/surgical procedures. HMSA performs prior authorization reviews to evaluate health care services for medical necessity in the following general categories: • Services for which aberrant or potential inappropriate patterns of care are identified • New technology or new uses of existing technology • Services with the potential for non-covered purposes (e.g., lifestyle enhancement, cosmetic services, surgery or supplies)	Pre-service authorization is not required for in-plan outpatient rehabilitative service. Pre-service authorization is required for out-of-plan outpatient rehabilitative service. Urgent pre-service decisions for Medicaid members are communicated within 3 business days of request receipt. Non-urgent pre-service decisions are communicated within 14 calendar days of request receipt. Medicaid members are allowed up to a 14-calendar day extension if they, or the provider, requests the extension or if the health plan justifies the need for an extension and it's in the member's interest. Members are informed of the right to file a grievance if they	Prior authorization is required for certain outpatient services. Medical necessity and appropriateness are required for prior authorization. Medical necessity is determined using Industry accepted Medical criteria. Outpatient services are requested via fax, web portal, phone or state portals from the provider. Services are reviewed dependent on code, place of service and clinical information received from the provider. Industry accepted medical criteria, `Ohana Clinical Coverage Guidelines and Benefit limits that are applied in this classification routinely include but are not	Certain outpatient services require a prior authorization with the exception of emergency services that are needed to evaluate or stabilize an emergency condition as well as direct access to women's health services. Members are held harmless for services/procedures that require a prior authorization by a participating provider (in-network) in the event the provider does not obtain a prior authorization. Members may be held liable for services/procedures that require a prior authorization provided by a non-participating provider without prior authorization (excluding as noted above emergent/stabilization/women's health services).	Industry accepted Medical Criteria are utilized to determine the appropriate medical necessity ("MN") per member. The aforementioned criteria provide assessment tools used to support accurate level of care recommendations. The assessment determines clinical need based on multiple levels, including: • Mental, • Social, • Physical, and • Current functioning levels. Based on the results obtained from these assessment tools, the appropriate amount of units based on medical necessity and services are authorized for 20 sessions. The session limit is to ensure that	CCS is comparable to all other MCO's except Kaiser. Pre-auth is required for outpatient services except for Kaiser. After discussion, the responses are comparable. **BH parity requirements met.**

Medical Necessity and if necessary may request a third party reviewer (Alicare) if necessary and/or conduct a Peer to Peer with requesting/treating provider. • The Medical Director will make a determination to approve or deny and pend the authorization back to the UM BH/Medical clinician • Based on the Medical Director's decision, the UM BH/Medical clinician will either approve or deny the request. • If decision is approved, written notification will be provided to the requesting/treating provider • If denied, written and verbal notification will be provided to the requesting/treating provider. Written notification will be given to member in simple language explaining reason for the decision and their appeal rights. • All adverse decisions are made by AlohaCare's Medical Directors	• Transplants or other complex treatments that can be triaged to ensure quality and prevent unexpected member out-of-pocket expenses HMSA utilizes medical policies for review of prior authorization requests. Medical policies are developed using the clinical evidence found in published medical literature, standards of care, professional society guidelines, and community practitioners' input.	disagree with the need for an extension. Approvals are the responsibility of the Clinical Chief (or designee). Board certified physicians from appropriate specialty areas assist in making determination of medical and clinical appropriateness. Only licensed physicians can make medical necessity denial determinations. Determinations are made after considering clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes also guided by the Kaiser Permanente Hawaii Region policies on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). There are no requirements for written treatment plans before a member receives services.	necessarily limited to the following: • Determination of prior level of function • Members age and previous services • Clinical information which must include assessments, tools and non-standardized testing • Plan of Care • Review of benefit limits using the Benefit Master list. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer review and we will send for a secondary review by a Medical Director		members are getting their needs met, treatment plans are being followed and that community resources are being connected to the member. If there is a concern that an authorization does not meet MN, we offer a peer to peer review and we will send for a secondary review by a Medical Director. Outpatient therapies such as individual, family and group do not have to have prior authorization for the first 20 sessions. After 20 sessions the provider can submit a request for additional services through web portal or fax. UM then determines the number of additional sessions and sends a fax informing the provider.	

Concurrent Review

5. 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?

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Concurrent reviews are not conducted during the course of treatment for outpatient medical services	Concurrent reviews are not required once a prior authorization has been obtained for an outpatient M/S treatments. If continued treatment is medically necessary, HMSA conducts prior authorization reviews for subsequent treatment period(s).	Concurrent review and authorization is not generally performed for outpatient services. A case may be reviewed if an extension is requested for pre-authorized services. Reviews consider clinical information, clinical urgency of the situation, and appropriate	Concurrent Review is not applicable to outpatient Services	Outlier management algorithms are applied to outpatient services based on the following criteria: •Treatment plans ranging from 1-24+ visits, with the likelihood for treatment being medically unnecessary increasing with higher number of visits •Treatment durations ranging from 1-365+ days, with the likelihood	Concurrent Review is not applicable to outpatient Services	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

		criteria/guideline references. These references may include - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD- 2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502). Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness.		for treatment being medically unnecessary increasing with longer treatment durations •Visits including multiple units of services, with the likelihood for treatment being medically unnecessary increasing with higher number of services per visit •Potential to bill for the same service using multiple levels of coding •Relatively low/modest cost per service • Variable rates of patient progress during a treatment plan • Variable approaches to patient care among providers •Coverage up to and including the point of maximum therapeutic benefit being attained, after which additional improvement is no longer expected, and coverage for the same services may no longer exist • A portion of patients never having complete resolution of their condition resulting in ongoing management for a chronic condition Based on the above criteria, the medical/surgical plan has identified the following services in the outpatient classification: •Chiropractic •Occupational Therapy •Physical Therapy Outpatient medical/surgical services rendered using E/M codes are not included in this outlier program. In order to ensure members have access to services available to them through their COC/SPD and the sponsor does not pay for non-covered services a utilization review program is then applied to the identified medical/surgical services. This utilization review program has the following attributes: •Differentiated UR process based on historical provider performance •Business rules identify attributes of cases with a high likelihood for medically unnecessary services		

				currently or in the relatively near future • Identified cases are clinically reviewed • In cases with apparent medically unnecessary services, peer to peer telephonic contact is initiated to make sure complete information is available • In cases where ongoing services have been determined to be unnecessary an adverse benefit determination is made and member/provider communication, compliant with all state and federal regulatory requirements, is issued •Appeals process is available for adverse determination		

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	Concurrent reviews are not required once a prior authorization has been obtained for outpatient M/S services. If continued treatment is medically necessary, HMSA conducts prior authorization reviews for subsequent treatment period(s).	Concurrent review processes are determined for each case after evaluation of clinical information, clinical urgency of the situation, and appropriate criteria/guideline references. These references may include - Medicare guidelines from The Centers for Medicare & Medical Services (CMS); and - Medicaid requirements stated within the State of Hawaii Department of Human Services RFP-MQD-2014-005. Processes and frequency of review are also guided by the Kaiser Permanente Hawaii Region policy on Utilization Decisions (#6425-502) and Out-of-Plan Requests for Care and Services (#5054-01-A). Only licensed physicians can make medical necessity denial determinations. Board certified physicians from appropriate specialty areas are used to assist in making determination of medical and clinical appropriateness. Concurrent review denial rate was 0.016% and appeal overturn rate was 0% during annual period	Concurrent Review is not applicable to outpatient Services	Concurrent review is a component of the plan's utilization management activities and includes medical necessity reviews. The Medical Director and other independently licensed clinical staff review care to detect and better manage over- and under-utilization and to determine whether continued services are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. If a service requires prior authorization and services require authorization beyond the initial. 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. 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	Concurrent Review is not applicable to outpatient Services	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

		ending June 2018.		consideration for individual consumer needs. UHC relies on the National Recognized Practice Guidelines and review and approve the use of these guidelines annually. UnitedHealthcare reviews these documents to adhere to NCQA 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 through review of current, new and emerging medical technologies. While “Concurrent” is a term that generally refers to management of inpatient cases over the course of an inpatient stay, the following is based on Prior Authorization requests for the period of January 2017 to June 2018.		

Total # Auths	Total #/% of Auths cases w/Initial Adverse Determination	Total #/% of Initial Adverse Determination Cases Appealed	Total #/% of Appealed Cases overturned on Appeal	Total #/% Adverse Determination Cases Reversed other than Ap	Total #/% of Auth Cases w/ Persistent Adverse Determination

				<table><tr><td></td><td></td><td></td><td></td><td>peal</td><td></td></tr><tr><td>9,559</td><td>2018/21.2%</td><td>48/0.5%</td><td>23/47.9%</td><td>1030/51.0%</td><td>965/10.2%</td></tr></table>		

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	Not applicable	Concurrent review and authorization is not generally performed for outpatient services. A case may be reviewed if an extension is requested for pre-authorized services.	Concurrent Review is not applicable to outpatient Services	•If a service requires prior authorization and services require authorization beyond the initial. •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. •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. UnitedHealthcare relies on the National Recognized Practice Guidelines and review and approve the use of these guidelines annually. UnitedHealthcare reviews these documents to adhere to NCQA standards.	Concurrent Review is not applicable to outpatient Services	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

Prescription Drugs

8. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
No tiers	Please refer to the NQTL – Prescription Drugs document	Prescription drug benefits are not tiered for Medicaid members.	The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process:	UnitedHealthcare does not restrict or set limits on prescription drugs provided in an outpatient setting. Due to the CMS Final Rule, tiers related to brand vs. generic have been established. The tiers are not	The selections of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process:	CCS is more stringent than AlohaCare, HMSA, Kaiser and United. **BH parity in question.** **11/5/18:**

			Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescriber's e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL <u>Clarified response 10/31/18</u>: No, prescription drug benefits are not tiered for Medicaid beneficiaries.	tied to copays. The conditions treated do not affect the tier assignment of a medication. **Tier Name** / **Drug Tier** Tier 1 / Generic Tier 2 / Brand	Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescriber's e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL <u>Clarified response 10/31/18</u>: No, prescription drug benefits are not tiered for Medicaid beneficiaries.	**Based on clarified response, BH parity is no longer in question.** **BH parity requirements met.**

<u>NETWORK ADMISSION REQUIREMENTS</u>

9. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
For M/S services, AlohaCare conducts annual and ad hoc assessments of our provider network delivery system to determine if it is meeting our standards for network adequacy, capacity, and member access. See attached Selections and Retention of Providers Policy. AlohaCare's Policy includes provider exclusion per federal and state requirements for government funded programs. Credentialing requirements include common, state-wide and national standards such as licensed, certified, accredited, and in good standing, with Appropriate medical liability, DEA, peer references, and other common credentialing and privileging verifications.	Providers must be appropriately licensed or certified in accordance with state and national guidelines, meet all standard educational and credentialing criteria for their specialty, not be an excluded entity with Medicare or Medicaid programs, and have met all continuing educational requirements specific to their provider type Provider must be willing to contract at sustainable rates and to submit all required documentation for both credentialing process and for system configuration for adjudication of provider claims. Provider onboarding process can be initiated either by the health Plan or Provider followed by	Kaiser Permanente Hawaii Region (KP) is an integrated model of care which provides 97% of KP member care via its employed providers and facilities. To augment KP's internal care delivery system, KP contracts with specialized service providers, both within and outside the State of Hawaii. Network admission requirements are comprised of several factors which vary according to the service provider. These factors include appropriate licensing, accreditation, good standing against government agency listings of excluded individuals/entities, education, training, board qualification, certification, reference checks, background	`Ohana provides contracted networks of qualified organizational health care providers, and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, provider disclosures, and licensure/certification. All applicable providers go through the credentialing process that is based on NCQA requirements. Credentialing of a provider is initiated prior to contracting with the provider. Once a provider has completed the credentialing process and approved by the Credentialing Committee, they are offered a contract with UnitedHealthcare. Participation criteria for practitioners include information about the provider, such as:	`Ohana provides contracted networks of qualified organizational health care providers, and community based case management providers (as applicable to state) to the enrolled membership in its Plan. `Ohana performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	All MCO's are comparable for their provider network credentialing. CCS is not more restrictive. **BH parity requirements met.**

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<td>execution of a contract between Plan and Provider for participation in one or more products. Plan monitors network needs on a regular basis in accordance with its practitioner availability policies and will initiate outreach to non-par Providers if network analysis shows a need in a specific geography. Also, non-par Providers frequently initiate a request for participation. Plan will either respond and begin contracting process or politely decline if credentialing requirements are not met. Plan retains all rights to determine which providers it adds to its provider networks.

HMSA has formal credentialing criteria and a Credentialing Committee.

See the attached requirements documents:
• Physicians (Medical Doctors, Osteopaths, Podiatrists and Oral Surgeons) 2018 HMSA Professional Credentialing Requirements
• Physical Therapists, Optometrists, and Clinical Psychologists 2018 HMSA Professional Credentialing Requirements
Behavior Analysts 2018 HMSA Professional Credentialing Requirements</td>
<td>checks, interviews with relevant departments, agreement to maintain compliance with requirements and code of ethics, acceptance of offered compensation, and other factors.

Initial evaluation of a provider is performed by the Provider Relations and Contracting representative and/or physician/provider recruiter and/or department physician chief who reviews the application, checks references, and interviews the applicant provider. Further interviews are conducted and recommendations to leadership are made.

Credentialing occurs thereafter with National Provider Identification confirmation, primary source verification, background checks, and a Medicare/Medicaid status query to ensure avoidance of providers who have been excluded from participation by the U.S. Department of Health and Human Services Office of Inspector General, Section 1128 (including Section 1128A) of the Social Security Act, and/or by the State Department of Human Services (DHS) from participating in the Medicaid program. Findings are evaluated by credentialing staff and committee prior to hiring/contracting.

KP refers to the Medicaid network adequacy requirements within the State of Hawaii Department of Human Services RFP-MQD-2014- 005:
<table>
<tr><th>Minutes of drive time</th><th>URBAN</th><th>RURAL</th></tr>
<tr><td>PCP</td><td>30</td><td>60</td></tr>
<tr><td>Specialist</td><td>30</td><td>60</td></tr>
<tr><td>Hospital</td><td>30</td><td>60</td></tr>
<tr><td>Emergency Facility</td><td>30</td><td>60</td></tr>
<tr><td>Mental Health</td><td>30</td><td>60</td></tr>
<tr><td>Pharmacy</td><td>15</td><td>60</td></tr>
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<td></td>
<td>1. Education
2. Licensing
3. Applicant must have full hospital admitting privileges, without Material Restrictions, conditions or other disciplinary actions, at a minimum of one participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Credentialing Entity determines that Applicant's practice requires such privileges.
4. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant.
5. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS.
6. Work History
7. Mal-practice Insurance or state approved alternative
8. Network participation

UnitedHealthcare ensures that it has the network capacity to serve the expected enrollment in the service area, that it offers an appropriate range of services and access to preventive, primary, acute, behavioral health services, and long-term services and supports (LTSS) and it maintains a sufficient number, mix, and geographic distribution of providers of covered services.

UnitedHealthcare network providers must meet availability standards for Medicaid members.</td>
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		24-Hr Pharmacy: 60: N/A		Our Medicaid members and providers are notified of the plan's policies for immediate care and for scheduling urgent, pediatric sick, adult sick and routine appointments. UnitedHealthcare monitors provider performance against the standards at a minimum on a quarterly basis. UnitedHealthcare ensures it's network has the capacity and is adequate to serve the expected enrollment in the service area to maintain a sufficient number, mix, and geographic distribution of providers for services; taking in consideration the distance that it takes the member to travel in normal traffic conditions, using usual travel means in a direct route from his/her home to the provider based on the GeoAccess Standards.		

10. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
No exclusions, except for those excluded from participation in government healthcare programs.	HMSA does not have any exclusions pertaining to provider types, facility types, or specialty providers.	No practitioner types, facility types, or specialty providers are specifically excluded from eligibility to enter into contracting consideration toward providing covered benefit services.	Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above.	UnitedHealthcare does not exclude any provider types however we may exclude a provider based on the credentialing criteria. UnitedHealthcare complies with state licensing requirements and if there is a practitioner type who is eligible a contract will be offered. All applicable providers must meet the requirements of our credentialing requirements.	Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above	All MCO's are comparable. **BH parity requirements met.**

11. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
No such limitations	There are no geographic limitations	Assuming the provider is within the U.S.A., there are no geographic limitations on provider inclusion. Each provider candidate's geographic area is considered in relation to the needs of the health plan's membership within that geographic area and Medicaid requirements stated within the	The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is). Clarified response 10/31/18: This question deals with the geographic limitations of our contracting efforts to get providers within our network and whether	UnitedHealthcare does not impose or have any geographic limitations on provider inclusions.	The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is). Clarified response 10/31/18: This question deals with the geographic limitations of our contracting efforts to get providers within our network and whether	CCS is more stringent. AlohaCare, HMSA, Kaiser and United all do not have geographic limitations. CCS is limited to the service area of the plan. **BH parity is in question.** **11/5/18:** **Based on the clarification provided, it seems that BH**

		State of Hawaii Department of Human Services RFP-MQD-2014-005.	we have more stringent contracting and credentialing requirements for BH providers than we do for medical providers. The answer is our contracting and credentialing requirements are the same regardless of provider specialty. Because the question asked about out-of-network providers, we stated that our only limitation re: contracting with providers was the boundaries of the geographic region defined by the State for their membership. We do not "contract" with providers outside the State's defined geographic service area. If a member requires care that is not available within our network of providers, we would identify the closest out of network provider available to provide the care and authorize via a Single Case Agreement. That, however, has nothing to do with our contracting requirements and the parity between how we contract for providers between medical and behavioral services.		we have more stringent contracting and credentialing requirements for BH providers than we do for medical providers. The answer is our contracting and credentialing requirements are the same regardless of provider specialty. Because the question asked about out-of-network providers, we stated that our only limitation re: contracting with providers was the boundaries of the geographic region defined by the State for their membership. We do not "contract" with providers outside the State's defined geographic service area. If a member requires care that is not available within our network of providers, we would identify the closest out of network provider available to provide the care and authorize via a Single Case Agreement. That, however, has nothing to do with our contracting requirements and the parity between how we contract for providers between medical and behavioral services.	**parity is no longer in question.** **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of- network benefits.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
AlohaCare members receive medically necessary care. OON care must be prior authorized and coverage determinations are made based on clinical review considering patient history with providers, and comparison of provider specialties, training, expertise, credentials, and on geography and proximity. If in-network providers of comparable credentials and specialties are available in the medical service area, care is re-directed to the network. If not, then OON care is authorized. This is also true for out of state non-emergency care.	QUEST Integration members have no out-of-network benefits except for emergencies. If a member is admitted for an emergent condition, no prior authorization or concurrent reviews are required until the time the member's condition is stabilized. If a member needs a treatment or service that is not available from network providers, exception can be made after a medical necessity review and verifying availability of comparable services within the network. If the out of network treatment is warranted, HMSA will contract with the out-of-network provider for a single case agreement.	Physician evaluates member. If out-of-plan referral appears appropriate, physician completes an order for the request. Department Chief receives referral request and performs evaluation/determination. Medical necessity approval from the Outside Medical Services Medical Director or other appropriate Department Chief /Designee is required for the following types of referral requests: • Requests for services from non-credentialed providers;	The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's benefit plan design dictates how members can access out of network benefits.	UnitedHealthcare provides access to Out of Network (OON) providers (non-contracted providers) if an in-network provider is unable to provide medically necessary services in an adequate and timely manner to a member and continue to authorize the use of non-contract providers for as long as UnitedHealthcare is unable to provide services through network providers. UnitedHealthcare requires prior authorization approval for OON providers prior to rendering the service.	The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services and when medically necessary services are not available in network. The State's benefit plan design dictates how members can access out of network benefits.	All MCO's are comparable for OON benefits. **BH parity requirements met.**

		• Requests for mainland/out of area services; • Experimental treatments/therapies; • Requests for services where there is internal capability; • Requests for transplantation services. Medical necessity determination is referred to Authorizations and Referral Management (ARM). If medical necessity is approved, ARM reviews request to ensure that referral guidelines and criteria are met: • The requested service is certified as medically necessary by Chief/Designee; • The service is a covered Health Plan benefit; • The requested service is not available within Plan; • The patient is an eligible Health Plan member; • The patient has benefits available • Referral parameters (frequency/ duration) are clearly defined; and • Selected provider/ practitioner is credentialed or has Letter of Agreement with health plan. If criteria met, ARM will generate the authorization, notify the receiving provider, notify the requesting practitioner of the approval, and generate a notification letter to the member.				

		Only licensed physicians can make medical necessity denial determinations.				

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
All provider contracts are negotiated rates and vary according to terms reached in negotiation. Most begin with the state's FFS fee schedule, or are a percentage of Medicare FFS fee schedule. This is true for physicians, PhDs and MAs.	Initial fees were established at the beginning of the QUEST program in 1994. At that time, fees were established based on the Medicaid FFS schedule at that time. Since then increases or decreases were based on the reimbursement rates set by the state to the Insurance plans. Adjustments are made to the changes in coding that occur nationally. For ABD and Non-ABD, we primarily follow the Medicaid fee schedule. Some provider's fees are individually negotiated. Psychiatrists and Psychologists are paid the same rate. Child Psychiatrists are paid 110% of the Psychiatrist fee. Social workers, Marriage Family Therapists, Mental health counselors, and APRNs are paid 85% of the psychiatrist rate.	In this island State of Hawaii, provider supply and demand in target geographic areas of need is a primary influencer of professional provider reimbursement rates for physicians, PhD, MA and other professionals. While the Medicaid fee schedule is considered, the actual provider reimbursement rates may be higher. Beyond the issues related to supply and demand, professional provider reimbursement rates are not specifically impacted by service type, practice size, and licensure.	`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	UnitedHealthcare's Medicaid Fee Schedule is developed using the State's Medicaid Fee Schedule with alignment using Medicare relatively. Where the fee source does not publish a specific fee amount, UnitedHealthcare will use the CMS Gap fill using a % of prevailing Medicare. UnitedHealthcare will use reasonable commercial efforts to implement the updates in its systems on or before the later of (i) 90 days after the effective date of any modification made by the Fee Source or (ii) 90 days after the date on which the Fee Source initially places information regarding such modification in the public domain (for example, when CMS distributes program memoranda to providers). UnitedHealthcare will make the updates effective in its system on the effective date of the change by the Fee Source. However, claims already processed prior to the change being implemented by UnitedHealthcare will not be reprocessed unless otherwise required by law.	`Ohana utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. Providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	All MCO's are comparable. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Medicare reimbursement, and service demand/network adequacy and capacity are the primary drivers for both M/S and MH/SUD providers. Some medical and mental health specialties are in a workforce shortage situation.	Due to access issues, provider rates may be negotiated to help the rural areas. Individually negotiated rates are reviewed on a case-by-case basis and could match Medicare or commercial business.	In this island State of Hawaii, provider supply and demand in target geographic areas of need is a primary influencer of professional provider reimbursement rates. While the Medicaid fee schedule is considered, the actual provider reimbursement rates may be higher. Beyond the issues related to supply and demand, professional provider	None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure	Professional provider reimbursement rates do not vary based on the factors listed above. In limited instances variations can occur based on availability of certain limited specialty services in Hawaii.	None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure	All MCO's are comparable. **BH parity requirements met.**

		reimbursement rates are not specifically impacted by service type, practice size, and licensure.	*`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.		*`Ohana utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	

NQTL ANALYSIS FOR BH PARITY – PRESCRIPTION DRUGS

MEDICAL MANAGEMENT STANDARDS

Medical Necessity Criteria Development

1. 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 benefits within each classification? 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
AlohaCare's Utilization Management Program (UMP) incorporates the functions of utilization review/management (e.g., prospective, concurrent and retrospective reviews) of medical, behavioral health, long term services and supports, pharmacy/drug services. The UMP monitors for over- or under-utilization, and inappropriate use of services. The AlohaCare UMP also includes services that promote the continuity and coordination of care through assistance and support during care transitions, disease management, and collaborative care and service coordination internally and externally. It objectively monitors and evaluates the cost of care based on medical or functional appropriateness. The AlohaCare UMP assesses not just clinical aspects of care, but also factors that impact how care is delivered/provided, such as cultural and linguistic awareness and sensitivity, enabling services, and continuous monitoring of quality of service. The UMP creation and decisions are developed by various committees comprised internal and external clinicians,	HMSA's QUEST Integration formulary is based on the CVS Caremark National Managed Medicaid Template Formulary. The CVS Caremark National P&T Committee manages this formulary and reviews the safety and efficacy of each drug to determine formulary inclusion or exclusion. Decisions are based on evidenced-based medicine principles, well established clinical practice guidelines, scientific evidence, peer-reviewed medical literature, and standards of practice.	The health plan does not establish medical necessity criteria for prescription drugs. The prescriber makes the final decision regarding what drug is medically necessary and appropriate for the member. If that drug is not on the formulary, the prescriber submits the prescription/order for the non-formulary drug to a Kaiser Permanente (KP) pharmacy. The pharmacist and prescriber may collaborate on evaluating the circumstances for considering the non-formulary drug, assessing the member's need for the non-formulary drug, and determining if a comparable formulary drug or over the counter drug can be considered for use. If the prescriber determines that a non-formulary drug must be utilized, then the health plan covers the non-formulary drug per the member's benefit plan.	Medical Necessity Criteria Development is not applicable to Prescription Drugs	As defined in the Hawaii Revised Statutes ("HRS") 432e-1.4, the medical necessity/appropriateness criteria for drug therapy are developed by UnitedHealthcare Pharmacy (UHCP) Team. Once developed or modified by UHCP the criteria is directed to the Pharmacy and Therapeutics (P&T) Committee process for review and adoption. The P&T Committee meets quarterly. Issues pertaining to drug selection and pharmacy program management are communicated quarterly through a newsletter to providers and are also available on the UnitedHealthcare Community Plan internet site.. An overview of the process is as follows: 1. Development of Criteria a. The process is generally initiated by the approval of a medication by the Food and Drug Administration (FDA). Once approved by the FDA the medication will be reviewed for inclusion in the preferred drug list (PDL). As part of the review medical necessity/appropriateness criteria for use may be drafted if deemed appropriate by the review. b. When drafting the medical necessity/appropriateness criteria the following are considered: review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice	Medical Necessity Criteria Development is not applicable to Prescription Drugs	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

non-clinicians, and subject matter experts. Such committees are: The Board Quality Committee (BOC), Medical Management Committee (MCC), Practitioners Advisory Committee (PAC), LTSS Quality Advisory Committee, Pharmacy & Therapeutics Committee (P&T), as well as direct director oversight by the Chief Medical Officer (CMO). Medical necessity is based on review using the criteria guidelines as outlined in the Medical Necessity Criteria policy and procedure, medical coverage policies, or using Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) guidance as applicable. The UM policies and procedures are reviewed annually and are updated as necessary. AlohaCare reviews and updates, on an annual basis, all AlohaCare medical policies related to medical necessity of the following services: specific diagnostics and treatments, new technologies, and DME/supplies; pharmaceuticals; clinical practice guidelines, based on national recommendations; and inter-rater reliability among UM nurses, pharmacists and physician directors. New medical policies related to medical necessity are vetted through a process that involves the following: • Research of available clinical information, coding, and national trends regarding medical necessity				guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. c. Criteria development will consider the likely impact of a drug product on patient compliance when compared to alternative products. d. The criteria will be presented to the UHC UM Committee and UHC P&T Committee 2. Modification of Criteria a. Annually UHCP will review clinical criteria to determine if the criteria need to be modified based on new evidence. b. Ad hoc reviews may be performed at any time when questions concerning a particular indication are raised by medical directors, pharmacy directors, managers, through the coverage review or appeal process. c. Any new FDA approved indication that would be considered a covered benefit will be considered for addition to the criteria. d. Modified criteria will be reviewed for approval/adoption via the UHC P&T Committee process. 3. Adoption of Criteria a. The criteria are reviewed and approved via the UHC P&T process. b. Once the criteria have been reviewed and accepted they will be adopted for use/implemented. The time period needed for implementation is 60 days.		

for the specific service by a medical policy analyst. • Vetting of the proposed medical policy among internal staff: o Chief Medical Officer, Medical Director, and Associate Medical Directors. o Senior Director of Long Term Services and Support (Service Coordination). o Director of Utilization Management. o Director of Health Plan Operations. o Pharmacy Manager. o Others as relevant. • Feedback from Practitioners Advisory Committee. • Approval of Medical Management Committee.						

2. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
As mentioned above, the UMP outlines the various committees and groups which collaborate on writing our medical and pharmacy policies. The requirements such has initial trials, step-therapies, and other various UM edits places on these therapies are created based on guidelines as outlined the Medical Necessity Criteria policy and procedure, medical coverage policies, or using Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) guidance as applicable.	Fail first requirements or step therapy (ST) criteria are based on standards of medical practice, current clinical principles and processes of pharmacotherapy, evidence-based drug information, expert opinion, drug labeling, randomized clinical trials, pharmacoeconomic studies, and outcomes research data. All ST requirements are reviewed and approved by the CVS Caremark National P&T Committee. ST requirements are reviewed annually or more frequently when new indications or information become available.	No step-therapy (aka "fail first") protocols are in place. The decision to implement such a protocol would be made by the Pharmacy & Therapeutics Committee and reviewed annually. Clarified response 10/31/18: Kaiser does not currently use step-therapy protocols for outpatient services/settings. See attached Drug Formulary policy (65-61-2.11), Section 4.2.4. *The Kaiser Permanente Hawaii Drug Formulary currently does not apply a traditional prior authorization (PA), step therapy, or treatment protocols and procedures, but in the event the P&T Committee decides to implement such utilization*	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line	The step-therapy drugs are routinely covered only after a sufficient trial of an indicated first-line agent has been adequately tried and failed. These medications may also be requested through the Prior authorization process. The provider must submit clinical notes along with the PA form to document what medications were attempted and failed. The factors that the P&T Committee use to determine step-therapy include the prescribing and delivery of quality cost effective care, monitoring of utilization, and enhanced PDL compliance.	`Ohana uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. `Ohana also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. `Ohana uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line	'Ohana HP and CCS: need to clarify use of QTLs. Kaiser: No protocols. **Need to discuss if BH parity requirements met.** **11/9/18:** **After discussion, the issue may be the wording of the question. Being that Kaiser has a unique business/medical model/ approach in comparison to the rest of the MCO's in Hawaii, if the question is addressed in a different way, there may not be a question of parity.** **BH parity requirements NOT met. Meetings set up with Kaiser to discuss options to remedy the parity issue across the state.**

		management programs, they will be reviewed at least annually. <u>Clarified response 12/12/18</u>: Kaiser Permanente does not impose fail first or step-therapy requirements. There are formulary guidelines in place which recommend preferred formulary agents. However, it is the prescribing provider who maintains the authority and responsibility to determine medical necessity. Thus, if the provider determines that first line drugs are highly likely to fail or are not medically appropriate for the patient, the patient may obtain second line drugs without attempting use of first line drugs.	therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.). <u>Clarified response 10/31/18</u>: The QL description was submitted in error due to a misinterpretation of the document line of questions. Quantity Limits (QL) rules and Step Therapy (ST) rules are two distinct methods of Utilization Management deployed to ensure proper use of medication therapies. There is no difference in how ST is applied between MH/SUD and M/S services. Our treatment of prescription drugs is	The purpose is to ensure safe, proper and cost effective medication use. Members are required to try and fail preferred agents prior to receiving non-preferred agents to encourage the use of cost-effective drug therapies (preferred agents) prior to being able to fill the more expensive drug therapies (non-preferred agents). Preferred agents are more cost-effective than non-preferred agents. Preferred agents typically account for nearly 80% of a program's total prescription fills, but only 20%-30% of the cost.	therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the DER process and will receive the ST medication. An example of ST criteria would be for Saphris tablet. The patient would have had to complete a trial and failure of a preferred alternative within the last 100 days or have a contraindication before the Saphris tablet would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - `Ohana uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.). <u>Clarified response 10/31/18</u>: The QL description was submitted in error due to a misinterpretation of the document line of questions. Quantity Limits (QL) rules and Step Therapy (ST) rules are two distinct methods of Utilization Management deployed to ensure proper use of medication therapies. There is no difference in how ST is applied between MH/SUD and M/S services. Our treatment of prescription drugs is in parity between MH/SUD and M/S services.	**12/17/18:** **After review/discussion of Kaiser's response, it seems that Kaiser does have a protocol that uses a formulary guidelines and will use drugs based on medical necessity or appropriateness as decided by the prescribing provider. As stated by Kaiser, "…if the provider determines that the first line drugs are highly likely to fail or are not medically appropriate for the patient, the patient may obtain second line drugs without attempting use of first line drugs."** **Based on Kaiser's response it has been determined that BH parity requirements have been fulfilled.** **<u>As of 12/17/18:</u>** **BH parity requirements met.**

			in parity between MH/SUD and M/S services.			

3. 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

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Just as the previously answered questions. Exclusions based on failure to complete a course of treatment and other exclusions are also taken into account in the writing of our UMP and individual UM edits on medications and procedures. These are developed using the same criteria as outlined above.	According to HMSA's Hepatitis C Policy, a repeat treatment for hepatitis C medication will not be covered if a member had inadequate compliance resulting in failure to achieve a sustained viral response. HMSA's Hepatitis C Policy is based on QI-172, which requires a member to have 100% medication compliance with hepatitis C medications.	There are no exclusions based on failure to complete a course of treatment	Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting. Clarified response 10/31/18: Step Therapies rules are applied to medications uniformly regardless of it being for a BH or Medical services. We follow all state guidance on administering our prescription drug benefit.	There are no exclusions based on failure to complete treatment.	`Ohana uses clinical standards and guidelines to develop coverage criteria that may contain exclusions for certain drug/products that may require a qualifying therapy that must be tried and failed prior to authorization for the drug/product being requested. Coverage criteria is reviewed quarterly during the Pharmacy and Therapeutics Committee meeting. Clarified response 10/31/18: Step Therapies rules are applied to medications uniformly regardless of it being for a BH or Medical services. We follow all state guidance on administering our prescription drug benefit.	CCS is more stringent than Kaiser, HMSA and United. **BH parity is in question.** **11/9/18:** **After discussion, the responses are comparable. 'Ohana documents "may contain exclusions", it is not a "yes".** **Based on this, BH parity requirements are no longer in question.** **BH parity requirements met.**

Prior Authorization

4. Prior authorization is required prior to coverage of rehabilitative services. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to these and other 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 psychological MH/SUD services for which prior authorization is required.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
For M/S services, based on LCDs and NCDs, manufacturers labeling information and other components of the UMP described in item #1 above, medications that require a PA, have quantity limits, or require step therapy are loaded into the Pharmacy Point Of Sale (POS) system by AlohaCare's Pharmacy Benefits Manager (Express Scripts, Inc so that they will not pay unless the PA is approved. Except for urgent and emergent needs during non-business hours, these are reviewed by AlohaCare Pharmacists before dispensing of medications and payment through the POS occurs. Interaction with the prescribing physician and review of the	Prior authorization (PA) helps promote safe and appropriate medication utilization. The goal is to ensure that the drug, dosing, and treatment duration are appropriate for the member. The CVS Caremark PA Center will collect information (e.g. diagnosis, previous medications, allergies, contraindications, etc) from the provider to determine whether the member meets the established criteria for the drug. PA criteria are based on standards of medical practice, current clinical principles and processes of pharmacotherapy, evidence-based drug information, expert opinion, drug labeling, randomized clinical trials, pharmacoeconomic studies, and outcomes research data. All	Prior authorization is not required for prescription drug coverage by health plan.	N/A for prescription NQTL Clarified response 10/31/18: Yes, Prior Authorizations are reviewed according to coverage criteria established through our Pharmacy & Therapeutic Committee and completed within the timeframes garnered in our contract with the State.	Medications that are on the UnitedHealthcare Prescription Drug List (PDL) are selected because they are considered both clinically appropriate and cost-effective. When a drug not listed on the PDL is requested by a provider, it must go through the prior authorization review. Prior authorization is required when a provider prescribes non-formulary/non-PDL medication or certain formulary medications that have precursor therapies, specific indications, or not routinely covered due to plan Benefit Limitations or Exclusions. An overview of the prior authorization process is as	N/A for prescription NQTL Clarified response 10/31/18: Yes, Prior Authorizations are reviewed according to coverage criteria established through our Pharmacy & Therapeutic Committee and completed within the timeframes garnered in our contract with the State.	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

medical record may be utilized to consider for meeting criteria.	PA requirements are reviewed and approved by the CVS Caremark National P&T Committee. PA requirements are reviewed annually or more frequently when new indications or information become available.			follows: • The provider prescribes a medication for the member that is one of the following: non-formulary; or, formulary but requires precursor therapies or has specific indications; or, not routinely covered due to Plan Benefit Limitations or Exclusions. • If the provider has advance knowledge of the prior authorization process, they can submit a prior authorization request prior to the pharmacy running a claim for the medication. • If the provider is not aware of the prior authorization the requirement, when the pharmacy submits a claim for the medication it will be with a message that prior authorization is required. • Should the member urgently need the medication, the pharmacy can submit a dynamic override code which will allow a 5 day supply of medication to be dispensed. This will allow time for prior authorization submission and urgent review. • The provider completes and submits a prior authorization request form along with relevant clinical documentation to support medical necessity. The request can be submitted either over the phone or via fax form. • The prior authorization request is received by pharmacy prior authorization unit and a clinical review for medical necessity is conducted. The request is reviewed against the applicable clinical policy and must be completed in amount of time allotted based upon the urgency of the request. • Urgent requests must be completed in 3 business days. • Standard requests must be completed in 14 calendar days. • Once the review is complete notice of action is sent to both the member and provider. If the notice of action is a denial then the member and provider are advised		

				other their options and Appeals Rights. Prior authorization requests are reviewed by the following staff: • Licensed Pharmacy Technicians • Licensed Clinical Pharmacists • Licensed Physicians Please note: Only a physician may deny a prior authorization request based upon lack of medical necessity. Assessing the approval denial rate for a particular drug and across the spectrum of drugs will indicate the rigor with which the authorization standards. An Inter-rater Reliability Process is used to measure and assess adherence to the approved clinical policies when reviewing prior authorization requests. Over application of prior authorization to a particular drug could be measured by the approval/denial rate. If the approval rate is very high, then the medication is being utilized appropriately and prior authorization could be unnecessary.		

Concurrent Review

5. 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?

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Medical and Utilization Management which includes: timely processing of referrals and prior authorization of medical, surgical, or behavioral health services in terms of specialty care, diagnostics, treatments; prospective, concurrent and retrospective reviews related to appropriate utilization; and medical policy development where coverage determination tools such as InterQual, Medicare NCD or LCD, DMERC do not	N/A	Concurrent review of prescribed drugs is not required for continued health plan coverage.	N/A for prescription NQTL	Medispan database is used to assist retail and mail order pharmacists with therapeutic decisions with at least 9 system edits. Duration of treatment, drug-drug interactions, and therapeutic duplication are some of the edits that are used The screening edits that are utilized include: 1) Drug-Drug Interaction Screening 2) Diagnosis Caution Screening 3) Drug Inferred Screening	N/A for prescription NQTL	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

adequately address specific requests for services; The AlohaCare Medical Director and Associate Medical Directors, under the direction of and in concert with the Chief Medical Officer, participate in medical management/utilization review decision making operations over the full scope of plan benefits through prospective, concurrent and retrospective review. AlohaCare's Pharmacy Manager provides day-to-day supervision and direction to staff within the Pharmacy Department and works collaboratively with the Chief Medical Officer, who has oversight responsibility, as well as the Medical Director and Associate Medical Directors on UM initiatives, issues and decisions relating to utilization management of medications, and administration of AlohaCare's formulary. Behavioral health expertise is necessary among the Medical Director and Associate Medical Directors.				4) Drug-Age Contraindication Screening 5) Drug-Sex Contraindication Screening 6) Duplicate Prescription Screening 7) Drug Class Duplication Screening 8) Refill Too Soon Therapeutic Dose Limits Screening		

6. What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review? Provide average denial rates and appeal overturn rates for concurrent review in this classification.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Medical and Utilization Management which includes: timely processing of referrals and prior authorization of medical, surgical, or behavioral health services in terms of specialty care, diagnostics, treatments; prospective, concurrent and retrospective reviews related to appropriate utilization; and medical policy development where coverage determination tools such as InterQual, Medicare NCD or LCD, DMERC do not	N/A	Concurrent review of prescribed drugs is not required for continued health plan coverage.	N/A for prescription NQTL	A concurrent DUR program screens all retail and mail service prescription claims at the point of service before the drug is dispensed. The concurrent DUR system screens each prescription against the member's prescription drug history. The system checks for inappropriate drug prescribing and utilization, as well as potentially dangerous medical implications or drug interactions.	N/A for prescription NQTL	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

adequately address specific requests for services; We currently do not perform any concurrent reviews for outpatient or pharmacy medications. Requests for post services are treated as Retrospective reviews. These are treated the same as regular or prospective reviews.				The program includes communication avenues through claims edits and messaging to the dispensing pharmacy at point-of-service. Our concurrent reviews do not have appeal overturn rates but the average number of prescriptions that were screened through the cDUR program during 2017 had a 53.9% paid rate; 20.3% were rejected; and 54.3% were reversed; total of 42.2% prescriptions. The prior authorization figures are listed below and do include appeal overturn rates. Med/Surg meds had 22 cases appealed with a 27.3% overturn rate. The approval rate for PA's were 51.9% with a denial rate of 48.1%.*		

7. Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
We currently do not perform any concurrent reviews for outpatient or pharmacy medications. Requests for post services are treated as Retrospective reviews. These are treated the same as regular or prospective reviews.	N/A	Concurrent review of prescribed drugs is not required for continued health plan coverage.	N/A for prescription NQTL	POS edits are conducted whenever a prescription is filled at point of service at a retail or mail order pharmacy. The UnitedHealthcare Pharmacy reviews the DUR summaries quarterly and they are then reviewed by the Quality Management Committee.	N/A for prescription NQTL	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services, which meets parity requirements. CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

Prescription Drugs

8. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
• No Tiers • Formulary or Non-Formulary Status Only • Closed Formulary PA required for selected medications and situations, including non-formulary, step therapy, and quantity limits	HMSA's QUEST Integration Formulary is not a tiered formulary.	Prescription drug benefits are not tiered for Medicaid members.	The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and	Due to the CMS Final Rule, tiers related to brand vs. generic have been established. The tiers are not tied to copays. The conditions treated do not affect the tier assignment of a medication. **Tier Name** / **Drug Tier** Tier 1 / Generic Tier 2 / Brand	The selections of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and	CCS is more stringent than HMSA, Kaiser and United. **BH parity is in question.** **11/5/18:** **Based on the clarified response, BH parity is no longer in question.** **BH parity requirements met.**

			Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescriber's e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL <u>Clarified response 10/31/18</u>: No, prescription drug benefits are not tiered for Medicaid beneficiaries.		Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescriber's e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL <u>Clarified response 10/31/18</u>: No, prescription drug benefits are not tiered for Medicaid beneficiaries.	

<u>NETWORK ADMISSION REQUIREMENTS</u>

9. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
The health plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. The health plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as: (1) requiring that the health plan contract with providers beyond the number necessary to meet the needs of its members; (2) precluding the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (3) precluding the health plan from	Every pharmacy must supply documentation, pass enrollment, and meet certification requirements prior to joining the pharmacy network. Enrollment requirements: - Provider Agreement (base contract) - Credentialing forms/answers to enrollment application questions - Copies of current state license(s) - Copy of DEA certificate - Copy of Liability policy - FWA training attestation - NCPDP and NPI - Network enrollment forms Credentialing verification process: - State Pharmacy and Pharmacist-In-Charge licenses (must be active, in-date, and in good standing) - Pharmacy's DEA license (must be active, in-date, and in good standing)	Not applicable for prescription drugs.	N/A for prescription NQTL	The State of Hawaii sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. We contractually require each pharmacy to ensure credentials and compliance as well as Chain and PSAO organizations to maintain a credentialing program for itself and their member pharmacies. **Processes:** We contractually require each pharmacy to ensure credentials and compliance as well as Chain and PSAO organizations to maintain a credentialing program for itself and their member pharmacies. Credentialing requirements, but are not limited to: • Validation of state pharmacy licenses • Validation of the Pharmacist in Charge License • Validation of the DEA license	N/A for prescription NQTL	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. The health plan is not required to contract with every willing provider. If the health plan does not or will not include individuals or groups of providers of a specialty grouping in its network, it shall provide that information in its proposal. AlohaCare's provider network team maintains the Selection and Retention of Providers policy which outlines the development, maintenance, assessment, and other aspects of the provider network.	- Pharmacy's NCPDP and NPI numbers - Liability policy (must be active and meet minimum coverage requirements) - Pharmacy address - Exclusion searches (all officers, owners, entities, and managing employees are checked against the Federal OIG/SAM databases and State Medicaid exclusion lists FWA training attestation (must be in-date and not set to expire within the next 30 days)			• Insurance showing adequate coverage • Copy Wholesale Invoice/Drug Purchase Packing Slip • Ownerships and affiliations • Review of disciplinary actions, convictions, restrictions and any other adverse actions In addition, each month we validate our pharmacy network against the U.S. Department of Health and Human Services, Office of Inspector General (OIG) list of excluded individuals and entities (LEIE) to ensure no excluded pharmacy is on that LEIE. Pharmacies, if identified on that list, are immediately termed from the pharmacy network. Pharmacies are required to insure compliance with professional standards that include, but not limited to: • Have an NCPDP# • Ability to transmit 100% of claims via the point of service system (POS) • Maintain verifiable records and signature logs • Allow for on-site audits of records and prescriptions • Maintain adequate insurance coverage • Comply with the Agreement and Provider Manual • Agree to comply with all Drug Utilization Review (DUR) and Client's plan design parameters • Comply with applicable State and Federal laws All pharmacies are fully re-credentialed at least every three years. Pharmacy's need to meet specific compound drug credentialing criteria, including but not limited to:		

				• Accreditation from one of the following two accreditation organizations: 1) PCAB - Pharmacy Compounding Accreditation Board 2) NABP-VPP – National Association of Boards of Pharmacy Verified Pharmacy Program • Maintain a continuous quality improvement process (inclusive of validation testing for endotoxin, stability and sterility), Beyond Use Date (BUD) verifications, clean room certifications, review of FDA approved vendors for API purchases, Anticipatory compounding procedure review, NCPDP D.0 multi-ingredient claims submission compliance, daily calibration and routine maintenance verifications (e.g. autoclave, electronic balances, convention oven, incubator, automated compounding devices such as pumps), staff competency evaluations, Media fill process verification testing, clean room garb procedures and testing, an ethics management compliance review to include business operations, compliance with Anti-Kickback and Stark law, state/federal pharmacy law, compliance with USP 795 and USP 797, defined allowable sales and marketing conduct, a		

				defined compounding code of conduct and pharmacy manual, and an onsite credentialing review. UHC provides a consistent and standard credentialing approach for our network pharmacies. As is the industry standard, our network pharmacies must comply with national and industry standards as listed above in the Processes Section, including but not limited to NCPDP, PCAB-VPP, for claims submission, contractual compliance, legal and pharmacy board requirements.		

10. 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
The health plan shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. The health plan shall not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. This is not to be construed as: (1) requiring that the health plan contract with providers beyond the number necessary to meet the needs of its members; (2) precluding the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (3) precluding the health plan from establishing measures that are	N/A	Not applicable for prescription drugs.	N/A for prescription NQTL	No	N/A for prescription NQTL	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

designed to maintain quality of services and control costs and are consistent with its responsibilities to members. The health plan is not required to contract with every willing provider. If the health plan does not or will not include individuals or groups of providers of a specialty grouping in its network, it shall provide that information in its proposal.						

11. 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.

ALOHACARE	HMSA	KAISER	‘OHANA	UNITED	‘OHANA CCS	COMPARABILITY/STRINGENCY
No geographic limitations	There are no geographic limitations HMSA has a sufficient network of pharmacies to ensure geographic pharmacy access standards	Assuming the pharmacy provider is within the U.S.A., there are no geographic limitations on provider inclusion.	N/A for prescription NQTL Clarified response 10/31/18: `Ohana follows all State and Federal GeoAccess guidance on Pharmacy Network access.	On an annual basis as part of the PBAoversight audit, UnitedHealthcare will validate network access levels by the review of GeoAccess reports. In the event that a network deficiency is confirmed, and is deemed to be correctable, UnitedHealthcare Community & State or the PBA is obligated to correct the stated Deficiency. For urban pharmacies the requirements are: • 1 Pharmacy within 15 minutes driving time (Urban is defined as the Honolulu Metropolitan Statistical Area); • 24 Hour Pharmacy for within 60 minutes Urban[Honolulu CBSA (MSA)/Estimated Driving Time The requirements for non-urban pharmacies are: • 1 Pharmacy within 60 minutes driving time Rural [Non-Honolulu CBSA (MSA) [Estimated Driving Time]	N/A for prescription NQTL Clarified response 10/31/18: `Ohana follows all State and Federal GeoAccess guidance on Pharmacy Network access.	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

12. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of- network benefits.

ALOHACARE	HMSA	KAISER	‘OHANA	UNITED	‘OHANA CCS	COMPARABILITY/STRINGENCY

OON dispensing of prescription medications is less frequently necessary than for professional and facility services, since the PBM's pharmacy network is extensive and includes all major national chains. If an OON pharmacy must be utilized, then a contract or letter of agreement must be obtained and the OON dispensing authorized. AlohaCare will approve dispensing of at least a 3 day supply of necessary medication at whatever rates the OON pharmacy may charge until a LOA can be signed.	Out-of-network pharmacy exceptions may occur if a member is on a trip out of state and needs access to medications or if a drug has limited distribution.	Physician prescriber evaluates member. If out-of- plan referral appears appropriate, physician completes an order for the request. Department Chief receives referral request and performs evaluation/determination. Medical necessity approval from the Outside Medical Services Medical Director or other appropriate Department Chief /Designee is required for the following types of referral requests: • Requests for services from non-credentialed providers; • Requests for mainland/out of area services; • Experimental treatments/therapies; • Requests for services where there is internal capability; • Requests for transplantation services. Medical necessity determination is referred to Authorizations and Referral Management (ARM). If medical necessity is approved, ARM reviews request to ensure that referral guidelines and criteria are met: • The requested service is certified as medically necessary by Chief/Designee; • The service is a covered Health Plan benefit; • The requested service is not available within Plan; • The patient is an eligible Health	N/A for prescription NQTL	If a member goes to an out of network pharmacy, the claim will reject at point of sale and the pharmacy can contact OptumRx to obtain info on how to apply to gain network pharmacy status. In order to become a Network Pharmacy Provider, a credentialing application must be obtained. The provider must meet the OptumRx credentialing requirements and be able to comply with the requirements of the Agreement and OptumRx Pharmacy Manual. All Network Pharmacy Providers shall be credentialed pursuant to the OptumRx credentialing policy prior to submitting any claims.	N/A for prescription NQTL	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

		Plan member; • The patient has benefits available • Referral parameters (frequency/ duration) are clearly defined; and • Selected provider/ practitioner is credentialed or has Letter of Agreement with health plan. If criteria met, ARM will generate the authorization, notify the receiving provider, notify the requesting practitioner of the approval, and generate a notification letter to the member. Only licensed physicians can make medical necessity denial determinations.				

13. How are reimbursement rate amounts determined for outpatient professionals, in writing and in operation? What standard is used? On average, what percentage of that standard is applied to M/S and MH/SUD outpatient professionals? Separately address physicians, PhD and MA professionals.

ALOHACARE	HMSA	KAISER	‘OHANA	UNITED	‘OHANA CCS	COMPARABILITY/STRINGENCY
PBM drug ingredient pricing is obtained based on national volumes for Medicaid and made available to AlohaCare by the PBM.	N/A	Not applicable for prescription drugs.	N/A for prescription NQTL	Reimbursement rates depend on the contract with the pharmacy. An equal percentage of the standard is applied to both M/S and MH/SUD.	N/A for prescription NQTL	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

14. 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, practice size, Medicare reimbursement rates, licensure, other.

ALOHACARE	HMSA	KAISER	‘OHANA	UNITED	‘OHANA CCS	COMPARABILITY/STRINGENCY
PBM professional dispensing fee pricing is obtained based on national volumes for Medicaid and made available to AlohaCare by the PBM.	N/A	Not applicable for prescription drugs.	N/A for prescription NQTL	Service type and geographic market affects reimbursement rates. Specialty pharmacies, for example, have a different reimbursement rate compared to a retail pharmacy. A small rural pharmacy can have a different rate of reimbursement than a retail chain pharmacy. 340B pharmacies have different reimbursement rates.	N/A for prescription NQTL	CCS has no restrictions. Therefore, BH services are not more stringent in comparison to M/S services. **BH parity requirements met.**

ATTACHMENT (D)

NQTL SUMMARIES

Specific MCOs

STATE OF HAWAII
DEPARTMENT HUMAN SERVICES

NQTL ANALYSIS SUMMARY– INPATIENT

Areas of Questionable BH Parity	AlohaCare	HMSA	Kaiser	Ohana	UHC	CCS	Action	Corrective Action Responsibility			Status
								MCO (s)	CCS	State	
Medical Necessity Criteria Development - #2: 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.				X		X	Per meeting on 11/5/18: Need to be clear that this only pertains to INPATIENT settings. Will be meeting with the MCO to rectify the situation. Need to explain to 'Ohana that it is the State's requirement to ensure BH parity across the state, therefore we need to discuss options to ensure compliance. State is currently working with CMS to update both CCS and QI RFPs to include BH parity requirements. On 12/5/18, 'Ohana submitted a clarified response that fulfilled the requirements to meet BH parity.	X		X	Completed
Medical Necessity Criteria Development - #3: Exclusions based on failure to complete a course of treatment (e.g., tobacco use disorder				X		X	Per meeting on 11/5/18: Need to be clear that this only pertains to INPATIENT settings. Will be meeting with the MCO to rectify the situation. Need to explain to	X		X	Completed

Areas of Questionable BH Parity	AlohaCare	HMSA	Kaiser	Ohana	UHC	CCS	Action	Corrective Action Responsibility			Status
								MCO (s)	CCS	State	
treatment)? If yes, describe the processes, strategies, evidentiary standards, and other factors in writing and in operation for these exclusions.							'Ohana that it is the State's requirement to ensure BH parity across the state, therefore we need to discuss options to ensure compliance. State is currently working with CMS to update both CCS and QI RFPs to include BH parity requirements. On 12/5/18, 'Ohana submitted a clarified response that fulfilled the requirements to meet BH parity.				

STATE OF HAWAII
DEPARTMENT HUMAN SERVICES

NQTL ANALYSIS SUMMARY– OUTPATIENT

Areas of Questionable BH Parity	AlohaCare	HMSA	Kaiser	Ohana	UHC	CCS	Action	Corrective Action Responsibility			Status
								MCO (s)	CCS	State	
Medical Necessity Criteria Development - #2: 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.			X				Per meeting on 11/5/18: Will meet with Kaiser to discuss their response for this NQTL question. Will pose the question in another way: For example: "Are there limitations or restrictions to use certain types of drugs first prior to use of other drugs based on cost or availability (e.g., use of oral prior to use of injectable antipsychotics)? On 12/12/18 Kaiser submitted a clarified response. After review and discussion, it was determined that their response fulfilled the requirement to meet BH parity.	X			Completed

STATE OF HAWAII
DEPARTMENT HUMAN SERVICES

NQTL ANALYSIS SUMMARY– PRESCRIPTION DRUGS

Areas of Questionable BH Parity	AlohaCare	HMSA	Kaiser	Ohana	UHC	CCS	Action	Corrective Action Responsibility			Status
								MCO (s)	CCS	State	
Medical Necessity Criteria Development - #2: 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.			X				Per meeting on 11/5/18: Will meet with Kaiser to discuss their response for this NQTL question. Will pose the question in another way: For example: "Are there limitations or restrictions to use certain types of drugs first prior to use of other drugs based on cost or availability (e.g., use of oral prior to use of injectable antipsychotics)? On 12/12/18 Kaiser submitted a clarified response. After review and discussion, it was determined that their response fulfilled the requirement to meet BH parity.	X			Completed

ATTACHMENT (E)

M/S & MH/SUD Benefit Table

Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) Benefits

Benefit Type	Inpatient	Outpatient	Prescription Drugs	Emergency Care
M/S	• Hospital facility fee – acute inpatient • Physician/surgeon fee – acute inpatient • Hospital facility fee (e.g., hospital room) – female sterilization • Professional fees – maternity delivery • Inpatient hospice facility fee (e.g., hospital room) • Skilled nursing facility fee (e.g., hospital room)	• Primary care visit to treat an injury, illness or condition • Other practitioner office visit • Specialist physician visit • Preventative care/screening immunization • Family planning • Prenatal care and preconception visits • Acupuncture • Health education • Child dental: diagnostic and preventive • Child eye exam • Outpatient surgery facility fee (e.g., Ambulatory Surgery Center) • Outpatient surgery-physician/surgeon fee • Outpatient surgery – facility fee – female sterilization • Outpatient surgery – physician/surgeon fee – female sterilization • Outpatient visit regarding outpatient surgery • BRCA testing and related genetic counseling • Laboratory tests • X-rays and diagnostic imaging • Imaging (CT/PET scans, MRIs) • Non-emergency ambulance transportation • Outpatient habilitation services • Home health • Hospice • Durable medical equipment, including in-home DME • Medical supplies • Prosthetic and orthotic service and devices • Diabetes equipment and supply services	• Tier one • Tier two • Tier three • Tier four	• Emergency room facility fee (waived if admitted) • Emergency room physician fee (waived if admitted) • Emergency medical transportation • Urgent care

		• Contact lenses for aniridia or aphakia • Infusion therapy • Child eye glasses/contact lenses • Child dental: basic services • Child dental: major services • Child medically necessary orthodontics		
MH	• Hospital facility fee (e.g., hospital room) – acute MH inpatient • Physician/surgeon fee – acute MH inpatient • Hospital facility fee (e.g., hospital room) – inpatient psychiatric observation for acute psychiatric crisis • Physician/surgeon fee – psychiatric observation for acute psychiatric crisis. • Short-term mental health crisis residential treatment • Residential treatment services for SMI and SED	• Individual and group mental health evaluation and treatment • Outpatient services for monitoring drug therapy • Behavioral health treatment office visit for autism or pervasive developmental disorder (PDD) • Short-term partial hospitalization • Short-term intensive outpatient psychiatric treatment • Outpatient psychiatric observation for an acute psychiatric crisis • Psychological testing to evaluate a mental disorder • Behavioral health treatment delivered in the home for autism or PDD • Non-emergency psychiatric transportation	• Tier one • Tier two • Tier three • Tier four	• Emergency room facility fee (waived if admitted) • Emergency room physician fee (waived if admitted) • Emergency medical/psychiatric transportation • Urgent care
SUD	• Hospital fee (e.g., hospital room) – SUD detoxification • SUD transitional residential recovery services	• Individual and group chemical dependency evaluation and counseling • Medical treatment for withdrawal symptoms • Day treatment program for substance use disorder • Intensive outpatient treatment for substance use disorder	• Tier one • Tier two • Tier three • Tier four	• Emergency room facility fee (waived if admitted) • Emergency room physician fee (waived if admitted) • Emergency medical/psychiatric transportation • Urgent care