

# 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. <sup>1</sup>

#### 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). <sup>2</sup>

#### 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.<sup>3</sup>

#### **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

Universal access

Efficient utilization

**S**tabilizing Costs

Transforming the way health care is provided

<sup>&</sup>lt;sup>1</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services (March 30, 2016), Final Rule, Federal Register Vol. 81 No. 6, Retrieved from: <a href="https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf">https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf</a>

<sup>&</sup>lt;sup>2</sup> Centers for Medicare and Medicaid (March 29, 2016), *Application of MHPAEA to Medicaid and CHIP (CMS-2333-F)*, Retrieved from: <a href="https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-parity-fr-rollout.pdf">https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-parity-fr-rollout.pdf</a>

<sup>&</sup>lt;sup>3</sup> 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: <a href="https://www.hhs.gov/programs/topic-sites/mental-health-parity/achieving-parity/cures-act-parity-listening-session/index.html">https://www.hhs.gov/programs/topic-sites/mental-health-parity/achieving-parity/cures-act-parity-listening-session/index.html</a>

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. <sup>4</sup>

2017: https://www.medicaid.gov/medicaid/benefits/downoads/bhs/parity-toolkit.pdf

<sup>&</sup>lt;sup>4</sup> Parity Compliance Toolkit, dated January 17,

Requirements for analysis included the following:

- Aggregate lifetime and annual dollar limits (AL/ADLs)
- Financial requirements and treatment limitations
  - o Copayments, coinsurance, deductibles, and out-of-pocket maximums
  - o Quantitative Treatment Limits (QTLs)
  - o Non-Quantitative Treatment Limits (NQTLs)
- Availability of information

Next steps included the following:

Identifying benefit package delivery	Five (5) QI MCO's and one (1) CCS carve-out BH program.
systems and the scope of the parity analysis	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 (copayments, 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:  • Refusal to cover higher-cost treatments/therapy until it is proven that the lower-cost treatment/therapy was ineffective.  • 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

- o Medical Necessity Criteria Development
- o Prior Authorization
- o Concurrent Review
- o Prescription Drugs

#### NETWORK ADMISSION REQUIREMENTS

- o Provider types
- o Geographic limitations
- O Standard for access to out-of-network benefits
- o Rates for outpatient providers
- o 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.

#### <u>12/20/18 ADDENDUM</u>:

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

#### Quest Integration

#### Benefit Plan Design #1:

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).	
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

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

 A. Identify the amount(s) of the out-of-pocket maximum(s). If there are	out-of-pocket
different out-of-pocket maximums for different coverage units (e.g.,	maximums in
ndividual and family out-of-pocket maximums), clearly identify these	the benefit
amounts.	plan.
3. 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			
	Copayment/C		Copayment/Co	i	
	oinsurance		nsurance	COS	
List All Benefits in Each	for Each	List Benefits in Each	for Each	ccs	
Classification / Subclassification	Benefit	Classification / Subclassification	Benefit		
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 feeacute inpatient	0	Physician/surgeon feeacute MH inpatient	0	Inpatient Detoxification Only	\$0
		Hospital facility fee (e.g., hospital room)inpatient psychiatric observation for acute			
Hospital facility fee (e.g., hospital room)female sterilization	0	psychiatric crisis	0	Inpatient Detoxification Only & Labs	\$0
Physician/surgeon feefemale sterilization	0	Physician/surgeon feepsychiatric 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 feesmaternity delivery	0	Physician/surgeon feeSUD 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		
, and a second s		Residential treatment services for SMI and SED	0		
	List		List		
	Copayment/C		Copayment/Coi		
	oinsurance		nsurance		
	for Each		for Each		
B. Inpatient, Out-of-Network	Benefit	B. Inpatient, Out-of-Network	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 feeacute inpatient	0	Physician/surgeon feeacute MH inpatient	0		
		Hospital facility fee (e.g., hospital room)inpatient psychiatric observation for acute			
Hospital facility fee (e.g., hospital room)female sterilization	0	psychiatric crisis	0		
Physician/surgeon feefemale sterilization	0	Physician/surgeon feepsychiatric 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 feesmaternity delivery	0	Physician/surgeon feeSUD 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		
	List		List		
	Copayment/C		Copayment/Coi		
	oinsurance		nsurance		
	for Each		for Each		
C. Outpatient, In-Network: Office Visits	Benefit	C. Outpatient, In-Network: Office Visits	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
		Behavioral health treatment Office Visit for autism or pervasive developmental			
Family planning	0	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
				Dun atition on Compine	\$0
				Practitioner Services	γU
				Psychological Testing	\$0

	1	1	I	Therapeutic Living Supports-Specialized Residential	\$0
	+			Treatment Facilities	\$0
	+			Transitional Housing	\$0
				Transitional nousing	ŞU
	LIST		LIST		LIST
	Copayment/C		Copayment/Coi		Copaymen
D. Outpatient, In-Network: Other Outpatient Items and Services (Can	oinsurance			D. Outpatient, In-Network: Other Outpatient Items	t/Coinsura
be combined with Outpatient, In-Network: Office Visits or shown	for Each	D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined		and Services (Can be combined with Outpatient, In-	nce
separately here.)	Benefit	with Outpatient, In-Network: Office Visits or shown separately here.)	Benefit	Network: Office Visits or shown separately here.)	for Each
					See above
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	0	Short-term partial hospitalization	0	See above Section C.	Section C.
Outpatient surgeryphysician/surgeon fee	0	Short-term intensive outpatient psychiatric treatment	0		
Outpatient surgery facility feefemale sterilization	0	Outpatient psychiatric observation for an acute psychiatric crisis	0		
Outpatient surgeryphysician/surgeon feefemale 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				1
	0				
Hospice	U				
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				
	List		List		
	Copayment/C		Copayment/Coi		
	oinsurance		nsurance		
	for Each		for Each		
E. Outpatient, Out-of-Network: Office Visits	Benefit	E. Outpatient, Out-of-Network: Office Visits	Benefit	E. Outpatient, Out-of-Network: Office Visits	
				N/A	N/A
	List		List		
	Copayment/C		Copayment/Coi	F. Outpatient, Out-of-Network: Other Outpatient	
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	oinsurance		nsurance	Items and Services (Can be combined with	
(Can be combined with Outpatient, Out-of-Network: Office Visits or	for Each	F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be	for Each	Outpatient, Out-of-Network: Office Visits or shown	
shown separately here.)	Benefit	combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	Benefit	separately here.)	

				N/A	N/A
	List		List		
	Copayment/C		Copayment/Co	i	
	oinsurance		nsurance		
	for Each		for Each		
G. Emergency	Benefit	G. Emergency	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		
	List		List		
	Copayment/C		Copayment/Co		
	oinsurance		nsurance		
	for Each		for Each		
H. Prescription Drugs	Benefit		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		
		AlohaCare			
Table 4: Quantitative Treatment Limitations including	hut not limited to		vicite por		
episode/year, outpatient services per episode/year.	but not illilited to,	limits on inpatient days per admission/episode or per year, outpatient v	isits per		
Medical/Surgical Benefits		Mental Health/Substance Use Disorder			
	Quantitative		Quantitative		
Copy Benefits Listed in Each	Treatment	Copy Benefits Listed in Each	Treatment		
Classification /Subclassification Above and Paste into the same	Limits that	Classification /Subclassification Above and Paste into the same	Limits that	CCS	
Classification/Subclassification Below	Apply to Each	Classification/Subclassification Below	Apply to Each		
A. Inpatient, In-Network	приусс вып	A. Inpatient, In-Network	Tippiy to Euch	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 feeacute inpatient	None	Physician/surgeon feeacute MH inpatient	None	Inpatient Detoxification Only	None
, , ,		Hospital facility fee (e.g., hospital room)inpatient psychiatric observation for acute		<u> </u>	
Hospital facility fee (e.g., hospital room)female sterilization	None	psychiatric crisis	None	Inpatient Detoxification Only & Labs	None
Physician/surgeon feefemale sterilization	None	Physician/surgeon feepsychiatric 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 feesmaternity delivery	None	Physician/surgeon feeSUD detoxification	None	<u> </u>	
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		
					6=1
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

				F		
						+
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
			Behavioral health treatment Office Visit for autism or pervasive developmental			
Family planning	None		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
,	One (1) exam					
	every 12					
Child eye exam	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	110
					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
					Transitional nousing	None
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-Network: Office Visits or shown			D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined		D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with Outpatient, In-	
separately here.)	List all QTLs		with Outpatient, In-Network: Office Visits or shown separately here.)	List all QTLs	Network: Office Visits or shown separately here.)	QTLs
					and the second s	See above
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	None		Short-term partial hospitalization	None	See above Section C.	Section C
Outpatient surgeryphysician/surgeon fee	None		Short-term intensive outpatient psychiatric treatment	None		-
Outpatient surgery facility feefemale sterilization	None		Outpatient psychiatric observation for an acute psychiatric crisis	<del> </del>		
	-			None		+
Outpatient surgeryphysician/surgeon feefemale sterilization	None		Psychological testing to evaluate a mental disorder	None		+
Outpatient visit regarding outpatient surgery	None		Day treatment program for substance use disorder Intensive outpatient treatment for substance use disorder	None		
BRCA testing and related genetic counseling	None		·	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					1
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					
initiasion therapy	Frames &					
	lenses limited					
	to one every					
	twelve	NONBU				
Child eye glasses/contact lenses	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	
F. Outpatient, Out-of-Network: Other Outpatient Items and Services					Items and Services (Can be combined with	
(Can be combined with Outpatient, Out-of-Network: Office Visits or			F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be		Outpatient, Out-of-Network: Office Visits or shown	
shown separately here.)	List all QTLs		combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	List all QTLs	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

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 Coin	surance				
Medical/Surgical Benefits		Mental Health/Substance Use Disorder Benefits			
List All Benefits in Each Classification /Subclassification	List Copayment/Coi nsurance for Each Benefit	List Benefits in Each Classification /Subclassification	List Copayment/Coins urance 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 feeacute inpatient	0	Physician/surgeon feeacute 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 feefemale sterilization  Hernital facility fee (e.g., bespital room), maternity delivery	0	Physician/surgeon feepsychiatric observation for acute psychiatric crisis	0	Inpatient Emergency Care Inpatient Psychiatric Services	\$0 \$0
Hospital facility fee (e.g., hospital room)maternity delivery  Professional feesmaternity delivery	0	Hospital facility fee (e.g., hospital room)SUD detoxification  Physician/surgeon feeSUD detoxification	0	impatient rsychiatric Services	,50 
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  Residential treatment services for SMI and SED	0		
B. Inpatient, Out-of-Network	List Copayment/Coi nsurance for Each Benefit	B. Inpatient, Out-of-Network	List Copayment/Coins urance for Each Benefit	B. Inpatient, Out-of-Network	
				N/A	N/A

	List Copayment/Coi nsurance		List Copayment/Coins urance		
C. Outpatient, In-Network: Office Visits	for Each Benefit	C. Outpatient, In-Network: Office Visits	_	C. Outpatient, In-Network: Office Visits	ćo
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
et.		Behavioral health treatment Office Visit for autism or pervasive developmental		Constitution	60
Family planning	0	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	1
				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
	List		List		
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be	Copayment/Coi			D. Outpatient, In-Network: Other Outpatient Items and	
combined with Outpatient, In-Network: Office Visits or shown separately	nsurance	D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined		Services (Can be combined with Outpatient, In-Network:	
here.)	for Each Benefit	with Outpatient, In-Network: Office Visits or shown separately here.)	for Each Benefit	Office Visits or shown separately here.)	
					See above
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	0	Short-term partial hospitalization	0	See above Section C.	Section C.
Outpatient surgeryphysician/surgeon fee	0	Short-term intensive outpatient psychiatric treatment	0		
Outpatient surgery facility feefemale sterilization	0	Outpatient psychiatric observation for an acute psychiatric crisis	0		
Outpatient surgeryphysician/surgeon feefemale sterilization	<u> </u>	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				

	T			1		1
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					
						List
						Copaymen
	List			List		t/Coinsura
	Copayment/Coi			Copayment/Coins		nce
	nsurance			urance		for Each
E. Outpatient, Out-of-Network: Office Visits	for Each Benefit		E. Outpatient, Out-of-Network: Office Visits		E. Outpatient, Out-of-Network: Office Visits	Benefit
E. Outpatient, Out-of-Network. Office visits	TOT Each Belletit		E. Outpatient, Out-of-Network. Office visits	TOT Each Belletit	•	_
					N/A	N/A
						List
						Copaymen
	List			List		t/Coinsura
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be	Copayment/Coi				F. Outpatient, Out-of-Network: Other Outpatient Items	nce
combined with Outpatient, Out-of-Network: Office Visits or shown separately	nsurance		F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be		and Services (Can be combined with Outpatient, Out-of-	for Each
here.)	for Each Benefit		combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	for Each Benefit	Network: Office Visits or shown separately here.)	Benefit
					N/A	N/A
	List			List		
	Copayment/Coi			Copayment/Coins		
	nsurance			urance		
G. Emergency	for Each Benefit		G. Emergency	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
<u> </u>	0		Urgent care	0	Out-of-state Emergency Behavioral Health Services	70
Urgent care	U		orgent care	U		
						1:-4
						List
						Copaymen
	List			List		t/Coinsura
	Copayment/Coi			Copayment/Coins		nce
	nsurance			urance		for Each
H. Prescription Drugs	for Each Benefit			for Each Benefit		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		
	•		HMSA	•		•
				• •		
lable 4: Quantitative Treatment Limitations, including, but no	ot limited to, li	mits on inpati	ent 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			
					L	<u> </u>

	<u> </u>			T	
	Quantitative		Quantitative		
Copy Benefits Listed in Each	Treatment	Copy Benefits Listed in Each	Treatment Limits		
Classification /Subclassification Above and Paste into the same	Limits that	Classification /Subclassification Above and Paste into the same	that Apply to Each		
Classification/Subclassification Below	Apply to Each	Classification/Subclassification Below	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 feeacute inpatient	None	Physician/surgeon feeacute MH inpatient	None	Inpatient Detoxification Only	None
		Hospital facility fee (e.g., hospital room)inpatient psychiatric observation for acute			
Hospital facility fee (e.g., hospital room)female sterilization	None	psychiatric crisis	None	Inpatient Detoxification Only & Labs	None
Physician/surgeon feefemale sterilization	None	Physician/surgeon feepsychiatric 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 feesmaternity delivery	None	Physician/surgeon feeSUD 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
		Behavioral health treatment Office Visit for autism or pervasive developmental		1,	+
Family planning	None	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
emia eye exam	- 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	None
				Hospitalization	None
				Practitioner Services	None
				Psychological Testing	
				Psychotherapy	None
					None
				Supported Employment Services  Therepoutis Living Supports Specialized Residential	None
				Therapeutic Living Supports-Specialized Residential	None
				Treatment Facilities	None
				Transitional Housing	None
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be				D. Outpatient, In-Network: Other Outpatient Items and	
combined with Outpatient, In-Network: Office Visits or shown separately	134 1105	D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined		Services (Can be combined with Outpatient, In-Network:	200
here.)	List all QTLs	with Outpatient, In-Network: Office Visits or shown separately here.)	List all QTLs	Office Visits or shown separately here.)	QTLs
					See above
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	None	Short-term partial hospitalization	None	See above Section C.	Section C.
Outpatient surgeryphysician/surgeon fee  Outpatient surgery facility feefemale sterilization	None	Short-term intensive outpatient psychiatric treatment	None		
	None	Outpatient psychiatric observation for an acute psychiatric crisis			

Outpatioint surgery, physician /surgery for female sterilization	None		Developed testing to evaluate a montal disorder	None	T	
Outpatient surgeryphysician/surgeon feefemale sterilization	None		Psychological testing to evaluate a mental disorder	None		
Outpatient visit regarding outpatient surgery	None 1 Per Lifetime	NON BH	Day treatment program for substance use disorder	None		
BRCA testing and related genetic counseling	Varied	INOIN RH	Intensive outpatient treatment for substance use disorder  Behavioral health therapy delivered in the home for autism and PDD	None		
Laboratory tests  Versus and diagnostic imaging	None		Nonemergency psychiatric transportation	None		
X-rays and diagnostic imaging			Nonemergency psychiatric transportation	None		
Imaging (CT/PET Scans, MRIs)  Nonemergency medical transportation	None None					
Noticine gency medical transportation	Auditory					
Outpatient rehabilitation services	Therapy Limits	NON BH				
Outpatient renabilitation services  Outpatient habilitation services	None	NON BH				1
Home health	None					
nome nearth	6 Month Life					
Hospice	Expectation	NON BH				
Durable medical equipment, including in-home DME	None	NON BIT				
Medical supplies	None					
Prosthetic and orthotic services and devices	None					<del>                                     </del>
Diabetes equipment and supply services	None					
Diabetes equipment and supply services	Tronc					1
	24 Month Period					
	> Age 21					
	12 Month Period					
Contact lenses for aniridia or aphakia	for < Age 21	NON BH				
Infusion therapy	None					
	1 pair in 12					
Child eye glasses/contact lenses	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					F. Outpatient, Out-of-Network: Other Outpatient Items	
combined with Outpatient, Out-of-Network: Office Visits or shown separately			F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be		and Services (Can be combined with Outpatient, Out-of-	
here.)	List all QTLs		combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	List all QTLs	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 OUEST Integration Formulary is a one-tiered closed formulary	<del>                                     </del>					<u> </u>

\*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** 

	member cost share is \$0 for all benefits,
different out-of-pocket maximums for different coverage units (e.g., individual	there is no
and family out-of-pocket maximums), clearly identify these amounts.	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 Coil Medical/Surgical Benefits		Mental Health/Substance Use Disorder Benefits			1
List All Benefits in Each Classification /Subclassification	Copayment/C oinsurance for Each Benefit	List Benefits in Each Classification /Subclassification	Copayment/Cooinsurance 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 feeacute inpatient	\$0	Physician/surgeon feeacute 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 feefemale sterilization	\$0	Physician/surgeon feepsychiatric 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 feesmaternity delivery	\$0	Physician/surgeon feeSUD detoxification	\$0		
Inpatient hospice facility fee (e.g., hospital room)	\$0	Short-term mental health crisis residential treatment	\$0		1
Skilled nursing facility fee (e.g., hospital room)	\$0	SUD transitional residential recovery services	\$0		1
		Residential treatment services for SMI and SED	\$0		1
B. Inpatient, Out-of-Network	List Copayment/C oinsurance for Each Benefit	B. Inpatient, Out-of-Network	List Copayment/C oinsurance for Each Benefit	B. Inpatient, Out-of-Network	
				N/A	N/A
	List Copayment/C oinsurance for Each		List Copayment/Coinsurance for Each		
C. Outpatient, In-Network: Office Visits	Benefit	C. Outpatient, In-Network: Office Visits		C. Outpatient, In-Network: Office Visits	40
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 \$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 \$0
Preventive care/screening/immunization  Family planning	\$0 \$0	Medical treatment for withdrawal symptoms  Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	\$0 \$0	Combined Therapy  Consultation	\$0 \$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
Cilia eye exam	ŞU			Maintenance Therapy	\$0
				Medication Management	\$0
				Member Education	\$0
				Methadone Management Services	\$0
	+			Non-Emergent Transportation	\$0
				Nurses Hotline	\$0 \$0
					ŞU
				Partial Hospitalization or Intensive Outpatient	ćo
				Hospitalization	\$0 \$0
				Practitioner Services	\$0
				Psychological Testing	\$0 \$0
				Psychotherapy	\$0 \$0
				Supported Employment Services	\$0
				Therapeutic Living Supports-Specialized Residential	\$0
				Treatment Facilities	\$0
	List		LIST	Transitional Housing	\$0
	Copayment/C		Copayment/C		
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be	oinsurance			D. Outpatient, In-Network: Other Outpatient Items	
combined with Outpatient, In-Network: Office Visits or shown separately	for Each	D. Outpatient, In-Network: Other Outpatient Items and Services (Can be	for Each	and Services (Can be combined with Outpatient, In-	
here.)	Benefit	combined with Outpatient, In-Network: Office Visits or shown separately here.)	Benefit	Network: Office Visits or shown separately here.)	
	Bellett	combined with outputient, in-recework. Office visits of shown separately here.	Deficite	including of the visits of shown separately here.	
					See above
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	\$0	Short-term partial hospitalization	\$0	See above Section C.	Section C.
Outpatient surgery-physician/surgeon fee	\$0	Short-term intensive outpatient psychiatric treatment	\$0	See above section c.	Section C.
Outpatient surgery facility feefemale sterilization	\$0	Outpatient psychiatric observation for an acute psychiatric crisis	\$0 \$0		
Outpatient surgeryphysician/surgeon feefemale sterilization	\$0	Psychological testing to evaluate a mental disorder	\$0		
Outpatient visit regarding outpatient surgery	\$0	Day treatment program for substance use disorder	\$0		<del>                                     </del>
BRCA testing and related genetic counseling	\$0	Intensive outpatient treatment for substance use disorder	\$0		
aboratory tests	\$0	Behavioral health treatment delivered in the home for autism or PDD	\$0		<del>                                     </del>
K-rays and diagnostic imaging	\$0	Nonemergency psychiatric transportation	\$0		
maging (CT/PET Scans, MRIs)	\$0	itotiemergency psychiatric transportation	γo		
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				
nfusion 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				
· ·	, ,				1
	1 1	•		•	

	List		List		
	Copayment/C		Copayment/C		
	oinsurance		oinsurance		
	for Each		for Each		
E. Outpatient, Out-of-Network: Office Visits	Benefit	E. Outpatient, Out-of-Network: Office Visits		E. Outpatient, Out-of-Network: Office Visits	
				N/A	N/A
			1		,
	List		List		
	Copayment/C		Copayment/C	F. Outpatient, Out-of-Network: Other Outpatient	
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be	oinsurance	F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be		Items and Services (Can be combined with	
combined with Outpatient, Out-of-Network: Office Visits or shown separately		combined with Outpatient, Out-of-Network: Office Visits or shown separately		Outpatient, Out-of-Network: Office Visits or shown	
nere.)	Benefit	here.)		separately here.)	
,		·		N/A	N/A
					,
	List		List		
	Copayment/C		Copayment/C		
	oinsurance		oinsurance		
	for Each		for Each		
G. Emergency	Benefit	G. Emergency	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
Jrgent care	\$0	Urgent care	\$0		
	List		List		
	Copayment/C		Copayment/C		
	oinsurance		oinsurance		
	for Each		for Each		
H. Prescription Drugs	Benefit		Benefit		
Tier One	\$0	Tier One	\$0	Generic Brand	\$0
Fier Two	\$0	Tier Two	\$0	Preferred Brand	\$0
Fier Three	N/A	Tier Three		Prescription OTC	\$0
		-			i
Fier Four	N/A	Tier Four	N/A		

#### **KAISER**

Table 4: Quantitative Treatment Limitations, including, but r	ot limited to, limit	s on inpatient days per admission/episode or per year, outpatient vis	its 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 feeacute inpatient	None	Physician/surgeon feeacute 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 feefemale sterilization	None	Physician/surgeon feepsychiatric 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 feesmaternity delivery	None	Physician/surgeon feeSUD 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	1	SUD transitional residential recovery services	None		1
Skilled Harsing racinty ree (e.g., nospital room)	None		Residential treatment services for SMI and SED	None		
			nesidential treatment services for sivil and SEB	None		
B. Inpatient, Out-of-Network	List all QTLs		B. Inpatient, Out-of-Network	List all OTLs	B. Inpatient, Out-of-Network	QTLs
27 mpulioni, out of from the	2.50 0.11 0.125		I mpatiently data in receiver.	2.00 0.11 0.120	N/A	N/A
	+					1.47.
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
Treventive care, screening, minianization	Hone		Behavioral health treatment Office Visit for autism or pervasive developmental	TTOTIC		IVOITE
Family planning	None		disorder (PDD)	None	Consultation	None
Prenatal care and preconception visits	None			None	Diagnostic Services	None
Acupuncture	None				Electro-Convulsive Therapy (ECT)	None
Health education	None				Group Therapy	None
Child dental: diagnostic and preventive	None					
Cinia dental. diagnostic and preventive	one per 12	-		+	Intensive Case Management	None
Child ave even	1	NON BH			Interpretation Convices	Mana
Child eye exam	months				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					D. Outpatient, In-Network: Other Outpatient Items	
combined with Outpatient, In-Network: Office Visits or shown separately			D. Outpatient, In-Network: Other Outpatient Items and Services (Can be		and Services (Can be combined with Outpatient, In-	
here.)	List all QTLs		combined with Outpatient, In-Network: Office Visits or shown separately here.)	List all QTLs	Network: Office Visits or shown separately here.)	QTLs
						See above
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)	None		Short-term partial hospitalization	None	See above Section C.	Section C
Outpatient surgeryphysician/surgeon fee	None		Short-term intensive outpatient psychiatric treatment	None		
Outpatient surgery facility feefemale sterilization	None		Outpatient psychiatric observation for an acute psychiatric crisis	None		
Outpatieint surgeryphysician/surgeon feefemale sterilization	None		Psychological testing to evaluate a mental disorder	None		
Outpatient visit regarding outpatient surgery	None	<u> </u>	Day treatment program for substance use disorder	None		
BRCA testing and related genetic counseling	None	<u> </u>	Intensive outpatient treatment for substance use disorder	None		
Laboratory tests	None	<u> </u>	Behavioral health therapy delivered in the home for autism and PDD	None		
·		<del> </del>	Nonemergency psychiatric transportation	None		
IX-rays and diagnostic imaging	None	1	INDITIENCE SETTLY DOYCHIALTIC LIGHTSDOLLALION			
X-rays and diagnostic imaging Imaging (CT/PET Scans, MRIs)	None None		Nonemergency psychiatric transportation	None		
Imaging (CT/PET Scans, MRIs)	None		Nonemergency psychiatric transportation	None		
				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					
	one pair of					
	eyeglasses					
	per 24					
Child eye glasses/contact lenses	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	
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be			F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be		Items and Services (Can be combined with	
combined with Outpatient, Out-of-Network: Office Visits or shown separately			combined with Outpatient, Out-of-Network: Office Visits or shown separately		Outpatient, Out-of-Network: Office Visits or shown	
here.)	List all QTLs		here.)	List all QTLs	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

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 NA
B. Identify any benefits that are not subject to the out-of-pocket maximum(s).	NA NA

rable 3. Financial requirements copayments and					
Coinsurance					
Medical/Surgical Benefits		Mental Health/Substance Use Disorder Benefits			
	List		List		
	Copayment/Coin		Copayment/Coin	CCS	
List All Benefits in Each	surance	List Benefits in Each	surance		
Classification / Subclassification	for Each Benefit	Classification / Subclassification	for Each Benefit		
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				
	List		List		List
	Copayment/Coin		Copayment/Coin		Copayme
B. Inpatient, Out-of-Network	surance	B. Inpatient, Out-of-Network	surance	B. Inpatient, Out-of-Network	nt/Coinsu
N/A	N/A	N/A	N/A	N/A	N/A
			· ·	1	,
	List		List		List
	Copayment/Coin		Copayment/Coin		Copayme
C. Outpatient, In-Network: Office Visits	surance	C. Outpatient, In-Network: Office Visits	surance	C. Outpatient, In-Network: Office Visits	nt/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	· ·	story Behavioral Health Services & Crisis Mgt	\$0
Durable Medical Equipment	\$0		ned Therapy	\$0
Family Planning Services	\$0	Children 3 - 20 \$0 Consulta		\$0
Hearing Services	\$0		stic Services	\$0
Home and Community Based Services	\$0		Convulsive Therapy (ECT)	\$0
Home Health	\$0	Comprehensive Behavioral Health Services \$0 Group T	• • • • • • • • • • • • • • • • • • • •	\$0
Hospice	\$0		ve Case Management	\$0
Hospital Services	\$0	·	etation Services	\$0
Laboratory Services	\$0		nance Therapy	\$0
Maternity Services	\$0		tion Management	\$0
Non-Emergency Transportation (NET)	\$0		er Education	\$0
Physician Services	\$0		lone Management Services	\$0
Podiatry Care Services	\$0		nergent Transportation	\$0
Preventive Services	\$0	Psychotropic Medications \$0 Nurses H		\$0
Private Duty Nursing	\$0		Hospitalization or Intensive Outpatient Hospitalization	\$0
Prosthetic & Orthotic Devices	\$0	Substance Abuse \$0 Practitio	oner Services	\$0
Radiology Services	\$0		ogical Testing	\$0
Rehabilitative Services (PT, OT, ST)	\$0	Psychoth		\$0
Skilled Nursing/Private Duty Nursing	\$0	Support	ted Employment Services	\$0
Smoking Cessation	\$0	Therape	eutic Living Supports-Specialized Residential	\$0
Telemedicine	\$0	Treatme	ent Facilities	\$0
Therapy Services	\$0	Transition	onal Housing	\$0
Vision Services	\$0			
	l link	lina.		
D. Outmatiant In Naturally Other Outmatiant Itama and Caminas (Can be	List	List Compared Coin D. Corton	ationt In Naturaly Other Outrationt Home and Comisse	
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be	Copayment/Coin		patient, In-Network: Other Outpatient Items and Services	
combined with Outpatient, In-Network: Office Visits or shown separately	surance 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.) for Each Benefit   shown s	combined with Outpatient, In-Network: Office Visits or	
here.)	See above	See above		See above
See above Section C.	Section C.			Section C.
See above Section C.	Section C.	See above Section C. See above	ve section c.	Section C.
	List	List		
	Copayment/Coin	Copayment/Coin		
E. Outpatient, Out-of-Network: Office Visits	surance		patient, Out-of-Network: Office Visits	
N/A	N/A	N/A N/A N/A	anemy car of heartern contest to the	N/A
	1.47.1			1.,
	List	List		
F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be			patient, Out-of-Network: Other Outpatient Items and	
combined with Outpatient, Out-of-Network: Office Visits or shown separately			s (Can be combined with Outpatient, Out-of-Network: Office	
here.)	for Each Benefit	here.) for Each Benefit Visits or		
	See above	See above		
See above Section C.	Section C.	See above Section C. Section C. N/A		N/A
	Copayment/Coin	Copayment/Coin		Copayme
G. Emergency	surance	G. Emergency surance G. Emer		nt/Coinsu
	1			
Emergency Room Services	\$0		ncy Room Services	\$0
Emergency Transportation/Ambulance	\$0		ncy Transportation/Ambulance	\$0
Urgent Care	\$0	Urgent Care \$0 Out-of-S	State Emergency Behavioral Health Services	\$0
				List
				Copayme
	List	List		nt/Coinsu
	Copayment/Coin	Copayment/Coin		rance
	surance	surance		for Each Benefit
H. Prescription Drugs	for Each Benefit	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
	7.2			7.5		7.2
	•		OHANA	•		Į.
Table 4: Quantitative Treatment Limitations in	cluding but not	limited to lin	nits on inpatient days per admission/episode or per year, outpatie	ent visits ner e	nisode/year outnatient services per enisode/year	
Medical/Surgical Benefits	letaurig, but not	quantitative	Mental Health/Substance Use Disorder	The visits per e	pisode/ year, outpatient services per episode/ year.	
Wicarday Sargical Schemes		quantitutive	Wented Freditify Substance Use Disorder			
Copy Benefits Listed in Each			Copy Benefits Listed in Each			
Classification /Subclassification Above and Paste into the same			Classification /Subclassification Above and Paste into the same			
Classification/Subclassification Below	List all QTLs		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. Outratiant In Naturaly Office Visits	List all OTI a		C. Outrations In Naturals Office White	List all OTLS	C. Outrations In Naturally Office Wielts	OTI -
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
			Behavioral Health Services for Children, Support for Emotional & Behavioral			
Dental Services	None		Development (SEBD) Program, Additional Behavioral Health Service for Childrent 3-20	None	Alcohol & Chemical Dependency Services	None
Diagnostic Services	None		Community Mental Health Services	None	Ambulatory Behavioral Health Services & Crisis Mgt	None
			Comprehensive Behavioral Health Services		ransonator, periameter median con media con median	110110
			Community Care Services			
Durable Medical Equipment	None		Adults 21>	None	Combined Therapy	None
Family Planning Services	None		Mental Health Outpatient Services	None	Consultation	None
	Adults- 1 per 3		·			
	years for adults					
	ages 21 and					
	older.					
	Hearing Exam					
	Adults- 1 per					
	year					
	Hearing Exam					
	Children -1					
	Hearing Initial					
	Evaluation/Select					
	ion					
	per year					
	Electroacoustic					
	Evaluation -					
	4 per year for					
Hagring Comitoes	children ages	NIONI DII	Mathadana Tractmant Comicae	N1 =	Dia manatia Camilana	NI -
Hearing Services	3yrs and under	NON BH	Methadone Treatment Services	None	Diagnostic Services	None

					T	1
	Meals -No more					
	than 2 meals per					
	day					
	Personal					
	Assistance					
	Services Level I -					
Home and Communtiy Base Services	Limited to 10	NON BH	Psychiatric / Psychological	None	Electro-Convulsive Therapy (ECT)	None
Home Health Services			Evaluation & Treatment			
	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		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
,	Limitst based on					
	procedure and					
	recommended					
Preventive Services	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
Same raising, i made budy raising	Limited to 2 quit				The apeado Eithig Supports Specialized Residential	INOTIC
Smoking Cessation	attempts per	NON BH			Treatment Facilities	None
Telemedicine	None				Transitional Housing	None
Therapy Services	None			+	Transitional flousing	None
merapy services	Notie					

	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					
Vision Services	every 24 months	NON BH				
D. Outpatient, In-Network: Other Outpatient Items and Services (Can be					D. Outpatient, In-Network: Other Outpatient Items and Services	
combined with Outpatient, In-Network: Office Visits or shown separately			D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined		(Can be combined with Outpatient, In-Network: Office Visits or	
here.)	List all QTLs		with Outpatient, In-Network: Office Visits or shown separately here.)	List all QTLs	shown separately here.)	QTLs
	See above			See above		See above
See above Section C.	section C.		See above Section C.	Section C.	See above Section C.	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			F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be		F. Outpatient, Out-of-Network: Other Outpatient Items and	
combined with Outpatient, Out-of-Network: Office Visits or shown separately			combined with Outpatient, Out-of-Network: Office Visits or shown separately		Services (Can be combined with Outpatient, Out-of-Network: Office	
here.)	List all QTLs		here.)	List all QTLs	Visits or shown separately here.)	QTLs
	See above			See above		
See above ection C.	Section C.		See above Section C.	Section C.	N/A	N/A
				-		
G. Emergency	List all QTLs		G. Emergency		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. Procegintian Druge	List all QTLs		U Procerintian Drugs	List all QTLs	H. Procegintian Drugs	OTLA
H. Prescription Drugs	-		H. Prescription Drugs Tier 1	-	H. Prescription Drugs	QTLs
Tier 1	None		Tier 2	None	Tier 1 Tier 2	None
Tier 2 Tier 3	None None		Tier 3	None	Tier 2	None
Tier 4				None		None
Hei 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 <i>exception</i> of emergency services that are needed to evaluate or stabilize an emergency	
Add or delete rows in each Classification/Subclassification, as needed	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 convices (procedures that require a prior authorization provided by a non-participating provider.	
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	
EATHOR ET		
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	

				1	
Table 3: Financial Requirements - Copayi	ments and				
Medical/Surgical Benefits		Mental Health/Substance Use Disorder Be	nefits		
List All Benefits in Each Classification /Subclassification	List Copayment/Coin surance	List Benefits in Each Classification /Subclassification	List Copayment/Coi nsurance	ccs	
A. Inpatient, In-Network		A. Inpatient, In-Network		A. Inpatient, In-Network	
Hospital facility fee (e.g., hospital room)acute	ĆO.	Uponital facility for /o a bounital years) couts MULingsticut	ćo	Inpatient Alcohol & Chemical Dependency	ćo
inpatient	\$0	Hospital facility fee (e.g., hospital room)acute MH inpatient	\$0	Services	\$0
Physician/surgeon feeacute inpatient	\$0	Physician/surgeon feeacute MH inpatient	\$0	Inpatient Detoxification Only	\$0
Hospital facility fee (e.g., hospital room)female	4.0	Hospital facility fee (e.g., hospital room)inpatient psychiatric	4.5		4-
sterilization	\$0	observation for acute psychiatric crisis	\$0	Inpatient Detoxification Only & Labs	\$0
	1.	Physician/surgeon feepsychiatric observation for acute			
Physician/surgeon feefemale sterilization	\$0	psychiatric crisis	\$0	Inpatient Emergency Care	\$0
Hospital facility fee (e.g., hospital room)maternity	1.				
delivery	\$0	Hospital facility fee (e.g., hospital room)SUD detoxification	\$0	Inpatient Psychiatric Services	\$0
Professional feesmaternity delivery	\$0	Physician/surgeon feeSUD 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		
	List Copayment/C oinsurance for Each		List Copayment/ Coinsurance for Each		List Copayme nt/Coinsu rance for Each
B. Inpatient, Out-of-Network	Benefit	B. Inpatient, Out-of-Network	Benefit	B. Inpatient, Out-of-Network	Benefit
Hospital facility fee (e.g., hospital room)acute			l.		
inpatient	\$0	Hospital facility fee (e.g., hospital room)acute MH inpatient	\$0	N/A	N/A
Physician/surgeon feeacute inpatient	\$0	Physician/surgeon feeacute MH inpatient	\$0		
Hospital facility fee (e.g., hospital room)female		Hospital facility fee (e.g., hospital room)inpatient psychiatric			
sterilization	\$0	 observation for acute psychiatric crisis	\$0		
		 Physician/surgeon feepsychiatric observation for acute			
Physician/surgeon feefemale sterilization	\$0	psychiatric crisis	\$0		

Hospital facility fee (e.g., hospital room)maternity					
delivery	\$0	Hospital facility fee (e.g., hospital room)SUD detoxification	\$0		
Professional feesmaternity delivery	\$0	Physician/surgeon feeSUD 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/C oinsurance 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
		Individual and group chemical dependency evaluation and		Ambulatory Behavioral Health Services & Crisis	
Specialist physician visit	\$0	counseling	\$0	Mgt	\$0
Preventive care/screening/immunization	\$0	Medical treatment for withdrawal symptoms	\$0	Combined Therapy	\$0
		Behavioral health treatment Office Visit for autism or			
Family planning	\$0	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
	Services are carved out to				4.5
Child dental: diagnostic and preventive	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	List Copayment/C oinsurance	D. Outpatient, In-Network: Other Outpatient Items and		D. Outpatient, In-Network: Other Outpatient Items and Services (Can be combined with	List Copayme nt/Coinsu rance
and Services (Can be combined with Outpatient, In-		Services (Can be combined with Outpatient, In-Network:	for Each	Outpatient, In-Network: Office Visits or shown	for Each
Network: Office Visits or shown separately here.)	Benefit	Office Visits or shown separately here.)	Benefit	separately here.)	Benefit
The state of the s	Jenene	Construction on the construction of the constr	Jenene		- Jonesia
Outpatient surgery facility fee (e.g. Ambulatory					See above
Surgery Center)	\$0	Short-term partial hospitalization	\$0	See above Section C.	Section C.
Outpatient surgeryphysician/surgeon fee	\$0	Short-term intensive outpatient psychiatric treatment	\$0		
		Outpatient psychiatric observation for an acute psychiatric			
Outpatient surgery facility feefemale sterilization	\$0	crisis	\$0		
Outpatient surgeryphysician/surgeon feefemale					
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		
		Behavioral health treatment delivered in the home for autism			
Laboratory tests	\$0	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				

	1 1		T		<del>1 1</del>
Durable medical equipment, including in-home DME	\$0				
Medical supplies	\$0				
Prosthetic and orthotic services and devices	\$0		1		
Diabetes equipment and supply services	\$0				
Contact lenses for aniridia or aphakia	\$0				
Infusion therapy	\$0				
Child eye glasses/contact lenses	\$0				
	Services are				
	carved out to				
Child dental: basic services	the State.				
Child dental: major services	Carve out				
Child medically necessary orthodontics	Carve out				
					List
	List		List		Copayme
	Copayment/C		Copayment/		nt/Coinsu
	oinsurance		Coinsurance		rance
	for Each		for Each		for Each
E. Outpatient, Out-of-Network: Office Visits	Benefit	E. Outpatient, Out-of-Network: Office Visits	Benefit	E. Outpatient, Out-of-Network: Office Visits	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		
		Individual and group chemical dependency evaluation and			
Specialist physician visit	\$0	counseling	\$0		
Preventive care/screening/immunization	\$0	Medical treatment for withdrawal symptoms	\$0		
		Behavioral health treatment Office Visit for autism or			
Family planning	\$0	pervasive developmental disorder (PDD)	\$0		
Prenatal care and preconception visits	\$0				
	Not a covered				
Acupuncture	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/C oinsurance 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.)	Coinsurance	F. Outpatient, Out-of-Network: Other Outpatient Items and Services (Can be combined with Outpatient, Out-of-Network: Office Visits or shown separately here.)	Copayme nt/Coinsu rance for Each
Outpatient surgery facility fee (e.g. Ambulatory						
Surgery Center)	\$0		Short-term partial hospitalization		N/A	N/A
Outpatient surgeryphysician/surgeon fee	\$0		Short-term intensive outpatient psychiatric treatment	\$0		
			Outpatient psychiatric observation for an acute psychiatric			
Outpatient surgery facility feefemale sterilization	\$0		crisis	\$0		
Outpatient surgeryphysician/surgeon feefemale						
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		
			Behavioral health treatment delivered in the home for autism			
Laboratory tests	\$0		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 NO	ON BH				
Child dental: major services	Carve out NO	ON BH				
Child medically necessary orthodontics	Carve out NO	ON BH				

	List Copayment/C			List Copayment/		List Copayme nt/Coinsu
	oinsurance			Coinsurance		rance
	for Each			for Each		for Each
G. Emergency	Benefit		G. Emergency	Benefit	G. Emergency	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
	40			40	Out-of-State Emergency Behavioral Health	40
Emergency medical transportation	\$0		Emergency medical/psychiatric transportation	\$0	Services	\$0
Urgent care	\$0		Urgent care	\$0		List
	List			List		Copayme
	Copayment/C			Copayment/		nt/Coinsu
	oinsurance			Coinsurance		rance
	for Each			for Each		for Each
H. Prescription Drugs	Benefit			Benefit		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			
<b>Table 4: Quantitative Treatment Limitation</b>	ons, includin	g, but no	t limited to, limits on inpatient days per admission	n/episode		
Medical/Surgical Benefits			Mental Health/Substance Use Disorde	r		
Copy Benefits Listed in Each			Copy Benefits Listed in Each			
Classification /Subclassification Above and Paste			Classification /Subclassification Above and Paste into the			
into the same Classification/Subclassification Below	List all QTLs		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 Alcohol & Chemical Dependency	
inpatient	None		Hospital facility fee (e.g., hospital room)acute MH inpatient	None	Services	None

Physician/surgeon feeacute inpatient	None	Physician/surgeon feeacute MH inpatient	None	Inpatient Detoxification Only	None
Hospital facility fee (e.g., hospital room)female		Hospital facility fee (e.g., hospital room)inpatient psychiatric			
sterilization	None	observation for acute psychiatric crisis	None	Inpatient Detoxification Only & Labs	None
		Physician/surgeon feepsychiatric observation for acute			
Physician/surgeon feefemale sterilization	None	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 feesmaternity delivery	None	Physician/surgeon feeSUD 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 feeacute inpatient	None	Physician/surgeon feeacute MH inpatient	None		
Hospital facility fee (e.g., hospital room)female		Hospital facility fee (e.g., hospital room)inpatient psychiatric			
sterilization	None	observation for acute psychiatric crisis	None		
		Physician/surgeon feepsychiatric observation for acute			
Physician/surgeon feefemale sterilization	None	psychiatric crisis	None		
Hospital facility fee (e.g., hospital room)maternity					
delivery	None	Hospital facility fee (e.g., hospital room)SUD detoxification	None		
Professional feesmaternity delivery	None	Physician/surgeon feeSUD 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
		Individual and group chemical dependency evaluation and		Ambulatory Behavioral Health Services & Crisis	
Specialist physician visit	None	counseling	None	Mgt	None
Preventive care/screening/immunization	None	Medical treatment for withdrawal symptoms	None	Combined Therapy	None
		Behavioral health treatment Office Visit for autism or			
Family planning	None	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.)		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 surgeryphysician/surgeon fee	None		Short-term intensive outpatient psychiatric treatment	None		
Outpatient surgery facility feefemale sterilization	None		Outpatient psychiatric observation for an acute psychiatric crisis	None		
Outpatieint surgeryphysician/surgeon feefemale 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		
			Behavioral health therapy delivered in the home for autism			
Laboratory tests	None		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		
			Individual and group chemical dependency evaluation and			
Specialist physician visit	None		counseling	None		
Preventive care/screening/immunization	None		Medical treatment for withdrawal symptoms	None		
			Behavioral health treatment Office Visit for autism or			
Family planning	None		pervasive developmental disorder (PDD)	None		
Prenatal care and preconception visits	None					
Acupuncture	N/A					
Health education	None					
Child dental: diagnostic and preventive	N/A					

	One every 12					
Child eye exam	months.	NON BH				
F. Outpatient, Out-of-Network: Other Outpatient					F. Outpatient, Out-of-Network: Other	
Items and Services (Can be combined with			F. Outpatient, Out-of-Network: Other Outpatient Items and		Outpatient Items and Services (Can be	
Outpatient, Out-of-Network: Office Visits or shown			Services (Can be combined with Outpatient, Out-of-Network:		combined with Outpatient, Out-of-Network:	
separately here.)	List all QTLs		Office Visits or shown separately here.)		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 surgeryphysician/surgeon fee	None		Short-term intensive outpatient psychiatric treatment	None		
			Outpatient psychiatric observation for an acute psychiatric			
Outpatient surgery facility feefemale sterilization	None		crisis	None		
Outpatieint surgeryphysician/surgeon feefemale						
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		
			Behavioral health therapy delivered in the home for autism			
Laboratory tests	None		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)		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:AlohaCareDate:August 3, 2018Contact Person:Don Ross, Dir Medicaid ProductEmail: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:	List of documents:							
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review					
(MS)	Disorder (MH/SUD)	Explanation and/or Plan						
Prior authorization is not required for	Prior authorization is not required for	Emergency services for Medical/BH is	No issues found.					
urgent care, emergency services and/or	urgent care, emergency services and/or	not subject to prior authorization review						
post-stabilization	post-stabilization	regardless whether or not the provider is	BH parity requirements					
care and services. AlohaCare members	care and services. AlohaCare members	within the plan's network.	met.					
are encouraged to communicate with	are encouraged to communicate with							
their PCP prior to the development of	their PCP prior to the development of							
an emergency situation. Members are	an emergency situation. Members are							
informed that they may seek emergency	informed that they may seek emergency							
services at the nearest hospital's	services at the nearest hospital's							
Emergency Room. If an emergency	Emergency Room. If an emergency							
situation occurs, members are advised	situation occurs, members are advised							
to seek emergency services through the	to seek emergency services through the							
EMS 911 system or through the local	EMS 911 system or through the local							
emergency system. The PCP is	emergency system. The PCP is							
encouraged to coordinate appropriate	encouraged to coordinate appropriate							
follow-up care with the attending	follow-up care with the attending							
physician and the member.	physician and the member.							
Emergency Services may include:	Emergency Services may include:							
<ul> <li>Emergency eye and hearing</li> </ul>	Emergency room services							
exams	<ul><li>Pathology/lab services,</li></ul>							
Emergency room services	diagnostic tests, radiology							
<ul><li>Pathology/lab services,</li></ul>	services, medical supplies and							
diagnostic tests, radiology	drugs within the ER visit							

- 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.

<ul> <li>that there is not adequate time to effect a safe transfer to another hospital before delivery</li> <li>that transfer may pose a threat to the health or safety or the woman or her unborn child</li> <li>The AlohaCare Member Handbook lists examples of when a member should go</li> </ul>		
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review					
(M/S)	Disorder	Explanation and/or Plan						
	(MH/SUD)							

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/Substa Disorder (MH/SUD)	nce Use Comparability/Stringency v Explanation and/or Plan			
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.

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

#### **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			

<sup>10.</sup> 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	Mental Health/Substance Use	Comparability/Stringency w/	State Review		
(M/S)	Disorder	Explanation and/or Plan			
	(MH/SUD)				
Per Credentialing policies and	Per Credentialing policies and	AlohaCare policy covers emergency	No issues found.		
licensing regulations, providers must	licensing regulations, providers must	services provided by providers providing			
provide services within the scope of	provide services within the scope of	care within scope of licensure and	BH parity requirements met.		
their license. AlohaCare will cover	their license. AlohaCare will cover	accreditation, regardless of whether the			
emergency services provided by any	emergency services provided by any	services are MH/SUD services or M/S			
provider practicing and providing care	provider practicing and providing care	services.			
within the scope of the provider's	within the scope of the provider's				
license and accreditation.	license and accreditation.				

<sup>11.</sup> 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.

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List	OI.	documents	

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

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

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

## **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 LIM review for innation LOC Concurrent review workflow Provider manual experts

List of documents: Procedures for conducting UM review for inpatient LOC, Concurrent review workflow, Provider manual excerpts,				
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
Inpatient H, Maternity/Newborn Care,	Inpatient Psychiatric Hospitalizations	Criteria/Guidelines used to make a	No issues found.	
and Sub-acute Short/Long Term	services include:	determination of Medical Necessity for		
Rehabilitation services include:		BH/Medical inpatient hospitalizations:	BH parity requirements	
	<ul> <li>room/board</li> </ul>		met.	
<ul> <li>Room and board</li> </ul>	<ul> <li>nursing care</li> </ul>	<ul> <li>Interqual</li> </ul>		
<ul><li>nursing care</li></ul>	<ul> <li>medical supplies and</li> </ul>	<ul> <li>Medical Necessity</li> </ul>		
<ul> <li>medical supplies</li> </ul>	equipment			
<ul> <li>equipment and drugs</li> </ul>	<ul> <li>medications and medication</li> </ul>	A notification from the facility within 24		
<ul> <li>diagnostic services</li> </ul>	management	hours of the member's acute admission is		
<ul> <li>physical therapy</li> </ul>	<ul> <li>diagnostic services</li> </ul>	required to initiate an authorization to be		
<ul> <li>occupational therapy</li> </ul>	<ul> <li>psychiatric and other</li> </ul>	created for review of the member's		
<ul> <li>audiology</li> </ul>	practitioner services	inpatient stay.		
<ul> <li>speech- language pathology</li> </ul>	<ul> <li>ancillary services</li> </ul>			
service	<ul> <li>other medically necessary</li> </ul>	<del>-</del>		
<ul> <li>other medically necessary</li> </ul>	services			
services.		BH/Medical nospitalizations.		
		Dahahilitation/Long term residential stays		
	Concurrent Review process:			
Concurrent Review process:		Divincular nospitanzations.		
	<b>★</b>	Comparability: Comparable criteria are		
	member's admission.	1 -		
service • other medically necessary services.		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		

- 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.	
nome.		

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

of care. Based on all available	of care. Based on all available	
information a determination is made	information a determination is made	
regarding LOC or LOS and pend the	regarding LOC or LOS and pend the	
authorization back to the clinician to	authorization back to the clinician to	
complete the authorization process or	complete the authorization process or	
continue the concurrent review.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
During a concurrent review of a	During a concurrent review of a	For Medical/BH services the process for	No issues found.	
member's acute/rehab inpatient stay,	member's BH acute/long term	making a determination to authorize		
our guidelines (Interqual) require a	inpatient stay, our guidelines	and/or deny the services are the same.	BH parity requirements met.	
series of tests, course of treatment,	(Interqual) require a series of tests,			
imaging, and intensity of rehab	course of treatment, imaging, and			
services to be conducted for each	intensity of BH services to be			
inpatient day. If the member is	conducted for each inpatient day. If the			
unwilling or unable to receive the	member is unwilling or unable to			
appropriate interventions a Medical	receive the appropriate interventions a			
Necessity review will be conducted	Medical Necessity review will be			
based on the Interqual guidelines. If	conducted based on the Interqual			
the guidelines are not met due to	guidelines. If the guidelines are not			
failure to complete a course of	met due to failure to complete a course			
treatment and the member's clinical	of treatment and the member's clinical			
state is not stable for discharge, the	state is not stable for discharge, the			
Level of care may be denied, but not	Level of care may be denied, but not			
the length of stay. Decisions are	the length of stay. Decisions are			
always based on our guidelines and	always based on our guidelines and			
Medical Necessity. Failure to complete	Medical Necessity. Failure to complete			
a course of treatment is not a	a course of treatment is not a			
determining factor for a denial.	determining factor for a denial.			

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

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

to Medical Directors for a secondary	denials regarding LOS/LOC are pended	PA by nearly half, effective January,	
review and decision determination.	to Medical Directors for a secondary	2018.	
Decisions are always based on our	review and decision determination.		
guidelines and Medical Necessity. The	Decisions are always based on our		
cost of the hospitalization/services is	guidelines and Medical Necessity. The		
not a factor used to make a decision	cost of the hospitalization/services is		
determination.	not a factor used to make a decision		
	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: Documents submitted for this item are included with Item #1 above				
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(M/S)	Disorder	Explanation and/or Plan		
	(MH/SUD)			
All process for concurrent review have	All process for concurrent review have	Based on the number of authorizations	No issues found.	
been addressed in the above columns.	been addressed in the above columns.	received for Medical/BH inpatient acute		
		and long term. The percent of cases that	BH parity requirements met.	
From Jan 2018 – June 2018 there were	From Jan 2018 – June 2018 there were	are denied are comparable.		
no appeals that was requested from	no appeals that were requested from			
UM for inpatient denials.	UM for inpatient BH denials.			
F 4 2010 1 2010 1	F 4 2010 4 2010 1		!	
From Jan 2018-June 2018 there were	From Jan 2018-June 2018 there were			
1904 authorizations for acute and LTC	196 authorizations for Acute BH			
inpatient authorizations out of which	inpatient 2 (1.02%) which were			
26 (1.37%) were denied.	partially approved.			

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

# 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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
No tiers	No tiers	No difference between patient	No issues found.
		populations.	
			BH parity requirements met.
		the same criteria for medication coverage	
		determinations	

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

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

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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
No exclusions, except for those	No exclusions, except for those	No difference in approach to provider	No issues found.
excluded from participation in	excluded from participation in	exclusion between M/S and MH/SUD	
government healthcare programs	government healthcare programs	providers.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	•	
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
AlohaCare members receive medically	AlohaCare members receive medically	There is no difference in the policies or	No issues found.
necessary care. OON care must be	necessary care. OON care must be	procedures for review of requests for	
prior authorized and coverage	prior authorized and coverage	OON care whether services are M/S or	BH parity requirements met.
determinations are made based on	determinations are made based on	MH/SUD services.	
clinical review considering patient	clinical review considering patient		
history with providers, and comparison	history with providers, and comparison		

of provider specialties, training,	of provider specialties, training,	
expertise, credentials, and on	expertise, credentials, and on	
geography and proximity. If in-	geography and proximity. If in-	
network providers of comparable	network providers of comparable	
credentials and specialties are	credentials and specialties are	
available in the medical service area,	available in the medical service area,	
care is re-directed to the network. If	care is re-directed to the network. If	
not, then OON care is authorized. This	not, then OON care is authorized. This	
is also true for out of state non-	is also true for out of state non-	
emergency care.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
All provider contracts are negotiated	All provider contracts are negotiated	No difference between M/S and MH/SUD	No issues found.
rates and vary according to terms	rates and vary according to terms	provider reimbursement approaches.	
reached in negotiation. Most begin	reached in negotiation. Most begin		BH parity requirements met.
with the state's FFS fee schedule, or	with the state's FFS fee schedule, or		
are a percentage of Medicare FFS fee	are a percentage of Medicare FFS fee		
schedule. This is true for physicians,	schedule. This is true for physicians,		
PhDs and MAs.	PhDs and MAs.		

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

## **OUTPATIENT**

Health Plan:AlohaCareDate:August 3, 2018Contact Person:Don Ross, Dir Medicaid ProductEmail: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 Mental Health/Substance Use Disorder Comparability/Stringency w/ Medical/Surgical State Review (MH/SUD) Explanation and/or Plan (MS) AlohaCare's Utilization Management AlohaCare's Utilization Management No issues found. Program (UMP) incorporates the functions Program (UMP) incorporates the functions **Comparability:** of utilization review/management (e.g., of utilization review/management (e.g., Criteria applied to make medical BH parity requirements met. prospective, concurrent and retrospective prospective, concurrent and retrospective necessity/appropriateness reviews) of medical, behavioral health, long reviews) of medical, behavioral health, long determination are selected from term services and supports, pharmacy/drug term services and supports, pharmacy/drug criteria available as national services. The UMP monitors for over- or services. The UMP monitors for over- or standard systems and based on under-utilization, and inappropriate use of under-utilization, and inappropriate use of the best available medical services. services. evidence reviewed by physicians, Psychologists, Pharmacists, and other clinical The AlohaCare UMP also includes services The AlohaCare UMP also includes services that promote the continuity and that promote the continuity and experts who serve on their coordination of care through assistance and coordination of care through assistance and committees and review boards. support during care transitions, disease support during care transitions, disease They include Interqual, Noridian management, and collaborative care and management, and collaborative care and (Medicare), ASAM, and service coordination internally and service coordination internally and AlohaCare policies and externally. It objectively monitors and externally. It objectively monitors and procedures based on NCOA evaluates the cost of care based on medical evaluates the cost of care based on medical requirements, and MQD rules, or functional appropriateness. or functional appropriateness. contract requirements, guidance and definitions. This is the same The AlohaCare UMP assesses not just The AlohaCare UMP assesses not just approach whether they are M/S clinical aspects of care, but also factors that clinical aspects of care, but also factors that or MH/SUD services. Services impact how care is delivered/provided, such impact how care is delivered/provided, such are selected for review based on

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:

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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:
  - Chief Medical Officer, Medical Director, and Associate Medical Directors.
  - Senior Director of Long Term Services and Support (Service Coordination).
  - o Director of Utilization Management.
  - O Director of Health Plan Operations.
  - o Pharmacy Manager.
  - 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:
  - Chief Medical Officer, Medical Director, and Associate Medical Directors.
  - Senior Director of Long Term Services and Support (Service Coordination).
  - o Director of Utilization Management.
  - O Director of Health Plan Operations.
  - o Pharmacy Manager.
  - 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/Provider s/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/Provider s/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 OI benefit plan will include 'CCS' in the plan name. Providers should bill the CCS program administrator for the MH services 1, 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 docume	List of documents: The same documents included with this submission for item #1 above.			
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
As mentioned above, the UMP	As mentioned above, the UMP	For Medical/BH services which require	No issues found.	
outlines the various committees and	outlines the various committees and	prior authorization, the process for making		
groups which collaborate on writing	groups which collaborate on writing	a determination to authorize and/or deny	BH parity requirements met.	
our medical and pharmacy policies.	our medical and pharmacy policies.	the services are the same. (see above		
The requirements, such as initial trials,	The requirements, such as initial trials,	description of auth process)		
step therapies, criteria, and other UM	step therapies, criteria, and other UM			
edits placed on these therapies are	edits placed on these therapies are			
developed from guidelines in Medical	developed from guidelines in Medical			
Necessity policy and procedure, and	Necessity policy and procedure, and			
by using Local Coverage	by using Local Coverage			
Determinations (LCDs) or National	Determinations (LCDs) or National			
Coverage Determinations (NCDs).	Coverage Determinations (NCDs).			
Clinician reviews services using	Clinician reviews services using			
appropriate guidelines based on the	appropriate guidelines based on the			
requested service using clinical notes	requested service using clinical notes			
that have been submitted by the	that have been submitted by the			
requesting provider. During the	requesting provider. During the			
review, if the guidelines are not met	review, if the guidelines are not met			
due to "failed first requirements or	due to "failed first requirements or step			
step therapies", clinician will contact	therapies", clinician will contact			
member's requesting PCP/Specialist to	member's requesting PCP/Specialist to			
request additional information to	request additional information to			
confirm that the member did fail "first	confirm that the member did fail "first			
requirements or step-therapies". If	requirements or step-therapies". If			
provider has additional information,	provider has additional information,			
review will continue using the	review will continue using the			
available information. If the allotted	available information. If the allotted			
timeframe for review is coming to a	timeframe for review is coming to a			
close, clinician can inform the	close, clinician can inform the provider			

provider that the timeframe is near and	that the timeframe is near and provide	
provide the option of an extension if	the option of an extension if an	
an extension of the review timeframe	extension of the review timeframe will	
will not have any adverse effects on	not have any adverse effects on the	
the member's health. Once all of the	member's health. Once all of the	
information is received and if it still	information is received and if it still	
does not meet the appropriate	does not meet the appropriate	
guidelines, a telephone call is made to	guidelines, a telephone call is made to	
the requesting provider to inform them	the requesting provider to inform them	
that the request is being sent to	that the request is being sent to	
Medical Director for secondary	Medical Director for secondary	
review. Should the provider wish to	review. Should the provider wish to	
conduct a peer to peer with the	conduct a peer to peer with the	
Medical Director prior to the	Medical Director prior to the	
determination of the decision, clinician	determination of the decision, clinician	
will arrange the peer to peer. Once all	will arrange the peer to peer. Once all	
of the information has been obtained	of the information has been obtained	
and peer to peer has been conducted	and peer to peer has been conducted	
the Medical Director will make a	the Medical Director will make a	
determination based on guidelines, and	determination based on guidelines and	
Medical Necessity. Medical Director	Medical Necessity. Medical Director	
will pend the authorization to the UM	will pend the authorization to the UM	
clinician to complete the authorization	clinician to complete the authorization	
process based on the Medical	process based on the Medical Directors	
Directors decision.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
No, however non-compliant to a	No, however non-compliant to a	For Medical/BH services which require	No issues found.	
course of treatment can be used as a	course of treatment can be used as a	prior authorization, the process for making		
determining factor during a review	determining factor during a review	a determination to authorize and/or deny	BH parity requirements met.	
should additional units be requested.	should additional units be requested.	the services are the same. (See PA		
These cases will be sent to Medical	These cases will be sent to Medical	process)		
Director for review and continuation	Director for review and continuation of			
of services is based on meeting the	services is based on meeting the			
appropriate guidelines and Medical	appropriate guidelines and Medical			
Necessity.	Necessity.			

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

Based on the Medical	Based on the Medical	
Director's decision, the UM	Director's decision, the UM	
BH/Medical clinician will either	BH/Medical clinician will either	
approve or deny the request.	approve or deny the request.	
<ul> <li>If decision is approved,</li> </ul>	• If decision is approved, written	
written notification will be provided to	notification will be provided to the	
the requesting/treating provider	requesting/treating provider	
• If denied, written and verbal	• If denied, written and verbal	
notification will be provided to the	notification will be provided to the	
requesting/treating provider. Written	requesting/treating provider. Written	
notification will be given to member in	notification will be given to member in	
simple language explaining reason for	simple language explaining reason for	
the decision and their appeal rights.	the decision and their appeal rights.	
<ul> <li>All adverse decisions are</li> </ul>	All adverse decisions are made	
made by AlohaCare's Medical	by AlohaCare's Medical Directors	
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(M/S)	Disorder	Explanation and/or Plan		
	(MH/SUD)			
Concurrent reviews are not conducted	Concurrent reviews are not conducted	The determination of continued services,	No issues found.	
during the course of treatment for	during the course of treatment for	should it be requested, is based on the		
outpatient medical services.	outpatient medical services.	efficacy of the prior service and whether	BH parity requirements met.	
		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.		

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

# **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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
For M/S services, AlohaCare conducts	For MH/SUD services, AlohaCare	No difference between patient	No issues found.
annual and ad hoc assessments of our	conducts annual and ad hoc	populations. Both M/S and MH/SUD	
provider network delivery system to	assessments of our provider network	Practitioners and Facilities undergo the	BH parity requirements met.
determine if it is meeting our standards	delivery system to determine if it is	same credentialing and network selection	
for network adequacy, capacity, and	meeting our standards for network	requirements for participation in	
member access. See attached	adequacy, capacity, and member	AlohaCare's network.	
Selections and Retention of Providers	access. See attached Selections and		
Policy. AlohaCare's Policy includes	Retention of Providers Policy		
provider exclusion per federal and	AlohaCare's Policy includes provider		
state requirements for government	exclusion per federal and state		
funded programs. Credentialing	requirements for government funded		
requirements include common, state-	programs. Credentialing requirements		
wide and national standards such as	include common, state-wide and		
licensed, certified, accredited, and in	national standards such as licensed,		
good standing, with Appropriate	certified, accredited, and in good		
medical liability, DEA, peer	standing, with Appropriate medical		
references, and other common	liability, DEA, peer references, and		
credentialing and privileging	other common credentialing and		
verifications.	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 Recruits			
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
No exclusions, except for those	No exclusions, except for those	No difference in approach to provider	No issues found.
excluded from participation in	excluded from participation in	exclusion between M/S and MH/SUD	
government healthcare programs.	government healthcare programs.	providers.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
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:	List of documents:				
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review		
(M/S)	Disorder	Explanation and/or Plan			
	(MH/SUD)	-			
AlohaCare members receive medically	AlohaCare members receive medically	There is no difference in the policies or	No issues found.		
necessary care. OON care must be	necessary care. OON care must be	procedures for review of requests for			
prior authorized and coverage	prior authorized and coverage	OON care whether services are M/S or	BH parity requirements met.		
determinations are made based on	determinations are made based on	MH/SUD services.			
clinical review considering patient	clinical review considering patient				
history with providers, and comparison	history with providers, and comparison				
of provider specialties, training,	of provider specialties, training,				
expertise, credentials, and on	expertise, credentials, and on				
geography and proximity. If in-	geography and proximity. If in-				
network providers of comparable	network providers of comparable				
credentials and specialties are	credentials and specialties are				
available in the medical service area,	available in the medical service area,				
care is re-directed to the network. If	care is re-directed to the network. If				
not, then OON care is authorized. This	not, then OON care is authorized. This				
is also true for out of state non-	is also true for out of state non-				
emergency care.	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: Provider Recruitment and retention policy						
	Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review			
	(M/S)	Disorder	Explanation and/or Plan				
		(MH/SUD)					
Ī	All provider contracts are negotiated	All provider contracts are negotiated	No difference between M/S and MH/SUD	No issues found.			
L	rates and vary according to terms	rates and vary according to terms	provider reimbursement approaches.				

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

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

### 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 Pro Service Organization Determinations (MM 04): AlphaCara Utilization

List of documents: Medical Manageme	ent Prior Authorizations and Pre-Service	Organization Determinations (MM-0	04); AlohaCare Utilization
Management Program			
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
AlohaCare's Utilization Management	AlohaCare's Utilization Management	No difference between patient	No issues found.
Program (UMP) incorporates the	Program (UMP) incorporates the	populations.	
functions of utilization	functions of utilization	Both MS and MH/SUD	BH parity requirements met.
review/management (e.g.,	review/management (e.g.,	populations utilize the same	
prospective, concurrent and	prospective, concurrent and	standards of criteria for medication coverage	
retrospective reviews) of medical,	retrospective reviews) of medical,	determinations.	
behavioral health, long term services	behavioral health, long term services	determinations.	
and supports, pharmacy/drug	and supports, pharmacy/drug		
services. The UMP monitors for	services. The UMP monitors for		
over- or under-utilization, and	over- or under-utilization, and		
inappropriate use of services.	inappropriate use of services.		
The AlohaCare UMP also includes	The AlohaCare UMP also includes		
services that promote the continuity	services that promote the continuity		
and coordination of care through	and coordination of care through		
assistance and support during care	assistance and support during care		
transitions, disease management, and	transitions, disease management, and		
collaborative care and service	collaborative care and service		
coordination internally and	coordination internally and		
externally. It objectively monitors	externally. It objectively monitors		
and evaluates the cost of care based	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 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.

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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 interrater 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:
  - Chief Medical Officer, Medical Director, and Associate Medical Directors.
  - Senior Director of Long Term Services and Support (Service Coordination).
  - o Director of Utilization Management.
  - o Director of Health Plan Operations.
  - o Pharmacy Manager.
  - Others as relevant.
- Feedback from Practitioners Advisory Committee.

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  - o Director of Utilization Management.
  - o Director of Health Plan Operations.
  - o Pharmacy Manager.
  - Others as relevant.
- Feedback from Practitioners Advisory Committee.

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

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); AlonaCare Utilization					
Management Program					
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review		
(MS)	Disorder (MH/SUD)	Explanation and/or Plan			
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	<ul> <li>No difference between patient populations.</li> <li>Both MS and MH/SUD populations utilize the same criteria for medication coverage determinations.</li> </ul>	No issues found.  BH parity requirements met.		

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

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

responsibility, as well as the Medical	responsibility, as well as the Medical	
Director and Associate Medical	Director and Associate Medical	
Directors on UM initiatives, issues	Directors on UM initiatives, issues	
and decisions relating to utilization	and decisions relating to utilization	
management of medications, and	management of medications, and	
administration of AlohaCare's	administration of AlohaCare's	
formulary. Behavioral health	formulary. Behavioral health	
expertise is necessary among the	expertise is necessary among the	
Medical Director and Associate	Medical Director and Associate	
Medical Directors.	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 Utiliza	ation Management Program		
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Medical and Utilization	Medical and Utilization	<ul> <li>No difference between patient</li> </ul>	No issues found.
Management which includes:	Management which includes:	populations.	
timely processing of referrals and	timely processing of referrals and	Both MS and MH/SUD	BH parity requirements met.
prior authorization of medical,	prior authorization of medical,	populations utilize the same	
surgical, or behavioral health	surgical, or behavioral health	criteria for medication and medical	
services in terms of specialty care,	services in terms of specialty care,	service determinations	
diagnostics, treatments;	diagnostics, treatments;		
prospective, concurrent and	prospective, concurrent and		
retrospective reviews related to	retrospective reviews related to		
appropriate utilization; and medical	appropriate utilization; and medical		
policy development where	policy development where		
coverage determination tools such	coverage determination tools such		
as InterQual, Medicare NCD or	as InterQual, Medicare NCD or		
LCD, DMERC do not adequately	LCD, DMERC do not adequately		
address specific requests for	address specific requests for		
services;	services;		
We surrently do not perform only	We surrently do not perform any		
We currently do not perform any concurrent reviews for outpatient or	We currently do not perform any concurrent reviews for outpatient or		
concurrent reviews for outpatient of	concurrent reviews for outpatient of		

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

### 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.

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

### **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	<ul> <li>No difference between patient populations.</li> <li>Both MS and MH/SUD populations utilize the same criteria for medication and medical service determinations</li> </ul>	No issues found.  BH parity requirements met.

members. The health plan is not	members. The health plan is not	
required to contract with every	required to contract with every	
willing provider. If the health	willing provider. If the health	
plan does not or will not	plan does not or will not	
include individuals or groups of	include individuals or groups of	
providers of a specialty grouping	providers of a specialty grouping	
in its network, it shall provide that	in its network, it shall provide that	
information in its proposal.	information in its proposal.	
AlohaCare's provider network	AlohaCare's provider network team	
team maintains the Selection and	maintains the Selection and	
Retention of Providers policy	Retention of Providers policy	
which outlines the development,	which outlines the development,	
maintenance, assessment, and other	maintenance, assessment, and other	
aspects of the provider network.	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	List of documents: QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals (RFP-MQD)			
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(M/S)	Disorder	Explanation and/or Plan		
	(MH/SUD)			
The health plan shall not	The health plan shall not	No difference between patient	No issues found.	
discriminate with respect to	discriminate with respect to	populations.		
participation, reimbursement, or	participation, reimbursement, or	Both MS and MH/SUD	BH parity requirements met.	
indemnification of any provider	indemnification of any provider	populations utilize the same		
who is acting within the	who is acting within the	criteria for medication and medical		
scope of his or her license	scope of his or her license	service determinations		
or certification under applicable	or certification under applicable			
State law, solely based on that	State law, solely based on that			
license or certification. The	license or certification. The health			
health plan shall not discriminate	plan shall not discriminate against			
against providers serving high-risk	providers serving high-risk			
populations or those that specialize	populations or those that specialize			
in conditions requiring costly	in conditions requiring costly			
treatments. This is not to be	treatments. This is not to be			
construed as: (1) requiring that the	construed as: (1) requiring that the			

1 1/1 1 / / / / 1	1 1.1 1	
health plan contract with providers	health plan contract with providers	
beyond the number necessary to	beyond the number necessary to	
meet the needs of its members; (2)	meet the needs of its members; (2)	
precluding the health plan from	precluding the health plan from	
using different reimbursement	using different reimbursement	
amounts for different specialties or	amounts for different specialties or	
for different practitioners in the	for different practitioners in the	
same specialty; or (3) precluding	same specialty; or (3) precluding	
the health plan from establishing	the health plan from establishing	
measures that are designed to	measures that are designed to	
maintain quality of services and	maintain quality of services and	
control costs and are consistent	control costs and are consistent	
with its responsibilities to	with its responsibilities to	
members. The health plan is not	members. The health plan is not	
required to contract with every	required to contract with every	
willing provider. If the health	willing provider. If the health	
plan does not or will not	plan does not or will not	
include individuals or groups of	include individuals or groups of	
providers of a specialty grouping	providers of a specialty grouping	
in its network, it shall provide that	in its network, it shall provide that	
information in its proposal.	information in its proposal.	
proposa.	morning in the proposition	

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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
<ul> <li>No geographic limitations</li> </ul>	No geographic limitations	No difference between patient	No issues found.
		populations.	
		Both MS and MH/SUD	BH parity requirements met.
		populations utilize the same	
		criteria for medication and medical	
		service determinations	

<sup>12.</sup> 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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	-	
OON dispensing of prescription	OON dispensing of prescription	There is no difference between MH/SUD	No issues found.
medications is less frequently	medications is less frequently	and M/S services regarding the handling	
necessary than for professional and	necessary than for professional and	of OON pharmacy dispensing and	BH parity requirements met.
facility services, since the PBM's	facility services, since the PBM's	coverage determinations.	
pharmacy network is extensive and	pharmacy network is extensive and		
includes all major national chains. If	includes all major national chains. If		
an OON pharmacy must be utilized,	an OON pharmacy must be utilized,		
then a contract or letter of agreement	then a contract or letter of agreement		
must be obtained and the OON	must be obtained and the OON		
dispensing authorized. AlohaCare will	dispensing authorized. AlohaCare will		
approve dispensing of at least a 3 day	approve dispensing of at least a 3 day		
supply of necessary medication at	supply of necessary medication at		
whatever rates the OON pharmacy	whatever rates the OON pharmacy		
may charge until a LOA can be signed.	may charge until a LOA can be signed.		

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

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

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

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

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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review		
(MS)	Disorder (MH/SUD)	Explanation and/or Plan			
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 Mental Health/Substance Use (M/S) 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 Mental Health/Substance Use Comparability/Stringency w/ State Review						
(M/S)	Disorder	Explanation and/or Plan				
(MH/SUD)		_				
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 Mental Health/Substance Use Comparability/Stringency w/ State Review					
(M/S)	Disorder	Explanation and/or Plan			
(MH/SUD)		•			
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 Mental Health/Substance Use Comparability/Stringency w/ State Review					
(M/S)	Disorder	Explanation and/or Plan			
(MH/SUD)		_			
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 Mental Health/Substance Use Comparability/Stringency w/ State Review						
(M/S) Disorder		Explanation and/or Plan				
(MH/SUD)						
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review		
(M/S)	Disorder	Explanation and/or Plan			
(MH/SUD)					
Providers must be appropriately	Providers must be appropriately	The processes and standards used in	No issues found.		
licensed or certified in accordance	licensed or certified in accordance	contracting and credentialing both MS and			
with state and national guidelines,	with state and national guidelines,	MH/SUD for Emergency providers are	BH parity requirements met.		
meet all standard educational and	meet all standard educational and	comparable and equally stringent.			
credentialing criteria for their	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.

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	Medical/Surgical Mental Health/Substance Use Comparability/Stringency			
(M/S)	(M/S) Disorder			
	_			
HMSA does not have any exclusions HMSA does not have any exclusions		Both sides do not have exclusions based	No issues found.	
pertaining to provider types, facility	pertaining to provider types, facility	on provider type, facility type, or specialty		
types, or specialty providers.	types, or specialty providers.	providers and are therefore comparable	BH parity requirements met.	
		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	Medical/Surgical Mental Health/Substance Use Comparability/Stringency w/				
(M/S) Disorder		Explanation and/or Plan			
	(MH/SUD)				
There are no geographic limitations  There are no geographic limitations		Both sides do not have geographic	No issues found.		
		limitations and are therefore comparable			
		and equally stringent.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review		
(M/S) Disorder		Explanation and/or Plan			
	(MH/SUD)				
QUEST Integration members have no	QUEST Integration members have no	The process determining access to out of	No issues found.		
out-of-network benefits except for	out-of-network benefits except for out-of-network benefits except for				
emergencies. If a member is admitted	emergencies. If a member is admitted	applied to both M/S and MH/SUD and are	BH parity requirements met.		
for an emergent condition, no prior	for an emergent condition, no prior	therefore comparable and equally			
authorization or concurrent reviews	authorization or concurrent reviews	stringent.			
are required until the time the	are required until the time the				
member's condition is stabilized.	member's condition is stabilized.				

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.

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List	OI.	documents.

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

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

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

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

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

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

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

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

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

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:	
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1. HMSA Utilization Management Program Description Beacon Policy on Objectivity in Clinical Decision Making

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

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

### **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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
Please refer to the NQTL- Prescription			No issues found.
Drugs document.			
			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	Comparability/Stringency w/ Explanation and/or Plan	State Review
(1115)	(MH/SUD)	DAPIGNATION UNIQUOT FIGURE	
Providers must be appropriately	Providers must be appropriately	The processes and standards used in	No issues found.
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	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	contracting and credentialing both MS and MH/SUD for inpatient providers are comparable and equally stringent.	BH parity requirements met.
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 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 onboarding process can be initiated either by the health Plan or		
Provider followed by execution of a	Provider followed by execution of a		

contract between Plan and Provider for	contract between Plan and Provider for	
participation in one or more products.	participation in one or more products.	
Plan monitors network needs on a	Plan monitors network needs on a	
regular basis in accordance with its	regular basis in accordance with its	
practitioner availability policies and	practitioner availability policies and	
will initiate outreach to non-par	will initiate outreach to non-par	
Providers if network analysis shows a	Providers if network analysis shows a	
need in a specific geography. Also,	need in a specific geography. Also,	
non-par Providers frequently initiate a	non-par Providers frequently initiate a	
request for participation. Plan will	request for participation. Plan will	
either respond and begin contracting	either respond and begin contracting	
process or politely decline if	process or politely decline if	
credentialing requirements are not	credentialing requirements are not met.	
met. Plan retains all rights to	Plan retains all rights to determine	
determine which providers it adds to	which providers it adds to its provider	
its provider networks.	networks.	
HMSA has formal credentialing	HMSA has formal credentialing	
criteria and a Credentialing	criteria and a Credentialing	
Committee.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
HMSA does not have any exclusions	HMSA does not have any exclusions	Both sides do not have exclusions based	No issues found.
pertaining to provider types, facility	pertaining to provider types, facility	on provider type, facility type, or specialty	
types, or specialty providers.	types, or specialty providers.	providers and are therefore comparable	BH parity requirements met.
		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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		

There are no geographic limitations	There are no geographic limitations	Both sides do not have geographic	No issues found.
		limitations and are therefore comparable	
		and equally stringent.	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-ofnetwork benefits.

List of documents:

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

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

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

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

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

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

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

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

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

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

non-par Providers frequently initiate a	non-par Providers frequently initiate a	
request for participation. Plan will	request for participation. Plan will	
either respond and begin contracting	either respond and begin contracting	
process or politely decline if	process or politely decline if	
credentialing requirements are not met.	credentialing requirements are not met.	
Plan retains all rights to determine	Plan retains all rights to determine	
which providers it adds to its provider	which providers it adds to its provider	
networks.	networks.	
HMSA has formal credentialing criteria	HMSA has formal credentialing	
and a Credentialing Committee.	criteria and a Credentialing	
	Committee.	
See the attached requirements		
documents:	See the attached requirements	
<ul> <li>Physicians (Medical Doctors,</li> </ul>	documents:	
Osteopaths, Podiatrists and	Marriage and Family	
Oral Surgeons) 2018 HMSA	Therapists and Mental Health	
Professional Credentialing	Counselors 2017 HMSA	
Requirements	Professional Credentialing	
<ul> <li>Physical Therapists,</li> </ul>	Requirements	
Optometrists, and Clinical	Clinical Social Workers 2018	
Psychologists 2018 HMSA	HMSA Professional	
Professional Credentialing	Credentialing Requirements	
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
HMSA does not have any exclusions	HMSA does not have any exclusions	Both sides do not have exclusions based	No issues found.
pertaining to provider types, facility	pertaining to provider types, facility	on provider type, facility type, or specialty	
types, or specialty providers.	types, or specialty providers.		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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
There are no geographic limitations	There are no geographic limitations	Both sides do not have geographic	No issues found.
		limitations and is therefore comparable	
		and equally stringent.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
QUEST Integration members have no	QUEST Integration members have no	The process determining access to out of	No issues found.
out-of-network benefits except for	out-of-network benefits except for	network services is equally applied to both	
emergencies. If a member is admitted	emergencies. If a member is admitted	M/S and MH/SUD benefits. Once an	BH parity requirements met.
for an emergent condition, no prior	for an emergent condition, no prior	exception is made, the same process is	
authorization or concurrent reviews	authorization or concurrent reviews are	used in paying for M/S and MH/SUD out	
are required until the time the	required until the time the member's	of network providers.	
member's condition is stabilized. If a	condition is stabilized. If a member		
member needs a treatment or service	needs a treatment or service that is not		
that is not available from network	available from network providers,		
providers, exception can be made after	exception can be made after a medical		
a medical necessity review and	necessity review and verifying		
verifying availability of comparable	availability of comparable services		
services within the network. If the out	within the network. If the out of		
of network treatment is warranted,	network treatment is warranted,		
HMSA will contract with the out-of-	HMSA will contract with the out-of-		
network provider for a single case	network provider for a single case		
agreement.	agreement.		

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

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

#### PRESCRIPTION DRUGS

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

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

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

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

# **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. CVS 2018 UM Program Description	on		
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
Prior authorization (PA) helps promote	Currently, there are no PA	Currently, there are no PA requirements	No issues found.
safe and appropriate medication	requirements on all MH/SUD drugs.	on any MH/SUD drugs and is therefore	
utilization. The goal is to ensure that		less stringent than MS. Parity is met.	BH parity requirements met.
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.			

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

	(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	Mental Health/Substance Use	Comparability/Stringency w/	State Review			
(M/S)	Disorder	Explanation and/or Plan				
	(MH/SUD)					
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review			
(M/S)	Disorder	Explanation and/or Plan				
	(MH/SUD)	_				
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
HMSA's QUEST Integration	HMSA's QUEST Integration	HMSA's QUEST Integration Formulary is	No issues found.
Formulary is not a tiered formulary.	Formulary is not a tiered formulary.	not a tiered formulary.	
			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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Every pharmacy must supply	Every pharmacy must supply	The processes and standards used for	No issues found.
documentation, pass enrollment, and	documentation, pass enrollment, and	network admission for both	DII'4'
meet certification requirements prior to joining the pharmacy network.	meet certification requirements prior to joining the pharmacy network.	medical/surgical and mental health/substance are the same and	BH parity requirements met.
Johning the pharmacy network.	Johning the pharmacy network.	therefore comparable and equally	met.
Enrollment requirements:	Enrollment requirements:	stringent.	
- Provider Agreement (base	- Provider Agreement (base	31111-81111	
contract)	contract)		
- Credentialing forms/answers to	- Credentialing forms/answers to		
enrollment application	enrollment application		
questions	questions		
- Copies of current state license(s)	- Copies of current state license(s)		
- Copy of DEA certificate	- Copy of DEA certificate		
- Copy of Liability policy	- Copy of Liability policy		
- FWA training attestation	- FWA training attestation		
- NCPDP and NPI	- NCPDP and NPI		
- Network enrollment forms	- Network enrollment forms		
Credentialing verification process:	Credentialing verification process:		
- State Pharmacy and Pharmacist-	- State Pharmacy and Pharmacist-		
In-Charge licenses (must be	In-Charge licenses (must be		
active, in-date, and in good	active, in-date, and in good		
standing)	standing)		
- Pharmacy's DEA license (must be active, in-date, and in good	- Pharmacy's DEA license (must be active, in-date, and in good		
standing)	standing)		
- Pharmacy's NCPDP and NPI	- Pharmacy's NCPDP and NPI		
numbers	numbers		
- Liability policy (must be active	- Liability policy (must be active		
and meet minimum coverage	and meet minimum coverage		
requirements)	requirements)		

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

Ι	ist of documents: N/A			
	Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
	(M/S)	Disorder	Explanation and/or Plan	
		(MH/SUD)		
N	J/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 m	List of documents: [Please include most current version of the QI RFP].				
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review		
(M/S)	Disorder	Explanation and/or Plan			
	(MH/SUD)				
There are no geographic limitations	There are no geographic limitations	Both sides do not have geographic	No issues found.		
		limitations and is therefore comparable			
HMSA has a sufficient network of	HMSA has a sufficient network of	and equally stringent.	BH parity requirements met.		
pharmacies to ensure geographic	pharmacies to ensure geographic				
pharmacy access standards (Section	pharmacy access standards (Section				
40.240 of the Quest Integration RFP)	40.240 of the Quest Integration RFP)				
are met.	are 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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Out-of-network pharmacy exceptions	Out-of-network pharmacy exceptions	The processes and standards used to	No issues found.
may occur if a member is on a trip out	may occur if a member is on a trip out	determine out-of-network pharmacy	
of state and needs access to	of state and needs access to	exceptions for both medical/surgical and	BH parity requirements met.
medications or if a drug has limited	medications or if a drug has limited	mental health/substance are the same and	
distribution.	distribution.	therefore comparable and equally	
		stringent.	

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	n: 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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
No medical necessity review is	No medical necessity review is	No medical necessity review is performed	No issues found.	
performed for emergency care.	performed for emergency care.	for emergency care for MS and MH/SUD		
		coverage.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
No step-therapy (aka "fail first")	No step-therapy (aka "fail first")	No step-therapy (aka "fail first")	No issues found.	
protocols are in place. The decision to	protocols are in place. The decision to	protocols are in place for both MS		
implement such a protocol would be	implement such a protocol would be	and MH/SUD coverage.	BH parity requirements	
made by the Pharmacy & Therapeutics	made by the Pharmacy & Therapeutics		met.	
Committee and reviewed annually.	Committee and reviewed annually	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.		

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

#### 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	Medical/Surgical Mental Health/Substance Use Comparability/Stringency w/					
(M/S)	Disorder	Explanation and/or Plan				
	(MH/SUD)	-				
Concurrent review is not required	Concurrent review is not required	Concurrent review is not required for	No issues found			
for emergency care.	for emergency care.	emergency care related to MS and				
		MH/SUD coverage.	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 o	documents: -0-			
	Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
	(M/S)	Disorder	Explanation and/or Plan	
		(MH/SUD)		
Concur	rent review is not required for	Concurrent review is not required	Concurrent review is not required for	No issues found
emerge	ency care.	for emergency care.	emergency care related to MS and	
			MH/SUD coverage.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Concurrent review is not required	Concurrent review is not required	Concurrent review is not required for	No issues found
for emergency care.	for emergency care.	emergency care related to MS and	
		MH/SUD coverage.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
Prescription drug benefits are	Prescription drug benefits are	Prescription drug benefits are	No issues found
not tiered for Medicaid	not tiered for Medicaid	not tiered for Medicaid	
members.	members.	members.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	-	
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review				
(M/S)	Disorder	Explanation and/or Plan					
	(MH/SUD)	-					
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	Mental Health/Substance Use	Comparability/Stringency (y/n) w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Professional provider	Professional provider	Professional provider reimbursement	No issues found.
reimbursement rates for	reimbursement rates for	rates for M/S and MH/SUD	
emergency care are determined	emergency care are determined	emergency care providers are	BH parity requirements met.
by Medicaid and Medicare fee	by Medicaid and Medicare fee	determined by Medicaid and Medicare	
schedules.	schedules.	fee schedules.	

# **INPATIENT**

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

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

Concurrent review and authorization	502).	
for continued coverage during		
inpatient acute hospitalization is	Concurrent review and authorization	
performed every 1-3 days. (Note:	for continued coverage during	
When member is confined to an	inpatient acute hospitalization is	
out-of-state inpatient facility, there	performed every 2 days. (Note:	
may be occasional concurrent	When member is confined to an out-	
review delays pending receipt of	of-state inpatient facility, there may	
requested concurrent medical	be occasional concurrent review	
information. Concurrent reviews	delays pending receipt of requested	
will be performed when information	concurrent medical information.	
is received.)	Concurrent reviews will be performed	
,	when information is received.)	
Concurrent review and authorization	,	
for continued coverage in an	Concurrent review and authorization	
alternate inpatient setting (e.g., SNF)	for continued coverage in an	
is performed every 7-14 days.	alternate inpatient setting (e.g.,	
	residential treatment) is performed	
Only licensed physicians can make	every 14 days.	
medical necessity denial		
determinations. Board certified	Only licensed physicians can make	
physicians from appropriate specialty	medical necessity denial	
areas are used to assist in making	determinations. Board certified	
determination of medical and clinical	physicians from appropriate specialty	
appropriateness.	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 Permanent	te Hawaii policy on Drug Formulary (#	<sup>1</sup> 65-61-2.11)-0-	
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
No step-therapy (aka "fail first")	No step-therapy (aka "fail first")	No step-therapy (aka "fail first")	No issues found.
protocols are in place. The	protocols are in place. The	protocols are in place for both MS	
decision to implement such a	decision to implement such a	and MH/SUD coverage.	BH parity requirements met.
protocol would be made by the	protocol would be made by the		
Pharmacy & Therapeutics	Pharmacy & Therapeutics	There is one Kaiser Permanente	
Committee and reviewed	Committee and reviewed annually.	Hawaii policy on Drug Formulary	

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

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

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

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

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

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

SCIVICCS (π3034-01-Λ)			•
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	1	
Concurrent review during inpatient	Concurrent review and authorization	There are two Kaiser Permanente	No issues found.
acute hospitalization is performed	for continued coverage during	Hawaii Region policies on Utilization	
every 1-3 days. (Note: When	inpatient acute hospitalization is	Decisions (#6425-502) and Out-of-	BH parity requirements met.
member is confined to an out-of-	performed every 2 days. (Note:	Plan Requests for Care and Services	
state inpatient facility, there may be	When member is confined to an out-	(#5054-01-A). Policy guidance	
occasional concurrent review delays	of-state inpatient facility, there may	applies to concurrent review for both	
pending receipt of requested	be occasional concurrent review	MS and MH/SUD coverage.	
concurrent medical information.	delays pending receipt of requested		
Concurrent reviews will be	concurrent medical information.	Frequency of inpatient concurrent	
performed when information	Concurrent reviews will be	review is very similar for MS and	
is received.)	performed when information is	MH/SUD coverage.	
	received.)		
Concurrent review in an alternate			
inpatient setting (e.g., SNF) is	Concurrent review and		
performed every 7-14 days.	authorization for continued		
	coverage in an alternate inpatient		
Processes and frequency of review	setting (e.g., residential treatment)		
are guided by the Kaiser	is performed every 14 days.		
Permanente Hawaii Region policy			
on Utilization Decisions (#6425-	Processes and frequency of review		
502) and Out-of-Plan Requests for	are also guided by the Kaiser		
Care and Services (#5054-01-A).	Permanente Hawaii Region policy		

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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Prescription drug benefits are	Prescription drug benefits are	Prescription drug benefits are	No issues found.
not tiered for Medicaid	not tiered for Medicaid	not tiered for Medicaid	
members.	members.	members.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Kaiser Permanente Hawaii Region	Kaiser Permanente Hawaii Region	Network admission requirements and	No issues found.
(KP) is an integrated model of	(KP) is an integrated model of	processes are comparable for M/S and	
care which provides 97% of KP	care which provides 97% of KP	MH/SUD providers.	BH parity requirements met.
member care via its employed	member care via its employed		
providers and facilities. To	providers and facilities. To		
augment KP's internal care	augment KP's internal care		
delivery system, KP contracts	delivery system, KP contracts with		
with specialized service providers, both within and outside the State	specialized service providers, both within and outside the State of		
of Hawaii.	Hawaii.		
or nawan.	Hawan.		
Network admission requirements are	Network admission requirements are		
comprised of several factors which	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 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 Medic	aid netw	ork	KP refers to the Medic	aid netw	ork
adequacy requirements	adequacy requirements within the State   adequacy requirements within the State				he State
of Hawaii Department of Human of Hawaii Department of Human					
Services RFP-MQD-20	014-005:		Services RFP-MQD-20	014-005:	
	T	1		T	1
Minutes of drive	Urban	Rural	Minutes of drive	Urban	Rural
time			time		
PCP	30	60	PCP	30	60
Specialist	30	60	Specialist	30	60
Hospital	30	60	Hospital	30	60
Emergency Facility	30	60	Emergency Facility	30	60
Mental Health	30	60	Mental Health	30	60
Pharmacy	15	60	Pharmacy	15	60
24-Hour Pharmacy	60	N/A	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
No practitioner types, facility types,	No practitioner types, facility types,	No practitioner types, facility types, or	No issues found.
or specialty providers are	or specialty providers are	specialty providers are specifically	
specifically excluded from	specifically excluded from	excluded from eligibility to enter into	BH parity requirements met.
eligibility to enter into contracting	eligibility to enter into contracting	contracting consideration toward	
consideration toward providing	consideration toward providing	providing M/S and MH/SUD covered	
covered benefit services.	covered benefit services.	benefit services.	

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

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

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)

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

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 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

member; or

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:

physician.

- 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.	Plan; • Selected provider is available to see the patient.	
Only licensed physicians can make medical necessity denial determinations.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review		
(M/S)	Disorder	Explanation and/or Plan			
	(MH/SUD)	_			
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	Mental Health/Substance Use	Comparability/Stringency (y/n) w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
In this island State of Hawaii,	In this island State of Hawaii, provider	Provider reimbursement rate	No issues found.
provider supply and demand in target	supply and demand in target	determination is comparable for M/S and	
geographic areas of need is a primary	geographic areas of need is a primary	MH/SUD providers.	BH parity requirements met.
influencer of professional provider	influencer of professional provider		
reimbursement rates. While the	reimbursement rates. While the		
Medicaid fee schedule is considered,	Medicaid fee schedule is considered,		
the actual provider reimbursement	the actual provider reimbursement		
rates may be higher.	rates may be higher.		

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

# **OUTPATIENT**

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

# 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)

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

Concurrent review and authorization is	Hawaii Region policy on Utilization	
not generally performed for outpatient	Decisions (#6425-502).	
services. A case may be reviewed if an		
extension is requested for pre-	Concurrent review and authorization for	
authorized services.	continued coverage is performed every	
	12 sessions.	
Only licensed physicians can make		
medical necessity denial	Only licensed physicians can make	
determinations. Board certified	medical necessity denial	
physicians from appropriate specialty	determinations. Board certified	
areas are used to assist in making	physicians from appropriate specialty	
determination of medical and clinical	areas are used to assist in making	
appropriateness.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
No step-therapy (aka "fail first")	No step-therapy (aka "fail first")	No step-therapy (aka "fail first")	No issues found.	
protocols are in place. The decision to	protocols are in place. The decision	protocols are in place for both MS and		
implement such a protocol would be	to implement such a protocol would	MH/SUD coverage.	BH parity requirements met.	
made by the Pharmacy & Therapeutics	be made by the Pharmacy &			
Committee and reviewed annually.	Therapeutics Committee and	There is one Kaiser Permanente Hawaii		
	reviewed annually.	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.		

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

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

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

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 preauthorized 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)

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

0% during annual period ending June	areas are used to assist in making	
2018.	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)

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

### 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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
Prescription drug benefits are	Prescription drug benefits are	Prescription drug benefits are	No issues found.
not tiered for Medicaid	not tiered for Medicaid	not tiered for Medicaid	
members.	members.	members.	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) Comparability/Stringency w/ Medical/Surgical Mental Health/Substance Use State Review Explanation and/or Plan (M/S)Disorder (MH/SUD) No issues found. Kaiser Permanente Hawaii Region Kaiser Permanente Hawaii Region (KP) Network admission requirements and is an integrated model of care which (KP) is an integrated model of processes are comparable for M/S and care which provides 97% of KP provides 97% of KP member care via MH/SUD providers. BH parity requirements met. member care via its employed its employed providers and facilities. To augment KP's internal care delivery providers and facilities. To augment KP's internal care system, KP contracts with specialized delivery system, KP contracts service providers, both within and with specialized service providers, outside the State of Hawaii. both within and outside the State of Hawaii. Network admission requirements are comprised of several factors which vary according to the service provider. Network admission requirements are These factors include appropriate comprised of several factors which licensing, accreditation, good standing vary according to the service against government agency listings of provider. These factors include excluded individuals/entities, education, appropriate licensing, accreditation, training, board qualification, good standing against government certification, reference checks, agency listings of excluded background checks, interviews with individuals/entities, education. relevant departments, agreement to training, board qualification, maintain compliance with requirements certification, reference checks. and code of ethics, acceptance of background checks, interviews with offered compensation, and other relevant departments, agreement to factors. maintain compliance with requirements and code of ethics, Initial evaluation of a provider is acceptance of offered compensation, performed by the Provider Relations and other factors. and Contracting representative and/or physician/provider recruiter and/or Initial evaluation of a provider is department physician chief who performed by the Provider Relations reviews the application, checks 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

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

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

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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	State Review
(117.5)	(MH/SUD)	Explanation and of Fran	
Physician evaluates member. If out-of-	Integrated Behavioral Health (IBH)	There are two Kaiser Permanente Hawaii	No issues found.
plan referral appears appropriate,	Call Center receives calls and conducts	Region policies on Utilization Decisions	100 Issues Tourie.
physician completes an order for the	initial screening and triage according	(#6425-502) and Out-of-Plan Requests for	BH parity requirements met.
request.	to established IBH protocol which may	Care and Services (#5054-01-A). Policy	222 purity requirements and
1	result in the following action:	guidance applies to both MS and	
Department Chief receives referral	Appoint member with plan provider	MH/SUD coverage.	
request and performs	within established timeframe	· ·	
evaluation/determination.	guidelines;	Process flow of evaluation and out-of-plan	
	Direct member to a Treatment Team	referral approval/denial tasks are generally	
Medical necessity approval from the	(Adult, Child or Chemical	the same for M/S and MH/SUD coverage.	
Outside Medical Services Medical	Dependency) for an assessment if	Specific operational routing of referral	
Director or other appropriate	member requests out-of-plan (OOP)	request varies between M/S and MH/SUD	
Department Chief /Designee is required	service or meets criteria for OOP	due to the respective member care needs,	
for the following types of referral	referral;	required specialty expertise and differing	
requests:	Direct member to IBH UM	organizational structure within the M/S	
• Requests for services from non-	Coordinator if IBH services are not	and MH/SUD departments. Referral	
credentialed providers;	appropriate for member; or	criteria used in the utilization management	
• Requests for mainland/out of area	If IBH lacks capacity and waiting	of behavioral health out-of- plan referrals	
services;	period for an intake is excessive as	are no more restrictive than the criteria	
• Experimental treatments/therapies;	determined by prudent medical care,	applied to medical/surgical benefits per Federal Mental Health Parity Law.	
• Requests for services where there is	the IBH Call Center practitioner will request an OOP referral approval from	rederal Mental Health Failty Law.	
internal capability;	an IBH physician.		
Requests for transplantation			
services.	IBH physician will make medical		
Medical necessity determination is	necessity determination and refer case		
referred to Authorizations and Referral	to IBH Utilization Management (UM).		
Management (ARM). If medical	If approved, IBH UM reviews referral		
necessity is approved, ARM reviews	request to ensure that referral		
request to ensure that referral	guidelines and criteria are met:		
guidelines and criteria are met:	The requested service is		
• The requested service is certified as	medically necessary;		
medically necessary by	The requested service is a		
Chief/Designee;	covered Health Plan benefit;		
• The service is a covered Health	<ul> <li>The requested service is not</li> </ul>		
Plan benefit;	available within Plan;		
The requested service is not	The service is available within		
available within Plan;	plan but the waiting period is		
	excessive as defined by		

<ul> <li>The patient is an eligible Health Plan member;</li> <li>The patient has benefits available</li> <li>Referral parameters (frequency/duration) are clearly defined; and</li> <li>Selected provider/ practitioner is credentialed or has Letter of Agreement with health plan.</li> <li>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.</li> <li>Only licensed physicians can make medical necessity denial determinations.</li> </ul>	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
In this island State of Hawaii, provider	In this island State of Hawaii, provider	Provider reimbursement rate determination	No issues found.
supply and demand in target	supply and demand in target	is comparable for M/S and MH/SUD	
geographic areas of need is a primary	geographic areas of need is a primary	providers.	BH parity requirements met.
influencer of professional provider	influencer of professional provider		
reimbursement rates for physicians,	reimbursement rates for physicians,		

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

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

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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
There are no exclusions based on	There are no exclusions based on	There are no exclusions based on failure to	No issues found.
failure to complete a course of	failure to complete a course of	complete a course of treatment for both MS	
treatment.	treatment.	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: -0-			
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Prior authorization is not required for	Prior authorization is not required for	Health plan does not require prior	No issues found.
prescription drug coverage by health	prescription drug coverage by health	authorization for prescription drug	

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

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

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

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

	.1	1
	thorony	1
	therapy.	1
	1 3	1

### **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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Prescription drug benefits are not tiered	Prescription drug benefits are not tiered	Prescription drug benefits are not tiered for	No issues found.
for Medicaid members.	for Medicaid members.	Medicaid members.	
			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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(M/S)	Disorder	Explanation and/or Plan		
	(MH/SUD)	-		
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
Assuming the pharmacy provider is	Assuming the pharmacy provider is	Assuming the pharmacy provider is within	No issues found.
within the U.S.A., there are no	within the U.S.A., there are no	the U.S.A., there are no geographic	
geographic limitations on provider	geographic limitations on provider	limitations on M/S and MH/SUD provider	BH parity requirements met.
inclusion.	inclusion.	inclusion.	

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)

Services (#3034-01-A)				
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(M/S)	Disorder	Explanation and/or Plan		
` '	(MH/SUD)	1		
Physician prescriber evaluates member.	Physician prescriber evaluates member.	There are two Kaiser Permanente Hawaii	No issues found.	
If out-of- plan referral appears	If out-of- plan referral appears	Region policies on Utilization Decisions		
appropriate, physician completes an	appropriate, physician completes an	(#6425-502) and Out-of-Plan Requests for	BH parity requirements met.	
order for the request.	order for the request.	Care and Services (#5054-01-A). Policy guidance for out-of-plan pharmacy		
Department Chief receives referral	Department Chief receives referral	utilization applies to both MS and		
request and performs	request and performs	MH/SUD coverage.		
evaluation/determination.	evaluation/determination.			
Medical necessity approval from the	Medical necessity approval from the			
Outside Medical Services Medical	Outside Medical Services Medical			
Director or other appropriate	Director or other appropriate			
Department Chief /Designee is required	Department Chief /Designee is required			
for the following types of referral	for the following types of referral			
requests:	requests:			
<ul> <li>Requests for services from</li> </ul>	<ul> <li>Requests for services from</li> </ul>			
non- credentialed providers;	non- credentialed providers;			
<ul> <li>Requests for mainland/out of</li> </ul>	<ul> <li>Requests for mainland/out of</li> </ul>			
area services;	area services;			
Experimental	Experimental			
treatments/therapies;	treatments/therapies;			
<ul> <li>Requests for services where</li> </ul>	<ul> <li>Requests for services where</li> </ul>			
there is internal capability;	there is internal capability;			

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

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.

Only licensed physicians can make

medical necessity denial

determinations.

List of documents: -0-

medical necessity denial

determinations.

Only licensed physicians can make

	Medical/Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)	Comparability/Stringency w/ Explanation and/or Plan	State Review
N	ot 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	Mental Health/Substance Use	Comparability/Stringency (y/n) w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	-	
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: <u>Lauren.toro@wellcare.com</u>	#: 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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
Since medical necessity review is not	Since medical necessity review is not	Since medical necessity review is not	N/A	
applicable to emergency care, this	applicable to emergency care, this	applicable to emergency care, this section		
section is not applicable	section is not applicable	is not applicable		

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

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

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

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

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

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

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

a. Verify clinical appropriateness	a. Verify clinical appropriateness	a. Verify clinical appropriateness	
b. Ensure drug safety	b. Ensure drug safety	b. Ensure drug safety	
c. Prevent fraud and diversion	c. Prevent fraud and diversion	c. Prevent fraud and diversion	
d. Detect members receiving	d. Detect members receiving	d. Detect members receiving	
duplicate or unnecessary medication	duplicate or unnecessary medication	duplicate or unnecessary medication	
therapies from multiple prescribers	therapies from multiple prescribers	therapies from multiple prescribers	
e. Detect and prevent substance abuse	e. Detect and prevent substance abuse	e. Detect and prevent substance abuse	
f. Allow coverage for medications	f. Allow coverage for medications	f. Allow coverage for medications	
not listed on the PDL	not listed on the PDL	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
There are no network requirements for	There are no network requirements for	There are no network requirements for	N/A
Emergency Care	Emergency Care	Emergency Care	

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

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

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

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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
There are no network requirements for	There are no network requirements for	There are no network requirements for	N/A
Emergency Care	Emergency Care	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	-	
There are no network requirements for	There are no network requirements for	There are no network requirements for	N/A
Emergency Care	Emergency Care	Emergency Care	

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

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

<ul> <li>Benefit restrictions, such as cosmetic procedures.</li> <li>Diagnosis and clinical must be supplied by the facility.</li> <li>Number of days approved are based on diagnosis and member co-morbidities.</li> <li>Concurrent reviews are every 3 days</li> <li>Discharge planning begins on admission</li> </ul>	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.	
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 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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(MS)	(MH/SUD)	and/or Plan		
`Ohana uses quantity limits ("QL") to	`Ohana uses quantity limits ("QL") to	Fail first requirements or step-therapy	Same process used for both M/S	
minimize inappropriate utilization,	minimize inappropriate utilization,	processes between M/S and MH/SUD are	& MH/SUD – no issues with	
waste, and stockpiling of drugs,	waste, and stockpiling of drugs,	identical. Thus, comparability between	parity. May have to have them	
ensuring that quantities supplied are	ensuring that quantities supplied are	M/S and MH/SUD meets parity	clarify use of QLs? Will do	
consistent with Federal Drug	consistent with Federal Drug	requirements.	overall comparison with all	
Administration (FDA) approved	Administration (FDA) approved		health plans first.	
clinical dosing guidelines. `Ohana	clinical dosing guidelines. `Ohana			
also utilizes QL to help prevent billing	also utilizes QL to help prevent billing		BH parity requirements met.	
errors. Requests for exceptions to the	errors. Requests for exceptions to the			
quantity limits listed on the Preferred	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.

- 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	diagnoses, lab values, trial and failure	
to be authorized (e.g., specific	of alternative drug(s), allergic reaction	
diagnoses, lab values, trial and failure	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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(MS)	(MH/SUD)	and/or Plan		
`Ohana uses clinical standards and	`Ohana uses clinical standards and	`Ohana uses clinical standards and	No issues found. Comparison	
guidelines to develop coverage criteria	guidelines to develop coverage criteria	guidelines to develop coverage criteria	was not done; however, the	
that may contain exclusions for certain	that may contain exclusions for certain	that may contain exclusions for certain	process for both M/S and	
drug/products that may require a	drug/products that may require a	drug/products that may require a	MH/SUD are identical.	
qualifying therapy that must be tried	qualifying therapy that must be tried	qualifying therapy that must be tried and		
and failed prior to authorization for the	and failed prior to authorization for the	failed prior to authorization for the	BH parity requirements met.	
drug/product being requested.	drug/product being requested.	drug/product being requested. Coverage		
Coverage criteria is reviewed quarterly	Coverage criteria is reviewed quarterly	criteria is reviewed quarterly during the		
during the Pharmacy and Therapeutics	during the Pharmacy and Therapeutics	Pharmacy and Therapeutics Committee		
Committee meeting.	Committee meeting.	meeting.		

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

skilled nursing services and	<ul> <li>Physical health, and</li> </ul>	
medical practitioner assessment	<ul> <li>School performance</li> </ul>	
daily.	1	
	Discharge planning that includes follow	
Additional days are approved based on	up appointments to the member's	
medical necessity.	primary care physician (PCP) and	
·	therapist(s), community resources	
Discharge planning begins on	needed is also discussed at concurrent	
admission for all Inpatient stays.	reviews to ensure safe transitions upon	
Discharge planning is reviewed as an	completion of treatment.	
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.		
and to prevent re-admissions.		

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

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.				
Medical/Surgical Mental Health/Substance Use Disorder Comparability/Stringency w/			State Review	
(M/S)				

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

# Prescription Drugs

medical necessity.

daily.

skilled nursing services and medical practitioner assessment

Additional days are approved based on

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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(M/S)	(MH/SUD)	and/or Plan		
The selection of which drugs are	The selections of which drugs are	Benefit plan construction processes	No issues found.	
covered use the same criteria for both	covered use the same criteria for both	between M/S and MH/SUD are identical.		
medical and behavioral. The following	medical and behavioral. The following	Thus, comparability between M/S and	BH parity requirements met.	
is a summary of that process:	is a summary of that process:	MH/SUD meets parity requirements.		

Preferred Drug List (PDL) design	Preferred Drug List (PDL) design
including the Rx utilization (UM)	including the Rx utilization (UM)
criteria are based on the following	criteria are based on the following
guiding principles and considerations	guiding principles and considerations
for all therapeutic classes and is	for all therapeutic classes and is
governed by the same standard	governed by the same standard
Pharmacy and Therapeutic (P&T)	Pharmacy and Therapeutic (P&T)
committee.	committee.
a. Verify clinical appropriateness	a. Verify clinical appropriateness
b. Ensure drug safety	b. Ensure drug safety
c. Prevent fraud and diversion	c. Prevent fraud and diversion
d. Detect members receiving	d. Detect members receiving
duplicate or unnecessary medication	duplicate or unnecessary medication
therapies from multiple prescribers	therapies from multiple prescribers
e. Detect and prevent substance	e. Detect and prevent substance
abuse	abuse
f. Allow coverage for medications	f. Allow coverage for medications
not listed on the PDL	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-0	01, C6CR-004, C6CR-009-PR-001		
Medical/Surgical	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(M/S)	(MH/SUD)	and/or Plan	
`Ohana provides contracted networks	`Ohana provides contracted networks	Network admission processes between	No issues found.
of qualified organizational health care	of qualified organizational health care	M/S and MH/SUD are identical. Thus,	
providers, and home and community-	providers, and community based case	comparability between M/S and MH/SUD	BH parity requirements met.
based service providers (as applicable	management providers (as applicable	meets parity requirements.	
to state) to the enrolled membership in	to state) to the enrolled membership in		
its Plan. `Ohana performs initial and	its Plan. `Ohana performs initial and		
ongoing assessments of its	ongoing assessments of its		
organizational providers in compliance	organizational providers in compliance		
with applicable local, state, and federal	with applicable local, state, and federal		
accreditation requirements.	accreditation requirements.		
Information and documentation on	Information and documentation on		
organizational providers is collected,	organizational providers is collected,		
verified, reviewed, and evaluated in	verified, reviewed, and evaluated in		

order t	to achieve a decision to approve	order to achieve a decision to approve
or den	ny network participation.	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-0	List of documents: C6CR-009, C6CR-001 C6CR-004, C6CR-009-PR-001				
Medical/Surgical	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review		
(M/S)	(MH/SUD)	and/or Plan			
Practitioner types, facility types, or	Practitioner types, facility types, or	Practitioner types, facility types, or	No issues found.		
specialty providers are not excluded in	specialty providers are not excluded in	specialty providers are not excluded			
writing or in operation from providing	writing or in operation from providing	whether M/S or MH/SUD providers.	BH parity requirements met.		
covered benefits if they meet the	covered benefits if they meet the	Thus, comparability between M/S and			
criteria outlined in the assessment	criteria outlined in the assessment	MH/SUD meets parity requirements.			
policies noted above.	policies noted above				

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

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

benefit plan design dictates how	benefit plan design dictates how	
members can access out of network	members can access out of network	
benefits.	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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(M/S)	(MH/SUD)	and/or Plan		
`Ohana utilizes the outpatient fee	`Ohana utilizes the outpatient fee	Reimbursement rate amounts are set by	No issues found.	
schedule prescribed by the State for	schedule prescribed by the State for	the State. Thus, comparability between		
reimbursing outpatient providers.	reimbursing outpatient providers.	M/S and MH/SUD meets parity	BH parity requirements met.	
Providers are reimbursed at 100% of	Providers are reimbursed at 100% of	requirements		
the State's fee schedule unless there is	the State's fee schedule unless there is			
a geographic or provider availability	a geographic or provider availability			
issue that requires a higher percentage	issue that requires a higher percentage			
of the State's fee schedule.	of the State's fee schedule.			

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

t requires a higher percentage of the that requires a higher percentage of the	
te's fee schedule. State's fee schedule.	

## **OUTPATIENT**

Health Plan: CCS		Date: 8/3/2018
Contact Person: Lauren Toro	Email: <u>Lauren.toro@wellcare.com</u>	#: 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 comorbidities 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	Utilization Management sends a fax regarding authorization or calls the
requested via fax, web portal, phone	provider to request further information.
or/and state portals from the provider.	For substance abuse outpatient services,
If there is a concern that an	`Ohana uses industry accepted medical
authorization does not meet medical	criteria and `Ohana Clinical Coverage
necessity, we offer a peer to peer	guidelines for criteria review. Examples
review and we will send for a	of applied criteria include:
secondary review by a Medical	Acute Intoxication and
Director.	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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(MS)	(MH/SUD)	and/or Plan		
`Ohana uses quantity limits ("QL") to	`Ohana uses quantity limits ("QL") to	Fail first requirements or step-therapy	Same process used for both M/S	
minimize inappropriate utilization,	minimize inappropriate utilization,	processes between M/S and MH/SUD are	& MH/SUD – no issues with	
waste, and stockpiling of drugs,	waste, and stockpiling of drugs,	identical. Thus, comparability between	parity. May have to have them	
ensuring that quantities supplied are	ensuring that quantities supplied are	M/S and MH/SUD meets parity	clarify use of QLs? Will do	
consistent with Federal Drug	consistent with Federal Drug	requirements.	overall comparison with all	
Administration (FDA) approved	Administration (FDA) approved		health plans first.	
clinical dosing guidelines. `Ohana	clinical dosing guidelines. `Ohana			
also utilizes QL to help prevent billing	also utilizes QL to help prevent billing		BH parity requirements met.	
errors. Requests for exceptions to the	errors. Requests for exceptions to the			
quantity limits listed on the Preferred	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.

- 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	
to be authorized (e.g., specific	diagnoses, lab values, trial and failure	
diagnoses, lab values, trial and failure	of alternative drug(s), allergic reaction	
of alternative drug(s), allergic reaction	to preferred product, etc.).	
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(MS)	(MH/SUD)	and/or Plan		
`Ohana uses clinical standards and	`Ohana uses clinical standards and	`Ohana uses clinical standards and	No issues found. Comparison	
guidelines to develop coverage criteria	guidelines to develop coverage criteria	guidelines to develop coverage criteria	was not done; however, the	
that may contain exclusions for certain	that may contain exclusions for certain	that may contain exclusions for certain	process for both M/S and	
drug/products that may require a	drug/products that may require a	drug/products that may require a	MH/SUD are identical.	
qualifying therapy that must be tried	qualifying therapy that must be tried	qualifying therapy that must be tried and		
and failed prior to authorization for the	and failed prior to authorization for the	failed prior to authorization for the	BH parity requirements met.	
drug/product being requested.	drug/product being requested.	drug/product being requested. Coverage		
Coverage criteria is reviewed quarterly	Coverage criteria is reviewed quarterly	criteria is reviewed quarterly during the		
during the Pharmacy and Therapeutics	during the Pharmacy and Therapeutics	Pharmacy and Therapeutics Committee		
Committee meeting.	Committee meeting.	meeting.		

### **Prior Authorization**

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

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

review with the provider.
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## 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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(M/S)	(MH/SUD)	and/or Plan	

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

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

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

#### Prescription Drugs

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

Pharmacy and Therapeutic (P&T)	Pharmacy and Therapeutic (P&T)	
committee.	committee.	
a. Verify clinical appropriateness	a. Verify clinical appropriateness	
b. Ensure drug safety	b. Ensure drug safety	
c. Prevent fraud and diversion	c. Prevent fraud and diversion	
d. Detect members receiving	d. Detect members receiving	
duplicate or unnecessary medication	duplicate or unnecessary medication	
therapies from multiple prescribers	therapies from multiple prescribers	
e. Detect and prevent substance	e. Detect and prevent substance	
abuse	abuse	
f. Allow coverage for medications	f. Allow coverage for medications	
not listed on the PDL	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-0	List of documents: C6CR-009, C6CR-001, C6CR-004, C6CR-009-PR-001			
Medical/Surgical	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(M/S)	(MH/SUD)	and/or Plan		
`Ohana provides contracted networks	`Ohana provides contracted networks	Network admission processes between	No issues found.	
of qualified organizational health care	of qualified organizational health care	M/S and MH/SUD are identical. Thus,		
providers, and home and community-	providers, and community based case	comparability between M/S and MH/SUD	BH parity requirements met.	
based service providers (as applicable	management providers (as applicable	meets parity requirements.		
to state) to the enrolled membership in	to state) to the enrolled membership in			
its Plan. `Ohana performs initial and	its Plan. `Ohana performs initial and			
ongoing assessments of its	ongoing assessments of its			
organizational providers in compliance	organizational providers in compliance			
with applicable local, state, and federal	with applicable local, state, and federal			
accreditation requirements.	accreditation requirements.			
Information and documentation on	Information and documentation on			
organizational providers is collected,	organizational providers is collected,			
verified, reviewed, and evaluated in	verified, reviewed, and evaluated in			
order to achieve a decision to approve	order to achieve a decision to approve			
or deny network participation.	or deny network participation.			

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

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

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

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

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

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

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

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.

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

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

T: 4 C 1		
List of documents:		
Elst of documents.		

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

a. Verify clinical appropriateness	a. Verify clinical appropriateness
b. Ensure drug safety	b. Ensure drug safety
c. Prevent fraud and diversion	c. Prevent fraud and diversion
d. Detect members receiving	d. Detect members receiving
duplicate or unnecessary medication	duplicate or unnecessary medication
therapies from multiple prescribers	therapies from multiple prescribers
e. Detect and prevent substance	e. Detect and prevent substance
abuse	abuse
f. Allow coverage for medications	f. Allow coverage for medications
not listed on the PDL	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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(M/S)	(MH/SUD)	and/or Plan	
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review		
(M/S)	(MH/SUD)	and/or Plan			
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(M/S)	(MH/SUD)	and/or Plan	
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review		
(M/S)	(MH/SUD)	and/or Plan			
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(M/S)	(MH/SUD)	and/or Plan	
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	Mental Health/Substance Use Disorder	Comparability/Stringency (y/n) w/	State Review
(M/S)	(MH/SUD)	Explanation and/or Plan	
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:	<u>Lauren.toro@wellcare.com</u>	#:	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
Since medical necessity review is not	Since medical necessity review is not	Since medical necessity review is not	N/A
applicable to emergency care, this	applicable to emergency care, this	applicable to emergency care, this section	
section is not applicable	section is not applicable	is not applicable	

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

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

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

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

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

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

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

a. Verify clinical appropriateness	a. Verify clinical appropriateness	a. Verify clinical appropriateness	
b. Ensure drug safety	b. Ensure drug safety	b. Ensure drug safety	
c. Prevent fraud and diversion	c. Prevent fraud and diversion	c. Prevent fraud and diversion	
d. Detect members receiving	d. Detect members receiving	d. Detect members receiving	
duplicate or unnecessary medication	duplicate or unnecessary medication	duplicate or unnecessary medication	
therapies from multiple prescribers	therapies from multiple prescribers	therapies from multiple prescribers	
e. Detect and prevent substance abuse	e. Detect and prevent substance abuse	e. Detect and prevent substance abuse	
f. Allow coverage for medications	f. Allow coverage for medications	f. Allow coverage for medications	
not listed on the PDL	not listed on the PDL	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
There are no network requirements for	There are no network requirements for	There are no network requirements for	N/A
Emergency Care	Emergency Care	Emergency Care	

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

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

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

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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(M/S)	Disorder	Explanation and/or Plan		
	(MH/SUD)	_		
There are no network requirements for	There are no network requirements for	There are no network requirements for	N/A	
Emergency Care	Emergency Care	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	-	
There are no network requirements for	There are no network requirements for	There are no network requirements for	N/A
Emergency Care	Emergency Care	Emergency Care	

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

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

<ul> <li>Number of days approved are based on diagnosis and member co-morbidities.</li> <li>Concurrent reviews are every 3 days</li> <li>Discharge planning begins on admission</li> </ul>	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.	
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	
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	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.	
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 F	Policy C20RX-150 Preferred Drug List		
Medical/Surgical	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(MS)	(MH/SUD)	and/or Plan	
`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	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	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.
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	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		Dir 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.

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

#### **Prior Authorization**

List of documents, C7LM 4.12, C7LM 4.12 DD 001

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: C/UM 4.12; C/UM-4	1.12 PR-001		
Medical/Surgical	Mental Health/Substance Use Disorder	Comparability/Stringency w/	State Review
(M/S)	(MH/SUD)	Explanation and/or Plan	
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/	State Review
(M/S)	(MH/SUD)	Explanation and/or Plan	
Concurrent review is not done	For facility contracts on a per diem	Concurrent review is done for all M/S	No issues found.
selectively; it is performed for all	(contracted by the day for all	and MH/SUD inpatient stays.	
inpatient stays to determine medical	diagnoses), concurrent reviews are not	Concurrent review is done to ensure	BH parity requirements met.
necessity of continued length of stay in	done selectively. They are performed	medical necessity for continued stays is	
addition to prepare for discharge	for BH Inpatient admissions to	met. The frequency of the review is	
planning.	determine the medical necessity of	based on the contract type: DRG (every	
Continued stays are reviewed every 3 –	continued stay, in addition to ensuring	3-5 days) vs. per diem contracts (every 2-	
5 days using Industry accepted Medical	safe transitions upon completion of	3 days). Comparability between M/S	
criteria and based on clinical	treatment for our member. Due to the	and MH/SUD meets parity requirements.	
complexity for the services requested.	per diem nature of these contracts,		
Each service requires clinical	concurrent reviews for BH Inpatient		
information to review for medical	admissions are completed, on average,		
necessity for the continued stay.	every 2-3 days and are based on		
Examples include:	medical necessity. Additional days are		
• Inpatient Hospital stay: What is	approved based on medical necessity.		
the treatment plan currently for	Many of medical necessity criteria		
the Inpatient stay?	points reflect symptomatology and		
Skilled Nursing Facility: What	treatment within the last 24 to 72 hours.		
was the Prior level of function	The criteria in this classification is used		
prior to the Inpatient hospital	to assess		
stay?	<ul> <li>Presenting problems,</li> </ul>		
• Inpatient Rehabilitation: Is the	<ul> <li>How long the patient has been</li> </ul>		
Member capable of tolerating 3	having difficulties,		
hours of skilled therapy, at least	<ul> <li>Interventions previously</li> </ul>		
5 days a week?	attempted,		
Long Acute Care: Member	<ul> <li>Social support</li> </ul>		
requires 6.5 hours/24 hours of	<ul> <li>Physical health, and</li> </ul>		
skilled nursing services and	<ul><li>School performance</li></ul>		
medical practitioner assessment	5 School performance		
daily.			

	Discharge planning that includes follow	
Additional days are approved based on	up appointments to the member's	
medical necessity.	primary care physician (PCP) and	
	therapist(s), community resources	
Discharge planning begins on	needed is also discussed at concurrent	
admission for all Inpatient stays.	reviews to ensure safe transitions upon	
Discharge planning is reviewed as an	completion of treatment.	
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.		

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

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

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?	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	Comparability between M/S and MH/SUD meets parity requirements.	
<ul> <li>Skilled Nursing Facility: What was the Prior level of function prior to the Inpatient hospital stay?</li> <li>Inpatient Rehabilitation: Is the Member capable of tolerating 3 hours of skilled therapy, at least 5 days a week?</li> <li>Long Acute Care: Member requires 6.5 hours/24 hours of skilled nursing services and medical practitioner assessment daily.</li> <li>Additional days are approved based on medical necessity.</li> </ul>	<ul> <li>Presenting problems,</li> <li>How long the patient has been having difficulties,</li> <li>Interventions previously attempted,</li> <li>Social support</li> <li>Physical health, and</li> <li>School performance</li> </ul>		

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

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

# <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.

List of documents: C6CR-009, C6CR-001, C6CR-004, C6CR-009-PR-001				
Medical/Surgical	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(M/S)	(MH/SUD)	and/or Plan		
`Ohana provides contracted networks	`Ohana provides contracted networks	Network admission processes between	No issues found.	
of qualified organizational health care	of qualified organizational health care	M/S and MH/SUD are identical. Thus,		
providers, and home and community-	providers, and community based case	comparability between M/S and MH/SUD	BH parity requirements met.	
based service providers (as applicable	management providers (as applicable	meets parity requirements.		
to state) to the enrolled membership in	to state) to the enrolled membership in			
its Plan. `Ohana performs initial and	its Plan. `Ohana performs initial and			
ongoing assessments of its	ongoing assessments of its			
organizational providers in compliance	organizational providers in compliance			
with applicable local, state, and federal	with applicable local, state, and federal			
accreditation requirements.	accreditation requirements.			
Information and documentation on	Information and documentation on			
organizational providers is collected,	organizational providers is collected,			
verified, reviewed, and evaluated in	verified, reviewed, and evaluated in			
order to achieve a decision to approve	order to achieve a decision to approve			
or deny network participation.	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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(M/S)	(MH/SUD)	and/or Plan		
Practitioner types, facility types, or	Practitioner types, facility types, or	Practitioner types, facility types, or	No issues found.	
specialty providers are not excluded in	specialty providers are not excluded in	specialty providers are not excluded		
writing or in operation from providing	writing or in operation from providing	whether M/S or MH/SUD providers.	BH parity requirements met.	
covered benefits if they meet the	covered benefits if they meet the	Thus, comparability between M/S and		
criteria outlined in the assessment	criteria outlined in the assessment	MH/SUD meets parity requirements.		
policies noted above.	policies noted above			

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

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

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

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

t requires a higher percentage of the that requires a higher percentage of the
te's fee schedule. State's fee schedule.

## **OUTPATIENT**

Health Plan: QI		Date: 8/3/2018
Contact Person: Lauren Toro	Email: <u>Lauren.toro@wellcare.com</u>	#: 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 comorbidities 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	Utilization Management sends a fax regarding authorization or calls the
requested via fax, web portal, phone	provider to request further information.
or/and state portals from the provider.	For substance abuse outpatient services,
If there is a concern that an	`Ohana uses industry accepted medical
authorization does not meet medical	criteria and `Ohana Clinical Coverage
necessity, we offer a peer to peer	guidelines for criteria review. Examples
review and we will send for a	of applied criteria include:
secondary review by a Medical	Acute Intoxication and
Director.	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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(MS)	(MH/SUD)	and/or Plan		
`Ohana uses quantity limits ("QL") to	`Ohana uses quantity limits ("QL") to	Fail first requirements or step-therapy	Same process used for both M/S	
minimize inappropriate utilization,	minimize inappropriate utilization,	processes between M/S and MH/SUD are	& MH/SUD – no issues with	
waste, and stockpiling of drugs,	waste, and stockpiling of drugs,	identical. Thus, comparability between	parity. May have to have them	
ensuring that quantities supplied are	ensuring that quantities supplied are	M/S and MH/SUD meets parity	clarify use of QLs? Will do	
consistent with Federal Drug	consistent with Federal Drug	requirements.	overall comparison with all	
Administration (FDA) approved	Administration (FDA) approved		health plans first.	
clinical dosing guidelines. `Ohana	clinical dosing guidelines. `Ohana			
also utilizes QL to help prevent billing	also utilizes QL to help prevent billing		BH parity requirements met.	
errors. Requests for exceptions to the	errors. Requests for exceptions to the			
quantity limits listed on the Preferred	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.

- 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	
to be authorized (e.g., specific	diagnoses, lab values, trial and failure	
diagnoses, lab values, trial and failure	of alternative drug(s), allergic reaction	
of alternative drug(s), allergic reaction	to preferred product, etc.).	
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(MS)	(MH/SUD)	and/or Plan		
`Ohana uses clinical standards and	`Ohana uses clinical standards and	`Ohana uses clinical standards and	No issues found. Comparison	
guidelines to develop coverage criteria	guidelines to develop coverage criteria	guidelines to develop coverage criteria	was not done; however, the	
that may contain exclusions for certain	that may contain exclusions for certain	that may contain exclusions for certain	process for both M/S and	
drug/products that may require a	drug/products that may require a	drug/products that may require a	MH/SUD are identical.	
qualifying therapy that must be tried	qualifying therapy that must be tried	qualifying therapy that must be tried and		
and failed prior to authorization for the	and failed prior to authorization for the	failed prior to authorization for the	BH parity requirements met.	
drug/product being requested.	drug/product being requested.	drug/product being requested. Coverage		
Coverage criteria is reviewed quarterly	Coverage criteria is reviewed quarterly	criteria is reviewed quarterly during the		
during the Pharmacy and Therapeutics	during the Pharmacy and Therapeutics	Pharmacy and Therapeutics Committee		
Committee meeting.	Committee meeting.	meeting.		

### **Prior Authorization**

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

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,	
choose to refer their stagnant patients to another therapist. Even though extended therapy is not always beneficial, many	
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(M/S)	(MH/SUD)	and/or Plan	

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

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

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

#### Prescription Drugs

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

Pharmacy and Therapeutic (P&T)	Pharmacy and Therapeutic (P&T)	
committee.	committee.	
a. Verify clinical appropriateness	a. Verify clinical appropriateness	
b. Ensure drug safety	b. Ensure drug safety	
c. Prevent fraud and diversion	c. Prevent fraud and diversion	
d. Detect members receiving	d. Detect members receiving	
duplicate or unnecessary medication	duplicate or unnecessary medication	
therapies from multiple prescribers	therapies from multiple prescribers	
e. Detect and prevent substance	e. Detect and prevent substance	
abuse	abuse	
f. Allow coverage for medications	f. Allow coverage for medications	
not listed on the PDL	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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(M/S)	(MH/SUD)	and/or Plan	
`Ohana provides contracted networks	`Ohana provides contracted networks	Network admission processes between	No issues found.
of qualified organizational health care	of qualified organizational health care	M/S and MH/SUD are identical. Thus,	
providers, and home and community-	providers, and community based case	comparability between M/S and MH/SUD	BH parity requirements met.
based service providers (as applicable	management providers (as applicable	meets parity requirements.	
to state) to the enrolled membership in	to state) to the enrolled membership in		
its Plan. `Ohana performs initial and	its Plan. `Ohana performs initial and		
ongoing assessments of its	ongoing assessments of its		
organizational providers in compliance	organizational providers in compliance		
with applicable local, state, and federal	with applicable local, state, and federal		
accreditation requirements.	accreditation requirements.		
Information and documentation on	Information and documentation on		
organizational providers is collected,	organizational providers is collected,		
verified, reviewed, and evaluated in	verified, reviewed, and evaluated in		
order to achieve a decision to approve	order to achieve a decision to approve		
or deny network participation.	or deny network participation.		

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

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

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

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

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

### PRESCRIPTION DRUGS

Health Plan: QI		Date: 8/3/2018
Contact Person: Lauren Toro	Email: <u>Lauren.toro@wellcare.com</u>	#: 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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(MS)	(MH/SUD)	and/or Plan	
Medical Necessity Criteria	Medical Necessity Criteria	N/A	N/A
Development is not applicable to	Development is not applicable to		
Prescription Drugs	Prescription Drugs		

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

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

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

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List of documents:		
Elst of documents.		

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

a. Verify clinical appropriateness	a. Verify clinical appropriateness
b. Ensure drug safety	b. Ensure drug safety
c. Prevent fraud and diversion	c. Prevent fraud and diversion
d. Detect members receiving	d. Detect members receiving
duplicate or unnecessary medication	duplicate or unnecessary medication
therapies from multiple prescribers	therapies from multiple prescribers
e. Detect and prevent substance	e. Detect and prevent substance
abuse	abuse
f. Allow coverage for medications	f. Allow coverage for medications
not listed on the PDL	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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(M/S)	(MH/SUD)	and/or Plan	
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(M/S)	(MH/SUD)	and/or Plan		
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review
(M/S)	(MH/SUD)	and/or Plan	
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(M/S)	(MH/SUD)	and/or Plan		
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	Mental Health/Substance Use Disorder	Comparability/Stringency w/ Explanation	State Review	
(M/S)	(MH/SUD)	and/or Plan		
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	Mental Health/Substance Use Disorder	Comparability/Stringency (y/n) w/	State Review	
(M/S)	(MH/SUD)	Explanation and/or Plan		
N/A for prescription NQTL	N/A for prescription NQTL	N/A for prescription NQTL	N/A	

### **EMERGENCY CARE**

Health Plan:UnitedHealthcare Community PlanDate:August 2, 2018Contact Person:Jocelyn Tafao#: 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



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

(A) Effectiveness is determined first	(A) Effectiveness is determined first	
by scientific evidence;	by scientific evidence;	
(B) If no scientific evidence exists,	(B) If no scientific evidence exists,	
then by professional standards of care;	then by professional standards of care;	
and	and	
(C) If no professional standards of care	(C) If no professional standards of care	
exist or if they exist but are outdated	exist or if they exist but are outdated	
or	or	
contradictory, then by expert opinion;	contradictory, then by expert opinion;	
and	and	
(4) Cost-effective for the medical	(4) Cost-effective for the medical	
condition being treated compared to	condition being treated compared to	
alternative health interventions,	alternative health interventions,	
including no intervention. For	including no intervention. For	
purposes of this paragraph, cost	purposes of this paragraph, cost	
effective shall not necessarily mean	effective shall not necessarily mean	
the lowest price."	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
Emergency Services do not require	Emergency Services do not require	NA	N/A
Prior Authorization.	Prior Authorization.		

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

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

### **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 PN-1003-Policy-Availa PN-1078-Policy-Select credentialing Process. bility GeoAccess\_1122 ion and Retention\_112

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

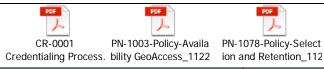
mix, and geographic distribution of providers of covered services.

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



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-Availa PN-1078-Policy-Select bility GeoAccess\_1122 ion 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	UnitedHealthcare does not impose or have any geographic limitations on	Same rules apply for both S/M and MH/SUD therefore comparable.	No issues found.
provider inclusions.	provider inclusions.		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-Availa PN-1078-Policy-Select bility GeoAccess\_1122 ion and Retention\_112

Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
UnitedHealthcare provides access to	UnitedHealthcare provides access to	Same rules apply for both S/M and	No issues found.
Out of Network (OON) providers	Out of Network (OON) providers	MH/SUD therefore comparable.	
(non-contracted providers) if an in-	(non-contracted providers) if an in-		BH parity requirements met.
network provider is unable to provide	network provider is unable to provide		
medically necessary services in an	medically necessary services in an		
adequate and timely manner to a	adequate and timely manner to a		
member and continue to authorize the	member and continue to authorize the		
use of non-contract providers for as	use of non-contract providers for as		
long as UnitedHealthcare is unable to	long as UnitedHealthcare is unable to		
provide services through network	provide services through network		
providers. UnitedHealthcare requires	providers. UnitedHealthcare requires		
prior authorization approval for OON	prior authorization approval for OON		
providers prior to rendering the	providers prior to rendering the		
service.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
UnitedHealthcare's Medicaid Fee	UnitedHealthcare's Medicaid Fee	Same process is applied for both M/S and	No issues found.
Schedule is developed using the	Schedule is developed using the	MH/SUD therefore comparable.	
State's Medicaid Fee Schedule with	State's Medicaid Fee Schedule with		BH parity requirements met.
alignment using Medicare relatively.	alignment using Medicare relatively.		
Where the fee source does not publish	Where the fee source does not publish		
a specific fee amount,	a specific fee amount,		
UnitedHealthcare will use the CMS	UnitedHealthcare will use the CMS		
Gap fill using a % of prevailing	Gap fill using a % of prevailing		
Medicare.	Medicare.		
UnitedHealthcare will use reasonable	UnitedHealthcare will use reasonable		
commercial efforts to implement the	commercial efforts to implement the		

updates in its systems on or before the	updates in its systems on or before the	
later of (i) 90 days after the effective	later of (i) 90 days after the effective	
date of any modification made by the	date of any modification made by the	
Fee Source or (ii) 90 days after the	Fee Source or (ii) 90 days after the	
date on which the Fee Source initially	date on which the Fee Source initially	
places information regarding such	places information regarding such	
modification in the public domain (for	modification in the public domain (for	
example, when CMS distributes	example, when CMS distributes	
program memoranda to providers).	program memoranda to providers).	
UnitedHealthcare will make the	UnitedHealthcare will make the	
updates effective in its system on the	updates effective in its system on the	
effective date of the change by the Fee	effective date of the change by the Fee	
Source. However, claims already	Source. However, claims already	
processed prior to the change being	processed prior to the change being	
implemented by UnitedHealthcare will	implemented by UnitedHealthcare will	
not be reprocessed unless otherwise	not be reprocessed unless otherwise	
required by law.	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	Mental Health/Substance Use	Comparability/Stringency (y/n) w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
Professional provider reimbursement	Professional provider reimbursement	Same process is applied for both M/S and	No issues found.
rates do not vary based on the factors	rates do not vary based on the factors	MH/SUD therefore comparable.	
listed above. In limited instances	listed above. In limited instances		BH parity requirements met.
variations can occur based on	variations can occur based on		
availability of certain limited specialty	availability of certain limited specialty		
services in Hawaii.	services in Hawaii.		

## **INPATIENT**

Health Plan: UnitedHealthcare Community Plan Date: August 2, 2018 Contact Person: Jocelyn Tafao #: 808-535-1058 Email: <u>Jocelyn\_tafao@uhc.com</u>

# 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-Clinic UM-1011-Policy-Prior- BH Standard Level of 2018 Optum al\_Review\_Criteria.pd Authorization.pdf Care Guidelines (0518 Behavioral UM Program

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

List of documents:				
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review	
(MS)	Disorder (MH/SUD)	Explanation and/or Plan		
MCG would be used to identify any	There are no first requirements or step	The MH/SUD process is not more	No issues found.	
criteria that would correlate between	therapies for inpatient	stringent than the M/S.		
the member's diagnoses and failure of	hospitalization. Member must meet the		BH parity requirements met.	
outpatient treatment. Application of a	medical necessity criteria for inpatient			
"fail first" or "step therapy"	admission.			
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.				

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

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

#### **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



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 not required for emergent admissions into an inpatient facility. Notification of the admission (emergent/non-emergent) is required. Subsequent concurrent reviews are conducted.	UnitedHealthcare applies the same prior authorization process for both M/S and MH/SUD.	No issues found.  BH parity requirements met.
Prior authorization is required for non- emergent admissions with subsequent concurrent reviews conducted by UnitedHealthcare.	Prior authorization is required for non- emergent admissions with subsequent concurrent reviews conducted by UnitedHealthcare.		

# **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 2018 Optum BH Standard Level of al\_Review\_Criteria.pd Behavioral UM Prograr Care Guidelines (0518

al_Review_Criteria.pu Beriaviorai divi Prograf Care	Guidelines (0310		
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Inpatient review is a component of the	Concurrent Review is conducted on all	The same process is applied for both the	No issues found.
medical plan's utilization management	acute inpatient admissions following	M/S and MH/SUD when performing	
activities. The Medical Director and	the initial authorization periods for	concurrent reviews that focuses on	BH parity requirements met.
other clinical staff review	admissions which require extension	promoting delivery of care that will	
hospitalizations to detect and better	beyond those initial covered days. The	promote efficient execution of the	
manage over- and under-utilization	factors that are explored in the	member's treatment plan based on medical	
and to determine whether the	decision, in addition to establishing	necessity. As such, the factors considered	
admission and continued stay are	that the member continues to meet the	for concurrent review and standards used	
consistent with the member's	medical necessity criteria established in	are similar and therefore the M/S and	
coverage, medically appropriate and	the level of care guidelines, is that the	MH/SUD inpatient processes are	
consistent with evidence-based	member continues to benefit from	comparable.	
guidelines.	treatment, that treatment is progressive		
Inpatient review also gives the plan	and cannot be provided at a lower level		
the opportunity to contribute to	of care, and that the treatment is		
decisions about discharge planning	appropriate to the member's clinical		
and case management. In addition, the plan may identify opportunities for	needs and necessary for continued improvement.		
quality improvement and cases that	improvement.		
are appropriate for referral to one of			
our disease management programs.			
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.		
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.		
<ul> <li>Participating facilities are required to</li> </ul>		
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).		
<ul> <li>Participating facilities must</li> </ul>		
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.		
A11 (* 1 * 2 * )		
All national inpatient care managers		
are Registered Nurses with an		
unencumbered license in the state that		
they are conducting medical necessity		
review.	<u> </u>	

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 2018 Optum al\_Review\_Criteria.pdi 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 <sup>TM</sup> 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 <sup>TM</sup> 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.	(MH/SUD)  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.

|--|

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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	1	
The Inpatient Care Manager prioritizes	Concurrent reviews are conducted	The M/S and MH/SUD processes for	No issues found.
and reviews criteria for all inpatient	approximately every 3 days on average	concurrent review including frequency are	
admissions based on medical necessity	for this level of care.	very similar and therefore considered	BH parity requirements met.
and non-medical necessity agreements.		comparable. Given the nature of some	
The ICM reviews the clinical		M/S inpatient stays (e.g.	
associated with the inpatient case and		ICU/CCU/NICU/PICU) a more frequent	
uses the priority review guide as		concurrent review may occur than the	
guidance for frequency of review.		average review frequency in a MH/SUD	
Level of care for medical necessity		inpatient stay.	
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.		

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

# **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







PN-1003-Policy-Availa PN-1078-Policy-Select Credentialing Process. bility GeoAccess 1122 ion and Retention 112

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



PN-1003-Policy-Availa PN-1078-Policy-Select Credentialing Process. bility GeoAccess\_1122 ion and Retention\_112

Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
UnitedHealthcare does not exclude	UnitedHealthcare does not exclude	Same process is applied for both M/S and	No issues found.
any provider types however we may	any provider types however we may	MH/SUD and therefore comparable.	
exclude a provider based on the	exclude a provider based on the		BH parity requirements met.
credentialing criteria.	credentialing criteria.		
UnitedHealthcare complies with state	UnitedHealthcare complies with state		
licensing requirements and if there is a	licensing requirements and if there is a		
practitioner type who is eligible a	practitioner type who is eligible a		
contract will be offered. All	contract will be offered. All		
applicable providers must meet the	applicable providers must meet the		
requirements of our credentialing	requirements of our credentialing		
requirements.	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-Availa PN-1078-Policy-Select bility GeoAccess\_1122 ion and Retention\_112

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

	(MH/SUD)		
UnitedHealthcare does not impose or	UnitedHealthcare does not impose or	Same process is applied for both M/S and	No issues found.
have any geographic limitations on	have any geographic limitations on	MH/SUD and therefore comparable.	
provider inclusions.	provider inclusions.		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-Availa PN-1078-Policy-Select bility GeoAccess\_1122 ion and Retention\_112

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

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

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

## **OUTPATIENT**

Health Plan:UnitedHealthcare Community PlanDate:August 2, 2018Contact Person:Jocelyn TafaoEmail: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-Clinic UM-1011-Policy-Prior- BH Standard Level of 2018 Optum

al_Review_Criteria.pd Authorization.pdf Care Guidelines (0518 Behavioral UM Program			
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
As defined in the Hawaii Revised	As defined in the Hawaii Revised Statutes	UnitedHealthcare uses evidenced based,	No issues found.
Statutes ("HRS") 432e-1.4, the	("HRS") 432e-1.4, the following	peer reviewed, industry standards to	
following components are taken into	components are taken into consideration:	determine the criteria for medical	BH parity requirements met.
consideration: "A health intervention	"A health intervention is medically	necessity for both M/S and MH/SUD and	
is medically necessary if it is	necessary if it is recommended by the	therefore the medical necessity criteria	
recommended by the treating	treating physician or treating licensed	used for M/S and MH/SUD are	
physician or treating licensed health	health care provider, is approved by the	effectively comparable.	
care provider, is approved by the	health plan's medical director		
health plan's medical director	or physician designee, and is:		
or physician designee, and is:	(1) For the purpose of treating a medical		
(1) For the purpose of treating a	condition;		
medical condition;	(2) The most appropriate delivery or level		
(2) The most appropriate delivery or	of service, considering potential benefits		
level of service, considering potential	and harms to the patient;		
benefits and harms to the patient;	(3) Known to be effective in improving		
(3) Known to be effective in	health outcomes; provided that:		
improving health outcomes; provided	(A) Effectiveness is determined first by		
that:	scientific evidence;		

- (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 sore may be soreidered	determine when utilization management	
standards of care may be considered.	determine when utilization management	
UnitedHealthcare reserves the right to	techniques should be best applied is based	
consult expert opinions in	on the scope of methodologies that are	
determining whether health care	used by the medical portion of the plan.	
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.

List of documents:			
Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
MCG would be used to identify any	There are no first requirements or step	The MH/SUD process is not more	No issues found.
criteria that would correlate between	therapies for outpatient services. The	stringent than the M/S.	
the member's diagnoses and failure of	member must meet the medical		BH parity requirements met.
outpatient treatment. Application of a	necessity criteria for the requested		
"fail first" or "step therapy"	level of OP services.		
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.		

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

#### **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	Prior authorization is required for	
authorization provided by a non-	non-routine OP services, OP	
participating provider without prior	methadone maintenance treatment,	
	1	
authorization (excluding as noted above	Intensive Outpatient Programming,	
emergent/stabilization/women's health	and Partial Hospitalization. Prior	
services).	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-Clinic 2018 Optum al\_Review\_Criteria.pd Behavioral UM Program

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

visits •Treatment durations ranging	to meet the medical necessity criteria	
from 1-365+ days, with the likelihood	established in the level of care	
for treatment being medically	guidelines, is that the member	
unnecessary increasing with longer	continues to benefit from treatment,	
treatment durations	that treatment is progressive and	
•Visits including multiple units of	cannot be provided at a lower level of	
services, with the likelihood for	care, and that the treatment is	
treatment being medically unnecessary	appropriate to the member's clinical	
increasing with higher number of	needs and necessary for continued	
services per visit	improvement.	
•Potential to bill for the same service		
using multiple levels of coding		
•Relatively low/modest cost per		
service		
<ul> <li>Variable rates of patient progress</li> </ul>		
during a treatment plan		
<ul> <li>Variable approaches to patient care</li> </ul>		
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		
<ul> <li>Identified cases are clinically</li> </ul>		
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 PDF PDF UM-1061-Policy-Clinic UM-1011-Policy-Prior-2018 Optum al\_Review\_Criteria.pd Authorization.pdf Behavioral UM Prograr Mental Health/Substance Use Comparability/Stringency w/ Medical/Surgical State Review (M/S)Disorder Explanation and/or Plan (MH/SUD) •Concurrent review is a component of Concurrent reviews are conducted via The same process is exercised for both the No issues found. review of faxed clinical documentation M/S and MH/SUD and therefore the plan's utilization management activities and includes medical for medical necessity. Notification to comparable. BH parity requirements met. necessity reviews. The Medical providers regarding authorization

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.

require eviden guideli Guidel clinica by Uni current techno While general inpatie on Price	ical review crit UnitedHealthca rent, new and ex anologies.  ile "Concurrent erally refers to atient cases ove atient stay, the i	ne adoption of inical practice		
Tota I # Aut hs  9,55	Adverse Determinatio n	Total #/% of #/% of Initial Appeale d Cases Determinati on Cases ed on Appeale A8/0.5% 23/47.9%	Total #/% Adverse Determinatio n Cases Reversed other than Appeal	Total #/% of Auth Cases w/Persistent Adverse Determinatio n

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

•The utilization management program	services with M/S, there are unique	
will use evidence-based, clinical	concurrent reviews to within MH/SUD.	
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.		

### **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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
UnitedHealthcare does not restrict or set	UnitedHealthcare does not restrict or set	The MH/SUD process is not more	No issues found.
limits on prescription drugs provided in	limits on prescription drugs provided in	stringent than the M/Sand therefore	
an outpatient setting.	an outpatient setting.	comparable.	BH parity requirements
			met.
Due to the CMS Final Rule, tiers related	Due to the CMS Final Rule, tiers related		
to brand vs. generic have been	to brand vs. generic have been		
established. The tiers are not tied to	established. The tiers are not tied to		
copays. The conditions treated do not	copays. The conditions treated do not		
affect the tier assignment of a	affect the tier assignment of a		
medication.	medication.		
Tier Name Drug Tier	Tier Name Drug Tier		
Tier 1 Generic	Tier 1 Generic		
Tier 2 Brand	Tier 2 Brand		

#### **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







PN-1003-Policy-Availa

PN-1078-Policy-Select

Credentialing Process. bility GeoAccess_1122	ion 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	(MH/SUD)  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	the standards at a minimum on a	
members and providers are notified of	quarterly basis.	
the plan's policies for immediate care		
and for scheduling urgent, pediatric	UnitedHealthcare ensures it's network	
sick, adult sick and routine	has the capacity and is adequate to	
appointments. UnitedHealthcare	serve the expected enrollment in the	
monitors provider performance against	service area to maintain a sufficient	
the standards at a minimum on a	number, mix, and geographic	
quarterly basis.	distribution of providers for services;	
	taking in consideration the distance that	
UnitedHealthcare ensures it's network	it takes the member to travel in normal	
has the capacity and is adequate to	traffic conditions, using usual travel	
serve the expected enrollment in the	means in a direct route from his/her	
service area to maintain a sufficient	home to the provider based on the	
number, mix, and geographic	GeoAccess Standards.	
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		

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



GeoAccess Standards.





CR-0001 Credentialing Process. bility GeoAccess\_1122

PN-1003-Policy-Availa PN-1078-Policy-Select ion and Retention\_112

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

practitioner type who is eligible a	practitioner type who is eligible a	
contract will be offered. All applicable	contract will be offered. All applicable	
providers must meet the requirements	providers must meet the requirements	
of our credentialing 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-Availa PN-1078-Policy-Select bility GeoAccess\_1122 ion and Retention\_112

Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	_	
UnitedHealthcare does not impose or	UnitedHealthcare does not impose or	Same process is applied for both M/S and	No issues found.
have any geographic limitations on	have any geographic limitations on	MH/SUD and therefore comparable.	
provider inclusions.	provider inclusions.		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-ofnetwork 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-Availa bility GeoAccess\_1122 PN-1078-Policy-Select ion and Retention\_112

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

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

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

#### PRESCRIPTION DRUGS

Health Plan:UnitedHealthcare Community PlanDate:August 2, 2018Contact Person:Jocelyn TafaoEmail: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-PharmacyCo

verageReviews.pdf

Medical/Surgical	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
As defined in the Hawaii Revised	As defined in the Hawaii Revised	The development, modification, and	No issues found.
Statutes ("HRS") 432e-1.4, the medical	Statutes ("HRS") 432e-1.4, the medical	adoption of medical	
necessity/appropriateness criteria for	necessity/appropriateness criteria for	necessity/appropriateness criteria follow	BH parity requirements
drug therapy are developed by	drug therapy are developed by	the same steps and processes for	met.
UnitedHealthcare Pharmacy (UHCP)	UnitedHealthcare Pharmacy (UHCP)	medical/surgical drugs as for behavioral	
Team. Once developed or modified by	Team. Once developed or modified by	health/substance use disorder drugs in the	
UHCP the criteria is directed to the	UHCP the criteria is directed to the	pharmacy benefit criteria therefore M/S	
Pharmacy and Therapeutics (P&T)	Pharmacy and Therapeutics (P&T)	and MH/SUD are comparable.	
Committee process for review and	Committee process for review and		
adoption. The P&T Committee meets	adoption. The P&T Committee meets		
quarterly. Issues pertaining to drug	quarterly. Issues pertaining to drug		
selection and pharmacy program	selection and pharmacy program		
management are communicated	management are communicated		
quarterly through a newsletter to	quarterly through a newsletter to		
providers and are also available on the	providers and are also available on the		
UnitedHealthcare Community Plan	UnitedHealthcare Community Plan		
internet site	internet site		
An overview of the process is as	An overview of the process is as		
follows:	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, peerreviewed 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
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- b. When drafting the medical necessity/appropriateness criteria the following are considered: review of FDA approved product labeling, peerreviewed 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	benefit will be considered for addition	
to the criteria.	to the criteria.	
d. Modified criteria will be reviewed for	d. Modified criteria will be reviewed for	
approval/adoption via the UHC P&T	approval/adoption via the UHC P&T	
Committee process.	Committee process.	
3. Adoption of Criteria	3. Adoption of Criteria	
a. The criteria are reviewed and	a. The criteria are reviewed and	
approved via the UHC P&T process.	approved via the UHC P&T process.	
b. Once the criteria have been reviewed	b. Once the criteria have been reviewed	
and accepted they will be adopted for	and accepted they will be adopted for	
use/implemented. The time period	use/implemented. The time period	
needed for implementation is 60 days.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
The step-therapy drugs are routinely	The step-therapy drugs are routinely	The step-therapy policy applies to both	No issues found.
covered only after a sufficient trial of	covered only after a sufficient trial of	M/S and MH/SUD therefore M/S and	
an indicated first-line agent has been	an indicated first-line agent has been	MH/SUD are comparable.	BH parity requirements met.
adequately tried and failed. These	adequately tried and failed. These		
medications may also be requested	medications may also be requested		
through the Prior authorization process. The provider must submit	through the Prior authorization process. The provider must submit		
clinical notes along with the PA form	clinical notes along with the PA form		
to document what medications were	to document what medications were		
attempted and failed.	attempted and failed.		
•	1		
The factors that the P&T Committee	The factors that the P&T Committee		
use to determine step-therapy include	use to determine step-therapy include		
the prescribing and delivery of quality	the prescribing and delivery of quality		
cost effective care, monitoring of	cost effective care, monitoring of		
utilization, and enhanced PDL	utilization, and enhanced PDL		
compliance.	compliance.		
The purpose is to ensure safe, proper	The purpose is to ensure safe, proper		
and cost effective medication use.	and cost effective medication use.		
Members are required to try and fail	Members are required to try and fail		
preferred agents prior to receiving	preferred agents prior to receiving		
non-preferred agents to encourage the	non-preferred agents to encourage the		

use of cost-effective drug therapies	use of cost-effective drug therapies	
(preferred agents) prior to being able	(preferred agents) prior to being able	
to fill the more expensive drug	to fill the more expensive drug	
therapies (non-preferred agents).	therapies (non-preferred agents).	
Preferred agents are more cost-	Preferred agents are more cost-	
effective than non-preferred agents.	effective than non-preferred agents.	
Preferred agents typically account for	Preferred agents typically account for	
nearly 80% of a program's total	nearly 80% of a program's total	
prescription fills, but only 20%-30%	prescription fills, but only 20%-30%	
of the cost.	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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(MS)	Disorder (MH/SUD)	Explanation and/or Plan	
There are no exclusions based on	There are no exclusions based on	Same requirement for both M/S and	No issues found.
failure to complete treatment.	failure to complete treatment.	MH/SUD.	
			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-PharmacyCo verageReviews.pdf

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

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	Appeals Rights.	
authorization requests. Over	Appeals regitts.	
application of prior authorization to a	Prior authorization requests are	
particular drug could be measured by	reviewed by the following staff:	
the approval/denial rate. If the	• Licensed Pharmacy Technicians	
	Licensed Clinical Pharmacists	
approval rate is very high, then the		
medication is being utilized	• Licensed Physicians	
appropriately and prior authorization	Please note: Only a physician may	
could be unnecessary.	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-DrugUtilizati onReview.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 If	f member is not in Community Care	Both M/S and MH/SUD are reviewed	No issues found.
retail and mail order		ervices (those members receive	equally through the concurrent review	
therapeutic decisions		Mental Health meds from Ohana	process therefore M/S and MH/SUD are	BH parity requirements met.
system edits. Duration	· · · · · · · · · · · · · · · · · · ·	nsurance), meds are reviewed through	comparable.	
drug-drug interaction		ur cDUR program which consists of		
duplication are some		arious Point of Sale edits. Medispan		
are used		atabase is used to assist retail and mail		
		rder pharmacists with therapeutic		
The screening edits the		ecisions with at least 9 system edits.		
include:		Ouration of treatment, drug-drug		
1) Drug-Drug In		nteractions, and therapeutic		
Screening		uplication are some of the edits that		
	C	re used		
3) Drug Inferred		31 ' 1', 1 , , , 1'1' 1		
		The screening edits that are utilized		
Screening  5) Drug Sey Co		nclude:		
	ntraindication	1) Drug-Drug Interaction		
Screening 6) Duplicate Pre	agarintian	Screening  2) Diagnosis Coution Screening		
6) Duplicate Pro	escription	<ul><li>2) Diagnosis Caution Screening</li><li>3) Drug Inferred Screening</li></ul>		
7) Drug Class D	Junlication	4) Drug-Age Contraindication		
Screening	rupilcation	Screening		
8) Refill Too So	non	5) Drug-Sex Contraindication		
9) Therapeutic l		Screening		
Screening	Jose Limits	6) Duplicate Prescription		
20100		Screening		
		7) Drug Class Duplication		
		Screening		
		8) Refill Too Soon		
	TI	herapeutic 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.

List of documents: PH-1010-DrugUtilizationReview				
PH-1010-DrugUtilizati onReview.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	A concurrent DUR program screens all	Although the overturn rate was higher	No issues found.
all retail and mail service prescription	retail and mail service prescription	MH/SUD, the approval and denial rates	
claims at the point of service before	claims at the point of service before	for prior authorizations were similar for	BH parity requirements met.
the drug is dispensed.	the drug is dispensed. The concurrent	both M/S and MH/SUD. Both classes of	
The concurrent DUR system screens	DUR system screens each prescription	medications are screened with the same	
each prescription against the member's	against the member's	criteria therefore M/S and MH/SUD are	
prescription drug history. The system	prescription drug history. The system	comparable.	
checks for inappropriate drug	checks for inappropriate drug		
prescribing and	prescribing and		
utilization, as well as potentially	utilization, as well as potentially		
dangerous medical implications or	dangerous medical implications or		
drug interactions.	drug interactions.		
The program includes communication	The program includes communication		
avenues through claims edits and	avenues through claims edits and		
messaging to	messaging to		
the dispensing pharmacy at point-of-	the dispensing pharmacy at point-of-		
service.	service.		
Our concurrent reviews do not have	Our concurrent reviews do not have		
appeal overturn rates but the average	appeal overturn rates but the average		
number of prescriptions that were	number of prescriptions that were		
screened through the cDUR program	screened through the cDUR program		
during 2017 had a 53.9% paid rate;	during 2017 had a 53.9% paid rate;		
20.3% were rejected; and 54.3% were	20.3% were rejected; and 54.3% were		
reversed; total of 42.2% prescriptions.	reversed; total of 42.2% prescriptions.		
The prior authorization figures are	The prior authorization figures are		
listed below and do include appeal	listed below and do include appeal		
overturn rates. Med/Surg meds had 22	overturn rates MH/SUD meds had 2		
cases appealed with a 27.3% overturn	cases with a 50% overturn rate for		
rate. The approval rate for PA's were	appeals. The approval rate for PA's		
51.9% with a denial rate of 48.1%.*	were 59.1 % with a denial rate of		
	41.9%*		

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

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

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

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

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

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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 onsite 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.

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- 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

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

• 1 Pharmacy within 60 minutes	• 1 Pharmacy within 60 minutes
driving time Rural [Non-	driving time Rural [Non-
Honolulu CBSA (MSA)	Honolulu CBSA (MSA)
[Estimated Driving Time]	[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	Mental Health/Substance Use	Comparability/Stringency w/	State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)	-	
If a member goes to an out of network	If a member goes to an out of network	The standards would be the same for M/S	No issues found.
pharmacy, the claim will reject at	pharmacy, the claim will reject at point	and MH/SUD prescriptions therefore	
point of sale and the pharmacy can	of sale and the pharmacy can contact	comparable.	BH parity requirements met.
contact OptumRx to obtain info on	OptumRx to obtain info on how to		
how to apply to gain network	apply to gain network pharmacy		
pharmacy status. In order to become a	status. In order to become a Network		
Network Pharmacy Provider, a	Pharmacy Provider, a credentialing		
credentialing application must be	application must be obtained. The		
obtained. The provider must meet the	provider must meet the OptumRx		
OptumRx credentialing requirements	credentialing requirements and be able		
and be able to comply with the	to comply with the requirements of the		
requirements of the Agreement and	Agreement and OptumRx Pharmacy		
OptumRx Pharmacy Manual. All	Manual. All Network Pharmacy		
Network Pharmacy Providers shall be	Providers shall be credentialed		
credentialed pursuant to the OptumRx	pursuant to the OptumRx credentialing		
credentialing policy prior to	policy prior to submitting any claims.		
submitting any claims.			

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 Mental Health/Substance Use		Comparability/Stringency w/	State Review
(M/S)	(M/S) Disorder		
	(MH/SUD)		
Reimbursement rates depend on the	Reimbursement rates depend on the	Although reimbursement prices are set at	No issues found.
contract with the pharmacy. An equal	contract with the pharmacy. An equal	the drug level, the strategy, evidence used	
		as resources, and the process to set drug	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	Medical/Surgical Mental Health/Substance Use		State Review
(M/S)	Disorder	Explanation and/or Plan	
	(MH/SUD)		
Service type and geographic market	Service type and geographic market	The factors that determine pharmacy	No issues found.
affects reimbursement rates. Specialty	affects reimbursement rates. Specialty	reimbursement can vary by pharmacy type	
pharmacies, for example, have a	pharmacies, for example, have a	(e.g. small, chain, 340B) but are the same	BH parity requirements met.
different reimbursement rate compared	different reimbursement rate compared	for both M/S and MH/SUD situations and	
to a retail pharmacy. A small rural	to a retail pharmacy. A small rural	therefore comparable.	
pharmacy can have a different rate of	pharmacy can have a different rate of		
reimbursement than a retail chain	reimbursement than a retail chain		
pharmacy. 340B pharmacies have	pharmacy. 340B pharmacies have		
different reimbursement rates.	different reimbursement rates.		

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

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

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

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

### **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	There are not prior authorization	Emergency Services do not	There are not prior authorization	CCS has no restrictions.
		required for emergency care.	requirements for Emergency Care	require Prior Authorization.	requirements for Emergency Care	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	There is no concurrent review for	Emergency Services do not	There is no concurrent review for	CCS has no restrictions.
		for emergency care.	Emergency Care	require concurrent review.	Emergency Care	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	There is no concurrent review for	NA for emergency services	There is no concurrent review for	CCS has no restrictions.
		for emergency care.	Emergency Care		Emergency Care	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.

## 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	Not applicable	Prescription drug benefits are	The selection of which drugs are	UnitedHealthcare does not restrict	The selection of which drugs are	CCS is more stringent than
		not tiered for Medicaid	covered use the same criteria for	or set limits on prescription drugs	covered use the same criteria for	AlohaCare, HMSA, Kaiser and
		members.	both medical and behavioral. The	provided in an emergency setting	both medical and behavioral. The	United.
			following is a summary of that	or take home drugs.	following is a summary of that	BH parity is in question.
			process:		process:	Bri parity is in question.
						11/5/18:
			Preferred Drug List (PDL) design		Preferred Drug List (PDL) design	BH parity no longer in question.
			including the Rx utilization (UM)		including the Rx utilization (UM)	
			criteria are based on the following		criteria are based on the following	BH parity requirements met.
			guiding principles and		guiding principles and	
			considerations for all therapeutic		considerations for all therapeutic	
			classes and is governed by the		classes and is governed by the	
			same standard Pharmacy and		same standard Pharmacy and	
			Therapeutic (P&T) committee.		Therapeutic (P&T) committee.	
			a Varify aliminal		a Varify aliminal	
			a. Verify clinical		a. Verify clinical	
			<ul><li>appropriateness</li><li>b. Ensure drug safety</li></ul>		appropriateness	
			c. Prevent fraud and diversion		<ul><li>b. Ensure drug safety</li><li>c. Prevent fraud and diversion</li></ul>	
			d. Detect members receiving		d. Detect members receiving	
			duplicate or unnecessary		duplicate or unnecessary	
			medication therapies from		medication therapies from	
			multiple prescriber's		multiple prescriber's	
			e. Detect and prevent substance		e. Detect and prevent substance	
			abuse		abuse	
			f. Allow coverage for		f. Allow coverage for	
			medications not listed on the PDL		medications not listed on the PDL	
			incarcations not fisted on the LDE		medications not fisted on the LDL	

Clarified response 10/31/18:	Clarified response 10/31/18:
No, prescription drug benefits are	No, prescription drug benefits are
not tiered for Medicaid	not tiered for Medicaid
beneficiaries. Since prescription	beneficiaries. Since prescription
drugs, by their very nature, are not	drugs, by their very nature, are not
emergent, this question does not	emergent, this question does not
really apply to this document.	really apply to this document.
Emergent drugs would be	Emergent drugs would be
administered by the facility where	administered by the facility where
the emergency is being treated	the emergency is being treated
(i.e., an emergency room at the	(i.e., an emergency room at the
facility where the patient presents	facility where the patient presents
	with their emergency) versus via a
prescription.	prescription.
	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

## 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	Not applicable for emergency care.	There are no network	The State of Hawaii sets the	There are no network	CCS has no restrictions.
	licensed or certified in accordance		requirements for Emergency Care	provider enrollment requirements	requirements for Emergency Care	Therefore, BH services are not
	with state and national guidelines,			for all provider types enrolled as		more stringent in comparison to
	meet all standard educational and			Medicaid providers. This includes		M/S services.
	credentialing criteria for their			requirements such as; NPI, tax ID,		
	specialty, not be an excluded			provider disclosures, and		BH parity requirements met.
	entity with Medicare or Medicaid			licensure/certification. All		
	programs, and have met all			applicable providers go through		
	continuing educational			the credentialing process that is		
	requirements specific to their			based on NCQA requirements.		
	provider type			Credentialing of a provider is		
				initiated prior to contracting with		
	Provider must be willing to			the provider. Once a provider has		
	contract at sustainable rates and to			completed the credentialing		
	submit all required documentation			process and approved by the		
	for both credentialing process and			Credentialing Committee, they are		
	for system configuration for			offered a contract with		
	adjudication of provider claims.			UnitedHealthcare.		
	Provider onboarding process can			Participation criteria for		
	be initiated either by the health			practitioners include information		
	Plan or Provider followed by			about the provider, such as:		
	execution of a contract between			1. Education		
	Plan and Provider for participation			2. Licensing		
	in one or more products. Plan			3. Applicant must have full		
	monitors network needs on a			hospital admitting privileges,		
	regular basis in accordance with			without Material Restrictions,		
	its practitioner availability policies			conditions or other disciplinary		

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	HMSA does not have any	Not applicable for emergency care.	There are no network	UnitedHealthcare does not	There are no network	CCS has no restrictions.
licensing regulations, providers	exclusions pertaining to provider		requirements for Emergency Care	exclude any provider types	requirements for Emergency Care	Therefore, BH services are not
must provide services within the	types, facility types, or specialty			however we may exclude a		more stringent in comparison to
scope of their license. AlohaCare	providers.			provider based on the		M/S services.
will cover emergency services				credentialing criteria.		
provided by any provider				UnitedHealthcare complies with		BH parity requirements met.
practicing and providing care				state licensing requirements and if		
within the scope of the provider's				there is a practitioner type who is		
license and accreditation.				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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
N/A	There are no geographic	Not applicable for emergency care.	There are no network	UnitedHealthcare does not impose	There are no network	CCS has no restrictions.
	limitations		requirements for Emergency Care	or have any geographic limitations	requirements for Emergency Care	Therefore, BH services are not
				on provider inclusions.		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	Not applicable for emergency care.	There are no network	UnitedHealthcare provides access	There are no network	CCS has no restrictions.
	no out-of-network benefits except		requirements for Emergency Care	to Out of Network (OON)	requirements for Emergency Care	Therefore, BH services are not
	for emergencies. If a member is			providers (non-contracted		more stringent in comparison to
	admitted for an emergent			providers) if an in-network		M/S services.
	condition, no prior authorization			provider is unable to provide		
	or concurrent reviews are required			medically necessary services in an		BH parity requirements met.
				adequate and timely manner to a		

until the time the member's		member and continue to authorize	
condition is stabilized.		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	Initial fees were established at the	Not applicable for emergency care.	There are no network	UnitedHealthcare's Medicaid Fee	There are no network	CCS has no restrictions.
negotiated rates and vary	beginning of the QUEST program		requirements for Emergency Care	Schedule is developed using the	requirements for Emergency Care	Therefore, BH services are not
according to terms reached in	in 1994. At that time, fees were			State's Medicaid Fee Schedule		more stringent in comparison to
negotiation. Most begin with the	established based on the Medicaid			with alignment using Medicare		M/S services.
state's FFS fee schedule, or are a	FFS schedule at that time. Since			relatively. Where the fee source		
percentage of Medicare FFS fee	then increases or decreases were			does not publish a specific fee		BH parity requirements met.
schedule. This is true for	based on the reimbursement rates			amount, UnitedHealthcare will use		
physicians, PhDs and MAs.	set by the state to the Insurance			the CMS Gap fill using a % of		
	plans. Adjustments are made to			prevailing Medicare.		
	the changes in coding that occur					
	nationally.			UnitedHealthcare will use		
				reasonable commercial efforts to		
	For ABD and Non-ABD, we			implement the updates in its		
	primarily follow the Medicaid fee			systems on or before the later of		
	schedule. Some provider's fees are			(i) 90 days after the effective date		
	individually negotiated.			of any modification made by the		
				Fee Source or (ii) 90 days after the		
	Psychiatrists and Psychologists are			date on which the Fee Source		
	paid the same rate. Child			initially places information		
	Psychiatrists are paid 110% of the			regarding such modification in the		
	Psychiatrist fee. Social workers,			public domain (for example, when		
	Marriage Family Therapists,			CMS distributes program		
	Mental health counselors, and			memoranda to providers).		
	APRNs are paid 85% of the			UnitedHealthcare will make the		
	psychiatrist rate.			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	Emergency Care follows	Professional provider	There are no network	Professional provider	There are no network	CCS has no restrictions.
service demand/network adequacy	professional fee schedule rates and	reimbursement rates for	requirements for Emergency Care	reimbursement rates do not vary	requirements for Emergency Care	Therefore, BH services are not
and capacity are the primary	hospitals are individually	emergency care are determined by		based on the factors listed above.		more stringent in comparison to
drivers for both M/S and	negotiated. All rates are based on	Medicaid and Medicare fee		In limited instances variations can		M/S services.
MH/SUD providers. Some	budget availability. Rural areas	schedules.		occur based on availability of		
medical and mental health	may play a factor due to access			certain limited specialty services		BH parity requirements met.
	issues.			in Hawaii.		

specialties are in a workforce			
specialities are in a workloved			
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	In developing medical necessity	Medical	Depending on the pre-service	As defined in the Hawaii Revised	Industry accepted Medical	All MCO's use federal and state
Care, and Sub-acute Short/Long	standards for Medical/Surgical	necessity/appropriateness	procedure, Industry accepted	Statutes ("HRS") 432e-1.4, the	Necessity Criteria (in addition to	guidelines to make determinations of medical necessity. All are
Term Rehabilitation services	services, HMSA considers	determinations are made after	Medical Criteria and approved	following components are taken	`Ohana's Clinical Coverage	comparable with CCS BH
include:	scientific evidence/peer reviewed	considering clinical	`Ohana Clinical Coverage	into consideration: "A health	Guidelines are utilized to assess	services.
	literature, professional standards	information, clinical urgency of	Guidelines are utilized to assess	intervention is medically	medical necessity (MN) and	Services.
<ul> <li>Room and board</li> </ul>	of care, expert opinion and	the situation, and appropriate	medical necessity and	necessary if it is recommended by	appropriateness.	BH parity requirements met.
<ul><li>nursing care</li></ul>	community input and utilizes	criteria/guideline references.	appropriateness.	the treating physician or treating	Authorizations are given based on	
<ul> <li>medical supplies</li> </ul>	multiple sources including:	These references may include	If none is available based on	licensed health care provider, is	MN. If there is a concern that an	
<ul> <li>equipment and drugs</li> </ul>	Hawaii Revised Statutes (HRS	- InterQual Criteria for Adult and	service requested, or criteria is	approved by the health plan's	authorization does not meet MN,	
<ul> <li>diagnostic services</li> </ul>	§432E-1.4)	Pediatric;	not met, a request is sent for a	medical director	we offer a peer to peer review.	
<ul> <li>physical therapy</li> </ul>	Blue Cross Blue Shield	- Medicare guidelines	secondary Medical Director	or physician designee, and is:	Industry accepted medical	
<ul> <li>occupational therapy</li> </ul>	Association guidelines and	from The Centers for	review	(1) For the purpose of treating a	necessity criteria in this	
• audiology	medical policies	Medicare & Medical	Industry accepted medical	medical condition;	classification routinely include:	
• speech-language	Milliman Care Guidelines	Services (CMS); and	necessity criteria in this	(2) The most appropriate delivery	• Level of clinical need that	
pathology service	(MCG)	- Medicaid requirements stated	classification and authorization	or level of service, considering	cannot be met in an	
• other medically necessary		within the State of Hawaii	rules include but are not limited	potential benefits and harms to the	outpatient environment.	
services.	Along with the available medical	Department of Human Services	to:	patient;	<ul> <li>Safety of the patient</li> </ul>	
services.	evidence, additional consideration	RFP-MQD- 2014-005.	<ul> <li>Clinical complexity,</li> </ul>	(3) Known to be effective in	regarding danger to self	
Concurrent Review process:	is given to factors such as a	D 1.0	<ul> <li>Place of service</li> </ul>	improving health outcomes;	or others,	
process.	treatment's cost-effectiveness,	Processes and frequency of	appropriateness,	provided that:	• current mental status,	
<ul> <li>Notification facesheet</li> </ul>	most appropriate delivery of level	review are also guided by the	<ul> <li>Financial and utilization</li> </ul>	(A) Effectiveness is determined	• compliance with	
received from facility	of service, and potential benefits	Kaiser Permanente Hawaii	data, and	first by scientific evidence;	medication and	
within 24 hours of	and harms to the patient to	Region policy on Utilization	Benefit restrictions, such	(B) If no scientific evidence		
member's admission.	determine medical necessary of	Decisions (#6425-502).	as cosmetic procedures.	exists, then by professional	duration of the current	
• Intake (TCSS) receives	medical/surgical treatments and	Con comment need on A	Diagnosis and clinical	standards of care; and	psychiatric event.	
notification facesheet and	services. Medical necessity	Concurrent review and authorization for continued		(C) If no professional standards of	Inpatient Psychiatric hospital	
creates authorization and	criteria (aka policies) are		must be supplied by the	care exist or if they exist but are outdated or	services are considered and	
pends them to the UM	developed by HMSA Medical Directors with input from medical	coverage during inpatient acute	facility.		treated as an emergency service.	
clinician for review	practitioners in the community.	hospitalization is performed	Number of days approved	contradictory, then by expert	As such, we request the provider	
<ul> <li>UM clinician accepts the</li> </ul>	practitioners in the community.	every 1-3 days. (Note: When member is confined to an out-	are based on diagnosis	opinion; and (4) Cost-effective for the medical	to notify us within 24 hours of	
authorization and request	Once policies are developed,	of-state inpatient facility, there	and member co-	condition being treated compared	admission and while an	
clinical notes from	reviews of the medical necessity	may be occasional concurrent	morbidities.	to alternative health interventions,	authorization is required, prior	
facility.	criteria are conducted at least	review delays pending receipt	<ul> <li>Concurrent reviews are</li> </ul>	including no intervention. For	authorization is not required.	
Based on clinical notes	annually and more frequently as	of requested concurrent medical	every 3 days	purposes of this paragraph, cost		
reviewed, clinician will	new evidences become available.	information. Concurrent	Discharge planning begins	effective shall not necessarily	Inpatient hospital services are	
approve length of stay	new evidences become available.	reviews will be performed	on admission	mean the lowest price."	considered and treated as an	
(LOS) and level of care		when information is received.)	Authorization is nearly always	mean the lowest price.	emergency service. We request	
(LOC) based on InterQual		when information is received.)	required for inpatient settings,	UnitedHealthcare uses Milliman	the provider to notify us within	
Criteria.		Concurrent review and	with some exceptions on the	Care Guidelines (MCG) evidenced	24 hours of admission. If there is	
		authorization for continued	claims side for newborn	based criteria to determine the	a concern that an authorization	
Every 2 days for Acute Inpatient		coverage in an alternate	deliveries.	most appropriate level of inpatient	does not meet MN, we offer a	
Every 7 days for SNF level of care		inpatient setting (e.g., SNF) is	Inpatient hospital services are	care with care guidelines specific	peer to peer review and we will	
		performed every 7-14 days.	considered and treated as an	to the member's admitting	send for a secondary review.	

<ul> <li>If criteria is not met,</li> </ul>		emergency service. We request the	diagnosis. MCG supports the	
concurrent review nurse	Only licensed physicians can make	provider to notify us within 24	nurse's approval decisions and	
will contact facility UM	medical necessity denial	hours of admission. If there is a	those cases that may not meet the	
review nurse to discuss	determinations. Board certified	concern that an authorization does	evidenced based criteria. When	
level of care.	physicians from appropriate	not meet MN, we offer a peer to	the member's clinical does not	
<ul> <li>If both the concurrent and</li> </ul>	specialty areas are used to assist in	peer review and we will send for a	appear to meet MCG inpatient	
facility nurses agree,	making determination of medical	secondary review.	guidelines, a higher level of	
continue with review	and clinical appropriateness.	seesing reviews	review is required. The case is	
If there is a disagreement	and eminear appropriateness.		then escalated to the receiving	
•			medical director to review for	
and level of care/length of			potential adverse determination	
stay is potentially denied,			(see Inpatient Medical Necessity	
authorization is pended to			document above). Medical review	
Medical Director for a			frequency is based off of	
Secondary review.			UnitedHealthcare Priority Review	
After the MD completes			Process (see document name and	
the secondary review, the				
MD returns the			number above). Health care	
authorization to the UM			services provided for the purpose	
clinician.			of preventing, evaluating,	
UM Clinician will process			diagnosing or treating a sickness,	
the denial and provide a			injury, mental illness, substance	
verbal/written notification			use disorder, condition, disease or	
to facility and written			its symptoms, which are all of the	
notification to member.			following as determined by	
<ul> <li>If member is still</li> </ul>			UnitedHealthcare or our designee,	
inpatient, concurrent			within our sole discretion.	
review will resume until			• In accordance with Generally	
member is discharged			Accepted Standards of Medical	
home.			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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Clinician will receive notification	There are no fail first requirements	No step-therapy (aka "fail first")	`Ohana uses quantity limits	MCG would be used to identify	`Ohana uses quantity limits	AlohaCare: Need to clarify
of the admission and request	for Inpatient treatments under	protocols are in place. The	("QL") to minimize inappropriate	any criteria that would correlate	("QL") to minimize inappropriate	answer. Does not pertain to step-
clinical notes to initiate	Medical/Surgical benefits.	decision to implement such a	utilization, waste, and stockpiling	between the member's diagnoses	utilization, waste, and stockpiling	therapy.
Concurrent review.	-	protocol would be made by the	of drugs, ensuring that quantities	and failure of outpatient treatment.	of drugs, ensuring that quantities	LIMOA KAIOED, N/A
Once the clinical notes is received,	Fail first requirements or step-	Pharmacy & Therapeutics	supplied are consistent with	Application of a "fail first" or	supplied are consistent with	HMSA, KAISER: N/A
the hospital stay is reviewed	therapies for prescription drugs	Committee and reviewed annually.	Federal Drug Administration	"step therapy" requirement is	Federal Drug Administration	OHANA HP & CCS: Both have
beginning on the day of	are not applicable in the Inpatient		(FDA) approved clinical dosing	based on use of nationally	(FDA) approved clinical dosing	ST protocols.
admission. The clinical notes are	document. Please refer to the		guidelines. `Ohana also utilizes	recognized clinical standards,	guidelines. `Ohana also utilizes	C. protocolo.
reviewed against Interqual	NQTL- Prescription Drugs		QL to help prevent billing errors.	which may be incorporated into	QL to help prevent billing errors.	Based on review of all MCO's it
guidelines starting with the day of	document		Requests for exceptions to the	the plan's review guidelines.	Requests for exceptions to the	seems that Ohana CCS is more
acute admission. If the length of			quantity limits listed on the	Based on, and consistent with,	quantity limits listed on the	stringent in comparison to HMSA
stay (LOS) or the level of care			Preferred Drug List (PDL) shall be	these nationally recognized	Preferred Drug List (PDL) shall be	and Kaiser.
(LOC) is not appropriate due to			reviewed for approval.	clinical standards, some of the	reviewed for approval.	DII monitor in in acception
inadequate interventions/services				plan's medical/surgical review		BH parity is in question.
being performed during the			`Ohana uses Step Therapy (ST)	guidelines have what may be	`Ohana uses Step Therapy (ST)	11/9/18:
member's inpatient confinement,			when there are several different	considered to be "fail first" or	when there are several different	Discussion needed with 'Ohana
the clinician will notify the			drugs available on the PDL for	"step therapy" protocols.	drugs available on the PDL for	about their protocols for step-
facility's CM/SW regarding the			treating a particular medical		treating a particular medical	therapy for INPATIENT settings.
failed requirements to continue the			condition. A ST is designed to		condition. A ST is designed to	Also to inform them that it is the
LOS or to remain in the LOC the			encourage the use of		encourage the use of	state's responsibility to bring all
member is currently at. If the			therapeutically-equivalent, lower-		therapeutically-equivalent, lower-	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.

Clarified response 10/31/18:
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.).

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.

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

### Clarified response 10/31/18:

product, etc.).

authorized (e.g., specific

diagnoses, lab values, trial and

failure of alternative drug(s),

allergic reaction to preferred

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.

# As of 12/17/18:

BH parity requirements met.

Clarified response 12/4/18	Clarified response 12/4/18
No, we would not use step	No, we would not use step
therapy rules in inpatient	therapy rules in inpatient
settings. This is only for	settings. This is only for
outpatient settings.	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

		,	yes, describe the processes, strategies			
ALOHACARE	HMSA	KAISER	'OHANA	UNITED	OHANA CCS	COMPARABILITY/STRINGENCY
During a concurrent review of a	There are no exclusions based on	There are no health plan	`Ohana uses clinical standards and	The medical/surgical inpatient	`Ohana uses clinical standards and	HMSA, Kaiser & UHC do not have
member's acute/rehab inpatient	failure to complete a course of	exclusions based on failure to	guidelines to develop coverage	benefit does not include	guidelines to develop coverage	exclusions.
stay, our guidelines (Interqual)	treatment under Inpatient	complete a course of treatment.	criteria that may contain	exclusions based on a failure to	criteria that may contain	'Ohana HP and CCS both have
require a series of tests, course of	Medical/Surgical benefits.		exclusions for certain	complete a course of treatment. As	exclusions for certain	the same standard.
treatment, imaging, and intensity			drug/products that may require a	noted in response to #1 above,	drug/products that may require a	the same standard.
of rehab services to be conducted			qualifying therapy that must be	inpatient coverage is determined	qualifying therapy that must be	Based on review of all MCO's it
for each inpatient day. If the			tried and failed prior to	by medical necessity.	tried and failed prior to	seems that Ohana CCS is more
member is unwilling or unable to			authorization for the drug/product		authorization for the drug/product	stringent in comparison to HMSA,
receive the appropriate			being requested. Coverage criteria		being requested. Coverage criteria	Kaiser & UHC.
interventions a Medical Necessity			is reviewed quarterly during the		is reviewed quarterly during the	
review will be conducted based on			Pharmacy and Therapeutics		Pharmacy and Therapeutics	BH parity is in question.
the Interqual guidelines. If the			Committee meeting.		Committee meeting.	11/9/18:
guidelines are not met due to						After discussion, the initial
failure to complete a course of			Clarified response 10/31/18:		Clarified response 10/31/18:	responses are comparable.
treatment and the member's			The QL description was submitted		The QL description was submitted	'Ohana documents "may
clinical state is not stable for			in error due to a misinterpretation		in error due to a misinterpretation	contain exclusions", it is not a
discharge, the Level of care may			of the document line of questions.		of the document line of questions.	"yes". In addition, they do
be denied, but not the length of			Quantity Limits (QL) rules and		Quantity Limits (QL) rules and	describe processes in the event
stay. Decisions are always based			Step Therapy (ST) rules are two		Step Therapy (ST) rules are two	there is an exclusion based on
on our guidelines and Medical			distinct methods of Utilization		distinct methods of Utilization	failure to complete a course of
Necessity. Failure to complete a			Management deployed to ensure		Management deployed to ensure	treatment.
course of treatment is not a			proper use of medication		proper use of medication	To be sure will have (Ohene re
determining factor for a denial.			therapies. There is no difference		therapies. There is no difference	To be sure, will have 'Ohana revisit to provide a definitive
			in how ST is applied between		in how ST is applied between	answer.
			MH/SUD and M/S services. Our		MH/SUD and M/S services. Our	answer.
			treatment of prescription drugs is		treatment of prescription drugs is	12/17/18:
			in parity between MH/SUD and		in parity between MH/SUD and	After review/discussion of
			M/S services.		M/S services.	'Ohana's revised response, with
						no step-therapy used in
			Clarified response 12/4/18		Clarified response 12/4/18	inpatient settings, there is NO
			No, we would not use step		No, we would not use step	question of parity.
			therapy rules in inpatient		therapy rules in inpatient	Ac of 42/47/49.
			settings. This is only for		settings. This is only for	As of 12/17/18: BH parity requirements met.
			outpatient settings.		outpatient settings.	Dir painty 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
acute hospitalization such as inpatient rehabilitation, a Prior	Prior authorization is not required for M/S acute Inpatient hospital admissions.	Pre-service authorization is not required for emergent	Pre-service, planned Inpatient surgeries, require prior authorization. Services are	Prior authorization is not required for emergent admissions into an inpatient facility. Notification of	Residential substance abuse is an example of non-acute inpatient level of care that requires prior	All non-emergent inpatient admissions require a prior authorization. All MCOs are comparable and there is no more
authorization is not required. A		inpatient	requested via fax, web portal,	the admission (emergent/non-	authorization.	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. Nonurgent 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 preplanned 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	Once the member is admitted to		
Kaiser Permanente Hawaii Region	the hospital a concurrent review		
policies on Utilization Decisions	will be conducted by the Inpatient		
(#6425-502) and Out-of-Plan	nurse every $3 - 5$ days depending		
Requests for Care and Services	on diagnosis, co-morbidities and		
(#5054-01-A).	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?

	•		That evidentially standards support the			
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	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 underutilization 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 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	Non-reimbursable charges are not	
	care: member age, diagnosis, co-	billable to the member. The	
	morbidities, prior level of	facility and the attending	
	function, home environment. The	physician have sole authority and	
	nurse reviewer will arrange	responsibility for the medical care	
	discharge planning for the	of patients. The plan's medical	
	member prior to discharge.	management decisions do not	
	Setting up services such as Skilled	override those obligations. We do	
	nursing facility, home health,	not ever direct an attending	
	durable equipment needs, care	physician to discharge a patient.	
	management referrals and follow-	We simply inform the member of	
	ups with their primary care	our determination.	
	provider or Specialist will assist a	<ul> <li>Participating facilities are</li> </ul>	
	safe discharge and to prevent re-	required to cooperate with all	
	admissions.	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.	
		telephonicany.	
		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.

7	ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY	
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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 Outof-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<sup>TM</sup> 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<sup>TM</sup> 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

% of	% of	% of	% of
Cases	Total	Adverse	Appeal
with	Cases	Determ	ed
Adv	Appea	ination	Cases
erse	Led	Cases	Overtur
Determ		with at	ned on
ination		Least	Appeal
		One	
		Day	
		Overtur	
		ned on	
		Appeal	
7.40%	0.50%	1.80%	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
<ul> <li>Every 2 days for Acute Inpatient</li> <li>Every 7 days for Long term rehab</li> </ul>	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.  Clarified response 10/31/18:	The Inpatient Care Manager prioritizes and reviews criteria for all inpatient admissions based on medical necessity and nonmedical 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  Clarified response 10/31/18: 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	patient's condition and the treatment
that 'Ohana HP be in parity with other	plan from the attending providers. On
MCO's. However, 'Ohana is in	average, medical reviews are
parity between how we manage	completed every 3-5 days and on
Concurrent Review between	average, behavioral reviews are
MH/SUD and M/S services. As	completed every 2-3 days. All
stated in our original response,	reviews are based on medical
concurrent review timeframes are	necessity.
done on average based on the	
patient's condition and the treatment	The P&P's we referenced for this
plan from the attending providers. On	include: C7UM-5.4 & C7UM- 5.4-
average, medical reviews are	PR-001, and have been sent with this
completed every 3-5 days and on	submission
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	Prescription drug benefits are	The selection of which drugs are	UnitedHealthcare does not restrict	The selections of which drugs are	CCS is more stringent than
	Formulary is not a tiered	not tiered for Medicaid	covered use the same criteria for	or set limits on prescription drugs	covered use the same criteria for	AlohaCare, HMSA, Kaiser and
	formulary.	members.	both medical and behavioral. The	provided in an inpatient setting or	both medical and behavioral. The	United.
			following is a summary of that	take home drugs.	following is a summary of that	BU pority is in assection
			process:		process:	BH parity is in question.
						As of 11/5/18:
			Preferred Drug List (PDL) design		Preferred Drug List (PDL) design	Based on clarification provided,
			including the Rx utilization (UM)		including the Rx utilization (UM)	BH parity is no longer in
			criteria are based on the following		criteria are based on the following	question.
			guiding principles and		guiding principles and	
			considerations for all therapeutic		considerations for all therapeutic	BH parity requirements met.
			classes and is governed by the		classes and is governed by the	
			same standard Pharmacy and		same standard Pharmacy and	
			Therapeutic (P&T) committee.		Therapeutic (P&T) committee.	
			a. Verify clinical		a. Verify clinical	
			appropriateness		appropriateness	
			b. Ensure drug safety		b. Ensure drug safety	
			c. Prevent fraud and diversion		c. Prevent fraud and diversion	
			d. Detect members receiving		d. Detect members receiving	
			duplicate or unnecessary		duplicate or unnecessary	
			medication therapies from		medication therapies from	
			multiple prescribers		multiple prescribers	
			e. Detect and prevent substance		e. Detect and prevent substance	
			abuse		abuse	
			f. Allow coverage for		f. Allow coverage for	
			medications not listed on the PDL		medications not listed on the PDL	

Clarified response 10/31/18:	Clarified response 10/31/18:	
No, prescription drug benefits are	No, prescription drug benefits are	
not tiered for Medicaid	not tiered for Medicaid	
beneficiaries.	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.

network adequacy.						
ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
For M/S services, AlohaCare	Providers must be appropriately	Kaiser Permanente Hawaii	`Ohana provides contracted	The State of Hawaii sets the	`Ohana provides contracted	All MCO's are comparable for
conducts annual and ad hoc	licensed or certified in accordance	Region (KP) is an integrated	networks of qualified	provider enrollment requirements	networks of qualified	provider credentialing.
assessments of our provider	with state and national guidelines,	model of care which provides	organizational health care	for all provider types enrolled as	organizational health care	PU pority requirements mot
network delivery system to	meet all standard educational and	97% of KP member care via	providers, and home and	Medicaid providers. This includes	providers, and community based	BH parity requirements met.
determine if it is meeting our	credentialing criteria for their	its employed providers and	community-based service	requirements such as; NPI, tax ID,	case management providers (as	
standards for network adequacy,	specialty, not be an excluded	facilities. To augment KP's	providers (as applicable to state)	provider disclosures, and	applicable to state) to the enrolled	
capacity, and member access. See	entity with Medicare or Medicaid	internal care delivery system,	to the enrolled membership in its	licensure/certification. All	membership in its Plan. `Ohana	
attached Selections and Retention	programs, and have met all	KP contracts with specialized	Plan. `Ohana performs initial and	applicable providers go through	performs initial and ongoing	
of Providers Policy. AlohaCare's	continuing educational	service providers, both within	ongoing assessments of its	the credentialing process that is	assessments of its organizational	
Policy includes provider exclusion	requirements specific to their	and outside the State of	organizational providers in	based on NCQA requirements.	providers in compliance with	
per federal and state requirements	provider type	Hawaii.	compliance with applicable local,	Credentialing of a provider is	applicable local, state, and federal	
for government funded programs.			state, and federal accreditation	initiated prior to contracting with	accreditation requirements.	
Credentialing requirements	Provider must be willing to	Network admission requirements	requirements. Information and	the provider. Once a provider has	Information and documentation on	
include common, state-wide and	contract at sustainable rates and to	are comprised of several factors	documentation on organizational	completed the credentialing	organizational providers is	
national standards such as	submit all required documentation	which vary according to the	providers is collected, verified,	process and approved by the	collected, verified, reviewed, and	
licensed, certified, accredited, and	for both credentialing process and	service provider. These factors	reviewed, and evaluated in order	Credentialing Committee, they are	evaluated in order to achieve a	
in good standing, with	for system configuration for	include appropriate licensing,	to achieve a decision to approve or	offered a contract with	decision to approve or deny	
Appropriate medical liability,	adjudication of provider claims.	accreditation, good standing	deny network participation	UnitedHealthcare.	network participation.	
DEA, peer references, and other		against government agency				
common credentialing and	Provider onboarding process can	listings of excluded		Participation criteria for		
privileging verifications.	be initiated either by the health	individuals/entities, education,		practitioners include information		
	Plan or Provider followed by	training, board qualification,		about the provider, such as:		
	execution of a contract between	certification, reference checks,		1. Education		
	Plan and Provider for participation	background checks, interviews		2. Licensing		
	in one or more products. Plan	with relevant departments,		3. Applicant must have full		
	monitors network needs on a	agreement to maintain compliance		hospital admitting privileges,		
	regular basis in accordance with	with requirements and code of		without Material Restrictions,		
	its practitioner availability policies	ethics, acceptance of offered		conditions or other disciplinary		
	and will initiate outreach to non-	compensation, and other factors.		actions, at a minimum of one		
	par Providers if network analysis			participating (Network) hospital,		
	shows a need in a specific	Initial evaluation of a provider is		or arrangements with a		
	geography. Also, non-par	performed by the Provider		Participating LIP to admit and		
	Providers frequently initiate a	Relations and Contracting		provide hospital coverage to		
	request for participation. Plan will			Covered Persons at a Participating		
	either respond and begin	physician/provider recruiter and/or		(Network) hospital, if the		
	contracting process or politely	department physician chief who		Credentialing Entity determines		
	decline if credentialing	reviews the application, checks		that Applicant's practice requires		
	requirements are not met. Plan	references, and interviews the		such privileges.		
	retains all rights to determine	applicant provider. Further interviews are conducted and		4. Current and unrestricted DEA		
	which providers it adds to its			or Controlled Substance		
	provider networks.	recommendations to leadership are		Certificate or acceptable substitute		
	UMSA has formal anadantialing	made.		in each state where the Applicant.		
	HMSA has formal credentialing	Cradentialing easy the reafter		5. The Applicant must not be		
	criteria and a Credentialing	Credentialing occurs thereafter with National Provider		ineligible, excluded or debarred		
	Committee.	with manonal flovidel	<u>l</u>	from participation in the Medicare	l	l

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.

005.		
Min. 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-Hr Pharmacy	60	NA

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	HMSA does not have any	No practitioner types, facility	Practitioner types, facility types,	UnitedHealthcare does not	Practitioner types, facility types,	All MCO's are comparable as they
excluded from participation in	exclusions pertaining to provider	types, or specialty providers are	or specialty providers are not	exclude any provider types	or specialty providers are not	do not exclude specialty providers.
government healthcare programs	types, facility types, or specialty	specifically excluded from	excluded in writing or in operation	however we may exclude a	excluded in writing or in operation	The only exclusions would be for
	providers.	eligibility to enter into contracting	from providing covered benefits if	provider based on the	from providing covered benefits if	those who do not meet
		consideration toward providing	they meet the criteria outlined in	credentialing criteria.	they meet the criteria outlined in	credentialing criteria.
		covered benefit services.	the assessment policies noted	UnitedHealthcare complies with	the assessment policies noted	BH parity requirements met.
			above	state licensing requirements and if	above	bit parity requirements met.
				there is a 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
No such limitations	There are no geographic	Assuming the provider is within	The only geographic limitations	UnitedHealthcare does not impose	The only geographic limitations	CCS is more stringent as they
	limitations	the U.S.A., there are no	on provider inclusion are the	or have any geographic limitations	on provider inclusion are the	have geographic limitations to only
		geographic limitations on	service area of the plan (i.e., the	on provider inclusions.	service area of the plan (i.e., the	the service area of the plan.
		provider inclusion.	provider must practice within the		provider must practice within the	AlohaCare, HMSA, Kaiser and United all have no geographic
			state where the Medicaid plan is).		state where the Medicaid plan is).	limitations.
		Each provider candidate's				iiiiitations.
		geographic area is considered in	Clarified response 10/31/18:		Clarified response 10/31/18:	BH parity is in question.
		relation to the needs of the health	This question deals with the		This question deals with the	13
		plan's membership within that	geographic limitations of our		geographic limitations of our	11/9/18:
		geographic area and Medicaid	contracting efforts to get providers		contracting efforts to get providers	After further discussion and
		requirements stated within the	within our network and whether		within our network and whether	review of the clarified response
		State of Hawaii Department of	we have more stringent		we have more stringent	by 'Ohana, it is comparable to
		Human Services RFP-MQD-	contracting and credentialing		contracting and credentialing	the rest of the MCO's in the
		2014-005.	requirements for BH providers		requirements for BH providers	state.
			than we do for medical providers.		than we do for medical providers.	BH parity is no longer in
			The answer is our contracting and		The answer is our contracting and	question.
			credentialing requirements are the		credentialing requirements are the	quotioni
			same regardless of provider		same regardless of provider	BH parity requirements met.
			specialty. Because the question		specialty. Because the question	
			asked about out-of-network		asked about out-of-network	
			providers, we stated that our only		providers, we stated that our only	
			limitation re: contracting with		limitation re: contracting with	
			providers was the boundaries of		providers was the boundaries of	
			the geographic region defined by		the geographic region defined by	
			the State for their membership.		the State for their membership.	
			We do not "contract" with		We do not "contract" with	
			providers outside the State's		providers outside the State's	
			defined geographic service area.		defined geographic service area.	
			If a member requires care that is		If a member requires care that is	
			not available within our network		not available within our network	
			of providers, we would identify		of providers, we would identify	
			the closest out of network provider		the closest out of network provider	
			available to provide the care and		available to provide the care and	

authorize via a Single Case	authorize via a Single Case	
Agreement. That, however, has	Agreement. That, however, has	
nothing to do with our contracting	nothing to do with our contracting	
requirements and the parity	requirements and the parity	
between how we contract for	between how we contract for	
providers between medical and	providers between medical and	
behavioral services.	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.

12. Describe the written and open	rating processes, strategies, evidentiar	y standards, or other factors applied i	n determining standards for access to	out-or- network benefits.		
ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
AlohaCare members receive	QUEST Integration members have	Physician evaluates member. If	The Medicaid plan is an HMO	UnitedHealthcare provides access	The Medicaid plan is an HMO	Comparable responses. CCS is
medically necessary care. OON	no out-of-network benefits except	out-of-plan referral appears	product, thus the member is	to Out of Network (OON)	product, thus the member is	not more stringent than the other
care must be prior authorized and	for emergencies. If a member is	appropriate, physician completes	restricted to their network	providers (non-contracted	restricted to their network	MCO's.
coverage determinations are made	admitted for an emergent	an order for the request.	providers for non-emergent,	providers) if an in-network	providers for non-emergent,	BH parity requirements met.
based on clinical review	condition, no prior authorization		routine care. Out-of-Network	provider is unable to provide	routine care. Out-of-Network	211 painty requirements men
considering patient history with	or concurrent reviews are required	Department Chief receives referral	coverage is available for	medically necessary services in an	coverage is available for	
providers, and comparison of	until the time the member's	request and performs	emergency services and when	adequate and timely manner to a	emergency services and when	
provider specialties, training,	condition is stabilized. If a	evaluation/determination.	medically necessary services are	member and continue to authorize	medically necessary services are	
expertise, credentials, and on	member needs a treatment or	M. 1: -1	not available in network. The	the use of non-contract providers	not available in network. The	
geography and proximity. If in-	service that is not available from	Medical necessity approval from	State's benefit plan design dictates how members can access out of	for as long as UnitedHealthcare is	State's benefit plan design dictates how members can access out of	
network providers of comparable	network providers, exception can	the Outside Medical Services Medical Director or other	network benefits.	unable to provide services through		
credentials and specialties are available in the medical service	be made after a medical necessity		network benefits.	network providers.	network benefits.	
	review and verifying availability	appropriate Department Chief		UnitedHealthcare requires prior		
area, care is re-directed to the network. If not, then OON care is	of comparable services within the network. If the out of network	/Designee is required for the following types of referral		authorization approval for OON providers prior to rendering the		
authorized. This is also true for	treatment is warranted, HMSA			service.		
	will contract with the out-of-	requests: • Requests for		service.		
out of state non-emergency care.	network provider for a single case	services				
	1	from non-				
	agreement.	credentialed				
		providers; • Requests for				
		mainland/out of area				
		services;				
		• Experimental				
		treatments/therapies;				
		• Requests for				
		services where				
		there is internal				
		capability;				
		• Requests for				
		transplantation services.				
		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	Initial fees were established at the	Not applicable for inpatient.	`Ohana utilizes the outpatient fee	UnitedHealthcare's Medicaid Fee	`Ohana utilizes the outpatient fee	All MCO's are comparable. CCS
negotiated rates and vary	beginning of the QUEST program		schedule prescribed by the State	Schedule is developed using the	schedule prescribed by the State	is not more stringent.
according to terms reached in	in 1994. At that time, fees were		for reimbursing outpatient	State's Medicaid Fee Schedule	for reimbursing outpatient	
negotiation. Most begin with the	established based on the Medicaid		providers. Providers are	with alignment using Medicare	providers. Providers are	BH parity requirements met.
state's FFS fee schedule, or are a	FFS schedule at that time. Since		reimbursed at 100% of the State's	relatively. Where the fee source	reimbursed at 100% of the State's	
percentage of Medicare FFS fee	then increases or decreases were		fee schedule unless there is a	does not publish a specific fee	fee schedule unless there is a	
schedule. This is true for	based on the reimbursement rates		geographic or provider availability	amount, UnitedHealthcare will use	geographic or provider availability	
physicians, PhDs and MAs.	set by the state to the Insurance		issue that requires a higher	the CMS Gap fill using a % of	issue that requires a higher	
	plans. Adjustments are made to		percentage of the State's fee	prevailing Medicare.	percentage of the State's fee	
	the changes in coding that occur		schedule.		schedule.	
	nationally.			UnitedHealthcare will use		
				reasonable commercial efforts to		
	For ABD and Non-ABD, we			implement the updates in its		
	primarily follow the Medicaid fee			systems on or before the later of		
	schedule. Some provider's fees are			(i) 90 days after the effective date		
	individually negotiated.			of any modification made by the		
				Fee Source or (ii) 90 days after the		
				date on which the Fee Source		

Psychiatrists and Psychologists are	initially places information
paid the same rate. Child	regarding such modification in the
Psychiatrists are paid 110% of the	public domain (for example, when
Psychiatrist fee. Social workers,	CMS distributes program
Marriage Family Therapists,	memoranda to providers).
Mental health counselors, and	UnitedHealthcare will make the
APRNs are paid 85% of the	updates effective in its system on
psychiatrist rate.	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	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:	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 applied 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.

processes, strategies, eviden	tiary standards, and other factors appl	ied during a medical necessity/ approp	priateness review? Specifically addre	ss how frequency of review is dete	rmined and potential results followin	g such a review.
ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
AlohaCare's Utilization	In developing medical necessity	Medical	Outpatient services are reviewed	As defined in the Hawaii	In reviewing medical necessity	All MCO medical necessity reviews
Management Program (UMP)	standards for Medical/Surgical	necessity/appropriateness	by the services requested,	Revised Statutes ("HRS") 432e-	and appropriateness, industry	are comparable.
incorporates the functions of	outpatient services, HMSA	determinations are made after	dependent on codes and place of	1.4, the following components	accepted Medical criteria are	
utilization review/management	considers scientific evidence/peer	considering clinical information,	service. Medical necessity is	are taken into consideration:	utilized which routinely include:	BH parity requirements met.
(e.g., prospective, concurrent and	reviewed literature, professional	clinical urgency of the situation,	reviewed using clinical criteria,	"A health intervention is	<ul> <li>Risk of Harm,</li> </ul>	
retrospective reviews) of medical,	standards of care, expert opinion	and appropriate criteria/guideline	including industry accepted	medically necessary if it is	<ul> <li>Functional Status,</li> </ul>	
behavioral health, long term	and community input and utilizes	references. These references may	medical criteria and `Ohana	recommended by the treating	• Co-Morbidity,	
services and supports,	multiple sources including:	include	Clinical Coverage guidelines, to	physician or treating licensed	Recovery Environment,	
pharmacy/drug services. The	<ul> <li>Hawaii Revised Statutes (HRS</li> </ul>	- Medicare guidelines	make a determination.	health care provider, is	<u> </u>	
UMP monitors for over- or under-	7	from The Centers for	The industry accepted and `Ohana	approved by the health plan's	Acceptance,	
utilization, and inappropriate use	Blue Cross Blue Shield	Medicare & Medical	criteria reviewed in this	medical director	Engagement in	
of services.	Association guidelines and	Services (CMS); and	classification for services ranging	or physician designee, and is:	treatment, and	
	medical policies	- Medicaid requirements stated	from Speech, Physical and	(1) For the purpose of treating a	<ul> <li>Level of Support.</li> </ul>	
The AlohaCare UMP also	Milliman Care Guidelines	within the State of Hawaii	Occupational therapy services to	medical condition;	<ul> <li>Level Care Assessment</li> </ul>	
includes services that promote the	(MCG)	Department of Human Services	pre-planned surgeries routinely	(2) The most appropriate	tools	
continuity and coordination of		RFP-MQD- 2014-005.	include but are not limited to the	delivery or level of service,	These criteria are utilized for	
care through assistance and	Along with the available medical		following:	considering potential benefits	Psych testing, ECT, Substance	
support during care transitions,	evidence, additional consideration	Processes and frequency of		and harms to the patient;	Abuse services, Day	
disease management, and	is given to factors such as a	review are also guided by the	<ul> <li>Imaging results</li> </ul>	(3) Known to be effective in	Rehabilitation, Community	
collaborative care and service	treatment's cost-effectiveness,	Kaiser Permanente Hawaii	<ul> <li>Members age</li> </ul>	improving health outcomes;	Support, and Psychiatric	
coordination internally and	most appropriate delivery of level	Region policy on Utilization	<ul> <li>Past medical history or</li> </ul>	provided that:	Residential Rehabilitation.	
externally. It objectively	of service, and potential benefits	Decisions (#6425-502).	co-morbidities	(A) Effectiveness is determined	Providers submit an Outpatient	
monitors and evaluates the cost of	and harms to the patient to		<ul> <li>Symptoms and diagnosis</li> </ul>	first by scientific evidence;	Services request form via web	
care based on medical or	determine medical necessary of	Concurrent review and	<ul> <li>Prior level of function</li> </ul>	(B) If no scientific evidence	portal or fax to Utilization review	
functional appropriateness.	medical/surgical treatments and	authorization is not generally		exists, then by professional	and any clinical information that	
	services. Medical necessity criteria	performed for outpatient services.	Providers submit outpatient	standards of care; and	they feel is appropriate for initial	
The AlohaCare UMP assesses not	(aka policies) are developed by	A case may be reviewed if an	service requests. Outpatient	(C) If no professional standards	and recurrent review. Utilization	
just clinical aspects of care, but	HMSA Medical Directors with	extension is requested for pre-	services are requested via fax,	of care exist or if they exist but	Management sends a fax	
also factors that impact how care	input from medical practitioners in	authorized services.	web portal, phone or/and state	are outdated or	regarding authorization or calls	
is delivered/provided, such as	the community.		portals from the provider.	contradictory, then by expert	the provider to request further	
cultural and linguistic awareness		Only licensed physicians can make	If there is a concern that an	opinion; and	information.	
and sensitivity, enabling services,	Once policies are developed,	medical necessity denial	authorization does not meet	(4) Cost-effective for the	For substance abuse outpatient	
and continuous monitoring of	reviews of the medical necessity	determinations. Board certified	medical necessity, we offer a peer	medical condition being treated	services, `Ohana uses industry	
quality of service.	criteria are conducted at least	physicians from appropriate	to peer review and we will send	compared to alternative health	accepted medical criteria and	
	annually and more frequently as	specialty areas are used to assist in	for a secondary review by a	interventions, including no	`Ohana Clinical Coverage	
The UMP creation and decisions	new evidences become available	making determination of medical	Medical Director.	intervention. For purposes of	guidelines for criteria review.	
are developed by various		and clinical appropriateness.		this paragraph, cost effective	Examples of applied criteria	
committees comprised internal				shall not necessarily mean the	include:	
and external clinicians, non-				lowest price."	<ul> <li>Acute Intoxication and</li> </ul>	
clinicians, and subject matter				UnitedHealthcom	Withdrawal	
experts. Such committees are:				UnitedHealthcare uses Milliman Care Guidelines	<ul> <li>Potential, Biochemical</li> </ul>	
The Board Quality Committee					complications,	
(BOC), Medical Management				(MCG) evidenced based criteria	,,	
Committee (MCC), Practitioners				to determine the most		

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:
  - Chief Medical
     Officer, Medical
     Director, and
     Associate Medical
     Directors.
  - 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).	Generally Accepted Standards
o Director of	of Medical Practice are
Utilization	standards that are based on
Management.	credible scientific evidence
o Director of Health	published in peer-reviewed
Plan Operations.	medical literature generally
o Pharmacy Manager.	recognized by the relevant
o Others as relevant.	medical community, relying
Feedback from Practitioners	primarily on controlled clinical
Advisory Committee.	trials, or, if not available,
	observational studies from more
pproval of Medical	than one institution that suggest
Ianagement Committee.	a causal relationship between
he following M/S services must	the service or treatment and
eet criteria for coverage:	health outcomes.
set entena for es verage.	If no credible scientific
mbulatom/Outratiant augasmy	evidence is available, then
mbulatory/Outpatient surgery	standards that are based on
urable Medical Equipment	Physician specialty society
DME)	recommendations or
rosthetics and Orthotics	professional standards of care
ye surgery	may be considered.
dult Strabismus	UnitedHealthcare reserves the
ome and Community Based	
ervices	right to consult expert opinions
ome Health	in determining whether health
ome IV and infusion	care services are Medically
erapy/drugs	Necessary. The decision to
	apply Physician specialty
yperbaric Oxygen therapy	society recommendations, the
ysterectomy	choice of expert and the
ousing and meals when	determination of when to use
aveling to approved services	any such expert opinion, shall
continence supplies	be within our sole discretion.
Iastectomy	UnitedHealthcare develops and
prophylactic/gynecomastia)	
IRI/MRA scans below the neck	maintains clinical policies that
lective inpatient stays and	describe the Generally
irgery	Accepted Standards of Medical
apatient rehab	Practice scientific evidence,
	prevailing medical standards
on-Formulary Medication	and clinical guidelines
B Ultrasound beyond 3x	supporting our determinations
ccupational Therapy	regarding specific services.
ut of State non-emergency	
rvices	
ET scans of the brain	
nysical Therapy	
JVA therapy	
eep Studies	
beech therapy	
erilization procedures	
on-Emergent Medical	
ransportation (NEMT)	
Criteria/Guidelines used to make	
determination of Medical	
lecessity for Medical Outpatient	
coossity for medical Outpatient	

		T	
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/Provi			
ders/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.

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

**ALOHACARE** 

**HMSA** 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.

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.

Kaiser does not currently use step-

therapy protocols for outpatient

services/settings. See attached

Clarified response 10/31/18:

KAISER

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** 

'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.

UNITED

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'OHANA CCS

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### COMPARABILITY/STRINGENCY

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.

Clarified response 12/12/18: 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.)

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.

- 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.).

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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.

As of 12/17/18: 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	There are no exclusions based on	There are no exclusions based on	`Ohana uses clinical standards and	The medical/surgical inpatient	`Ohana uses clinical standards and	HMSA, Kaiser and UHC do not
course of treatment can be used as	failure to complete a course of	failure to complete a course of	guidelines to develop coverage	benefit does not include	guidelines to develop coverage	have exclusions.
a determining factor during a	treatment under Outpatient	treatment.	criteria that may contain	exclusions based on a failure to	criteria that may contain	'Ohana HP and CCS have the
review should additional units be	Medical/Surgical benefits.		exclusions for certain	complete a course of treatment. As	exclusions for certain	same standard.
requested. These cases will be sent			drug/products that may require a	noted in response to #1 above,	drug/products that may require a	Same Standard.
to Medical Director for review and			qualifying therapy that must be	inpatient coverage is determined	qualifying therapy that must be	Based on review of all MCO's it
continuation of services is based			tried and failed prior to	by medical necessity.	tried and failed prior to	seems that Ohana CCS is more
on meeting the appropriate			authorization for the drug/product		authorization for the drug/product	stringent in comparison to HMSA,
guidelines and Medical Necessity.			being requested. Coverage criteria		being requested. Coverage criteria	Kaiser and UHC.
			is reviewed quarterly during the		is reviewed quarterly during the	DU monitor in immonstion
			Pharmacy and Therapeutics		Pharmacy and Therapeutics	BH parity is in question.
			Committee meeting.		Committee meeting.	11/9/18:
			Clarified response 10/31/18:		Clarified response 10/31/18:	After discussion, the responses
			The QL description was submitted		The QL description was submitted	are comparable. 'Ohana
			in error due to a misinterpretation		in error due to a misinterpretation	documents "may contain
			*		*	exclusions", it is not a "yes".
			of the document line of questions.		of the document line of questions.	Board on this BU novity
			Quantity Limits (QL) rules and		Quantity Limits (QL) rules and	Based on this, BH parity requirements are no longer in
			Step Therapy (ST) rules are two		Step Therapy (ST) rules are two	question.
			distinct methods of Utilization		distinct methods of Utilization	
			Management deployed to ensure		Management deployed to ensure	BH parity requirements met.
			proper use of medication		proper use of medication	
			therapies.		therapies.	

## **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
<b>Prior Authorization Review</b>	Prior authorization is required for	Pre-service authorization is not	Prior authorization is required for	Certain outpatient services require	Industry accepted Medical Criteria	CCS is comparable to all other
Process	rehabilitative services such as	required for in-plan outpatient	certain outpatient services.	a prior authorization with the	are utilized to determine the	MCO's except Kaiser. Pre-auth is
	Physical Therapy, Occupational	rehabilitative service. Pre-	Medical necessity and	exception of emergency services	appropriate medical necessity	required for outpatient services
• PA Outpatient Medical services	Therapy, and Speech Therapy and	service authorization is required	appropriateness are required for	that are needed to evaluate or	("MN") per member. The	except for Kaiser.
made	for certain outpatient	for out-of-plan outpatient	prior authorization. Medical	stabilize an emergency condition	aforementioned criteria provide	After discussion, the responses
• Intake (TCSS) accepts request	medical/surgical procedures.	rehabilitative service.	necessity is determined using	as well as direct access to	assessment tools used to support	are comparable.
and creates authorization and			Industry accepted Medical criteria.	women's health services. Members	accurate level of care	are comparable.
pends them to the UM clinician	HMSA performs prior	Urgent pre-service decisions for		are held harmless for	recommendations. The assessment	BH parity requirements met.
for review	authorization reviews to evaluate	Medicaid members are	Outpatient services are requested	services/procedures that require a	determines clinical need based on	. , .
UM BH/Medical clinician	health care services for medical	communicated within 3 business	via fax, web portal, phone or state	prior authorization by a	multiple levels, including:	
accepts the authorization and	necessity in the following general	days of request receipt. Non-	portals from the provider. Services	participating provider (in-	<ul> <li>Mental,</li> </ul>	
applies the appropriate guidelines	categories:	urgent pre-service decisions are	are reviewed dependent on code,	network) in the event the provider	• Social,	
based on the request	• Services for which aberrant or	communicated within 14 calendar	place of service and clinical	does not obtain a prior	<ul> <li>Physical, and</li> </ul>	
• If guidelines are met, clinician	potential inappropriate patterns of	days of request receipt.	information received from the	authorization. Members may be	Current functioning	
approves the request and written	care are identified	Medicaid members are allowed	provider.	held liable for services/procedures	levels.	
notification of the decision is sent	• New technology or new uses of	up to a 14-calendar day extension		that require a prior authorization	Based on the results obtained from	
to the requesting and treating	existing technology	if they, or the provider, requests	Industry accepted medical criteria,	provided by a non-participating	these assessment tools, the	
provider	• Services with the potential for	the extension or if the health plan	`Ohana Clinical Coverage	provider without prior	•	
• If guidelines are not met, the	non-covered purposes (e.g.,	justifies the need for an extension	Guidelines and Benefit limits that	authorization (excluding as noted	appropriate amount of units based	
authorization is sent to a Medical	lifestyle enhancement,	and it's in the member's interest.	are applied in this classification	above	on medical necessity and services are authorized for 20 sessions.	
Director for a secondary review.	cosmetic services, surgery or	Members are informed of the	routinely include but are not	emergent/stabilization/women's		
Medical Directors will review for	supplies)	right to file a grievance if they		health services).	The session limit is to ensure that	

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	msure quality and prevent mexpected member out-of-pocket expenses  MSA utilizes medical policies for review of prior authorization equests. Medical policies are eveloped using the clinical vidence found in published medical literature, standards of fore, professional society	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.	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	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	
Director's decision, the UM BH/Medical clinician will either gui	are, professional society uidelines, and community ractitioners' input.	•		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?

member receives services.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
Concurrent reviews are not	Concurrent reviews are not	Concurrent review and	Concurrent Review is not	Outlier management algorithms	Concurrent Review is not	CCS has no restrictions.
conducted during the course of	required once a prior authorization	authorization is not generally	applicable to outpatient Services	are applied to outpatient services	applicable to outpatient Services	Therefore, BH services are not
treatment for outpatient medical	has been obtained for an	performed for outpatient services.		based on the following criteria:		more stringent in comparison to
services	outpatient M/S treatments. If	A case may be reviewed if an		•Treatment plans ranging from 1-		M/S services.
	continued treatment is medically	extension is requested for pre-		24+ visits, with the likelihood for		
	necessary, HMSA conducts prior	authorized services.		treatment being medically		BH parity requirements met.
	authorization reviews for			unnecessary increasing with		
	subsequent treatment period(s).	Reviews consider clinical		higher number of visits		
		information, clinical urgency of		•Treatment durations ranging from		
		the situation, and appropriate		1-365+ days, with the likelihood		

criteria/guideline references. for treatment being medically These references may include unnecessary increasing with - Medicare guidelines longer treatment durations from The Centers for •Visits including multiple units of Medicare & Medical services, with the likelihood for treatment being medically Services (CMS); and - Medicaid requirements stated unnecessary increasing with within the State of Hawaii higher number of services per visit •Potential to bill for the same Department of Human Services RFP-MQD- 2014-005. service using multiple levels of coding •Relatively low/modest cost per Processes and frequency of review are also guided by the service Kaiser Permanente Hawaii • Variable rates of patient Region policy on Utilization progress during a treatment plan Decisions (#6425-502). • Variable approaches to patient care among providers Only licensed physicians can make •Coverage up to and including the medical necessity denial point of maximum therapeutic determinations. Board certified benefit being attained, after which additional improvement is no physicians from appropriate specialty areas are used to assist in longer expected, and coverage for making determination of medical the same services may no longer and clinical appropriateness. 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 noncovered 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	Concurrent review processes are	Concurrent Review is not	Concurrent review is a component	Concurrent Review is not	CCS has no restrictions. Therefore,
	required once a prior authorization	determined for each case after	applicable to outpatient Services	of the plan's utilization	applicable to outpatient Services	BH services are not more stringent
	has been obtained for outpatient	evaluation of clinical		management activities and		in comparison to M/S services.
	M/S services. If continued	information, clinical urgency of		includes medical necessity		
	treatment is medically necessary,	the situation, and appropriate		reviews. The Medical Director and		BH parity requirements met.
	HMSA conducts prior	criteria/guideline references.		other independently licensed		
	authorization reviews for	These references may include		clinical staff review care to detect		
	subsequent treatment period(s).	- Medicare guidelines from The		and better manage over- and		
		Centers for Medicare & Medical		under-utilization and to determine		
		Services (CMS); and		whether continued services are		
		- Medicaid requirements stated		consistent with the member's		
		within the State of		coverage, medically appropriate		
		Hawaii Department of Human		and consistent with evidence-		
		Services RFP-MQD-		based guidelines.		
		2014-005.		If a service requires prior		
				authorization and services require		
		Processes and frequency of review		authorization beyond the initial.		
		are also guided by the Kaiser		The concurrent review considers		
		Permanente Hawaii Region policy on Utilization Decisions (#6425-		such criteria as length of		
		502) and Out-of-Plan Requests for		treatment, diagnosis, treatment		
		Care and Services (#5054-01-A).		plan concerns, prior services,		
		Care and Services (#3034-01-11).		efficiency of treatment, quality of		
		Only licensed physicians can make		care concerns, social determinants		
		medical necessity denial		of health, etc.		
		determinations. Board certified		The utilization management		
		physicians from appropriate		program will use evidence-based,		
		specialty areas are used to assist in		clinical review criteria to support		
		making determination of medical		clinical review decisions and		
		and clinical appropriateness.		determine length of		
				authorizations. Staff will apply the		
		Concurrent review denial rate was		clinical review criteria		
		0.016% and appeal overturn rate		consistently in accordance with		
		was 0% during annual period		written procedures and with		

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.	
the National Recognized Practice Guidelines and review and approve the use of these guidelines annually. UnitedHealthcare reviews these documents to adhere to NCQA standards.	
Guidelines and review and approve the use of these guidelines annually.  UnitedHealthcare reviews these documents to adhere to NCQA standards.	
approve the use of these guidelines annually. UnitedHealthcare reviews these documents to adhere to NCQA standards.	
guidelines annually. UnitedHealthcare reviews these documents to adhere to NCQA standards.	
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documents to adhere to NCQA standards.	
standards.	
UnitedHealthcare Clinical	
Services Medical Management	
(LICSMM) utilizes external and	
(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	
avidance based clinical practice	
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.	
Tot   "7   ai	
Tota   #/   ver   of	
Tota I % se Au	
#/%   of   De   th	
#/% of Ap ter Cas of Initi pe mi es of Initi pe	
of   Initi   pe   mi   es	
hs Adv d ion Per	
case erse Cas Cas sist	
s Dete es es ent	
w/In rmin ov Re Ad   itial atio ert ver ver	
itial atio ert ver   Adv n urn sed se	
erse Case ed oth De	
Total   Dete   s   on   er   ter	
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				pe al		
			201 23/ 8/21 48/0 47. .2% .5% 9%	10 9 30/ 5 51. (	96 5/1 0.2	
		9,559	.2%   .5%   9%	0%   9	%	

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	Concurrent Review is not	•If a service requires prior	Concurrent Review is not	CCS has no restrictions.
		authorization is not generally	applicable to outpatient Services	authorization and services require	applicable to outpatient Services	Therefore, BH services are not
		performed for outpatient services.		authorization beyond the initial.		more stringent in comparison to
		A case may be reviewed if an		•The concurrent review considers		M/S services.
		extension is requested for pre-		such criteria as length of		
		authorized services.		treatment, diagnosis, treatment		BH parity requirements met.
				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.		

## 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 drug benefits are	The selection of which drugs are	UnitedHealthcare does not restrict	The selections of which drugs are	CCS is more stringent than
	Prescription Drugs document	not tiered for Medicaid	covered use the same criteria for	or set limits on prescription drugs	covered use the same criteria for	AlohaCare, HMSA, Kaiser and
		members.	both medical and behavioral. The	provided in an outpatient setting.	both medical and behavioral. The	United.
		111011110 02.51	following is a summary of that		following is a summary of that	DII monitoriu monation
			process:	Due to the CMS Final Rule, tiers	process:	BH parity in question.
				related to brand vs. generic have		11/5/18:
				been established. The tiers are not		11/3/10.

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  Clarified response 10/31/18: No prescription drug benefits are	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.  tied to copays. The condition treated do not affect the tier assignment of a medication.  Tier Name Drug Tier  Tier 1 Generic  Tier 2 Brand	including the Rx utilization (UM) parity is no longer in question
1vo, prescription drug benefits are	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	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

## 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	Providers must be appropriately	Kaiser Permanente Hawaii	`Ohana provides contracted	The State of Hawaii sets the	`Ohana provides contracted	All MCO's are comparable for their
conducts annual and ad hoc	licensed or certified in accordance	Region (KP) is an integrated	networks of qualified	provider enrollment requirements	networks of qualified	provider network credentialing.
assessments of our provider	with state and national guidelines,	model of care which provides	organizational health care	for all provider types enrolled as	organizational health care	CCS is not more restrictive.
network delivery system to	meet all standard educational and	97% of KP member care via its	providers, and home and	Medicaid providers. This includes	providers, and community based	DII manifer na merimana anta mast
determine if it is meeting our	credentialing criteria for their	employed providers and	community-based service	requirements such as; NPI, tax ID,	case management providers (as	BH parity requirements met.
standards for network adequacy,	specialty, not be an excluded	facilities. To augment KP's	providers (as applicable to state)	provider disclosures, and	applicable to state) to the enrolled	
capacity, and member access. See	entity with Medicare or Medicaid	internal care delivery system,	to the enrolled membership in its	licensure/certification. All	membership in its Plan. `Ohana	
attached Selections and Retention	programs, and have met all	KP contracts with specialized	Plan. `Ohana performs initial and	applicable providers go through	performs initial and ongoing	
of Providers Policy. AlohaCare's	continuing educational	service providers, both within	ongoing assessments of its	the credentialing process that is	assessments of its organizational	
Policy includes provider exclusion	requirements specific to their	and outside the State of Hawaii.	organizational providers in	based on NCQA requirements.	providers in compliance with	
per federal and state requirements	provider type		compliance with applicable local,	Credentialing of a provider is	applicable local, state, and federal	
for government funded programs.		Network admission requirements	state, and federal accreditation	initiated prior to contracting with	accreditation requirements.	
Credentialing requirements	Provider must be willing to	are comprised of several factors	requirements. Information and	the provider. Once a provider has	Information and documentation on	
include common, state-wide and	contract at sustainable rates and to	which vary according to the	documentation on organizational	completed the credentialing	organizational providers is	
national standards such as	submit all required documentation	service provider. These factors	providers is collected, verified,	process and approved by the	collected, verified, reviewed, and	
licensed, certified, accredited, and	for both credentialing process and	include appropriate licensing,	reviewed, and evaluated in order	Credentialing Committee, they are	evaluated in order to achieve a	
in good standing, with	for system configuration for	accreditation, good standing	to achieve a decision to approve or	offered a contract with	decision to approve or deny	
Appropriate medical liability,	adjudication of provider claims.	against government agency listings	deny network participation.	UnitedHealthcare.	network participation.	
DEA, peer references, and other		of excluded individuals/entities,				
common credentialing and	Provider onboarding process can	education, training, board		Participation criteria for		
privileging verifications.	be initiated either by the health	qualification, certification,		practitioners include information		
	Plan or Provider followed by	reference checks, background		about the provider, such as:		
	·		·			

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 nonpar 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 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:

101 MQD 2011	005.	
Minutes of drive	URBAN	RURAL
time		
PCP	30	60
Specialist	30	60
Hospital	30	60
Emergency	30	60
Facility		
Mental Health	30	60
Pharmacy	15	60

- 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 inclinible, excluded or debarred.
- 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.

24-Hr	60	N/A	Our Medicaid members and
Pharmacy			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	HMSA does not have any	No practitioner types, facility	Practitioner types, facility types,	UnitedHealthcare does not	Practitioner types, facility types,	All MCO's are comparable.
excluded from participation in	exclusions pertaining to provider	types, or specialty providers are	or specialty providers are not	exclude any provider types	or specialty providers are not	
government healthcare programs.	types, facility types, or specialty	specifically excluded from	excluded in writing or in operation	however we may exclude a	excluded in writing or in operation	BH parity requirements met.
	providers.	eligibility to enter into contracting	from providing covered benefits if	provider based on the	from providing covered benefits if	
		consideration toward providing	they meet the criteria outlined in	credentialing criteria.	they meet the criteria outlined in	
		covered benefit services.	the assessment policies noted	UnitedHealthcare complies with	the assessment policies noted	
			above.	state licensing requirements and if	above	
				there is a 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.

ALOHACARE	HMSA	KAISER	'OHANA	UNITED	'OHANA CCS	COMPARABILITY/STRINGENCY
No such limitations	There are no geographic	Assuming the provider is within	The only geographic limitations	UnitedHealthcare does not impose	The only geographic limitations	CCS is more stringent.
	limitations	the U.S.A., there are no	on provider inclusion are the	or have any geographic limitations	on provider inclusion are the	AlohaCare, HMSA, Kaiser and
		geographic limitations on	service area of the plan (i.e., the	on provider inclusions.	service area of the plan (i.e., the	United all do not have geographic
		provider inclusion.	provider must practice within the		provider must practice within the	limitations. CCS is limited to the
			state where the Medicaid plan is).		state where the Medicaid plan is).	service area of the plan.
		Each provider candidate's			_	BH parity is in question.
		geographic area is considered in	Clarified response 10/31/18:		Clarified response 10/31/18:	Bit parity is in question.
		relation to the needs of the health	This question deals with the		This question deals with the	
		plan's membership within that	geographic limitations of our		geographic limitations of our	11/5/18:
		geographic area and Medicaid	contracting efforts to get providers		contracting efforts to get providers	Based on the clarification
		requirements stated within the	within our network and whether		within our network and whether	provided, it seems that BH

State of Hawaii Department		we have more stringent parity is no longer in question.
Human Services RFP-MQD		contracting and credentialing
2014-005.	requirements for BH providers	requirements for BH providers BH parity requirements met.
	than we do for medical providers.	than we do for medical providers.
	The answer is our contracting and	The answer is our contracting and
	credentialing requirements are the	credentialing requirements are the
	same regardless of provider	same regardless of provider
	specialty. Because the question	specialty. Because the question
	asked about out-of-network	asked about out-of-network
	providers, we stated that our only	providers, we stated that our only
	limitation re: contracting with	limitation re: contracting with
	providers was the boundaries of	providers was the boundaries of
	the geographic region defined by	the geographic region defined by
	the State for their membership.	the State for their membership.
	We do not "contract" with	We do not "contract" with
	providers outside the State's	providers outside the State's
	defined geographic service area.	defined geographic service area.
	If a member requires care that is	If a member requires care that is
	not available within our network	not available within our network
	of providers, we would identify	of providers, we would identify
	the closest out of network provider	the closest out of network provider
	available to provide the care and	available to provide the care and
	authorize via a Single Case	authorize via a Single Case
	Agreement. That, however, has	Agreement. That, however, has
	nothing to do with our contracting	nothing to do with our contracting
	requirements and the parity	requirements and the parity
	between how we contract for	between how we contract for
	providers between medical and	providers between medical and
	behavioral services.	behavioral services.
· · · · · · · · · · · · · · · · · · ·	<u> </u>	

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	QUEST Integration members have	Physician evaluates member. If	The Medicaid plan is an HMO	UnitedHealthcare provides access	The Medicaid plan is an HMO	All MCO's are comparable for
medically necessary care. OON	no out-of-network benefits except	out-of-plan referral appears	product, thus the member is	to Out of Network (OON)	product, thus the member is	OON benefits.
care must be prior authorized and	for emergencies. If a member is	appropriate, physician completes	restricted to their network	providers (non-contracted	restricted to their network	DUiti
coverage determinations are made	admitted for an emergent	an order for the request.	providers for non-emergent,	providers) if an in-network	providers for non-emergent,	BH parity requirements met.
based on clinical review	condition, no prior authorization		routine care. Out-of-Network	provider is unable to provide	routine care. Out-of-Network	
considering patient history with	or concurrent reviews are required	Department Chief receives	coverage is available for	medically necessary services in an	coverage is available for	
providers, and comparison of	until the time the member's	referral request and	emergency services and when	adequate and timely manner to a	emergency services and when	
provider specialties, training,	condition is stabilized. If a	performs	medically necessary services are	member and continue to authorize	medically necessary services are	
expertise, credentials, and on	member needs a treatment or	evaluation/determination.	not available in network. The	the use of non-contract providers	not available in network. The	
geography and proximity. If in-	service that is not available from		State's benefit plan design dictates	for as long as UnitedHealthcare is	State's benefit plan design dictates	
network providers of comparable	network providers, exception can	Medical necessity approval from	how members can access out of	unable to provide services through	how members can access out of	
credentials and specialties are	be made after a medical necessity	the Outside Medical Services	network benefits.	network providers.	network benefits.	
available in the medical service	review and verifying availability	Medical Director or other		UnitedHealthcare requires prior		
area, care is re-directed to the	of comparable services within the	appropriate Department Chief		authorization approval for OON		
network. If not, then OON care is	network. If the out of network	/Designee is required for the		providers prior to rendering the		
authorized. This is also true for	treatment is warranted, HMSA	following types of referral		service.		
out of state non-emergency care.	will contract with the out-of-	requests:				
	network provider for a single case	<ul> <li>Requests for</li> </ul>				
	agreement.	services				
		from non-				
		credentialed				
		providers;				

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mainthum/found of more secretarial secretarial secretarial tourisemental tourisemental tourisemental secretariaes.  Requests for services where secretariaes secretariaes where secretar	Requests for		
services:  - Propermetal-project - Propermetal-project - Requests for services where there is instead opposition; - Committee of the project	mainland/out of area		
Experimental treatments thereprise; Requests for there is numeral capability; Request of the control of the con	services:		
nearment-therapies;  - Requests for services whereas and services whereas a service whereas a se			
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service where during the street of the stree	treatments/therapies,		
there is internal capability: Recquests for Interpolation services.  Medical necessity determination is referred to Authorizations and letelerial Management (AMA). If the leteral Management (AMA) is reven. AMM neviews request to ensure that referred guidelines and criteria are rest:  The requested service is conflied service in conflied service is conflied service in conflied to the service is a crossed Health  The requested service is not available within Plung The requested service is not available within Plung The patient is an interpolation The requested service is not available within Plung The patient is an interpolation Service is a convect of the service is	Requests for		
equalities; Requests for Irangulatistion services.  Medical processity Idearmonation is referred to Authorizations and Reformal Management (ARM). If nendeal nucleosity is approved, ARM reviews request to ensure that referral guidelines and treatment in the response of the response of the referral guidelines and treatment in the response of the resp	services where		
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Medical necessity determination is referred to Authorizations and Referral medical necessity is approved. ARM reviews requests to ensure that referral guidelines and crieria are met:  The equested service is certified and the review is a covered Health Plan Denetti Plan Denetti Plan Denetti The requested available within Plan  The patient is an eligible Health Plan member; The patient is and eligible Health It criteria met. ARM will generate the authorization, outfly the receiving provider, practitioner of the approval, and generate an offication relater to	transplantation services		
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determination is referred to Authorizations and Referral Management (ARM). II medical accessity is upproved, ARM reviews request to ensure that referral gatachines and critical and accessing the second of the sec	N. 1. 1		
Authorizations and Referral Management (ARM). If readieal necessity is approved. ARM reviews request to ensure that referral guidelines and criteria are met:  • The requested service's certified on medically ChiefDesignee • The service is a covered Health Plan henefit; • The requested service is not available within Plan; • The patient is on eligible Health Plan temesters  • The patient is on eligible Health  Plan temesters  • Referral parameters (requency) durations) are clearly defined, and • Selected provider practificate is  • Criteria may, ARM will generate the authorization notify the receiving provider, notify the requesting practitions of the approval, and generate the authorization notify the receiving provider, notify the receiving provider.			
Management (ARM). If melicial necessity is approved, ARM reviews request to ensure that referred guidelines and eriteria ate net:  Transparent recommendation of the property			
medical necessity is approved, AMM reviews request to resure that referral gudelines and criteria are met:  - The requested - Service is certified - as medically - Chief Designee: - The service is a - covered Health - Plan benefit; - The requested - service is not - available within - Plan; - The praire via an - eligible leathin - Plan; - The praire via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible leathin - Plan member; - The parient via an - eligible repeated via an -			
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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 receiving provider and generate a notification letter to			
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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	<ul> <li>The patient has benefits</li> </ul>		
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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			
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	duration) are clearly		
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	duration) are clearly		
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	defined; and		
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			
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	practitioner is		
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	credentialed or has		
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			
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	with health plan		
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notify the requesting practitioner of the approval, and generate a notification letter to	notify the receiving provider,		
practitioner of the approval, and generate a notification letter to	notify the requesting		
generate a notification letter to	practitioner of the approval and		
the member.	generate a notification letter to		
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	me 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	Initial fees were established at the	In this island State of Hawaii,	`Ohana utilizes the outpatient fee	UnitedHealthcare's Medicaid Fee	`Ohana utilizes the outpatient fee	All MCO's are comparable.
negotiated rates and vary	beginning of the QUEST program	provider supply and demand in	schedule prescribed by the State	Schedule is developed using the	schedule prescribed by the State	
according to terms reached in	in 1994. At that time, fees were	target geographic areas of need	for reimbursing outpatient	State's Medicaid Fee Schedule	for reimbursing outpatient	BH parity requirements met.
negotiation. Most begin with the	established based on the Medicaid	is a primary influencer of	providers. Providers are	with alignment using Medicare	providers. Providers are	
state's FFS fee schedule, or are a	FFS schedule at that time. Since	professional provider	reimbursed at 100% of the State's	relatively. Where the fee source	reimbursed at 100% of the State's	
percentage of Medicare FFS fee	then increases or decreases were	reimbursement rates for	fee schedule unless there is a	does not publish a specific fee	fee schedule unless there is a	
schedule. This is true for	based on the reimbursement rates	physicians, PhD, MA and other	geographic or provider availability	amount, UnitedHealthcare will use	geographic or provider availability	
physicians, PhDs and MAs.	set by the state to the Insurance	professionals. While the	issue that requires a higher	the CMS Gap fill using a % of	issue that requires a higher	
	plans. Adjustments are made to	Medicaid fee schedule is	percentage of the State's fee	prevailing Medicare.	percentage of the State's fee	
	the changes in coding that occur	considered, the actual provider	schedule.		schedule.	
	nationally.	reimbursement rates may be		UnitedHealthcare will use		
		higher.		reasonable commercial efforts to		
	For ABD and Non-ABD, we			implement the updates in its		
	primarily follow the Medicaid fee	Beyond the issues related to		systems on or before the later of		
	schedule. Some provider's fees are	supply and demand,		(i) 90 days after the effective date		
	individually negotiated.	professional provider		of any modification made by the		
		reimbursement rates are not		Fee Source or (ii) 90 days after the		
	Psychiatrists and Psychologists are	specifically impacted by service		date on which the Fee Source		
	paid the same rate. Child	type, practice size, and		initially places information		
	Psychiatrists are paid 110% of the	licensure.		regarding such modification in the		
	Psychiatrist fee. Social workers,			public domain (for example, when		
	Marriage Family Therapists,			CMS distributes program		
	Mental health counselors, and			memoranda to providers).		
	APRNs are paid 85% of the			UnitedHealthcare will make the		
	psychiatrist rate.			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	Due to access issues, provider	In this island State of Hawaii,	None of the following factors	Professional provider	None of the following factors	All MCO's are comparable.
service demand/network adequacy	rates may be negotiated to help the	provider supply and demand in	affect how professional provider	reimbursement rates do not vary	affect how professional provider	
and capacity are the primary	rural areas. Individually	target geographic areas of need	reimbursement rates are	based on the factors listed above.	reimbursement rates are	BH parity requirements met.
drivers for both M/S and	negotiated rates are reviewed on a	is a primary influencer of	determined:	In limited instances variations can	determined:	
MH/SUD providers. Some	case-by-case basis and could	professional provider	Service Type	occur based on availability of	Service Type	
medical and mental health	match Medicare or commercial	reimbursement rates. While the	<ul> <li>Service demand</li> </ul>	certain limited specialty services	Service demand	
specialties are in a workforce	business.	Medicaid fee schedule is	<ul> <li>Provider Supply</li> </ul>	in Hawaii.	Provider Supply	
shortage situation.		considered, the actual provider	Practice Size		Practice Size	
		reimbursement rates may be	Medicare reimbursement		Medicare reimbursement	
		higher.	rates		rates	
		Beyond the issues related to supply			• Licensure	
		and demand, professional provider				

reimbursement rates are not	*`Ohana utilizes the fee schedule	*`Ohana utilizes the fee schedule	
specifically impacted by service	prescribed by the State for	prescribed by the State for	
type, practice size, and licensure.	reimbursing outpatient providers	reimbursing outpatient providers	
	as noted above. All providers are	as noted above. All providers are	
	reimbursed at 100% of the State's	reimbursed at 100% of the State's	
	fee schedule unless there is a	fee schedule unless there is a	
	geographic or provider availability	geographic or provider availability	
	issue that requires a higher	issue that requires a higher	
	percentage of the State's fee	percentage of the State's fee	
	schedule.	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	HMSA's QUEST Integration	The health plan does not establish	Medical Necessity Criteria	As defined in the Hawaii Revised	Medical Necessity Criteria	CCS has no restrictions.
Management Program (UMP)	formulary is based on the CVS	medical necessity criteria for	Development is not applicable to	Statutes ("HRS") 432e-1.4, the	Development is not applicable to	Therefore, BH services are not
incorporates the functions of	Caremark National Managed	prescription drugs. The	Prescription Drugs	medical necessity/appropriateness	Prescription Drugs	more stringent in comparison to
utilization review/management	Medicaid Template Formulary.	prescriber makes the final		criteria for drug therapy are		M/S services.
(e.g., prospective, concurrent	The CVS Caremark National P&T	decision regarding what drug is		developed by UnitedHealthcare		
and retrospective reviews) of	Committee manages this	medically necessary and		Pharmacy (UHCP) Team. Once		BH parity requirements met.
medical, behavioral health,	formulary and reviews the safety	appropriate for the member. If		developed or modified by UHCP		
	and efficacy of each drug to	that drug is not on the formulary,		the criteria is directed to the		
long term services and	determine formulary inclusion or	the prescriber submits the		Pharmacy and Therapeutics (P&T)		
supports, pharmacy/drug services. The UMP monitors	exclusion. Decisions are based on	prescription/order for the		Committee process for review and		
	evidenced-based medicine	non-formulary drug to a Kaiser		adoption. The P&T Committee		
for over- or under-utilization,	principles, well established	Permanente (KP) pharmacy. The		meets quarterly. Issues pertaining		
and inappropriate use of	clinical practice guidelines, scientific evidence, peer-reviewed	pharmacist and prescriber may collaborate on evaluating the		to drug selection and pharmacy program management are		
services.	medical literature, and standards	circumstances for considering the		communicated quarterly through a		
TI ALL C. IDAD.	of practice.	non-formulary drug, assessing the		newsletter to providers and are		
The AlohaCare UMP also	or practice.	member's need for the non-		also available on the		
includes services that promote		formulary drug, and determining if		UnitedHealthcare Community		
the continuity and coordination		a comparable formulary drug or		Plan internet site		
of care through assistance and		over the counter drug can be				
support during care transitions,		considered for use. If the		An overview of the process is as		
disease management, and		prescriber determines that a non-		follows:		
collaborative care and service		formulary drug must be utilized,		1. Development of Criteria		
coordination internally and		then the health plan covers the		a. The process is generally		
externally. It objectively		non-formulary drug per the		initiated by the approval of a		
monitors and evaluates the cost		member's benefit plan.		medication by the Food and Drug		
of care based on medical or				Administration (FDA). Once		
functional appropriateness.				approved by the FDA the medication will be reviewed for		
				inclusion in the preferred drug list		
The AlohaCare UMP assesses				(PDL). As part of the review		
not just clinical aspects of care,				medical necessity/appropriateness		
but also factors that impact how				criteria for use may be drafted if		
care is delivered/provided, such				deemed appropriate by the review.		
as cultural and linguistic				b. When drafting the medical		
awareness and sensitivity,				necessity/appropriateness criteria		
enabling services, and				the following are considered:		
continuous monitoring of				review of FDA approved product		
quality of service.				labeling, peer-reviewed medical		
				literature, including randomized		
The UMP creation and				clinical trials, drug comparison		
decisions are developed by				studies, pharmacoeconomic		
various committees comprised				studies, outcomes research data,		
internal and external clinicians,				published clinical practice		

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	y a			
medical policy analyst.				
<ul> <li>Vetting of the proposed</li> </ul>				
medical policy among				
internal staff:				
<ul> <li>Chief Medical</li> </ul>				
Officer, Medica				
Director, and				
Associate Medi	al			
Directors.				
<ul> <li>Senior Director</li> </ul>	of			
Long Term Ser	ces			
and Support				
(Service				
Coordination).				
<ul> <li>Director of</li> </ul>				
Utilization				
Management.				
<ul> <li>Director of Hea</li> </ul>				
Plan Operation				
<ul> <li>Pharmacy Man</li> </ul>	ger.			
<ul> <li>Others as relevant</li> </ul>	it.			
<ul> <li>Feedback from</li> </ul>				
Practitioners Advisory				
Committee.				
<ul> <li>Approval of Medical</li> </ul>				
Management Committe	۶.			
		<u> </u>		

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)  Fail first req therapy (ST) standards of current clinic processes of evidence-base expert opinion current	virements or step of criteria are based on medical practice, cal principles and pharmacotherapy, sed drug information, on, drug labeling, clinical trials, conomic studies, and search data. All ST is are reviewed and the CVS Caremark T Committee. ST is are reviewed more frequently when ons or information lable.  No step-ther protocols are decision to it protocol were pharmacy & Committee at the committee at the criteria are based on protocols are decision to it protocol were pharmacy & Committee at the criteria are based on protocols are decision to it protocol were pharmacy & Committee at the criteria are based on protocols are decision to it protocol were pharmacy & Committee at the criteria are based on medical practice, and protocol were pharmacy & Committee at the criteria are based on protocols are decision to it protocol were pharmacy & Committee at the criteria are based on medical practice, and protocol were pharmacy & Committee at the criteria are based on protocols are decision to it protocol were pharmacy & Committee at the criteria are based on protocol were pharmacy & Committee at the criteria are based on protocols are decision to it protocol were pharmacy & Committee at the criteria are protocol were pharmacy & Clarified results are reviewed and the CVS Caremark are reviewed more frequently when ons or information lable.	erapy (aka "fail first") re in place. The implement such a rould be made by the & Therapeutics and reviewed annually.  response 10/31/18: s not currently use step- ptocols for outpatient ttings. See attached fullary policy (65-61- fion 4.2.4. re Permanente Hawaii fullary currently does to traditional prior fon (PA), step therapy, fut protocols and s, but in the event the mittee decides to	`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	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.

Clarified response 12/12/18: 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.).

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

The purpose is to ensure safe, proper and cost effective medication use. Members are required to try and fail preferred agents prior to receiving nonpreferred agents to encourage the use of cost-effective drug therapies (preferred agents) prior to being able to fill the more expensive drug therapies (nonpreferred agents). Preferred agents are more cost-effective than nonpreferred 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

#### Clarified response 10/31/18:

failure of alternative drug(s),

allergic reaction to preferred

product, etc.).

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.

### As of 12/17/18:

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	According to HMSA's Hepatitis C	There are no exclusions based on	Ohana uses clinical standards and	There are no exclusions based on	`Ohana uses clinical standards and	CCS is more stringent than
questions. Exclusions based on	Policy, a repeat treatment for	failure to complete a course of	guidelines to develop coverage	failure to complete treatment.	guidelines to develop coverage	Kaiser, HMSA and United.
failure to complete a course of treatment and other exclusions are	hepatitis C medication will not be covered if a member had	treatment	criteria that may contain exclusions for certain		criteria that may contain exclusions for certain	BH parity is in question.
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.	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.		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.	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.
			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.		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.	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	Prior authorization (PA) helps	Prior authorization is not required	N/A for prescription NQTL	Medications that are on the	N/A for prescription NQTL	CCS has no restrictions.
and NCDs, manufacturers labeling	promote safe and appropriate	for prescription drug coverage by		UnitedHealthcare Prescription		Therefore, BH services are not
information and other components	medication utilization. The goal is	health plan.	Clarified response 10/31/18:	Drug List (PDL) are selected	Clarified response 10/31/18:	more stringent in comparison to
of the UMP described in item #1	to ensure that the drug, dosing,		Yes, Prior Authorizations are	because they are considered both	Yes, Prior Authorizations are	M/S services.
above, medications that require a	and treatment duration are		reviewed according to coverage	clinically appropriate and cost-	reviewed according to coverage	
PA, have quantity limits, or	appropriate for the member. The		criteria established through our	effective. When a drug not listed	criteria established through our	BH parity requirements met.
require step therapy are loaded	CVS Caremark PA Center will		Pharmacy & Therapeutic	on the PDL is requested by a	Pharmacy & Therapeutic	
into the Pharmacy Point Of Sale	collect information (e.g. diagnosis,		Committee and completed within	provider, it must go through the	Committee and completed within	
(POS) system by AlohaCare's	previous medications, allergies,		the timeframes garnered in our	prior authorization review.	the timeframes garnered in our	
Pharmacy Benefits Manager	contraindications, etc) from the		contract with the State.		contract with the State.	
(Express Scripts, Inc so that they	provider to determine whether the			Prior authorization is required		
will not pay unless the PA is	member meets the established			when a provider prescribes non-		
approved. Except for urgent and	criteria for the drug. PA criteria			formulary/non-PDL medication or		
emergent needs during non-	are based on standards of medical			certain formulary medications that		
business hours, these are reviewed	practice, current clinical principles			have precursor therapies, specific		
by AlohaCare Pharmacists before	and processes of			indications, or not routinely		
dispensing of medications and	pharmacotherapy, evidence-based			covered due to plan Benefit		
payment through the POS occurs.	drug information, expert opinion,			Limitations or Exclusions.		
Interaction with the prescribing	drug labeling, randomized clinical					
physician and review of the	trials, pharmacoeconomic studies,			An overview of the prior		
	and outcomes research data. All			authorization process is as		

medical record may be utilized to	PA requirements are reviewed and	follows:
consider for meeting criteria.	approved by the CVS Caremark	• The provider prescribes a
8	National P&T Committee. PA	medication for the member that is
	requirements are reviewed	one of the following: non-
	annually or more frequently when	formulary; or, formulary but
	new indications or information	requires precursor therapies or has
	become available.	
	become available.	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.	
		annocossary.	

## 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	N/A	Concurrent review of prescribed	N/A for prescription NQTL	Medispan database is used to	N/A for prescription NQTL	CCS has no restrictions.
Management which includes:		drugs is not required for continued		assist retail and mail order		Therefore, BH services are not
timely processing of referrals		health plan coverage.		pharmacists with therapeutic		more stringent in comparison to
and prior authorization of				decisions with at least 9 system		M/S services.
medical, surgical, or behavioral				edits. Duration of treatment, drug-		
health services in terms of				drug interactions, and therapeutic		BH parity requirements met.
specialty care, diagnostics,				duplication are some of the edits		
				that are used		
treatments; prospective,						
concurrent and retrospective				The screening edits that are		
reviews related to appropriate				utilized include:		
utilization; and medical policy				Drug-Drug Interaction		
development where coverage				Screening		
determination tools such as				2) Diagnosis Caution		
InterQual, Medicare NCD or				Screening		
LCD, DMERC do not				3) Drug Inferred Screening		

1 11 '6'	 	1) B	
adequately address specific		4) Drug-Age	
requests for services;		Contraindication	
		Screening 5) Description	
The AlohaCare Medical		5) Drug-Sex	
Director and Associate		Contraindication	
Medical Directors, under the		Screening 6) Duplicate Prescription	
direction of and in concert with		Screening	
the Chief Medical Officer,		7) Drug Class Duplication	
participate in medical		Screening	
management/utilization review		8) Refill Too Soon	
decision making operations		Therapeutic Dose Limits	
over the full scope of plan		Screening	
benefits through prospective,		6	
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.			

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	N/A	Concurrent review of prescribed	N/A for prescription NQTL	A concurrent DUR program	N/A for prescription NQTL	CCS has no restrictions.
Management which includes:		drugs is not required for continued		screens all retail and mail service		Therefore, BH services are not
timely processing of referrals		health plan coverage.		prescription claims at the point of		more stringent in comparison to
and prior authorization of				service before the drug is		M/S services.
medical, surgical, or behavioral				dispensed.		
health services in terms of				The concurrent DUR system		BH parity requirements met.
specialty care, diagnostics,				screens each prescription against		
-				the member's		
treatments; prospective,				prescription drug history. The		
concurrent and retrospective				system checks for inappropriate		
reviews related to appropriate				drug prescribing and		
utilization; and medical policy				utilization, as well as potentially		
development where coverage				dangerous medical implications or		
determination tools such as				drug interactions.		
InterQual, Medicare NCD or						
LCD, DMERC do not						

adequately address specific	The program includes
requests for services;	communication avenues through
requests for services,	claims edits and messaging to
We currently do not perform	the dispensing pharmacy at point-
* *	of-service.
any concurrent reviews for	
outpatient or pharmacy	Our concurrent reviews do not
medications. Requests for post	have appeal overturn rates but the
services are treated as	average number of prescriptions
Retrospective reviews. These	that were screened through the
are treated the same as regular	cDUR program during 2017 had a
or prospective reviews.	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	N/A	Concurrent review of prescribed	N/A for prescription NQTL	POS edits are conducted whenever	N/A for prescription NQTL	CCS has no restrictions.
any concurrent reviews for		drugs is not required for continued		a prescription is filled at point of		Therefore, BH services are not
outpatient or pharmacy		health plan coverage.		service at a retail or mail order		more stringent in comparison to
medications. Requests for post				pharmacy.		M/S services, which meets parity
services are treated as				The UnitedHealthcare Pharmacy		requirements. CCS has no
Retrospective reviews. These				reviews the DUR summaries		restrictions. Therefore, BH
are treated the same as regular				quarterly and they are then		services are not more stringent in
				reviewed by the Quality		comparison to M/S services.
or prospective reviews.				Management Committee.		
						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	HMSA's QUEST Integration	Prescription drug benefits are not	The selection of which drugs are	Due to the CMS Final Rule, tiers	The selections of which drugs are	CCS is more stringent than
Formulary or Non-Formulary	Formulary is not a tiered	tiered for Medicaid members.	covered use the same criteria for	related to brand vs. generic have	covered use the same criteria for	HMSA, Kaiser and United.
Status Only	formulary.		both medical and behavioral. The	been established. The tiers are not	both medical and behavioral. The	DIL control to the more of the
Closed Formulary			following is a summary of that	tied to copays. The conditions	following is a summary of that	BH parity is in question.
PA required for selected			process:	treated do not affect the tier	process:	11/5/18:
medications and situations,				assignment of a medication.		Based on the clarified
including non-formulary, step			Preferred Drug List (PDL) design		Preferred Drug List (PDL) design	response, BH parity is no
therapy, and quantity limits			including the Rx utilization (UM)	Tier Name Drug Tier	including the Rx utilization (UM)	longer in question.
			criteria are based on the following	Tier 1 Generic	criteria are based on the following	
			guiding principles and	Tier 2 Brand	guiding principles and	BH parity requirements met.
			considerations for all therapeutic		considerations for all therapeutic	
			classes and is governed by the		classes and is governed by the	
			same standard Pharmacy and		same standard Pharmacy and	

	Therapeutic (P&T) committee.	Therapeutic (P&T) committee.
	a. Verify clinical appropriateness	a. Verify clinical appropriateness
	<ul><li>b. Ensure drug safety</li><li>c. Prevent fraud and diversion</li></ul>	<ul><li>b. Ensure drug safety</li><li>c. Prevent fraud and diversion</li></ul>
	d. Detect members receiving	d. Detect members receiving
	duplicate or unnecessary medication therapies from	duplicate or unnecessary medication therapies from
	multiple prescriber's	multiple prescriber's
	e. Detect and prevent substance	e. Detect and prevent substance
	abuse f. Allow coverage for	abuse f. Allow coverage for
	medications not listed on the PDL	medications not listed on the PDL
	Clarified response 10/31/18:	Clarified response 10/31/18:
	No, prescription drug benefits are not tiered for Medicaid	No, prescription drug benefits are not tiered for Medicaid
	beneficiaries.	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
The health plan shall not	Every pharmacy must supply	Not applicable for prescription	N/A for prescription NQTL	The State of Hawaii sets the	N/A for prescription NQTL	CCS has no restrictions.
discriminate with respect to	documentation, pass enrollment,	drugs.		provider enrollment requirements		Therefore, BH services are not
participation, reimbursement,	and meet certification			for all provider types enrolled as		more stringent in comparison to
or indemnification of any	requirements prior to joining the			Medicaid providers. We		M/S services.
provider who is acting	pharmacy network.			contractually require each		DT 1
within the scope of his or	Engallment as swinson sate.			pharmacy to ensure credentials		BH parity requirements met.
her license or certification	Enrollment requirements: - Provider Agreement (base			and compliance as well as Chain and PSAO organizations to		
under applicable State law,	contract)			maintain a credentialing program		
solely based on that license or	- Credentialing			for itself and their member		
certification. The health plan	forms/answers to			pharmacies.		
shall not discriminate against	enrollment application			p.i.i.i.uv.iv.ii		
providers serving high-risk	questions			Processes:		
populations or those that	- Copies of current state			We contractually require each		
specialize in conditions	license(s)			pharmacy to ensure credentials		
requiring costly treatments.	<ul> <li>Copy of DEA certificate</li> </ul>			and compliance as well as Chain		
This is not to be construed as:	- Copy of Liability policy			and PSAO organizations to		
(1) requiring that the health	- FWA training attestation			maintain a credentialing program		
plan contract with providers	<ul><li>NCPDP and NPI</li><li>Network enrollment forms</li></ul>			for itself and their member		
beyond the number necessary	- Network enrollment forms			pharmacies.		
to meet the needs of its	Credentialing verification process:			Credentialing requirements, but		
members; (2) precluding the	- State Pharmacy and			are not limited to:		
health plan from using	Pharmacist-In-Charge			Validation of state		
different reimbursement	licenses (must be active,			pharmacy licenses		
amounts for different	in-date, and in good			<ul> <li>Validation of the</li> </ul>		
specialties or for different	standing)			Pharmacist in Charge		
practitioners in the same	- Pharmacy's DEA license			License		
specialty; or (3) precluding	(must be active, in-date,			Validation of the DEA		
the health plan from	and in good standing)			license		

- t - l'i-l' - l' - l' - l' - l' - l' - l'	
establishing measures that are - Pharmacy's NCPDP and - Insurance showing	
designed to maintain quality of NPI numbers adequate coverage	
designed to maintain quarty of	
bet vices and control costs and	
are consistent with its  active and meet minimum  Invoice/Drug Purchase	
responsibilities to members.  Coverage requirements)  Packing Slip	
- Pharmacy address	
The health plan is not required Exclusion searches (all Exclusion searches)	
to contract with every willing  officers, owners, entities,  Review of disciplinary	
and managing employees	
Touristions and any	
individuals or groups of Federal OIG/SAM other adverse actions	
providers of a specialty databases and State	
grouping in its network, it shall  Medicaid exclusion lists  In addition, each month we	
provide that information in its  FWA training attestation (must be validate our pharmacy network	
proposal. in-date and not set to expire within against the U.S. Department of	
AlohaCare's provider network the next 30 days) Health and Human Services,	
Office of Increase Consul (OIC)	
list of avaluded individuels and	
I RETENTION OF PROVINCES NOTICE	
which outlines the development,	
excluded pharmacy is on that	
other aspects of the provider that list, are immediately termed	
network.  from the pharmacy network.	
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	
State and rederal laws	
All pharmacies are fully re-	
credentialed at least every three	
years.	
years.	
T3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
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
etanility) Devend Lies
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,
Submission compitance,
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
tasting aloon room garb
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 USD 707, defined
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.	

<sup>10.</sup> 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	N/A	Not applicable for prescription	N/A for prescription NQTL	No	N/A for prescription NQTL	CCS has no restrictions.
discriminate with respect to		drugs.				Therefore, BH services are not
participation, reimbursement,						more stringent in comparison to
or indemnification of any						M/S services.
provider who is acting						DII
within the scope of his or						BH parity requirements met.
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 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	Assuming the pharmacy provider	N/A for prescription NQTL	On an annual basis as part of the	N/A for prescription NQTL	CCS has no restrictions.
	limitations	is within the U.S.A., there are no		PBAoversight audit,		Therefore, BH services are not
		geographic limitations on provider	Clarified response 10/31/18:	UnitedHealthcare will validate	Clarified response 10/31/18:	more stringent in comparison to
	HMSA has a sufficient network of	inclusion.	`Ohana follows all State and	network access levels by the	`Ohana follows all State and	M/S services.
	pharmacies to ensure geographic		Federal GeoAccess guidance on	review of GeoAccess reports. In	Federal GeoAccess guidance on	
	pharmacy access standards		Pharmacy Network access.	the event that a network	Pharmacy Network access.	BH parity requirements met.
				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);		
				<ul> <li>24 Hour Pharmacy for</li> </ul>		
				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]		
				1 IIIIe J		

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
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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 noncredentialed 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	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.
		• The service is a				

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.		
1		
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.		
the member.		
Only linemed about the con-		
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	N/A	Not applicable for prescription	N/A for prescription NQTL	Reimbursement rates depend on	N/A for prescription NQTL	CCS has no restrictions.
obtained based on national		drugs.		the contract with the pharmacy.		Therefore, BH services are not
volumes for Medicaid and made				An equal percentage of the		more stringent in comparison to
available to AlohaCare by the				standard is applied to both M/S		M/S services.
PBM.				and MH/SUD.		
						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	N/A	Not applicable for prescription	N/A for prescription NQTL	Service type and geographic	N/A for prescription NQTL	CCS has no restrictions.
pricing is obtained based on		drugs.		market affects reimbursement		Therefore, BH services are not
national volumes for Medicaid				rates. Specialty pharmacies, for		more stringent in comparison to
and made available to AlohaCare				example, have a different		M/S services.
by the PBM.				reimbursement rate compared to a		
				retail pharmacy. A small rural		BH parity requirements met.
				pharmacy can have a different rate		
				of reimbursement than a retail		
				chain pharmacy. 340B pharmacies		
				have different reimbursement		,
				rates.		!

# ATTACHMENT (D) NQTL SUMMARIES

Specific MCOs

## STATE OF HAWAII DEPARTMENT HUMAN SERVICES

# NQTL ANALYSIS SUMMARY- INPATIENT

Areas of Questionable BH Parity	Care		er	na	D)	S	Action	Corrective Action Responsibility			Status
	AlohaCare	HMSA	Kaiser	Ohana	UHC	CCS		MCO (s)	CCS	State	
Medical Necessity Criteria  Development - #2:  Fail first requirements or steptherapies (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	as of Gnestionaple BH barity  HMSA  UHC  CCS		ט	) [8	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	Care	, Y	er	na	D	S	Action		ective A sponsibi		Status
	eas of Questionable BH Parity    AlohaCare   HMSA		CCS		MCO (s)	CCS	State				
Medical Necessity Criteria  Development - #2:  Fail first requirements or steptherapies (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	Care	, Y	er	na	D	S	Action		ective A sponsibi		Status
	Areas of Questionable BH Parity    AlohaCare		ΠΠ	CCS		MCO (s)	CCS	State			
Medical Necessity Criteria  Development - #2:  Fail first requirements or steptherapies (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

# $Medical/Surgical\ (M/S)\ and\ Mental\ Health/Substance\ Use\ Disorder\ (MH/SUD)\ Benefits$

Hospital facility fee — acute inpatient  Physician/surgeon fee — acute inpatient  Physician/surgeon fee — acute inpatient  Hospital facility fee (e.g., hospital room) - female sterilization  Professional foes — maternity delivery  Inpatient hospice facility fee (e.g., hospital room)  Silited nursing facility fee (e.g., hospital room)  Silited nursing facility fee (e.g., hospital room)  Silited nursing facility fee (e.g., hospital room)  Child dental: diagnostic and preventive  Child eye exam  Outpatient surgery facility fee (e.g., Ambulatory Surgery Center)  Outpatient surgery – physician/surgeon fee  - (mand sterilization  Outpatient surgery – physican/surgeon fee  - (mand sterilization)  Outpatient surgery – facility fee  - (mand sterilization)  - Tier two  Tier four  - Tier four  - Tier two  - Tier tw	Benefit	Inpatient	Outpatient	Prescription Drugs	Emergency Care
inpatient  Physicians/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 rursing facility fee (e.g., hospital room)  Skilled rursing facility fee (e.g., hospital room)  Skilled rursing facility fee (e.g., hospital room)  M/S  M/S  M/S  M/S  M/S  Inpatient hospice facility fee (e.g., hospital room)  Loughairent surgery facility fee (e.g., ambulatory Surgery Center)  Outpatient surgery – facility fee (e.g., ambulatory Surgery Center)  Outpatient surgery – facility fee – female sterilization  Outpatient surgery – physician/surgeon fee – female sterilization  Outpatient surgery – physician/surgeon fee – female sterilization  Outpatient surgery – gearding – gear	Type	-	-		
including in-home DME  ■ Medical supplies		<ul> <li>inpatient</li> <li>Physician/surgeon fee – acute inpatient</li> <li>Hospital facility fee (e.g., hospital room) – female sterilization</li> <li>Professional fees – maternity delivery</li> <li>Inpatient hospice facility fee (e.g., hospital room)</li> <li>Skilled nursing facility fee (e.g.,</li> </ul>	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	<ul><li> Tier two</li><li> Tier three</li></ul>	<ul> <li>(waived if admitted)</li> <li>Emergency room physician fee (waived if admitted)</li> <li>Emergency medical transportation</li> </ul>
			<ul> <li>Prosthetic and orthotic service and devices</li> </ul>		
			Diabetes equipment and supply		

		<ul> <li>Contact lenses for aniridia or aphakia</li> <li>Infusion therapy</li> <li>Child eye glasses/contact lenses</li> <li>Child dental: basic services</li> <li>Child dental: major services</li> <li>Child medically necessary orthodontics</li> </ul>		
МН	<ul> <li>Hospital facility fee (e.g., hospital room) – acute MH inpatient</li> <li>Physician/surgeon fee – acute MH inpatient</li> <li>Hospital facility fee (e.g., hospital room) – inpatient psychiatric observation for acute psychiatric crisis</li> <li>Physician/surgeon fee – psychiatric observation for acute psychiatric crisis.</li> <li>Short-term mental health crisis residential treatment</li> <li>Residential treatment services for SMI and SED</li> </ul>	<ul> <li>Individual and group mental health evaluation and treatment</li> <li>Outpatient services for monitoring drug therapy</li> <li>Behavioral health treatment office visit for autism or pervasive developmental disorder (PDD)</li> <li>Short-term partial hospitalization</li> <li>Short-term intensive outpatient psychiatric treatment</li> <li>Outpatient psychiatric observation for an acute psychiatric crisis</li> <li>Psychological testing to evaluate a mental disorder</li> <li>Behavioral health treatment delivered in the home for autism or PDD</li> <li>Non-emergency psychiatric transportation</li> </ul>	<ul> <li>Tier one</li> <li>Tier two</li> <li>Tier three</li> <li>Tier four</li> </ul>	<ul> <li>Emergency room facility fee (waived if admitted)</li> <li>Emergency room physician fee (waived if admitted)</li> <li>Emergency medical/psychiatric transportation</li> <li>Urgent care</li> </ul>
SUD	<ul> <li>Hospital fee (e.g., hospital room) – SUD detoxification</li> <li>SUD transitional residential recovery services</li> </ul>	<ul> <li>Individual and group chemical dependency evaluation and counseling</li> <li>Medical treatment for withdrawal symptoms</li> <li>Day treatment program for substance use disorder</li> <li>Intensive outpatient treatment for substance use disorder</li> </ul>	<ul> <li>Tier one</li> <li>Tier two</li> <li>Tier three</li> <li>Tier four</li> </ul>	<ul> <li>Emergency room facility fee         (waived if admitted)</li> <li>Emergency room physician fee         (waived if admitted)</li> <li>Emergency medical/psychiatric         transportation</li> <li>Urgent care</li> </ul>