HEALTH WEALTH CAREER

FINAL DETERMINATION FOR THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT ANALYSIS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

OCTOBER 2, 2017

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EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to provide technical assistance with assessing compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA herein referenced as “Parity”). Mercer has drafted a comprehensive final report that includes the Parity analysis methodology and benefit packages assessed, the standard chosen to define mental health/substance use disorder (MH/SUD) and medical/surgical (M/S) benefits, classification definitions, benefit mapping, the detail and results of claims-based testing, and the side-by-side analysis relative to each applicable non-quantitative treatment limit (NQTL) and associated final compliance recommendations[1].

Mercer used a team of members with specialized knowledge for pharmacy, financial requirements/quantitative treatment limits (FR/QTLs) and NQTLs to manage and implement AHCCCS’ Parity analysis. Because Parity analyses are repeated when benefit packages, utilization, or delivery system components change, Mercer trained designated AHCCCS staff to apply Mercer’s overall approach to the Parity analysis. As part of the analysis, AHCCCS and Mercer identified all the benefit packages to which Parity applies. The AHCCCS service delivery system currently includes partially and fully integrated managed care organizations (MCOs), although the agency is taking steps to establish a care delivery system of fully integrated managed care organizations responsible for managing the full scope of MH/SUD and M/S services by 2019.

To complete the Parity analysis, AHCCCS and Mercer performed and documented the following activities:

- Confirmed benefit packages and service delivery systems included under the AHCCCS program that are subject to parity;

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[1] Mercer is not a law firm and our services should not serve as a substitute for legal advice. Accordingly, Mercer recommends that AHCCCS secure the advice of legal counsel with respect to any legal matters related to the services performed by Mercer or otherwise.

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- Defined MH, SUD and M/S benefits consistent with a generally recognized independent standard of current medical practice;
- Assigned each service to one of four classifications (inpatient, outpatient, emergency care, prescription drugs) applying the same reasonable standard to M/S and MH/SUD benefits;
- Analyzed financial requirements (FRs), quantitative treatment limits (QTLs), and aggregate lifetime and annual dollar limits (AL/ADLs) applied to each classification of identified benefit packages;
- Evaluated each NQTL for compliance applied to MH/SUD and M/S benefits to determine Parity requirements for comparability and stringency.

The Parity regulations define MH/SUD benefits as benefits for items or services for MH or SUDs, as defined by the State, in accordance with applicable Federal and State law. Any condition/disorder defined by the State as being or as not being a MH or SUD benefit must be defined consistent with generally recognized independent standards of current medical practice [for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Diseases (ICD), or State guidelines]. MH/SUD benefits include long-term care (LTC) services. Based on a review of the available standards, AHCCCS has defined MH, SUD and M/S benefits consistent with the ICD-10-Clinical Modification (ICD-10).

The State must assign each service to one of four classifications (inpatient, outpatient, emergency care and prescription drug) identified in the regulation. In defining the classifications for purposes of determining which benefits are included in each classification, the State is required to apply the same definitions of classifications to M/S and MH/SUD benefits. In general, classification definitions relate to how AHCCCS constructs and manages Medicaid benefits. When determining how to assign benefits to classifications, AHCCCS chose to define classifications based on the setting in which the services are delivered. The same standards for classifying benefits were applied to all M/S and MH/SUD benefits, including intermediate services and LTC services. Applying these standards resulted in services being mapped to more than one classification and a service(s) being classified as both an M/S benefit and an MH/SUD benefit.

In accordance with the Parity rule, FRs, QTLs and AL/ADLs applicable to MH/SUD benefits must be identified and analyzed in each classification of a benefit package. The State and Mercer worked to define the benefit packages and benefit classifications consistent with requirements of the Parity rule. Section 7 of this document provides a detailed summary analysis of all identified MH/SUD FRs, QTLs and AL/ADLs. Mercer was able to determine that no AL/ADLs apply to MH/SUD services. The analysis found that the FRs that apply to MH/SUD are not applied within any classification of MH/SUD benefits more restrictively than the predominant financial requirement applied to substantially all M/S benefits in the same classification. QTLs applied to MH/SUD benefits are expected to be permissible under the

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Medicaid/CHIP Parity Rule as the current limits are applied equally to MH/SUD and M/S benefits, or are more often applied to M/S benefits than to MH/SUD benefits. Mercer's review of state documentation and MCO questionnaire responses did not identify AL/ADLs applicable to any MH/SUD services. As a result, no AL/ADL review or testing was necessary.

A NQTL is a limit on the scope or duration of benefits, such as prior authorization (PA) or network admission standards. Soft limits are benefit limits that allow for a member to exceed numerical limits for M/S and MH/SUD benefits on the basis of medical necessity are also considered NQTLs. Mercer collaborated with AHCCCS and their contracted MCOs to identify all applicable MH/SUD NQTLs and then assessed the application of those same NQTLs for M/S benefits. To evaluate each NQTL for compliance with Parity requirements for both comparability and stringency, the State and Mercer tailored data collection templates and collected information about the processes, strategies, evidentiary standards and other factors applicable to each NQTL (in writing and in operation) relative to M/S and MH/SUD benefits in each classification.

During this stage of the Parity analysis, AHCCCS identified four categories of NQTLs that are applied to MH/SUD benefits:

- Utilization Management NQTLs;
- Medical Necessity NQTLs;
- Documentation Requirements NQTLs; and
- Out-of-Network (OON)/Geographic Area Coverage NQTLs.

Section 8, NQTLs includes the MH/SUD NQTLs that have been identified for benefit packages to which Parity applies and for which the State is responsible for performing the Parity analysis (i.e., non-integrated benefit packages). The summary includes a description of the comparability and stringency of NQTL strategies, evidentiary standards and processes. Additionally, for identified issues regarding compliance with the Parity Rule, a summary is provided of the actions that the State has taken or plans to implement to address them. Appendix C, *NQTL Compliance Determinations*, demonstrates how each MH/SUD benefit package meets Parity requirements of comparability and stringency for the associated processes, strategies, evidentiary standards and other factors, in writing and in operation, as they apply to M/S and MH/SUD benefits in the same classification. Appendix C includes a side-by-side analysis of the M/S and MH/SUD NQTL processes, strategies and evidentiary standards and other factors. AHCCCS endorsed the final parity determinations with Mercer providing recommendations for best practices and other approaches to address potential parity issues.

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INTRODUCTION

AHCCCS contracted with Mercer, part of Mercer Health & Benefits LLC, to provide technical assistance with the MHPAEA to Medicaid and the Children's Health Insurance Program (CHIP) as it applies to the AHCCCS program.

The comprehensive final report herein describes the Parity analysis methodology and benefit packages assessed, the standard chosen to define MH/SUD and M/S benefits, classification definitions, benefit mapping, the detail and results of any claims-based testing, and summary results of the side-by-side analysis of information collected relative to each applicable NQTL, and associated final compliance recommendations in a format consistent with Parity documentation requirements.

To complete the Parity analysis, AHCCCS and Mercer performed and documented the following activities:

- Confirmed benefit packages and service delivery systems included under the AHCCCS program that are subject to parity;
- Defined MH, SUD and M/S benefits consistent with a generally recognized independent standard of current medical practice;
- Assigned each service to one of four classifications (inpatient, outpatient, emergency care, prescription drugs) applying the same reasonable standard to M/S and MH/SUD benefits;
- Analyzed FRs, QTLs and AL/ADLs in each classification of identified benefit packages;
- Evaluated each NQTL for compliance with Parity requirements for comparability and stringency.

Compliance with the Medicaid/CHIP Parity regulation is required by October 2, 2017. This narrative documents the outcomes of Parity testing for AHCCCS' Medicaid and CHIP programs with the Medicaid/CHIP Parity provisions specific to any NQTLs, FRs, QTLs and AL/ADLs identified and applied to MH/SUD benefits.

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METHODOLOGY

Mercer used a team of members with specialized knowledge for pharmacy, FR/QTLs and NQTLs to manage and implement AHCCCS' Parity analysis. Because Parity analyses are repeated when benefit packages, utilization, or delivery system components change, Mercer trained designated AHCCCS staff to apply Mercer's overall approach to the Parity analysis.

IDENTIFYING BENEFIT PACKAGES TO WHICH PARITY APPLIES

One of the first tasks that Mercer completed was an analysis that confirmed the benefit packages and service delivery systems included under the AHCCCS program that are subject to Parity, consistent with Mercer's understanding of the application of the requirements. AHCCCS and Mercer identified all the benefit packages to which Parity applies. A benefit package includes all benefits provided to a specific population group regardless of delivery system. See Appendix A, *AHCCCS Benefit Packages*. The review identified each benefit package (i.e., benefits that AHCCCS provides to specific population groups or targeted residents [e.g., persons determined to have a serious mental illness]) to which Parity applies, the various delivery systems implementing those benefit packages, and confirmed whether the State or the MCO was responsible for the Parity analysis. Once the scope of benefit packages and contractual arrangements to which Parity applies was defined, Mercer met with AHCCCS to review and ensure that all possible contingencies had been addressed and to gain AHCCCS' endorsement of the approach.

COMMUNICATION AND ENGAGEMENT PLAN

Mercer designed a communication and engagement plan that included all affected MCOs statewide. The communication plan addressed outreach strategies to the MCOs, timelines, opportunities for feedback, data requirements, data quality expectations and resubmission timelines. The communication plan also detailed regular meetings with AHCCCS personnel (and contractors as needed) and included review and approval timelines for the overall Parity analysis report. Intermittent project milestones and timelines, draft submissions and

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periodic status updates regarding the Parity analysis and a final review timeline were also included. Mercer implemented the following steps to ensure that the data collection process was efficient and minimized administrative burden for AHCCCS' contractors:

- Developed specific outreach strategies to AHCCCS contracted plans, including meeting with the plans in advance of distribution of the approved data collection template to provide education about Parity, set expectations for the types and amount of information necessary for the Parity analysis, review how to complete the data collection template and answer any questions or address concerns.
- Customized existing data collection templates to ensure standardized data collection and reporting of required information across contractors of the same type. Mercer obtained AHCCCS' approval of the templates prior to distribution to the plans.

- The information request phase of the Parity analysis incorporated the following promising practices:
  - Used common language that is aligned and familiar to the entities that responded to the data requests.
  - Included thorough and clear written instructions with the data request to ensure consistency in responses.
  - Identified all of the entities (including State staff as applicable) involved in the development, assignment, or application of NQTLs to benefits.
  - Helped the contractors identify the staff within their organizations that were best suited to respond to complete the data collection template.
  - Expressed the expectation that Parity data collection is an iterative process and that the contractors would need to provide additional information after the initial response to the data collection template was reviewed. Mercer worked with AHCCCS to define the maximum number of requests that Mercer initiated to obtain the needed information from each MCO.
  - Allowed sufficient time for the entities to respond by allowing at least 30 days for a response to the initial data request. As information was collected from the entities, Mercer stored the data in a standardized and secure format to facilitate ongoing collection, tracking, analysis and reporting.

DEFINING MH, SUD AND M/S BENEFITS

Parity requires the analysis of MH/SUD and M/S benefits, which are differentiated based upon the condition (MH/SUD or M/S condition) for which the benefit applies. Parity requires a State to define MH/SUD and M/S conditions consistent with generally recognized independent standards of current medical practice (e.g., the most current version of the DSM, the most current version of the ICD or State guidelines). MH/SUD and M/S benefits are benefits for items or services for MH/SUD and M/S conditions respectively; regardless of the type of provider that delivers the service.

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MAPPING BENEFITS TO FOUR CLASSIFICATIONS (INPATIENT, OUTPATIENT, EMERGENCY CARE AND PRESCRIPTION DRUG)

The Parity analysis requires that all medical and MH/SUD Medicaid benefits are mapped to one of more benefit classifications: Inpatient, Outpatient, Emergency Care, and Prescription Drug. There is one permissible sub-classification under the outpatient category; office visits versus all other outpatient. MH/SUD services must be provided to MCO enrollees in every classification in which M/S benefits are provided. Standards used to assign MH/SUD benefits to a classification must be reasonable and be the same standards used for M/S benefits. AHCCCS mapped benefits to classifications by designating assignments which were included with the data collection templates that were sent to the MCOs.

IDENTIFY AND TEST FRS, QTLS AND ANNUAL LIFE-TIME DOLLAR LIMITS

The law and the Final Medicaid/CHIP Rule (Final Rule) require that the AL/ADLS, FRs and QTLs on MH/SUD benefits are not more restrictive than those applied to M/S benefits consistent with the results of claims-based testing. Mercer reviewed plan documents and data collected from applicable entities to identify the presence of the following elements across the service delivery system:

- FRs: Payment by beneficiaries for services received that are in addition to payments made by the state, MCO, prepaid inpatient health plan, or prepaid ambulatory health plan for those services. This includes copayments and coinsurance.
- QTLs: Limits on the scope or duration of a benefit that are expressed numerically. This includes day or visit limits.
- Aggregate Lifetime or Annual Dollar Limits: Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.

Mercer assessed whether AHCCCS applies any FRs, QTLs or AL/ADLS apply to MH/SUD benefits. Mercer determined that the two-part claims-based test outlined in the regulations as “substantially-all” and “predominant” tests on M/S benefits was not necessary to determine whether FR, QTL or aggregate lifetime or annual dollar limits can be (and to what extent it can be) applied to MH/SUD benefits (see Section 7 for additional information).

IDENTIFYING AND TESTING NQTLS

Non-quantitative treatment limitations are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits. Because the Parity Rule does not identify an exhaustive list of NQTLs, Mercer assisted AHCCCS and its MCOs in identifying potential MH/SUD NQTLs. Mercer conducted a thorough analysis of each benefit package and delivery system using information collected for each NQTL about the processes, strategies, evidentiary standards or other factors that limit the scope or duration of a MH/SUD benefit.

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PARITY DETERMINATION AND DOCUMENTATION

Mercer issued a preliminary determination regarding whether Parity requirements were met using approaches aligned with industry standards and ongoing clarification from Centers for Medicare & Medicaid Services (CMS). Mercer provided information for AHCCCS to determine compliance with Parity requirements, both from a state-wide policy perspective and within each contracting entity managing or providing services to Medicaid populations consistent with the Medicaid Parity Rule. Mercer reviewed the preliminary compliance determinations with AHCCCS, including summary level data, results of the analysis and a draft report.

Mercer further assisted AHCCCS by recommending possible systemic and benefit package-specific action to correct identified Parity compliance issues. For benefit packages that did not meet Parity requirements (in the aggregate or within a geographic service area), Mercer provided technical consulting advice to AHCCCS regarding approaches to remedy the identified issue(s). AHCCCS plans to work with the applicable entities to develop and monitor specific corrective action plans as necessary.

Mercer has also offered AHCCCS technical assistance regarding the type and extent of documentation that may be required to be reported to CMS and posted via the State's website. Mercer also advised AHCCCS about the circumstances in which documentation should be updated when there is a change that might impact Parity compliance.

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SERVICE DELIVERY AND BENEFIT PACKAGES

The AHCCCS service delivery system is currently comprised of partially and fully integrated MCOs, although the agency is taking steps to establish a care delivery system of integrated MCOs responsible for managing the full scope of MH/SUD and M/S services by 2019. Three Regional Behavioral Health Authorities (RBHAs) administer all medically necessary covered behavioral health benefits to all MCO enrollees with the exception of dual eligible (Medicare and Medicaid) adults who have not been determined to have a serious mental illness (SMI), a limited pharmacy benefit administered by M/S Plans for specified behavioral health conditions, children eligible under the Children's Rehabilitative Services (CRS) Program and American Indian MCO enrollees that access services through the American Indian Health Program. Each RBHA is contractually required to provide services to eligible members in a defined geographic service area.

AHCCCS contracts with multiple acute care health plans that manage the M/S benefits for MCO enrollees. In addition, these Plans administer a fully integrated benefit package for non-SMI dual eligible adults. The Comprehensive Medical and Dental Program (CMDP) is a health plan dedicated to serving adopted children and children in the foster care system. Some of the acute care health plans operate statewide while others are assigned to designated geographic service areas.

MCO enrollees eligible for the Arizona Long Term Care System/Developmental Disabilities (ALTCS/DD) Program are assigned to the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). DES/DDD MCO enrollees receive LTC benefits from DES/DDD; M/S benefits from a subset of acute care health plans and behavioral health benefits through one of the three RBHAs. Three additional LTC Plans administer a fully integrated benefit package (MH/SUD, M/S and LTC) to MCO enrollees who are eligible under the ALTCS Elderly and Physically Disabled Program.

A single statewide CRS contractor oversees four coverage types for eligible children under the program. The coverage types are a) CRS Fully Integrated (CRS services, MH/SUD, M/S), b) CRS Partially Integrated Acute (CRS and M/S for American Indian members), c) CRS Partially Integrated Behavioral Health (CRS and MH/SUD for members assigned to DES/DDD or CMDP), and d) CRS only (CRS for American Indians).

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Below is a summary of the AHCCCS contracted Plans by partially and fully integrated benefit packages. Please see Appendix A, *AHCCCS Benefit Packages,* for a summary of service delivery system combinations and benefit package combinations.

PARTIALLY INTEGRATED BENEFIT PACKAGES			FULLY INTEGRATED BENEFIT PACKAGES		
MH/SUD Plans	M/S Plans	LTC Plans	MH/SUD Plans – SMI	M/S Plans – Dual Eligible & CRS	LTC Plans
Mercy Maricopa Integrated Care (MMIC) Cenpatico Integrated Care (CIC) Health Choice Integrated Care (HCIC)	Care 1st United Health Care (UHC) University Family Care (UFC) Mercy Care Plan (MCP) Health Net Health Choice CMDP United Healthcare Community Plan (UHCCP – CRS)	DES/DDD	MMIC CIC HCIC	Care 1st UHC UFC Health Choice Health Net MCP UHCCP - CRS	MCP LTC UHC LTC Banner UFC LTC

Appendix B, *Benefit Packages, Services and Classifications,* identifies each benefit package to which Parity applies and lists the MH/SUD, LTC and M/S benefits by classification. The AHCCCS State Plan covers MH/SUD benefits in each classification (inpatient, outpatient, emergency care, prescription drugs) in which there is an M/S benefit.

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DEFINITION OF MH/SUD AND M/S CONDITIONS

The final regulations (Parity) that apply Parity to Medicaid and the CHIP generally require that limitations applied to MH/SUD benefits are no more restrictive than the limitations applied to M/S benefits. In order to conduct the Parity analysis, the AHCCCS was required to define MH, SUD and M/S benefits.

The Parity regulations define MH/SUD benefits as benefits for items or services for MH or SUDs, as defined by the State, in accordance with applicable Federal and State law. Any condition/disorder defined by the State as being or as not being a MH or SUD benefit must be defined consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines). MH/SUD benefits include LTC services.

Based on a review of the available standards, AHCCCS has defined MH, SUD and M/S benefits consistent with the ICD-10. The ICD-10 is a classification of diseases with codes and descriptors arranged within a Tabular List of Diseases. There are 21 chapters — each based on the impacted body system or the nature of injury and disease. Note that ICD is one of the two example standards provided in the final Parity regulations. ICD-10 is an advantageous choice for AHCCCS because AHCCCS already uses ICD as its standard for payment purposes, which avoids the administrative burden associated with selecting a different standard.

For purposes of Parity, AHCCCS defined MH and SUDs as those conditions in ICD-10 Chapter 5, "Mental, Behavioral and Neurodevelopmental Disorders", sub-chapters 2–7 and 10–11. Sub-chapter 1, Mental Disorders Due to Known Physiological Conditions, is excluded from the MH condition definition (and included in the M/S condition definition, see below) because the physiological condition is primary for these diagnostic codes. Similarly, sub-chapters 8 and 9 (e.g., intellectual disabilities, specific developmental disorders of speech and language, specific developmental disorders of scholastic skills and pervasive developmental disorders) are excluded from the definition of MH conditions (and included in the M/S condition definition, see below) because they are neurodevelopmental conditions, which are separate and distinct from Mental and Behavioral conditions, as indicated by the chapter title.

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Under Parity, M/S benefits means benefits for items or services for medical conditions or surgical procedures, as defined by the State and in accordance with applicable Federal and State law, but does not include MH/SUD benefits. As required for defining MH/SUD benefits, any condition defined by the state as being or as not being a M/S condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the ICD or State guidelines). M/S benefits include LTC services.

The ICD-10 includes the following chapters:

1. Certain infectious and parasitic diseases (A00-B99)
2. Neoplasms (C00-D49)
3. Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
4. Endocrine, nutritional and metabolic diseases (E00-E89)
5. Mental, behavioral and neurodevelopmental disorders (F01-199)[2]
6. Diseases of the nervous system (G00-G99)
7. Diseases of the eye and adnexa (H00-H59)
8. Diseases of the ear and mastoid process (H60-H95)
9. Diseases of the circulatory system (I00-I99)
10. Diseases of the respiratory system (J00-J99)
11. Diseases of the digestive system (K00-K95)
12. Diseases of the skin and subcutaneous tissue (L00-L99)
13. Diseases of the musculoskeletal system and connective tissue (M00-M99)
14. Diseases of the genitourinary system (N00-N99)
15. Pregnancy, childbirth and the puerperium (O00-O99)
16. Certain conditions originating in the perinatal period (P00-P96)
17. Congenital malformations, deformations and chromosomal abnormalities (Q00-Q9A)
18. Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)
19. Injury, poisoning and certain other consequences of external causes (S00-T88)

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[2] As described above, subchapters 2-7 and 10-11 are MHSUD conditions. Subchapters 1, 8-9 are M/S.

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20. External causes of morbidity and mortality (V00-Y99.9)
21. Factors influencing health status and contact with health service (Z00-Z99)

After further review, AHCCCS chose to exclude Chapter 21 (bolded above) from the definition of M/S conditions because the ICD does not treat Z codes as either medical or MH/SUD conditions. The ICD-10 states that “Z codes” “are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00-Y89 are recorded as diagnoses or problems. This can arise in two main ways:

(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem which is in itself not a disease or injury.
(b) When some circumstance or problem is present which influences the person’s health status but is not in itself a current illness or injury.”

Z codes include the following subchapters:

Z00-Z13	Persons encountering health services for examinations
Z14-Z15	Genetic carrier and genetic susceptibility to disease
Z16	Resistance to antimicrobial drugs
Z17	Estrogen receptor status
Z18	Retained foreign body fragments
Z20-Z28	Persons with potential health hazards related to communicable diseases
Z30-Z39	Persons encountering health services in circumstances related to reproduction
Z40-Z53	Encounters for other specific health care
Z55-Z65	Persons with potential health hazards related to socioeconomic and psychosocial circumstances
Z66	Do not resuscitate status
Z67	Blood type
Z68	Body mass index
Z69-Z76	Persons encountering health services in other circumstances
Z77-Z99	Persons with potential health hazards related to family and personal history and certain conditions influencing health status

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The result of excluding the Z codes from the definition of M/S and MH/SUD conditions is that costs, FRs, QTLs and NQTLs associated with Z codes are not included in the Parity analysis. For example, certain preventive services provided during an office visit which, consistent with Federal law, do not have copays would not be included in the cost analysis of any financial requirement or QTL applicable to MH/SUD outpatient benefits.

It is important to note that based on discussions with coding experts, there may be instances where a Chapter 21 diagnosis code may accompany another medical diagnosis code to provide informational support. As an example, if a child is receiving care for lack of expected normal physiological development, specifically delayed physiological milestones (R62.0), the claim may include a secondary diagnosis code such as Z00.7 (a referral from an encounter for examination for period of delayed growth in childhood). AHCCCS chose to exclude Z codes from the definition of M/S conditions and refined the definition to only exclude procedures where a Z code is the primary diagnosis code on the claim.

The Medicaid Parity Rule does not distinguish preventive care from other items and services that need to be evaluated. It also does not address whether certain conditions can be classified as either M/S or MH/SUD (which is the result of excluding Z codes). Mercer recommended that AHCCCS consult with CMS and AHCCCS's legal counsel prior to implementing this strategy.

In responding to a question during a Parity webinar about how to classify certain benefits such as newborn screenings or immunizations, (which are included in the Z Code chapter), CMS encouraged states to identify a clear standard and ensure that it is being applied consistently across services. CMS indicated that the state has flexibility to determine what that standard is; however, it must be applied in a reasonable manner. It should be noted, however, that the Federal government has exempted preventive services from commercial Parity requirements when the only MH/SUD benefits covered by a plan are those necessary to meet Federal prevention requirements. The government did not choose to exclude preventive services from the definition of M/S benefits in either rule.

Parity requires AHCCCS to define MH/SUD and M/S conditions consistent with a generally recognized independent standard of current medical practice such as the ICD-10. Applying the structure and content of the ICD-10 allows AHCCCS to define M/S benefits to exclude items and services for which Z Codes are the primary diagnosis. The result of this exclusion is that costs, FRs, QTLs and NQTLs associated with Z codes are not part of the Parity analysis for FRs, QTLs or NQTLs applicable to MH/SUD benefits.

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BENEFIT CLASSIFICATIONS

The State must assign each service to one of four classifications identified in the regulation. In defining what benefits are included in a classification, the State must apply the same reasonable standard of defining classifications to M/S and MH/SUD benefits. In general, classification definitions relate to how AHCCCS constructs and manages Medicaid benefits. Because Parity requirements for FRs, QTL and NQTLs apply by classification, mapping benefits to classifications has significant implications for the types and levels of FRs and treatment limitations that may be applied to MH/SUD benefits.

Although the law does not require states to apply specific classification definitions, states may not assign M/S and MH/SUD benefits to a classification solely for the purpose of assuring certain FRs or treatment limitations will be applicable — this practice would not be considered a reasonable standard. As one classification was defined, AHCCCS evaluated the Parity implications for services mapped to the other classifications, but have not defined classifications for the purpose of retaining certain limits.

AHCCCS reviewed the Final Parity Rule Analysis and Response to Public Comments as well as the *CMS Parity Compliance ToolKit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* to inform the definitions for each classification. When determining how to assign benefits to classifications, AHCCCS chose to define classifications on the basis of the setting in which the services are delivered. The same standards for classifying benefits must be applied to all M/S and MH/SUD benefits, including intermediate services and LTC services. Applying these standards may result in services being mapped to more than one classification or a service(s) being classified as both an M/S benefit and an MH/SUD benefit.

The definitions below reflect the State's definition for each classification identified in the regulation as it applies to M/S and MH/SUD benefits.

- **Inpatient:** All covered services or items provided to a member in a setting that requires an overnight stay.

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- **Outpatient:** All covered services or items provided to a member in a setting that does not require an overnight stay, which do not otherwise meet the definition of inpatient, prescription drug or emergency care services.
- **Emergency Care:** All covered emergency services or items to treat an emergency medical condition delivered in an emergency department setting.
- **Prescription Drugs:** Covered medications, drugs and associated supplies and services that require a prescription to be dispensed. Includes drugs claimed using the NCPDP claim forms.

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AL/ADLS, FRS AND QTLS

Mercer provided assistance to AHCCCS by collecting data regarding FRs, QTLs and AL/ADLs. Mercer and AHCCCS have collaborated to help the MCOs identify any AL/ADLs, FRs or QTLs applied to MH/SUD benefits. In general, Parity regulations require that any FRs or treatment limitations applied to MH/SUD benefits are no more restrictive than the FRs and treatment limitations applied to M/S benefits in each benefit classification.

In accordance with the Medicaid/CHIP Parity rule, FRs, QTLs and AL/ADLs applicable to MH/SUD benefits must be analyzed in each classification (i.e., Inpatient, Outpatient, Emergency Care and Prescription Drugs) of a benefit package. The State and Mercer worked to define the benefit packages and benefit classifications consistent with requirements of the Medicaid/CHIP Parity rule; see Section 6 of this document. It is important to note, however, that a benefit package represents a set of unique services and benefit administrator combinations. In addition to these unique combinations, Mercer identified the following additional special populations applicable to the analysis that necessitated separate benefit packages:

- Transitional Medical Assistance (mandatory co-payments).
- Other Special Populations (optional co-payments): AHCCCS for Families with Children (1931); Young Adult Transitional Insurance for young adults who were in foster care; State Adoption Assistance for Special Needs Children who are being adopted; Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled; SSI Medical Assistance Only (SSI MAO) for individuals who are age 65 or older, blind or disabled; Freedom to Work. Individuals eligible for AHCCCS through any of the programs above may be charged nominal copays, unless they are receiving a covered service that is exempt from copays or the individual is in a group that cannot be charged copays (see list below). Nominal copays are also referred to as optional copays. If a member has a nominal copay, then a provider cannot deny the service if the member states that s/he is unable to pay the copay.
- Members that are exempt from nominal copays include:

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- Members under age 19.
- Members determined to be SMI.
- Members enrolled in the ALTCS.
- Members enrolled in the CRS program.
- Members eligible as Qualified Medicare Beneficiaries.
- Members who are acute care members residing in nursing homes, or residential facilities when the acute care member's medical condition would otherwise require hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year.
- Members who receive hospice care.
- Members enrolled in the Breast and Cervical Cancer program.
- Members who are pregnant and throughout the postpartum period following the pregnancy.
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638 or urban Indian health programs.
- Members receiving Title IV-E Adoption Subsidy or Foster Care Assistance.
- Members receiving Title IV-B Child Welfare Services.
- Members in the Adult Group.

For a FR or QTL applied to a MH/SUD benefit to be permissible under the Medicaid/CHIP Parity rule, a two-part, cost-based test must be conducted. In order for a type of FR/QTL (e.g., copay or visit limit) to be allowable, that type of FR/QTL must apply to at least two-thirds of the costs of M/S benefits in the same classification of a benefit package; this is referred to as the "substantially all" test. If the type of FR/QTL passes the substantially all test, then the predominant level of the FR/QTL (e.g., the amount of the copay or the number of visits) must be determined. The predominant level of an FR/QTL is the most restrictive level of the type of FR/QTL that may be applied to MH/SUD benefits in that classification of a benefit package. The predominant level of FR/QTL is the level of FR/QTL that applies to more than one-half of the costs of M/S benefits subject to that type of FR/QTL in that classification of a benefit package.

For an AL/ADL to be allowable, the limitation must be applied to at least one-third of the costs of M/S benefits across benefit classifications. Note that if an AL/ADL passes the one-third test, the Medicaid/CHIP Parity Rule prescribes additional analyses to determine if the AL/ADL may be applied to MH/SUD benefits.

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Mercer developed a list of FRs, QTLs and AL/ADLs that are currently applied to MH/SUD benefits in benefit packages to which the Medicaid/CHIP Parity Rule applies. This information was assembled through a documentation review and a questionnaire that was completed by the MCOs. This list also included limits applied to M/S benefits (in addition to MH/SUD benefits) to allow for an initial review to screen out AL/ADLs, FRs or QTLs that could not pass (e.g., no AL/ADL, FR or QTL was applicable to M/S benefits in a classification, so no AL/ADL, FR or QTL can apply to MH/SUD benefits in a classification). Note that benefits limited by FRs, QTLs and/or AL/ADLs, which are also subject to medical necessity review, were included in the NQTL review.

Mercer reviewed all MH/SUD FRs, QTLs and AL/ADLs relative to applicable Medicaid/CHIP Parity rule requirements. Mercer was able to determine the results of Parity testing for AHCCCS's AL/ADLs, FRs and QTLs without a detailed cost-based analysis and the results are presented below.

FR CONSIDERATIONS

FRs are payments made by a beneficiary for services received (e.g., copayments). Based on Mercer's review of state documentation and survey responses from the MCOs, the current Medicaid program includes the following copayment requirements[3] (see table below). For purposes of this analysis, it is important to note that, based on the AHCCCS copayment requirements, copayments are not applicable to preventative visits (such as well visits, immunizations, pap smears, colonoscopies and mammograms).

[3] https://www.azahcccs.gov/PlansProviders/RatesAndBilling/copayments.html.

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AHCCCS Copayment Schedule

	MANDATORY COPAYMENTS TRANSITIONAL MEDICAL ASSISTANCE (TMA)	OPTIONAL COPAYMENTS OTHER SPECIAL POPULATIONS[4]
Prescriptions	$2.30	$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	$4.00	$3.40
Out-patient services for physical, occupational and speech therapy	$3.00	$2.30
Outpatient non-emergency or voluntary surgical procedures	$3.00	N/A

Below are the steps used to assess the FRs in the AHCCCS program.

Step 1: Identify FRs applicable to MH/SUD services from the AHCCCS copayment schedule. Consistent with AHCCCS definitions of MH/SUD and M/S benefits, Mercer identified that certain prescription drugs and office visits associated with copays may be MH/SUD benefits. Note that outpatient therapies and non-emergency surgery are primarily M/S services and associated FRs would not need to be tested per the Parity rule.

Step 2: For each benefit package and service associated with a copayment (in Step 1), bucket these into one of the four benefit classification for purposes of Parity; based on 42 CFR 438.910(c)(2)(ii), an additional Outpatient — Office sub-classification may be used in determining Parity compliance for FRs and QTLs. Mercer categorized prescriptions in the Prescription Drug category and office visits into the Outpatient — Office sub-classification.

Step 3: Perform the substantially all test and, if necessary, the predominant test. As mentioned above, Mercer was able to determine the results of the two-part test without doing a detailed cost-based analysis. See the table below for the results of the two-part test.

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[4] Other special populations are identified in the section above.

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Results of the Substantially All and Predominant Level Review (Two-Part Test)

	TMA		OTHER SPECIAL POPULATIONS	
	Substantially All Test Results	Predominant Level	Substantially All Test Results	Predominant Level
Inpatient	N/A	N/A	N/A	N/A
Outpatient — Office	100%	$4.00	100%	$3.40
Outpatient — Other	N/A	N/A	N/A	N/A
Emergency Care	N/A	N/A	N/A	N/A
Prescription Drugs	100%	$2.30	100%	$2.30

Note: The prescription drug FR is not tiered based on AHCCCS copayment policy.

Mercer did not perform a cost-based test since the results of the two-part test could be determined based on factors of reasonability; see below for specific notes:

- **Outpatient — Office Copayment:** All outpatient office visits in all benefit packages require a copay[5]. Because all Outpatient — Office visits have the same copayment ($4.00 for TMA and $3.40 for Other Special Populations), it can be concluded without testing that these are the respective predominant limits.
- **Prescription Drugs:** A copayment applies to all prescription drugs irrespective of whether they are primarily for M/S or MH/SUD conditions. Thus all prescription drugs are assigned a copayment. Because all prescription drugs have the same level of copayment ($2.30), it can be concluded without testing that this is the predominant limit.

It is important to note that Medicaid also mandates a universal cost sharing out of pocket maximum that can be charged to any one individual. Specifically for AHCCCS, the amount of total copays cannot be more than 5% of the family's total income during a calendar quarter. Because this limit is mandated by Medicaid, it is not analyzed as an FR.

As a result, the identified FRs applicable to MH/SUD benefits appear to be consistent with Parity requirements.

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[5] AHCCCS defined MH, SUD and M/S benefits (consistent with International Classification of Diseases (ICD)-10) to exclude Z codes, which are not services or items for the treatment of a MH, SUD or M/S condition. As a result, most preventive services for which no copay is applied were not included in the Parity analysis.

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QTL CONSIDERATIONS

Mercer reviewed State and MCO documentation to compile a list of potential MH/SUD QTLs. Mercer found that no QTLs are applied to MH/SUD benefits in the Inpatient, Emergency or Prescription Drug classification of any benefit package. For the Outpatient benefit classification, there were some potential QTLs noted in the table below.

Potential QTLs Applied to Benefits for Any Benefit Package

CONTRACTOR	TYPE OF QTL	BENEFIT	LIMIT	SERVICE CATEGORY
All	Hour Limit	Respite	600 Hours/Year	Outpatient
All	Visit Limit	Occupational Therapy	15 Visits per Contract Year	Outpatient

Occupational Therapy (OT) was added as a benefit starting October 1, 2017. The hard limit of 15 OT visits is equally applied for members regardless of whether the principle/primary diagnosis is a M/S diagnosis or a MH/SUD diagnosis that necessitates the occupational therapy. AHCCCS believes the coverage is equal treatment and should meet the parity requirement. As this report describes, there are two tests that must be passed to make the limit allowable. First, the "substantially all" test requiring the service limit applied to OT for MH/SUD diagnosis must apply to at least two-thirds of the costs of M/S benefits in the same classification of benefit. This would mean that two-thirds of all the M/S benefit costs classified as outpatient would have a 15-visit limit in order to require the visit limit on solely OT when the principle diagnosis is MH/SUD. This requirement is illogical and doesn't indicate true parity. The second, the "predominant level" test, would only be conducted when the "substantially all" test is passed.

AHCCCS believes that this type of testing for parity was likely not the intent of the law and could have unintended consequences of limiting access to care. If the state had no occupational therapy benefit at all, parity requirements would be met. Thus, this type of testing could limit states' ability to add benefits if the practical result of the test is that limits cannot be applied consistently on both M/S and MH/SUD.

AHCCCS also researched the parity implications for the annual limit of 600 hours for respite services. CMS clarified through a Frequently Asked Questions publication dated October 11, 2017 that long term supports and services, such as personal care and respite, could be defined as either MH/SUD or M/S, depending on the condition of the beneficiary being treated. CMS further clarified that, for these benefits, the state may define the benefit as MH/SUD or M/S for the entire beneficiary population using a reasonable method, such as whether the service is most commonly or frequently provided due to a MH/SUD or M/S condition. For example, if more than 50% of spending on respite

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services is for beneficiaries who are receiving the service due to a M/S conditions, the state may reasonably define respite services as a M/S benefit for the purposes of the parity analysis.[6]

AHCCCS evaluated service encounter data during calendar year 2016 across all applicable benefit packages and determined that respite services are more commonly provided due to M/S conditions (i.e., more than 50% of spending on respite care is for beneficiaries who are receiving the service due to M/S conditions). Therefore, AHCCCS has determined that the respite limit is permissible under Parity requirements.

AL/ADL CONSIDERATIONS

Under Parity, an aggregate lifetime dollar limit is a dollar limit on the total amount of specified benefits that may be paid. An aggregate annual dollar limit is a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period. Mercer's review of state documentation and MCO questionnaire responses did not identify any AL/ADL applicable to any MH/SUD services. As a result, no AL/ADL review or testing was necessary.

CONCLUSIONS

As noted above, QTLs applied to MH/SUD benefits are expected to be permissible under the Medicaid/CHIP Parity Rule as the current limits are applied equally to MH/SUD and M/S benefits, or are more often applied to M/S benefits.

[6] Frequently Asked Questions, Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP. Center for Medicare and Medicaid Services, October 11, 2017.

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8
NQTLS

A NQTL is a non-numerical limit on the scope or duration of benefit coverage, such as PA or network admission standards. Soft limits are benefit limits that allow for a member to exceed numerical limits for M/S and MH/SUD benefits on the basis of medical necessity and are also considered NQTLs. Mercer collaborated with AHCCCS and their contracted MCOs to identify all applicable NQTLs.

To evaluate each NQTL for compliance with Parity requirements for both comparability and stringency, the State and Mercer tailored data collection templates and collected information about the processes, strategies, evidentiary standards and other factors applicable to each NQTL (in writing and in operation) relative to M/S and MH/SUD benefits in each classification. Each NQTL questionnaire was tailored to the benefit packages managed by a specific entity. The questionnaire was completed by each entity administering benefits for a benefit package, including M/S administrators. For every delivery system that provides a combination of M/S and MHSUD benefits to MCO enrollees, Mercer compiled the information collected into a side-by-side chart for analysis.

Mercer also collected policies and procedures that outlined MCO operations and utilized the protocols and other relevant information to determine whether benefit administration aligns with Parity requirements. Mercer did not restrict the NQTL analysis to a desk review of relevant documentation but also included a review of other data, such as telephonic and onsite interviews with MCO staff and written responses to MCO staff questions.

The following summary includes the MH/SUD NQTLs that have been identified for benefits packages to which Parity applies and for which the State is responsible for performing the Parity analysis (i.e., non-integrated benefit packages). The summary includes findings for NQTL strategies, evidentiary standards and processes. Actions that the State has taken or plans to implement to address any identified issues regarding compliance with the Parity Rule are presented. Appendix C, *NQTL Compliance Determinations*, demonstrates how each MH/SUD benefit package meets Parity requirements of comparability and stringency for the associated processes, strategies, evidentiary standards and other factors, in writing and in operation, as they apply to M/S and MH/SUD benefits in the same classification. Appendix C includes a side-by-side analysis of the M/S and MH/SUD NQTL processes, strategies and evidentiary standards and other factors.

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UTILIZATION MANAGEMENT NQTLS

The responses to Mercer's questionnaires for PA, concurrent review, retrospective review and referral NQTLs from Plans managing MH/SUD benefits and those managing M/S benefits support that the analysis of these NQTLs can be effectively consolidated, as the strategies, evidentiary standards and processes for each are substantively similar. Accordingly, these individual NQTLs have been grouped and renamed "Utilization Management NQTLs." Please note that throughout Section 8, when referring to "Plans" it is generalized to both Plans that provide MH/SUD services and those that provide M/S services, unless otherwise noted.

FINDINGS

Strategy

- All Plans report that they employ utilization management (UM) strategies to ensure the appropriateness of services to treat the condition and to manage high cost services/benefits.
- Consistent with the AHCCCS requirements, the Plans reported reviewing UM strategies and practices at least on an annual basis, with some Plans reporting that utilization spikes or trends may prompt an earlier review. Changes to UM strategies and practices are reviewed and approved through the Plans' UM Committees.

Evidentiary Standards

- All Plans reported primarily using nationally-recognized, evidence-based clinical decision making criteria (e.g., InterQual, Milliman Care Guidelines [MCG], American Society of Addiction medicine [ASAM] for SUD). Modifications or development of criteria is limited to situations in which such criteria are not available or when required to do so by federal regulation or State of Arizona (State)-specific requirements.
- Plans reported using utilization data and service costs to identify services that are subject to UM NQTLs (nearly all services in the inpatient classification being subject to UM strategies and much more limited set of services in the outpatient classification).
- Plans consistently reported monitoring denial rates, overturned appeals, average length of stay and readmission rates (for services in the inpatient classification), and inter-rater reliability (IRR) testing to assess the stringency of the NQTL and potential over/under application. IRR testing is an AHCCCS requirement; however, Plans are permitted to choose their minimum performance standards, as applied to IRR, and there appears to be variation (ranging from 80–90% for those Plans responding) between Plans managing MH/SUD benefits versus those managing M/S benefits.

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Process

- There is variability between the methods for how a provider initiates UM review processes (PA, concurrent review and retrospective review) for MH/SUD services/benefits and their M/S counterparts. Most Plans offer several options, with the majority offering review by phone, fax or portal. However, there are limitations applied by Plans managing MH/SUD benefits (e.g., MMIC requires that authorization requests are submitted by fax only) which creates Parity compliance concerns when compared to practices by most Plans managing M/S services that offer more expanded options.
- Most Plans use either a single page request or telephonic request for UM reviews with supporting clinical documentation to demonstrate medical necessity (as defined by clinical criteria set used); however, Plans managing MH/SUD residential and Home Care Training to the Home Care Client (HCTC) services require much more lengthy forms and supporting clinical documentation. Plans managing M/S skilled nursing facilities (SNFs), assisted living facilities (ALFs) and long-term hospital care also require more extensive information to demonstrate medical necessity such as an admission assessment, physician orders, a treatment plan and a discharge plan.
- All Plans reported the timeframes used for conducting PA was 14 days for standard requests, and up to three days for expedited requests. Extensions of time for up to 14 days were noted as used by the Plans when necessary to obtain additional information to support the authorization. Most Plans did not provide the timeframes used for concurrent review/continued authorization.
- All Plans responded that UM reviews are conducted by Arizona licensed healthcare professionals, and only physicians are authorized to deny a request for authorization or coverage.
- Most Plans managing M/S benefits noted that they permit an opportunity for a peer-to-peer conversation in the event of an anticipated denial, while only one Plan managing MH/SUD benefits reported providing such an opportunity.
- Some Plans provided the average length of authorization and how the Plan determines the length of authorization (e.g., prescribed by national clinical guidelines and criteria). There may be some variability in practices based on the level of care and types of services.
- MMIC's approval process for behavioral health residential facility (BHRF) following PA includes the submission of a referral packet to potential BHRF providers. Providers screen members for program appropriateness (e.g., an all-male facility, a home with no stairs), and members assert their preferences. This is, at best, a 3–5 day process, but can extend to over 45 days, requiring clinical documentation from the "team" to reaffirm clinical need.
- Consistent across all Plans, the failure to meet the UM NQTL results in non-coverage of the service/benefit. Similarly, all Plans have an exception for the PA of all services when provided in the event of an emergency.
- Variability is present in the application of requirements for concurrent/continued authorization between the MH/SUD Plans and M/S Plans, with M/S Plans reporting that they do not apply this NQTL to services in the outpatient classification (with exception to: the CMDP and the American Indian Health Program).

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Actions taken by the State to resolve identified Parity compliance issues

- The State established a consistent Minimum Performance Standard of 90% for IRR testing applicable to all Plans, those managing MH/SUD services/benefits and those managing M/S services/benefits.
- The State required Plans managing MH/SUD services/benefits to offer at least two modalities (fax, portal or telephonic) for providers to initiate UM reviews.
- The State now requires for all Plans, that when a Plan notifies a provider that a requested service has been denied, the Plan must inform the provider of the option to request a peer-to-peer discussion with the Contractor's Medical Director (MD).
- For comparison purposes against the extent of documentation required for MH/SUD residential and HCTC services, the State completed research and provided information to Mercer on documentation needed to place a member in a SNF, ALF or a LTC hospital. The review confirmed that there are more extensive documentation requirements for these services, such as current chest x-ray, H&P physician's orders for SNFs and a preadmission screening and resident review, which was deemed appropriate based on the complexity of the member's needs and the intensity of treatment in these levels of care. As such, the required documentation associated with the UM NQTL for MH/SUD benefits appears to be comparable to the documentation requirements for M/S benefits.

MEDICAL NECESSITY CRITERIA NQTLS

The Request for Information responses support that the development of Medical Necessity and Clinical Criteria includes experimental/investigational coverage exclusion criteria and can accordingly be consolidated for purposes of Parity analysis.

FINDINGS

Strategy

- Plans consistently described that the purpose of the development of Medical Necessity Criteria is to assist in the consistent reviews of particular health services to determine coverage. Factors in the development of criteria include changes in regulatory systems (CMS and State requirements), nationally-recognized clinical criteria and peer reviewed medical literature. Plans assess new technology and new uses of existing technology as part of this process. Services determined to be experimental, investigational or unproven are not covered.

Evidentiary Standards

- All Plans primarily use nationally-recognized, evidence-based clinical decision making criteria (e.g., InterQual, MCG or ASAM for SUD). Modifications or development of criteria is limited to situations in which such criteria are not available or when required to do so by

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regulation or contract. For psychiatric acute, inpatient and subacute services, RBHAs use criteria historically developed by the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), however MMIC planned to utilize MCG criteria by October 2, 2017 for these services.

- The Plans' responses for the type of evidence/data used to assess the stringency of the NQTL had slight variation in the precise type of data or information used, but generally included review of utilization data, denial rates and provider feedback/complaints. Several Plans also indicated that they regularly review newly released literature, published research and Food and Drug Administration approvals.

Process

- Plans reported that reviews of Medical Necessity/Clinical Criteria are physician-led (usually by the MD or Chief Medical Officer of the Plan), using the types of evidence noted above and conducted at least annually. Approval of Medical Necessity/Clinical Criteria is done through the Plans' UM Committees, as required under the AHCCCS Medical Policy Manual.
- Plans use a similar approach and evidence for the assessment and determination of coverage for new technologies or new uses of existing technologies (versus what would be considered experimental/investigational/unproven); however, variation was identified with respect to how Plans manage incoming requests for coverage of these services. In addition to requiring a review for medical necessity, the Plan must also conduct a contemporaneous review for adding coverage and developing the Plan's coverage criteria for the service. One Plan managing MH/SUD services/benefits also reported requiring client-specific, clinical documentation to support the request for coverage. Another Plan managing MH/SUD services/benefits noted the need for a more expedited review when there is a client-specific request attached, no clear State standards for timeframes appear to be established for these types of reviews.

Actions to be taken by the State to resolve identified Parity compliance issues

- The State will remove policy requirement for RBHAs to use ADHS/DBHS developed clinical decision making criteria for psychiatric acute, inpatient and subacute services, and similarly permit these Plans managing MH/SUD services/benefits to use nationally-recognized standards. The State will align policy requirements that relate to the adaptation or development of criteria (including criteria for new technology or new use of existing criteria) where nationally-recognized criteria are not available to apply to all Plans. Specifically, that policy will require that the adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the U.S. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.
- The State will establish uniform timeframe requirements for all Plans to use when making coverage determinations when the request involves new technologies/new use of existing technologies.

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DOCUMENTATION REQUIREMENTS NQTLS

This strategy is applied because these are populations with chronic, complex conditions and needs, many with multiple systems involved in the delivery of support systems, as opposed to episodic treatment needs of other Medicaid eligible participants. The need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning), that can offer various perspectives on the members overall functioning is critical to successful outcomes.

FINDINGS

Strategy

- Two Plans managing MH/SUD benefits (MMIC and CIC) and two Plans managing M/S benefits (DES/DDD and CRS) require the development of an assessment and service plan by an inter-disciplinary team, including the member and family members. The purpose is to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. For MMIC and CIC, in addition to the aforementioned purpose, this process includes a determination of medical necessity for identified services.
- These requirements apply to services in the inpatient and outpatient classifications.

Evidentiary Standards

- For the Plans that manage MH/SUD services/benefits (RBHAs), Adult Recovery Teams and Child and Family Teams (ART/CFT) are responsible for the completion of the comprehensive assessment/service plans. ART/CFT protocols are reportedly clinical-based best practices for these populations, and are required by AHCCCS by contract and policy.
- For the Plan managing M/S benefits (DDD specifically for Long-Term Services and Supports [LTSS] to the ALTCS developmentally disabled [DD] members), Arizona Administrative Code, Title 6, Chapter 6 requires these service plan requirements.
- To inform this strategy, Plans that manage MH/SUD services/benefits conduct annual case file reviews and monitor access to service data; however, none shared actual performance findings.

Process

- Involves member (family) participation and other inter-disciplinary participants (depending upon member acuity and choice) to develop a comprehensive written service plan, identifying the necessary/desired services for the member.
- DES/DDD, MMIC and CIC reported that this is necessary for service coverage/access. HCIC indicated that this process is concurrent to accessing service and will not result in the denial of coverage or access.

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- Assessment and service planning has a number of required process steps and based upon a number of variables (e.g., participant availability) can take an extended period of time to complete. Service plans may only be completed by a Behavioral Health Professional (BHP) or Behavioral Health Medical Professional, or a Behavioral Health Technician under the supervision of a BHP.
- None of the other Plans managing M/S services apply this NQTL, except for DES/DDD.

Follow-up Actions

- The State's MD reviewed options to address potential barriers for timely access/coverage of MH/SUD services due to assessment and service planning requirements. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. The requirements are supported by State policy and protocols and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multi-systemic involvement.

OON/GEOGRAPHIC AREA COVERAGE NQTLS

The information provided by all Plans support that the processes, strategies and evidentiary standards for coverage of OON and out-of-geographic area are substantially similar, and accordingly can be consolidated for purposes of Parity analysis.

FINDINGS

Strategy

- Plans managing MH/SUD services/benefits (RBHAs) report not applying limits to OON providers, with the exception of MMIC for services in the outpatient classification. However, this information conflicts with their responses to prompts for coverage limitations for providers who are out-of-geographic area and OON.
- There is general consistency amongst the Plans managing M/S services/benefits for applying OON/Geographic Area Coverage limitations.
- There is consistency for all Plans about the rationale for applying limits.

Evidentiary Standards

- There is general consistency on the evidence that supports this NQTL. Some Plans cited to AHCCCS standards for network adequacy and requirements to be an AHCCCS-registered provider.

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Process

- Plans reporting limits shared that they limit coverage to in-network, in-state providers, with the only exceptions being for emergent services and for requests for services for which a member's needs cannot be met in-network.
- Plans verify that the provider is AHCCCS registered or facilitate that process and conducts required credentialing (verification of insurance, exclusion lists, accreditations). Additionally, Plans develop Single Case Agreements or Letters of Authorization with OON or out-of-geographic area providers. For non-emergent services, most Plans reported requiring PA of OON or out-of-geographic (out-of-state) services to verify medical necessity and to ensure that an in-network provider is not available to meet the clinical need.
- Out-of-state placements for MH/SUD services require AHCCCS notification and approval. No similar requirement appears to be applied for out-of-state M/S services, except for DES/DDD approvals of out-of-state placements for individuals with developmental disabilities.

Follow-up Actions

- AHCCCS is taking actions to remove the requirement for AHCCCS prior approval of planned out-of-state MH/SUD services and instead, require notification only, as is currently required for planned, out-of-state M/S services.

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APPENDIX A: AHCCCS BENEFIT PACKAGES

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Benefit Package	Populations	Contractors	Sub- Population	Counties	Other MCO Enrollee Relationships	Conducts Analysis?	
						AHCCCS	Plan
Acute - Physical Health	Title XIX Adults Title XIX Children Title XXI Adults Title XXI Children Title XIX SMI Adults Title XXI SMI Adults Dual-Eligible Non-SMI Adults Dual-Eligible Children DDD Title XIX Adults DDD Title XIX Children Medicare Cost Sharing EPD Title XIX Adults EPD Title XIX Children EPD CRS Title XIX Children EPD CRS Title XXI Children EPD CRS Title XIX Adults (18-21) EPD CRS Title XXI Adults (18-19) American Indians	United Health Care Community Care (CRS Fully Integrated)	Title XIX Adults (up to age 21) Title XIX Children Title XXI Adults (up to age 21) Title XXI Children Title XIX SMI Adults (up to age 21) American Indians	Statewide	All RBHAs	X	
		United Health Care Community Care (CRS Partial Acute)	American Indians	Statewide	TRBHAs All RBHAs	X X	
		DCS/CMDP	Title XIX Children Medicare Cost Sharing	Statewide	All RBHAs UHC (CRS, BH)	X X	
		Mercy Care Plan	Title XIX Adults Title XIX Children Title XXI Adults Title XXI Children Dual-Eligible Non-SMI Adults DDD Title XIX Adults DDD Title XIX Children American Indians	Maricopa Pima	MMIC Cenpatico IC All TRBHAs	X	
		Mercy Maricopa IC	Title XIX SMI Adults Title XXI SMI Adults	Maricopa	None		X
		Care1st Arizona	Title XIX Adults Title XIX Children Title XXI Adults Title XXI Children Dual-Eligible Non-SMI Adults Dual-Eligible Children DDD Title XIX Adults DDD Title XIX Children American Indians	Maricopa Pima	MMIC Cenpatico IC All TRBHAs	X	
		Health Choice Arizona	Title XIX Adults Title XIX Children Title XXI Adults Title XXI Children Dual-Eligible Non-SMI Adults Dual-Eligible Children American Indians	Apache Coconino Gila Mohave Navajo Pima Pinal	HCIC Cenpatico IC All TRBHAs	X	

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Benefit Package	Populations	Contractors	Sub- Population	Counties	Other MCO Enrollee Relationships	Conducts Analysis?	
						AHCCCS	Plan
Behavioral Health	Title XIX SMI Adults Title XXI SMI Adults DDD Title XIX SMI Adults DDD Title XIX Children DDD Title XIX Non - SMI Adults Title XIX CMDP Children Title XIX Children Title XXI Children Title XIX Non-SMI Adults Title XXI Non-SMI Adults Dual Eligible Children Dual Eligible Non - SMI Adults Medicare Cost Sharing Groups (e.g. QMB) CRS Title XIX SMI Adults (up to age 21) CRS Title XXI SMI Adults (up to age 21) CRS Title XIX Non-SMI Adults (up to age 21) CRS Title XXI Non-SMI Adults (up to age 21)	Mercy Care Plan	Dual Eligible Non - SMI Adults Title XIX Children Title XXI Children Dual Eligible Children Medicare Cost Sharing Groups (e.g. QMB) American Indians DDD Title XIX Children DDD Title XIX Non - SMI Adults Title XIX Non-SMI Adults Title XXI Non-SMI Adults	Maricopa Pima	MMIC Cenpatico IC LTC DD DES	X	
		Mercy Maricopa IC	Title XIX SMI Adults Title XXI SMI Adults DDD Title XIX SMI Adults DDD Title XIX Children DDD Title XIX Non - SMI Adults Title XIX CMDP Children Title XIX Children Title XXI Children Title XIX Non-SMI Adults Title XXI Non-SMI Adults Dual Eligible Children Dual Eligible Non - SMI Adults Medicare Cost Sharing Groups (e.g. QMB)	Maricopa	Mercy Care Plan Care1st Arizona Health Net Access United Health Care LTC DD DES DCS/CMDP (Except Title XIX & Title XXI SMI Adults)	X	X
		Care1st Arizona	Dual Eligible Non - SMI Adults Title XIX Children Title XXI Children Dual Eligible Children Medicare Cost Sharing Groups (e.g. QMB) American Indians DDD Title XIX Children DDD Title XIX Non - SMI Adults Title XIX Non-SMI Adults Title XXI Non-SMI Adults	Maricopa Pima	MMIC Cenpatico IC LTC DD DES	X	
		Health Choice Arizona	Dual Eligible Non - SMI Adults Title XIX Children Title XXI Children Dual Eligible Children Medicare Cost Sharing Groups (e.g. QMB) American Indians DDD Title XIX Children DDD Title XIX Non - SMI Adults Title XIX Non-SMI Adults Title XXI Non-SMI Adults	Apache Coconino Gila Mohave Navajo Pima Pinal	Cenpatico IC LTC DD DES	X	

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Benefit Package	Populations	Contractors	Sub- Population	Counties	Other MCO Enrollee Relationships	Conducts Analysis?	
						AHCCCS	Plan
		Health Choice IC	Title XIX SMI Adults Title XXI SMI Adults DDD Title XIX SMI Adults DDD Title XIX Children DDD Title XIX Non - SMI Adults Title XIX CMDP Children Title XIX Children Title XXI Children Title XIX Non-SMI Adults Title XXI Non-SMI Adults Dual Eligible Children Dual Eligible Non - SMI Adults Medicare Cost Sharing Groups (e.g. QMB)	Apache Coconino Gila Mohave Navajo Yavapai	Health Choice Arizona United Health Care University Family Care LTC DD DES DCS/CMDP (Except Title XIX & Title XXI SMI Adults)	X	X
		HealthNet Access	Dual Eligible Non - SMI Adults Title XIX Children Title XXI Children Dual Eligible Children Medicare Cost Sharing Groups (e.g. QMB) American Indians DDD Title XIX Children DDD Title XIX Non - SMI Adults Title XIX Non-SMI Adults Title XXI Non-SMI Adults	Maricopa	MMIC All TRBHAs LTC DD DES	X	
		Cenpatico IC	Title XIX SMI Adults Title XXI SMI Adults DDD Title XIX SMI Adults DDD Title XIX Children DDD Title XIX Non - SMI Adults Title XIX CMDP Children Title XIX Children Title XXI Children Title XIX Non-SMI Adults Title XXI Non-SMI Adults Dual Eligible Children Dual Eligible Non - SMI Adults Medicare Cost Sharing Groups (e.g. QMB)	Cochise Graham Greenlee La Paz Pima Pinal Santa Cruz Yuma	United Health Care University Family Care LTC DD DES DCS/CMDP (Except Title XIX & Title XXI SMI Adults)	X	X
		United Health Care	Dual Eligible Non - SMI Adults Title XIX Children Title XXI Children Dual Eligible Children Medicare Cost Sharing Groups (e.g. QMB) American Indians DDD Title XIX Children DDD Title XIX Non - SMI Adults Title XIX Non-SMI Adults Title XXI Non-SMI Adults	Apache Cochise Coconino Graham Greenlee La Paz Maricopa Navajo Pima Santa Cruz Yavapai Yuma	HCIC MMIC Cenpatico IC All TRBHAs LTC DD DES	X	

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Benefit Package	Populations	Contractors	Sub- Population	Counties	Other MCO Enrollee Relationships	Conducts Analysis?	
						AHCCCS	Plan
		Health Choice IC	Title XIX SMI Adults Title XXI SMI Adults	Apache Coconino Gila Mohave Navajo Yavapai	None		X
		HealthNet Access	Title XIX Adults Title XIX Children Title XXI Adults Title XXI Children Dual-Eligible Non-SMI Adults Dual-Eligible Children American Indians	Maricopa	MMIC All TRBHAs	X	
		Cenpatico IC	Title XIX SMI Adults Title XXI SMI Adults	Cochise Graham Greenlee La Paz Pima Pinal Santa Cruz Yuma	None		X
		United Health Care	Title XIX Adults Title XIX Children Title XXI Adults Title XXI Children Dual-Eligible Non-SMI Adults Dual-Eligible Children DDD Title XIX Adults DDD Title XIX Children American Indians	Apache Cochise Coconino Graham Greenlee La Paz Maricopa Navajo Pima Santa Cruz Yavapai Yuma	HCIC MMIC Cenpatico IC All TRBHAs	X	
		University Family Care	Title XIX Adults Title XIX Children Title XXI Adults Title XXI Children Dual-Eligible Non-SMI Adults Dual-Eligible Children American Indians	Cochise Gila Graham Greenlee La Paz Pima Pinal Santa Cruz Yavapai Yuma	Cenpatico IC HCIC All TRBHAs	X	

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Benefit Package	Populations	Contractors	Sub- Population	Counties	Other MCO Enrollee Relationships	Conducts Analysis?	
						AHCCCS	Plan
		University Family Care	Dual Eligible Non - SMI Adults Title XIX Children Title XXI Children Dual Eligible Children Medicare Cost Sharing Groups (e.g. QMB) American Indians DDD Title XIX Children DDD Title XIX Non - SMI Adults Title XIX Non-SMI Adults Title XXI Non-SMI Adults	Cochise Gila Graham Greenlee La Paz Pima Pinal Santa Cruz Yavapai Yuma	Cenpatico IC HCIC All TRBHAs LTC DD DES	X	
		United Health Care Community Care	CRS Title XIX SMI Adults (up to age 21) CRS Title XXI SMI Adults (up to age 21) CRS Title XIX Non-SMI Adults (up to age 21) CRS Title XXI Non-SMI Adults (up to age 21)	Statewide	MMIC Cenpatico IC HCIC All TRBHAs LTC DD DES DCS/CMDP	X	
		Navajo Nation	American Indians	Statewide	All Acute Physical Health Plans, CRS contractor & IC RBHAs	X	
		Gila River RBHA	American Indians	Statewide	All Acute Physical Health Plans, CRS contractor & IC RBHAs	X	
		White Mountain Apache Tribe	American Indians	Statewide	All Acute Physical Health Plans, CRS contractor & IC RBHAs	X	
		Colorado River Indian Tribe	American Indians	Statewide	All Acute Physical Health Plans, CRS contractor & IC RBHAs	X	
		Pasqua Yaqui Tribe	American Indians	Statewide	All Acute Physical Health Plans, CRS contractor & IC RBHAs	X	

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Benefit Package	Populations	Contractors	Sub- Population	Counties	Other MCO Enrollee Relationships	Conducts Analysis?	
						AHCCCS	Plan
CRS - Fully Integrated	Title XIX Adults (up to age 21) Title XIX Children Title XXI Adults (up to age 21) Title XXI Children Title XIX SMI Adults (up to age 21) Title XXI SMI Adults (up to age 21) American Indian Adults (up to age 21) American Indian Children	United Health Care Community Care	Title XIX Adults (up to age 21) Title XIX Children Title XXI Adults (up to age 21) Title XXI Children Title XIX SMI Adults (up to age 21) Title XXI SMI Adults (up to age 21) American Indian Adults (up to age 21) American Indians	Statewide	MMIC HCIC Cenpatico IC	X	
CRS Partially Integrated - Acute	American Indian Adults (up to age 21) American Indian Children	United Health Care Community Care (acute, CRS)	American Indian Adults American Indian Children	Statewide	MMIC HCIC Cenpatico IC TRBHAS	X	
CRS Partially Integrated - BH	CMDP Title XIX Children CMDP Title XIX Adults (up to age 21) DDD Title XIX Adults (up to age 21) DDD Title XIX Children DDD Dual Eligible Children DDD Dual Eligible Adults (up to age 21) DDD Medicare Cost Sharing Groups (e.g. QMB)	United Health Care Community Care (CRS, BH)	CMDP Title XIX Children CMDP Title XIX Adults (up to age 21) DDD Title XIX Adults (up to age 21) DDD Title XIX Children DDD Dual Eligible Children DDD Dual Eligible Adults (up to age 21) DDD Medicare Cost Sharing Groups (e.g. QMB)	Statewide	DCS/CMDP Mercy Care Plan Care1st Arizona HealthChoice Arizona United Health Care HealthNet Access University Family Care All TRBHAS	X	
CRS Only	American Indian Adults (up to age 21) American Indian Children American Indian DDD Adults (up to age 21) American Indian DDD Children American Indian CMDP Children American Indian CMDP YATI (up to age 21) American Indian EPD FFS AHIP Members from a T/RHBA	United Health Care Community Care (CRS)	American Indian Adults (up to age 21) American Indian Children American Indian DDD Adults (up to age 21) American Indian DDD Children American Indian CMDP Children American Indian CMDP YATI (up to age 21) American Indian EPD FFS AHIP Members from a T/RHBA	Statewide	All Acute Physical Health Plans, TRBHAs & IC RBHAs	X	

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Benefit Package	Populations	Contractors	Sub- Population	Counties	Other MCO Enrollee Relationships	Conduct Analysis?	
						MCO	State
ALTCS - DDD	DDD Title XIX Adults	LTC DD DES	DDD Title XIX Adults	Statewide	HCIC		
	DDD Title XIX Children		DDD Title XIX Children		Cenpatico IC		
	DDD Title XIX SMI Adults (acute, DDD)		DDD Title XIX SMI Adults (acute, DDD)		MMIC		
	DDD Dual Eligible Children		DDD Dual Eligible Children		All TRBHAs		
	DDD Dual Eligible Adults		DDD Dual Eligible Adults		United HealthCare Community Care (CRS, BH)		**X**
	DDD Medicare Cost Sharing Groups (e.g., QMB)		DDD Medicare Cost Sharing Groups (e.g., QMB)				
	CRS (Partially Integrated BH) DDD Adults (up to age 21)		CRS (Partially Integrated BH) DDD Adults (up to age 21)				
	CRS (Partially Integrated BH) DDD Children		CRS (Partially Integrated BH) DDD Children				
	DDD American Indians		DDD American Indians				

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Benefit Package	Populations	Contractors	Sub- Population	Counties	Other MCO Enrollee Relationships	Conduct Analysis?	
						MCO	State
ALTCS - EPD	EPD Title XIX Adults EPD Title XIX Children EPD CRS Title XIX Adults (up to age 21) EPD CRS Title XIX Children EPD American Indians	Mercy Care Plan (LTC)	EPD Title XIX Adults EPD Title XIX Children EPD CRS Title XIX Adults (up to age 21) EPD CRS Title XIX Children EPD American Indians	Maricopa Pima	MMIC Cenpatico IC TRBHAs		**X**
		Banner-University Family Care (LTC)	EPD Title XIX Adults EPD Title XIX Children EPD CRS Title XIX Adults (up to age 21) EPD CRS Title XIX Children EPD American Indians	Cochise Gila Graham Greenlee Maricopa Pinal	MMIC HCIC Cenpatico IC TRBHAs		**X**
		United HealthCare LTC	EPD Title XIX Adults EPD Title XIX Children EPD CRS Title XIX Adults (up to age 21) EPD CRS Title XIX Children EPD American Indians	Apache Coconino La Paz Maricopa Mohave Navajo Pima Santa Cruz Yavapai Yuma	MMIC HCIC Cenpatico IC TRBHAs		**X**

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APPENDIX B: BENEFIT PACKAGES, SERVICES AND CLASSIFICATIONS

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Benefit Packages (Populations)	Classification	Outpatient	Outpatient	Outpatient	Outpatient	Emergency/Outpatient	Inpatient	Inpatient	Outpatient	Prescription	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient
	Covered Services	Behavioral Health Therapeutic Home Care	Behavioral Management	Case Management	Emergency Behavioral Health Care	Evaluation	Inpatient Hospital	Inpatient Psychiatric Facilities	Laboratory and Radiology	Medications	Medication Management	Methadone/LAAM	Partial Care	Individual Therapy	Group and Family Therapy	Psychosocial Rehabilitation	Respite	Screening	Emergency Transportation	Non-Emergency Transportation
AHIP Members from a T/RHBA		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS American Indian Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS American Indian Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian EPD FFS		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indians (Age 0 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CMDP Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CMDP Title XIX Adults (up to age 25)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CMDP Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) CMDP Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) CMDP Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) DDD Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) DDD Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS Title XIX Non-SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS Title XXI SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Medicare Cost Sharing Groups (e.g. QMB)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Non - SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible CMDP Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible CMDP Adults (up to age 25)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible CMDP Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible Non - SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual-Eligible Non-SMI Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD American Indians		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Adults (18-21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Adults (18-19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Adults (Age 18 - 19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD Title XIX Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medicare Cost Sharing (Age 0 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medicare Cost Sharing Groups (e.g. QMB) (21 and older)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Non - SMI Adults (Age 18 - 19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Non - SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Non-SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI SMI Adults (Age 18 - 19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

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Benefit Packages (Populations)	Classification	Inpatient	Inpatient	Inpatient	Inpatient	Inpatient	Inpatient	Inpatient	Inpatient	Inpatient	Inpatient	Outpatient	Outpatient	Outpatient	Outpatient
	Covered Services	Nursing Facility	ICF	Behavioral Health Inpatient Facility	IMD	Inpatient Psychiatric Residential Treatment Center	Assisted Living Facilities	Community Residential Services	Adult Developmental Home	Child Developmental Certified Home	Group Home for Persons with Developmental	Personal Care Services	Private Duty Nursing	Supported Employment/Center Based Employment	Direct Care Services
AHIP Members from a T/RHBA															
American Indian Adults															
American Indian Adults (up to age 21)															
CRS American Indian Children															
CRS American Indian Adults (up to age 21)															
American Indian DDD Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian EPD FFS		X	X	X	X	X	X					X	X		X
American Indians (Age 0 - 20)															
CMDP Title XIX Adults (up to age 21)															
CMDP Title XIX Adults (up to age 25)															
CMDP Title XIX Children															
CRS (Partially Integrated BH) CMDP Adults (up to age 21)															
CRS (Partially Integrated BH) CMDP Children															
CRS (Partially Integrated BH) DDD Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) DDD Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS Title XIX Non-SMI Adults (up to age 21)															
CRS Title XXI SMI Adults (up to age 21)															
DDD Dual Eligible Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Medicare Cost Sharing Groups (e.g. QMB)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Non - SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible Children															
Dual Eligible CMDP Adults (up to age 21)															
Dual Eligible CMDP Adults (up to age 25)															
Dual Eligible CMDP Children															
Dual Eligible Non - SMI Adults															
Dual-Eligible Non-SMI Adults (Age 18 - 20)															
EPD American Indians		X	X	X	X	X	X					X	X		X
EPD CRS Title XIX Adults (18-21)		X	X	X	X	X	X					X	X		X
EPD CRS Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X					X	X		X
EPD CRS Title XIX Adults (up to age 21)		X	X	X	X	X	X					X	X		X
EPD CRS Title XIX Children		X	X	X	X	X	X					X	X		X
EPD CRS Title XXI Adults (18-19)		X	X	X	X	X	X					X	X		X
EPD CRS Title XXI Adults (Age 18 - 19)		X	X	X	X	X	X					X	X		X
EPD CRS Title XXI Children		X	X	X	X	X	X					X	X		X
EPD Title XIX Adults		X	X	X	X	X	X					X	X		X
EPD Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X					X	X		X
EPD Title XIX Children		X	X	X	X	X	X					X	X		X
Medicare Cost Sharing (Age 0 - 20)															
Medicare Cost Sharing Groups (e.g. QMB) (21 and older)															
Title XIX Adults															
Title XIX Adults (Age 18 - 20)															
Title XIX Adults (up to age 21)															
Title XIX Children															
Title XIX SMI Adults															
Title XIX SMI Adults (up to age 21)															
Title XXI Children															
Title XXI Non - SMI Adults (Age 18 - 19)															
Title XXI Non - SMI Adults (up to age 21)															
Title XXI Non-SMI Adults															
Title XXI SMI Adults															
Title XXI SMI Adults (Age 18 - 19)															

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Benefit Packages (Populations)	Classification	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Inpatient/Outpatient	Inpatient/ Outpatient	Inpatient/ Outpatient/	Inpatient/Outpatient	Inpatient/ Outpatient	Inpatient/ Outpatient	Outpatient
	Covered Services	Adult Day Health Care	Community Transition Services	Emergency Alert System	Rehabilitation Services	Home Delivered Meals	Home Health Service	Home Modifications	Respite	Rehabilitative Services	Medical Supplies	Medical Equipment	Durable Medical Equipment	Nutritional Assessment & Therapy	Transportation
AHIP Members from a T/RHBA															
American Indian Adults															
American Indian Adults (up to age 21)															
CRS American Indian Children															
CRS American Indian Adults (up to age 21)															
American Indian DDD Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian EPD FFS		X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indians (Age 0 - 20)															
CMDP Title XIX Adults (up to age 21)															
CMDP Title XIX Adults (up to age 25)															
CMDP Title XIX Children															
CRS (Partially Integrated BH) CMDP Adults (up to age 21)															
CRS (Partially Integrated BH) CMDP Children															
CRS (Partially Integrated BH) DDD Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) DDD Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS Title XIX Non-SMI Adults (up to age 21)															
CRS Title XXI SMI Adults (up to age 21)															
DDD Dual Eligible Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Medicare Cost Sharing Groups (e.g. QMB)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Non - SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible Children															
Dual Eligible CMDP Adults (up to age 21)															
Dual Eligible CMDP Adults (up to age 25)															
Dual Eligible CMDP Children															
Dual Eligible Non - SMI Adults															
Dual-Eligible Non-SMI Adults (Age 18 - 20)															
EPD American Indians		X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Adults (18-21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Adults (18-19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Adults (Age 18 - 19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD Title XIX Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medicare Cost Sharing (Age 0 - 20)															
Medicare Cost Sharing Groups (e.g. QMB) (21 and older)															
Title XIX Adults															
Title XIX Adults (Age 18 - 20)															
Title XIX Adults (up to age 21)															
Title XIX Children															
Title XIX SMI Adults															
Title XIX SMI Adults (up to age 21)															
Title XXI Children															
Title XXI Non - SMI Adults (Age 18 - 19)															
Title XXI Non - SMI Adults (up to age 21)															
Title XXI Non-SMI Adults															
Title XXI SMI Adults															
Title XXI SMI Adults (Age 18 - 19)															

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Benefit Packages (Populations)	Classification	Outpatient	Inpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Emergency	Outpatient	Outpatient	Inpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Inpatient/Outpatient
	Covered Services	Audiology	Breast Reconstruction	Chiropractic	Cochlear Implants	Emergency Dental Services	Preventive & Therapeutic Dental Services	Surgical Services-Dentist	Dialysis	Emergency Services-Medical	Emergency Eye Exam	Vision Exam	Lens Post Cataract Surgery	Medical Conditions-Eye	Health Risk Assessment & Screening	Preventive Exams	HIV/AIDS Therapy	Home Health Services	Hospice
AHIP Members from a T/RHBA		X	X				X	X	X	X		X				X	X	X	X
American Indian Adults		X	X				X	X	X	X		X				X	X	X	X
American Indian Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
CRS American Indian Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
CRS American Indian Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
American Indian DDD Adults		X	X				X	X	X	X		X				X	X	X	X
American Indian DDD Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
American Indian DDD Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
American Indian EPD FFS		X	X				X	X	X	X		X				X	X	X	X
American Indians (Age 0 - 20)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
CMDP Title XIX Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
CMDP Title XIX Adults (up to age 25)		X	X				X	X	X	X		X				X	X	X	X
CMDP Title XIX Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
CRS (Partially Integrated BH) CMDP Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
CRS (Partially Integrated BH) CMDP Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
CRS (Partially Integrated BH) DDD Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
CRS (Partially Integrated BH) DDD Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
CRS Title XIX Non-SMI Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
CRS Title XXI SMI Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
DDD Dual Eligible Adults		X	X				X	X	X	X		X				X	X	X	X
DDD Dual Eligible Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
DDD Dual Eligible Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
DDD Medicare Cost Sharing Groups (e.g. QMB)		X	X				X	X	X	X		X				X	X	X	X
DDD Title XIX Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
DDD Title XIX Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
DDD Title XIX Non - SMI Adults		X	X				X	X	X	X		X				X	X	X	X
DDD Title XIX SMI Adults		X	X				X	X	X	X		X				X	X	X	X
DDD Title XIX SMI Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
Dual Eligible Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
Dual Eligible CMDP Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
Dual Eligible CMDP Adults (up to age 25)		X	X				X	X	X	X		X				X	X	X	X
Dual Eligible CMDP Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
Dual Eligible Non - SMI Adults		X	X				X	X	X	X		X				X	X	X	X
Dual-Eligible Non-SMI Adults (Age 18 - 20)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
EPD American Indians		X	X				X	X	X	X		X				X	X	X	X
EPD CRS Title XIX Adults (18-21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
EPD CRS Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
EPD CRS Title XIX Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
EPD CRS Title XIX Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
EPD CRS Title XXI Adults (18-19)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
EPD CRS Title XXI Adults (Age 18 - 19)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
EPD CRS Title XXI Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
EPD Title XIX Adults		X	X				X	X	X	X		X				X	X	X	X
EPD Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
EPD Title XIX Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
Medicare Cost Sharing (Age 0 - 20)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
Medicare Cost Sharing Groups (e.g. QMB) (21 and older)		X	X				X	X	X	X		X				X	X	X	X
Title XIX Adults		X	X				X	X	X	X		X				X	X	X	X
Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
Title XIX Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
Title XIX Children		X	X	X	X	X	X		X	X	X	X				X	X	X	X
Title XIX SMI Adults		X	X				X	X	X	X		X				X	X	X	X
Title XIX SMI Adults (up to age 21)		X	X	X	X	X	X		X	X	X	X				X	X	X	X
Title XXI Children			X	X	X	X		X	X	X	X	X				X	X	X	X
Title XXI Non - SMI Adults (Age 18 - 19)			X	X	X	X		X	X	X	X	X				X	X	X	X
Title XXI Non - SMI Adults (up to age 21)			X	X	X	X		X	X	X	X	X				X	X	X	X
Title XXI Non-SMI Adults			X	X	X	X		X	X	X	X	X				X	X	X	X
Title XXI SMI Adults			X	X	X	X		X	X	X	X	X				X	X	X	X
Title XXI SMI Adults (Age 18 - 19)			X	X	X	X		X	X	X	X	X				X	X	X	X

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Benefit Packages (Populations)	Classification	Inpatient	Inpatient	Outpatient	Inpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Outpatient	Inpatient/Outpatient	Inpatient/Outpatient/Emergency	Outpatient	Outpatient	Inpatient	Inpatient/Outpatient	Inpatient/Outpatient/Emergency
	Covered Services	Hospital-Inpatient	Hospital-Observation	Hospital-Outpatient	Hysterectomy	Immunizations	Laboratory	Maternity Services	Family Planning	EPSDT	EPSDT-Other	Medical Foods	Durable Medical Equipment	Medical Supplies	Prosthetic	Orthotic Devices	Nursing Facilities	Non-Physician First Surgical Assistant	Physician Services
AHIP Members from a T/RHBA		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
American Indian Adults		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
American Indian Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS American Indian Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS American Indian Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Adults		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
American Indian DDD Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian EPD FFS		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
American Indians (Age 0 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CMDP Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CMDP Title XIX Adults (up to age 25)		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
CMDP Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) CMDP Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) CMDP Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) DDD Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) DDD Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS Title XIX Non-SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS Title XXI SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Adults		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
DDD Dual Eligible Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Medicare Cost Sharing Groups (e.g. QMB)		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
DDD Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Non - SMI Adults		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
DDD Title XIX SMI Adults		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
DDD Title XIX SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible CMDP Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible CMDP Adults (up to age 25)		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
Dual Eligible CMDP Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible Non - SMI Adults		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
Dual-Eligible Non-SMI Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD American Indians		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
EPD CRS Title XIX Adults (18-21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Adults (18-19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Adults (Age 18 - 19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD Title XIX Adults		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
EPD Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medicare Cost Sharing (Age 0 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medicare Cost Sharing Groups (e.g. QMB) (21 and older)		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
Title XIX Adults		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX SMI Adults		X	X	X	X	X	X	X			X	X	X	X		X	X	X	
Title XIX SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Non - SMI Adults (Age 18 - 19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Non - SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Non-SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI SMI Adults (Age 18 - 19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

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Benefit Packages (Populations)	Classification	Outpatient	Prescription/Emergency/Inpatient	Outpatient	Outpatient	Inpatient/Outpatient/Emergency	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Outpatient	Outpatient	Inpatient	Prescription	Outpatient	Outpatient	Emergency/Outpatient
	Covered Services	Foot and Ankle Services	Prescription Drugs	Primary Care Provider	Private Duty Nursing	Radiology & Medical Imaging	Occupational Therapy-Inpatient	Occupational Therapy-Outpatient	Physical Therapy-Inpatient	Physical Therapy-Outpatient	Speech Therapy-Inpatient	Speech Therapy-Outpatient	Respiratory Therapy	Total Outpatient Parenteral Nutrition	Non-Experimental Transplants	Transplant Related Immunosuppressant Drugs	Transportation-Emergency	Transportation-Non-Emergency	Triage
AHIP Members from a T/RHBA		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
American Indian Adults		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
American Indian Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS American Indian Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS American Indian Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Adults		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
American Indian DDD Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian DDD Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Indian EPD FFS		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
American Indians (Age 0 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CMDP Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CMDP Title XIX Adults (up to age 25)		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
CMDP Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) CMDP Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) CMDP Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) DDD Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS (Partially Integrated BH) DDD Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS Title XIX Non-SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CRS Title XXI SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Adults		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
DDD Dual Eligible Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Dual Eligible Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Medicare Cost Sharing Groups (e.g. QMB)		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
DDD Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DDD Title XIX Non - SMI Adults		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
DDD Title XIX SMI Adults		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
DDD Title XIX SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible CMDP Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible CMDP Adults (up to age 25)		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
Dual Eligible CMDP Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dual Eligible Non - SMI Adults		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
Dual-Eligible Non-SMI Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD American Indians		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
EPD CRS Title XIX Adults (18-21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Adults (18-19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Adults (Age 18 - 19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD CRS Title XXI Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD Title XIX Adults		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
EPD Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
EPD Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medicare Cost Sharing (Age 0 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Medicare Cost Sharing Groups (e.g. QMB) (21 and older)		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
Title XIX Adults		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
Title XIX Adults (Age 18 - 20)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XIX SMI Adults		X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X
Title XIX SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Children		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Non - SMI Adults (Age 18 - 19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Non - SMI Adults (up to age 21)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI Non-SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI SMI Adults		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Title XXI SMI Adults (Age 18 - 19)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

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APPENDIX C: COMPLIANCE DETERMINATIONS

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient Behavioral Health Inpatient Facility Electro-convulsive treatment provided in an inpatient setting Behavioral Health Residential Facility Home care training to home care client
	M/S: Planned Inpatient Procedures/Surgeries

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The M/S plan cites the need for the prior authorization (PA) and concurrent review to ensure the appropriateness of the service and to ascertain if there is an appropriate lower level of care or alternate to hospital based services. The M/S Plan reviews retrospective services to asses if there are meeting regulatory guidelines, assess for potential quality of care and fraud, waste and abuse concerns, and to assess for inappropriate coding and over utilization based on evidence based guidelines.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	The M/S plan reports using utilization and cost data to support the application of the UM strategies.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to admission by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a telephonic review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms ranging from three to eleven pages (for BH residential) in length. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 days (hospital) and 30 days for behavioral health inpatient facilities for persons under the age of 21. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, using ALOS benchmarks. Emergency Services do not require prior authorization per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only Medical Directors are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to accessing the services by requests initiated via telephone or facsimile. Concurrent review must be conducted prior to the expiration of the authorization and can be completed via telephone, on-site and/or by fax. The service authorization request must be complete with hospital name, reason for the admission, procedure (applicable CPT code) and diagnosis code (ICD-10). Supporting documentation includes correlating medical progress notes, and if applicable, lab and diagnostic test results, consultant notes, and any other medical documentation from the medical record pertinent to the service being requested. Care1st follows the federal timeframe requirements for prior authorization - three business days for expedited service authorization request and up to 14 calendar days for routine requests. The Plan uses DRGs and thus does not establish a length of authorization upfront. The concurrent review process would assess for outliers to the ALOS once admitted. Emergency and maternity triage services do not require prior authorization.

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	The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. The provider has the opportunity for a peer to peer reconsideration. Reviewers utilize nationally-recognized medical necessity guidelines, MCG. Only Medical Directors are authorized to exercise discretion in the application of UM strategies to particular cases. In the event that the Plan determines that the service does not meet medical necessity through PA, concurrent review or retrospective review, the outcome would be a denial of payment. For retrospective review, inpatient claims are reviewed, including claims under investigation for fraud or abuse or claims under review for medical necessity (pended for review), or retro eligibility of the member post inpatient admission or discharge. The Hospital EMR is accessed or medical records are requested to support the claim. If the clinical data is not received and prior authorization was not obtained, the claim is allowed to be denied.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	The UM guidelines are reviewed at least annually to review and add new CPT codes and to assess if there are changes required due to new evidence based guidelines or changes to standard of practice. The plan utilizes an inter-rater reliability testing process with a minimum performance threshold of 85%. Denial rates, average length of stay and readmissions are tracked and monitored by the Plan to assess the effectiveness of the UM strategies.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., prior authorization, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for three options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested (e.g., the M/S Plan reported things like medical progress notes, labs, medical consultations and diagnostic test results, whereas the MH/SUD Plan requires a an eleven page request form to be completed summarizing clinical, functional and demographic information for MH/SUD residential services based upon the long-term nature of that type of service). Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. The MH/SUD Plan permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member, whereas the M/S Plan restricts retrospective review for purposes of FWA reviews. In this case, the NQTL is applied to MH/SUD less restrictively. The approach to determining the length of authorizations are comparable across each Plan. Length of authorization is tied to evidence-based guidelines when such guidelines are present for the service. Variations between MH/SUD and M/S lengths of stay appear to be tied to the type of service as opposed to comparability or stringency of approach. Both plans utilize an inter-rater reliability testing process, though the MH/SUD minimum threshold is more permissive which could lead to greater variation in the application of medical necessity criteria. To address this variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, average length of stay, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="2">Benefit Package(s): Child</td></tr>
<tr><td colspan="2">Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="2">Non-quantitative treatment limit (NQTL): Utilization Management (UM)</td></tr>
<tr><td colspan="2">Classification: Inpatient</td></tr>
<tr><td rowspan="2">Services</td><td>MH/SUD:
Inpatient Psychiatric Acute Inpatient Hospital
Subacute/Inpatient Behavioral Health Inpatient Facility
Electro-convulsive treatment provided in an inpatient setting
Behavioral Health Residential Facility
Home care training to home care client</td></tr>
<tr><td>M/S:
All inpatient services</td></tr>
</table>

<table>
<tr><th colspan="2">Comparability of Strategy</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.</td><td>The Plan reports that the rationale for applying PA, concurrent review and retrospective review is that the costs of services used to diagnose or treat conditions are high relative to commonly used alternative services.</td></tr>
<tr><th colspan="2">Comparability of Evidence</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.</td><td>To support the UM strategies related to PA, concurrent review and retrospective review, the Plan utilizes a nationally-recognized, medical necessity guidelines (InterQual).</td></tr>
</table>

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to admission by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a telephonic review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms ranging from three to eleven pages (for BH residential) in length. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 days (hospital) and 30 days for behavioral health inpatient facilities for persons under the age of 21. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, using ALOS benchmarks. Emergency Services do not require prior authorization per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only Medical Directors are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to admission by requests initiated via telephone or facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit clinical documentation by completing the mandatory fields within the provider portal or completing the designated PA form with all mandatory fields completed. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed healthcare professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with guidelines distributed to network providers that include, but are not limited to, nationally recognized MN guidelines, InterQual, developed by professional medical associations. An exception to PA is emergency services, which can be reviewed retrospectively. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine eligibility or coverage for the member. The Plan did not identify any discretion that is applied to the UM strategies. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	UM strategies are reviewed annually or with any changes that AHCCCS has implemented. Additionally, when a denial results in either a claim dispute or a grievance, a review of the UM strategy may occur to ensure accordance with best practices. Overturned appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for IRR. Grievance and complaints as well as appeals will also at times trigger a review of the criteria to determine if they are too stringent.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., prior authorization, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. The MH/SUD Plan reported using cost and utilization data to identify high cost services subject to UM strategies, whereas the M/S Plan did not respond to the data used to identify high cost services. However, for both Plans, all services in the inpatient classification are subject to UM strategies, demonstrating comparability in approach and application. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for three options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG and InterQual) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM NQTL results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an inter-rater reliability testing process, though the M/S Plan did not provide the MPS used for IRR testing. To address any potential variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, average length of stay, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="2">Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult</td></tr>
<tr><td colspan="2">Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Net (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="2">Non-quantitative treatment limit (NQTL): Utilization Management (UM)</td></tr>
<tr><td colspan="2">Classification: Inpatient</td></tr>
<tr><td rowspan="2">Services</td><td>MH/SUD:
Inpatient Psychiatric Acute Inpatient Hospital
Subacute/Inpatient Behavioral Health Inpatient Facility
Electro-convulsive treatment provided in an inpatient setting
Behavioral Health Residential Facility
Home care training to home care client</td></tr>
<tr><td>M/S:
Inpatient Services including acute hospital, acute rehab, skilled nursing facility (SNF), long term acute care hospital (LTACH).</td></tr>
</table>

<table>
<tr><th colspan="2">Comparability of Strategy</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.</td><td>The Plan reports that the rationale for applying PA, concurrent review and retrospective review is to ensure that the quality and type of service is appropriate to the member's needs.</td></tr>
<tr><th colspan="2">Comparability of Evidence</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.</td><td>To support the UM strategies related to PA, concurrent review and retrospective review, the Plan utilizes a nationally recognized industry guideline for the determination of medical necessity (MCG and InterQual).</td></tr>
</table>

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to admission by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a telephonic review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms ranging from three to eleven pages (for BH residential) in length. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 days (hospital) and 30 days for behavioral health inpatient facilities for persons under the age of 21. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, using ALOS benchmarks. Emergency Services do not require prior authorization per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only Medical Directors are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit clinical documentation by completing the mandatory fields within the provider portal or completing the designated PA form with all mandatory fields completed. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed healthcare professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	The CMO or designee performs an annual review of all existing clinical policies to determine continued applicability and appropriateness. In connection with this annual review, the CMO or designee is responsible for identifying which policies require revisions. The Plan requires annual IRR, reviews denial rates, readmission rates and grievances to assess the application and stringency of the UM strategies.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., prior authorization, concurrent review, retrospective review) to ensure the appropriateness of services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use nationally-recognized medical necessity criteria to determine coverage of inpatient services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for three options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. MH/SUD Plan offers the provider the opportunity for a peer to peer reconsideration, whereas the M/S Plan does not. However, in that instance, the NQTL is applied less stringently for MH/SUD benefits. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an inter-rater reliability testing process, however, the M/S Plan did not report the MPS for IRR testing. Regardless, to address any potential variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, average length of stay, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient Behavioral Health Inpatient Facility Electro-convulsive treatment provided in an inpatient setting Behavioral Health Residential Facility Home care training to home care client
	M/S: Inpatient stay Hospital Skilled Nursing Facility Acute rehabilitation Long Term Acute Care

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is to ensure that services are provided as necessary and managed efficiently and not over utilized. Services are high cost services and should be applied to symptoms that will benefit from the application of the service.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	Plan tracks and trends utilization and spending thresholds. Evidence reported by the Plan indicates these are high risk/high cost services.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to admission by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a telephonic review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms ranging from three to eleven pages (for BH residential) in length. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 days (hospital) and 30 days for behavioral health inpatient facilities for persons under the age of 21. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, using ALOS benchmarks. Emergency Services do not require prior authorization per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only Medical Directors are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile. The requesting provider must submit the PA with supporting clinical documentation required per MCG guidelines. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request.UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into considering before changes are made. AHCCCS guidelines, policy updates, MCG annual updates, Aetna clinical policy guidelines and monthly updates are also considered and may prompt a review more frequent than annually. The Plan relies on claims data, provider utilization data, readmission rates, and predictive analytics. IRR testing is required annually for all existing staff and within 90 days of hire for new staff.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., prior authorization, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for two options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For both Plans, the failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The approach to determining the length of authorizations are comparable across each Plan. Length of authorization is tied to evidence-based guidelines when such guidelines are present for the service. Both plans utilize an inter-rater reliability testing process, however, the M/S Plan did not report the MPS for IRR testing. Regardless, to address any potential variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, average length of stay, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient Behavioral Health Inpatient Facility Electro-convulsive treatment provided in an inpatient setting Behavioral Health Residential Facility Home care training to home care client
	M/S: Skilled Nursing Facility Acute Inpatient Rehab (AIR) Facility Long Term Acute Care Acute Inpatient Admissions Hospice Care (Inpatient)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is that the costs of services used to diagnose or treat conditions is high relative to commonly used alternative services.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to admission by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a telephonic review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms ranging from three to eleven pages (for BH residential) in length. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 days (hospital) and 30 days for behavioral health inpatient facilities for persons under the age of 21. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, using ALOS benchmarks. Emergency Services do not require prior authorization per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only Medical Directors are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit clinical documentation by completing the mandatory fields within the provider portal or completing the designated PA form with all mandatory fields completed. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request.UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., prior authorization, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for three options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. MH/SUD Plan offers the provider the opportunity for a peer to peer reconsideration, whereas the M/S Plan does not. However, in that instance, the NQTL is applied less stringently for MH/SUD benefits. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. The MH/SUD Plan permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an inter-rater reliability testing process, however, the M/S Plan did not report the MPS for IRR testing. Regardless, to address any potential variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, average length of stay, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient BH Inpatient Facility ECT provided in an inpatient setting BH Residential Facility
	M/S: Planned Inpatient Procedures/Surgeries

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA) and concurrent review due to associated high costs and to ensure it is the most appropriate care to meet the member's need. Retrospective review is in place to address circumstances in which the provider failed to notify the health plan of the member's admission within 72 hours of admission or the member became eligible for services after discharge (prior period coverage).	The M/S plan cites the need for the PA and concurrent review to ensure the appropriateness of the service and to ascertain if there is an appropriate lower level of care or alternate to hospital based services. The M/S Plan reviews retrospective services to asses if there are meeting regulatory guidelines, assess for potential quality of care and fraud, waste and abuse concerns, and to assess for inappropriate coding and over utilization based on evidence based guidelines.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	The M/S plan reports using utilization and cost data to support the application of the UM strategies.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via facsimile, telephone or through a provider portal. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a scheduled telephonic review. The information required is based on the level of service being requested. For the Arizona State Hospital, the provider fills out a specific form. For emergency hospitalization, the provider notifies Cenpatico of the admission and supplies the CON and other clinical documents. For a BHRF admission coming from a hospital, the provider provides notice of admission and supporting clinical documentation. For BHRF admissions from the community, a PA is required and an out-of-home packet (form) is filled out. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 -5 days (hospital) and 14 days for behavioral health residential facilities. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilizes McKesson, InterQual Criteria and ASAM Criteria. Emergency Services do not require prior authorization per federal requirement. The medical director (MD) will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only MDs are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain PA prior to accessing the services by requests initiated via telephone or facsimile. Concurrent review must be conducted prior to the expiration of the authorization and can be completed via telephone, on-site and/or by fax. The service authorization request must be complete with hospital name, reason for the admission, procedure (applicable CPT code) and diagnosis code (ICD-10). Supporting documentation includes correlating medical progress notes, and if applicable, lab and diagnostic test results, consultant notes, and any other medical documentation from the medical record pertinent to the service being requested. Care1st follows the federal timeframe requirements for PA - 3 business days for expedited service authorization request and up to 14 calendar days for routine requests. The Plan uses DRGs and thus does not establish a length of authorization upfront. The concurrent review process would assess for outliers to the average length of stay (ALOS) once admitted. Emergency and maternity triage services do not require PA. The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. The provider has the opportunity for a peer to peer reconsideration. Reviewers utilize nationally-recognized medical necessity guidelines, Milliman Care Guidelines (MCG). Only Medical Directors (MDs) are authorized to exercise discretion in the application of UM strategies to particular cases. In the event that the Plan determines that the service does not meet medical necessity through PA, concurrent review or retrospective review, the outcome would be a denial of payment. For retrospective review, inpatient claims are reviewed, including claims under investigation for fraud or abuse or claims under review for medical necessity (pended for review), or retro eligibility of the member post inpatient admission or discharge. The Hospital electric medical record is accessed or medical records are requested to support the claim. If the clinical data is not received and PA was not obtained, the claim is allowed to be denied.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. Inter-rater reliability (IRR) testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	The UM guidelines are reviewed at least annually to review and add new CPT codes and to assess if there are changes required due to new evidence based guidelines or changes to standard of practice. The plan utilizes an inter-rater reliability testing process with a minimum performance threshold of 85%. Denial rates, average length of stay and readmissions are tracked and monitored by the Plan to assess the effectiveness of the UM strategies.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA requests to be initiated via multiple options. The MH/SUD Plan only allows concurrent reviews to be conducted telephonically. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested (e.g., the M/S Plan reported things like medical progress notes, labs, medical consultations and diagnostic test results, whereas the MH/SUD Plan requires a an out-of-home packet to be completed summarizing clinical, functional and demographic information for MH/SUD residential services based upon the long-term nature of that type of service). Timelines for authorization decisions are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. The MH/SUD Plan permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member, whereas the M/S Plan restricts retrospective review for purposes of FWA reviews. In this case, the NQTL is applied to MH/SUD less restrictively. The approach to determining the length of authorizations are comparable across each Plan. Length of authorization is tied to evidence-based guidelines when such guidelines are present for the service. Variations between MH/SUD and M/S lengths of stay appear to be tied to the type of service as opposed to comparability or stringency of approach. Both plans utilize an inter-rater reliability testing process. The State plans to establish a mandatory MPS of 90% for IRR testing to reduce variation across contractors. Both Plans review and monitor data such as denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
Services	**MH/SUD:** Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient BH Inpatient Facility ECT provided in an inpatient setting BH Residential Facility
	M/S: All inpatient services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA) and concurrent review due to associated high costs and to ensure it is the most appropriate care to meet the member's need. Retrospective review is in place to address circumstances in which the provider failed to notify the health plan of the member's admission within 72 hours of admission or the member became eligible for services after discharge (prior period coverage).	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is that the costs of services used to diagnose or treat conditions are high relative to commonly used alternative services.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	To support the UM strategies related to PA, concurrent review and retrospective review, the Plan utilizes a nationally-recognized, medical necessity guidelines (InterQual).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via facsimile, telephone or through a provider portal. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a scheduled telephonic review. The information required is based on the level of service being requested. For the Arizona State Hospital, the provider fills out a specific form. For emergency hospitalization, the provider notifies Cenpatico of the admission and supplies the CON and other clinical documents. For a BHRF admission coming from a hospital, the provider provides notice of admission and supporting clinical documentation. For BHRF admissions from the community, a PA is required and an out-of-home packet (form) is filled out. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 -5 days (hospital) and 14 days for behavioral health residential facilities.	Provider must obtain PA prior to admission by requests initiated via telephone or facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit clinical documentation by completing the mandatory fields within the provider portal or completing the designated PA form with all mandatory fields completed. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed healthcare professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with guidelines distributed to network providers that include, but are not limited to, nationally recognized MN guidelines, InterQual, developed by professional medical associations. An exception to PA is emergency services, which can be reviewed retrospectively. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine eligibility or coverage for the member. The Plan did not identify any discretion that is applied to the UM strategies. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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<table>
<tr><td>The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilizes McKesson, InterQual Criteria and ASAM Criteria. Emergency Services do not require PA per federal requirement. The medical director (MD) will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only MDs are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.</td><td></td></tr>
<tr><th colspan="2">Stringency of Strategy and Evidence</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>Plan reviews medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS and readmissions. IRR testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.</td><td>UM strategies are reviewed annually or with any changes that Arizona Health Care Cost Containment System (AHCCCS) has implemented. Additionally, when a denial results in either a claim dispute or a grievance, a review of the UM strategy may occur to ensure accordance with best practices. Overturned appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for IRR. Grievance and complaints as well as appeals will also at times trigger a review of the criteria to determine if they are too stringent.</td></tr>
</table>

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. The MH/SUD Plan reported using cost and utilization data to identify high cost services subject to UM strategies, whereas the M/S Plan did not respond to the data used to identify high cost services. However, for both Plans, all services in the inpatient classification are subject to UM strategies, demonstrating comparability in approach and application. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit prior authorization requests to be initiated via multiple options. The MH/SUD Plan only allows concurrent reviews to be conducted telephonically. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested (e.g., the M/S Plan reported things like medical progress notes, labs, medical consultations and diagnostic test results, whereas the MH/SUD Plan requires a an out-of-home packet to be completed summarizing clinical, functional and demographic information for MH/SUD residential services based upon the long-term nature of that type of service). Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM NQTL results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an inter-rater reliability (IRR) testing process. The State plans to establish a mandatory MPS of 90% for IRR testing to reduce possible variation across contractors. Both Plans review and monitor data such as denial rates, average length of stay (ALOS), readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="2">Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult</td></tr>
<tr><td colspan="2">Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="2">Non-quantitative treatment limit (NQTL): Utilization Management (UM)</td></tr>
<tr><td colspan="2">Classification: Inpatient</td></tr>
<tr><td rowspan="2">Services</td><td>MH/SUD:
Inpatient Psychiatric
Acute Inpatient Hospital
Subacute/Inpatient BH Inpatient Facility
ECT provided in an inpatient setting
BH Residential Facility</td></tr>
<tr><td>M/S:
All admissions to the following inpatient levels of care: acute, sub-acute, observation are subject to prior authorization (PA) concurrent review.</td></tr>
<tr><td colspan="2">Comparability of Strategy</td></tr>
<tr><td>MH/SUD</td><td>M/S</td></tr>
<tr><td>The MH/SUD plan subjects these services to PA and concurrent review due to associated high costs and to ensure it is the most appropriate care to meet the member's need. Retrospective review is in place to address circumstances in which the provider failed to notify the health plan of the member's admission within 72 hours of admission or the member became eligible for services after discharge (prior period coverage).</td><td>The Plan reports that the rationale for applying PA and concurrent review is to manage over- and under-utilization of inpatient services to ensure members care and treatment is managed and delivered timely at the right level of care. Retrospective review ensures care was at the appropriate level and based on medical necessity.</td></tr>
</table>

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Comparability of Evidence	
MH/SUD	**M/S**
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	The health plan determines which inpatient services require pre-service authorization based on utilization data, cost, and/or proclivity for over-utilization. For retrospective review, evidenced based guidelines are used to determine medical necessity. InterQual is the primary guideline.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via facsimile, telephone or through a provider portal. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a scheduled telephonic review. The information required is based on the level of service being requested. For the Arizona State Hospital, the provider fills out a specific form. For emergency hospitalization, the provider notifies Cenpatico of the admission and supplies the CON and other clinical documents. For a BHRF admission coming from a hospital, the provider provides notice of admission and supporting clinical documentation. For BHRF admissions from the community, a PA is required and an out-of-home packet (form) is filled out. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 -5 days (hospital) and 14 days for behavioral health residential facilities.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a facsimile or telephonically. The requesting provider must submit clinical documentation by submitting the designated one page PA form with all mandatory fields completed. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The length of the authorization is determined by adherence to InterQual criteria. Average lengths of authorization for PA are 90 days. Concurrent reviews continue at a minimum of every 3 days. The Plan utilizes licensed healthcare professionals to render authorization decisions while a physician is required to deny a PA request. If further review is needed a Medical Director (MD) will review for medical necessity and make a final determination. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan indicated that an MD can exercise discretion when applying the UM strategies based on the member's needs. Retrospective reviews are conducted when the Plan is made aware of inpatient service utilization either by late notification, when a claim is submitted, or when a provider disputes a claim payment/denial. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilizes McKesson, InterQual Criteria and ASAM Criteria. Emergency Services do not require PA per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only MDs authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. Inter-rater reliability (IRR) testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	Health Choice utilizes claims data to monitor, track and trend practice patterns, analyzes services rendered to determine and manage what services require PA. This data is reviewed annually or if noted spikes/trends in utilization changes throughout the year. The data is reviewed and analyzed, then presented to Senior and Clinical Health Plan Leadership. The plan utilizes several metrics to measure the efficacy of PA such as: IRR to ensure accuracy and consistently of criteria, denial trends, over- and under-utilization data, grievance and appeals reports, benefit changes.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. The MH/SUD Plan permits PA requests to be initiated via multiple options, while the M/S Plan restricts requests to a single method. The MH/SUD Plan only allows concurrent reviews to be conducted telephonically, but the M/S Plan allows multiple methods to conduct a concurrent review. To address these inconsistencies, the State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested (e.g., the M/S Plan reported things like medical progress notes, labs, medical consultations and diagnostic test results, whereas the MH/SUD Plan requires a an out-of-home packet to be completed summarizing clinical, functional and demographic information for MH/SUD residential services based upon the long-term nature of that type of service). Timelines for authorization decisions are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For both Plans, the failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The approach to determining the length of authorizations are comparable across each Plan. Length of authorization is tied to evidence-based guidelines when such guidelines are present for the service. Both plans utilize an IRR testing process. The State plans to establish a mandatory MPS of 90% for IRR testing to reduce variation across contractors. Both Plans review and monitor data such as denial rates, average length of stay, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient BH Inpatient Facility ECT provided in an inpatient setting BH Residential Facility
	M/S: Inpatient stay Hospital Skilled Nursing Facility Acute rehabilitation Long Term Acute Care

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA) and concurrent review due to associated high costs and to ensure it is the most appropriate care to meet the member's need. Retrospective review is in place to address circumstances in which the provider failed to notify the health plan of the member's admission within 72 hours of admission or the member became eligible for services after discharge (prior period coverage).	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is to ensure that services are provided as necessary and managed efficiently and not over utilized. Services are high cost services and should be applied to symptoms that will benefit from the application of the service.

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Comparability of Evidence	
MH/SUD	**M/S**
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	Plan tracks and trends utilization and spending thresholds. Evidence reported by the Plan indicates these are high risk/high cost services.
Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via facsimile, telephone or through a provider portal. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a scheduled telephonic review. The information required is based on the level of service being requested. For the Arizona State Hospital, the provider fills out a specific form. For emergency hospitalization, the provider notifies Cenpatico of the admission and supplies the CON and other clinical documents. For a BHRF admission coming from a hospital, the provider provides notice of admission and supporting clinical documentation. For BHRF admissions from the community, a PA is required and an out-of-home packet (form) is filled out. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 -5 days (hospital) and 14 days for behavioral health residential facilities.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile. The requesting provider must submit the PA with supporting clinical documentation required per MCG guidelines. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request.UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilizes McKesson, InterQual Criteria and ASAM Criteria. Emergency Services do not require PA per federal requirement. The medical director (MD) will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only MDs are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, average length of stay (ALOS), and readmissions. Inter-rater reliability (IRR) testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into considering before changes are made. Arizona Health Care Cost Containment System (AHCCCS) guidelines, policy updates, Milliman Care Guidelines (MCG) annual updates, Aetna clinical policy guidelines and monthly updates are also considered and may prompt a review more frequent than annually. The Plan relies on claims data, provider utilization data, readmission rates, and predictive analytics. IRR testing is required annually for all existing staff and within 90 days of hire for new staff.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit prior authorization requests to be initiated via multiple options. The MH/SUD Plan only allows concurrent reviews to be conducted telephonically. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested (e.g., the M/S Plan reported things like medical progress notes, labs, medical consultations and diagnostic test results, whereas the MH/SUD Plan requires a an out-of-home packet to be completed summarizing clinical, functional and demographic information for MH/SUD residential services based upon the long-term nature of that type of service). Timelines for authorization decisions are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For both Plans, the failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The approach to determining the length of authorizations are comparable across each Plan. Length of authorization is tied to evidence-based guidelines when such guidelines are present for the service. Both plans utilize an inter-rater reliability (IRR) testing process. The State plans to establish a mandatory MPS of 90% for IRR testing to reduce variation across contractors. Both Plans review and monitor data such as denial rates, average length of stay (ALOS), readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient BH Inpatient Facility ECT provided in an inpatient setting BH Residential Facility
	M/S: Elective hospitalizations, skilled nursing facilities and inpatient rehabilitation services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA) and concurrent review due to associated high costs and to ensure it is the most appropriate care to meet the member's need. Retrospective review is in place to address circumstances in which the provider failed to notify the health plan of the member's admission within 72 hours of admission or the member became eligible for services after discharge (prior period coverage).	The Plan reports that the rationale for applying PA and concurrent review is because of high cost. The purpose for retrospective review is to assure through audit, that the correct billing for the appropriate services of patient care performed match the reimbursement at the most affordable level of cost effectiveness.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	To support the UM strategies related to PA, concurrent review and retrospective review, the Plan utilizes national, state, and health plan utilization and cost data.

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Comparability and Stringency of Processes	
MH/SUD	M/S
Providers must obtain PA prior to admission by requests initiated via facsimile, telephone or through a provider portal. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a scheduled telephonic review. The information required is based on the level of service being requested. For the Arizona State Hospital, the provider fills out a specific form. For emergency hospitalization, the provider notifies Cenpatico of the admission and supplies the CON and other clinical documents. For a BHRF admission coming from a hospital, the provider provides notice of admission and supporting clinical documentation. For BHRF admissions from the community, a PA is required and an out-of-home packet (form) is filled out. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 -5 days (hospital) and 14 days for behavioral health residential facilities.	Providers must obtain prior authorization prior to admission by requests initiated in writing via facsimile. Prior authorization must be conducted prior to accessing the service. Concurrent review is initiated by the contractual obligation of the IP facility to notify the Plan of the admission via facsimile. A one page form is required as part of the PA request. Concurrent review nurses gather information on members in inpatient facilities by themselves with the assistance of facility staff. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Medical directors are able to use their clinical expertise when exceptions are warranted before or after peer to peer discussion with the treating provider. Other exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan allows discretion to be applied to the UM strategies by medical directors when considering the best interest of the member. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilizes McKesson, InterQual Criteria and ASAM Criteria. Emergency Services do not require PA for federal requirement. The medical director (MD) will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only MDs are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, average length of stay (ALOS), and readmissions. Inter-rater reliability (IRR) testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The Plan uses IRR results and tracks overturn rates of appeals. Utilization rates are also monitored to oversee proper application of these reviews. For retrospective reviews, the Plan uses budgeted versus actual audits and compares prior year performance with current year performance. The Plan also utilizes encounter data (paid claims) with failed encounters being a determinate of a system or manual process issue in paying the claim correctly.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans reported using claims and utilization data to identify high cost services subject to UM strategies. For both Plans, all services in the inpatient classification are subject to UM strategies, demonstrating comparability in approach and application. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. The MH/SUD Plan permits PA requests to be initiated via multiple methods, but restricts concurrent review requests to telephonic only. The M/S Plan requires the PA and concurrent review requests to be in writing and submitted via facsimile. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG and InterQual) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Both Plans offer the provider the opportunity for a peer to peer reconsideration. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM NQTL results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an IRR testing process. To address any potential variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient BH Inpatient Facility ECT provided in an inpatient setting BH Residential Facility
	M/S: Skilled Nursing Facility Acute Inpatient Rehab (AIR) Facility Long Term Acute Care Acute Inpatient Admissions Hospice Care (Inpatient)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA) and concurrent review due to associated high costs and to ensure it is the most appropriate care to meet the member's need. Retrospective review is in place to address circumstances in which the provider failed to notify the health plan of the member's admission within 72 hours of admission or the member became eligible for services after discharge (prior period coverage).	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is that the costs of services used to diagnose or treat conditions is high relative to commonly used alternative services.

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Comparability of Evidence	
MH/SUD	**M/S**
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via facsimile, telephone or through a provider portal. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a scheduled telephonic review. The information required is based on the level of service being requested. For the Arizona State Hospital, the provider fills out a specific form. For emergency hospitalization, the provider notifies Cenpatico of the admission and supplies the CON and other clinical documents. For a BHRF admission coming from a hospital, the provider provides notice of admission and supporting clinical documentation. For BHRF admissions from the community, a prior authorization is required and an out-of-home packet (form) is filled out. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 -5 days (hospital) and 14 days for behavioral health residential facilities.	Providers must obtain PA prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit clinical documentation by completing the mandatory fields within the provider portal or completing the designated PA form with all mandatory fields completed. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilizes McKesson, InterQual Criteria and ASAM Criteria. Emergency Services do not require PA per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only MDs are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. inter-rater reliability (IRR) testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA requests to be initiated via multiple options. The MH/SUD Plan only allows concurrent reviews to be conducted telephonically. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested (e.g., the M/S Plan reported things like medical progress notes, labs, medical consultations and diagnostic test results, whereas the MH/SUD Plan requires a an out-of-home packet to be completed summarizing clinical, functional and demographic information for MH/SUD residential services based upon the long-term nature of that type of service). Timelines for authorization decisions are the same for MH/SUD and M/S and required in their respective contracts. MH/SUD Plan offers the provider the opportunity for a peer to peer reconsideration, whereas the M/S Plan does not. However, in that instance, the NQTL is applied less stringently for MH/SUD benefits. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. The MH/SUD Plan permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The approach to determining the length of authorizations are comparable across each Plan. Length of authorization is tied to evidence-based guidelines when such guidelines are present for the service. Variations between MH/SUD and M/S lengths of stay appear to be tied to the type of service as opposed to comparability or stringency of approach. Both plans utilize an inter-rater reliability (IRR) testing process. The State plans to establish a mandatory MPS of 90% for IRR testing to reduce variation across contractors. Both Plans review and monitor data such as denial rates, average length of stay (ALOS), readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient Behavioral Health Inpatient Facility Electro-convulsive treatment provided in an inpatient setting Behavioral Health Residential Facility
	M/S: All inpatient services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is that the costs of services used to diagnose or treat conditions are high relative to commonly used alternative services.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD plan reports using utilization and service rate data to support the application of UM strategies.	To support the UM strategies related to PA, concurrent review and retrospective review, the Plan utilizes a nationally-recognized, medical necessity guidelines (InterQual).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain PA prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and it is the responsibility of the requesting provider to submit information on the date provided by the Plan after each review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms comprised of a single page in length. BHIF documentation is more extensive to support longer lengths of stay and family involvement. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, InterQual, using average length of stay (ALOS) benchmarks. Emergency Services do not require prior authorization per federal requirement. If the information does not support the request, the utilization review (UR) staff reaches out for additional information to support medical necessity. Only Medical Directors (MDs) are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain PA prior to admission by requests initiated via telephone or facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit clinical documentation by completing the mandatory fields within the provider portal or completing the designated PA form with all mandatory fields completed. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed healthcare professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with guidelines distributed to network providers that include, but are not limited to, nationally recognized MN guidelines, InterQual, developed by professional medical associations. An exception to PA is emergency services, which can be reviewed retrospectively. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine eligibility or coverage for the member. The Plan did not identify any discretion that is applied to the UM strategies. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Chief Medical Officer reviews authorization criteria at least annually to ensure it meets all applicable federal and state requirements, as well as best practices. Analysis includes PA decision outcomes and the rationale for requiring PA for types of services which are high dollar, high-risk, or may identify members in need of care management. PA requirements are approved by Medical Management (MM) Committee and submitted to State as part of MM/UM plan. HCIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS and readmissions on a quarterly basis. Additionally, IRR is within three months of hire and annually thereafter for all UR staff.	UM strategies are reviewed annually or with any changes that AHCCCS has implemented. Additionally, when a denial results in either a claim dispute or a grievance, a review of the UM strategy may occur to ensure accordance with best practices. Overturned appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for IRR. Grievance and complaints as well as appeals will also at times trigger a review of the criteria to determine if they are too stringent.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. The MH/SUD Plan reported using service rate and utilization data to identify high cost services subject to UM strategies, whereas the M/S Plan did not respond to the data used to identify high cost services. However, for both Plans, all services in the inpatient classification are subject to UM strategies, demonstrating comparability in approach and application. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (InterQual) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM NQTL results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an inter-rater reliability (IRR) testing process. To address any potential variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="2">Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult</td></tr>
<tr><td colspan="2">Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="2">Non-quantitative treatment limit (NQTL): Utilization Management (UM)</td></tr>
<tr><td colspan="2">Classification: Inpatient</td></tr>
<tr><td rowspan="2">Services</td><td>MH/SUD:
Inpatient Psychiatric Acute Inpatient Hospital
Subacute/Inpatient Behavioral Health Inpatient Facility
Electro-convulsive treatment provided in an inpatient setting
Behavioral Health Residential Facility</td></tr>
<tr><td>M/S:
All admissions to the following inpatient levels of care: acute, sub-acute, observation are subject to prior authorization concurrent review.</td></tr>
</table>

Comparability of Strategy	
MH/SUD	**M/S**
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The Plan reports that the rationale for applying PA and concurrent review is to manage over- and under-utilization of inpatient services to ensure members care and treatment is managed and delivered timely at the right level of care. Retrospective review ensures care was at the appropriate level and based on medical necessity.

Comparability of Evidence	
MH/SUD	**M/S**
The MH/SUD plan reports using utilization and service rate data to support the application of UM strategies.	The health plan determines which inpatient services require pre-service authorization based on utilization data, cost, and/or proclivity for over-utilization. For retrospective review, evidenced based guidelines are used to determine medical necessity. InterQual is the primary guideline.

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Comparability and Stringency of Processes	
MH/SUD	M/S
Provider must obtain PA prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and it is the responsibility of the requesting provider to submit information on the date provided by the Plan after each review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms comprised of a single page in length. BHIF documentation is more extensive to support longer lengths of stay and family involvement. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 4 days (hospital) and 30 days for behavioral health inpatient facilities for persons under the age of 21. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, InterQual, using ALOS benchmarks. Emergency Services do not require prior authorization per federal requirement. If the information does not support the request, the utilization review (UR) staff reaches out for additional information to support medical necessity. Only Medical Directors (MDs) are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a facsimile or telephonically. The requesting provider must submit clinical documentation by submitting the designated one page PA form with all mandatory fields completed. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The length of the authorization is determined by adherence to InterQual criteria. Average lengths of authorization for PA are 90 days. Concurrent reviews continue at a minimum of every 3 days. The Plan utilizes licensed healthcare professionals to render authorization decisions while a physician is required to deny a PA request. If further review is needed a Medical Director will review for medical necessity and make a final determination. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan indicated that an MD can exercise discretion when applying the UM strategies based on the member's needs. Retrospective reviews are conducted when the Plan is made aware of inpatient service utilization either by late notification, when a claim is submitted, or when a provider disputes a claim payment/denial. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Chief Medical Officer reviews authorization criteria at least annually to ensure it meets all applicable federal and state requirements, as well as best practices. Analysis includes PA decision outcomes and the rationale for requiring PA for types of services which are high dollar, high-risk, or may identify members in need of care management. PA requirements are approved by Medical Management (MM) Committee and submitted to State as part of MM/UM plan. HCIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS and readmissions on a quarterly basis. Additionally, IRR is within three months of hire and annually thereafter for all UR staff.	Health Choice utilizes claims data to monitor, track and trend practice patterns, analyzes services rendered to determine and manage what services require PA. This data is reviewed annually or if noted spikes/trends in utilization changes throughout the year. The data is reviewed and analyzed, then presented to Senior and Clinical Health Plan Leadership. The plan utilizes several metrics to measure the efficacy of PA such as: IRR to ensure accuracy and consistently of criteria, denial trends, over- and under-utilization data, grievance and appeals reports, benefit changes.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services and manage under and over utilization, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans reported using service rate and utilization data to identify high cost services subject to UM strategies. For both Plans, all services in the inpatient classification are subject to UM strategies, demonstrating comparability in approach and application. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods, though the M/S plan restricts PA requests to facsimile only. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (InterQual) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM NQTL results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an inter-rater reliability testing (IRR) process. To address any potential variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, ALOS readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient Behavioral Health Inpatient Facility Electro-convulsive treatment provided in an inpatient setting Behavioral Health Residential Facility
	M/S: Elective hospitalizations, skilled nursing facilities and inpatient rehabilitation services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The Plan reports that the rationale for applying PA and concurrent review is because of high cost. The purpose for retrospective review is to assure through audit, that the correct billing for the appropriate services of patient care performed match the reimbursement at the most affordable level of cost effectiveness.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD plan reports using utilization and service rate data to support the application of UM strategies.	To support the UM strategies related to PA, concurrent review and retrospective review, the Plan utilizes national, state, and health plan utilization and cost data.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain PA prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and it is the responsibility of the requesting provider to submit information on the date provided by the Plan after each review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms comprised of a single page in length. BHIF documentation is more extensive to support longer lengths of stay and family involvement. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 4 days (hospital) and 30 days for behavioral health inpatient facilities for persons under the age of 21. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, InterQual, using ALOS benchmarks. Emergency Services do not require PA per federal requirement. If the information does not support the request, the utilization review (UR) staff reaches out for additional information to support medical necessity. Only Medical Directors (MDs) are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated in writing via facsimile. Prior authorization must be conducted prior to accessing the service. Concurrent review is initiated by the contractual obligation of the IP facility to notify the Plan of the admission via facsimile. A one page form is required as part of the PA request. Concurrent review nurses gather information on members in inpatient facilities by themselves with the assistance of facility staff. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Medical directors are able to use their clinical expertise when exceptions are warranted before or after peer to peer discussion with the treating provider. Other exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan allows discretion to be applied to the UM strategies by medical directors when considering the best interest of the member. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Chief Medical Officer reviews authorization criteria at least annually to ensure it meets all applicable federal and state requirements, as well as best practices. Analysis includes PA decision outcomes and the rationale for requiring PA for types of services which are high dollar, high-risk, or may identify members in need of care management. PA requirements are approved by Medical Management (MM) Committee and submitted to State as part of MM/UM plan. HCIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS and readmissions on a quarterly basis. Additionally, IRR is within three months of hire and annually thereafter for all UR staff.	The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The Plan uses Interrater reliability results and tracks overturn rates of appeals. Utilization rates are also monitored to oversee proper application of these reviews. For retrospective reviews, the Plan uses budgeted versus actual audits and compares prior year performance with current year performance. The Plan also utilizes encounter data (paid claims) with failed encounters being a determinate of a system or manual process issue in paying the claim correctly.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans reported using claims and utilization data to identify high cost services subject to UM strategies. For both Plans, all services in the inpatient classification are subject to UM strategies, demonstrating comparability in approach and application. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. The MH/SUD Plan permits PA and concurrent review requests to be initiated via multiple methods, while the M/S Plan requires the request to be in writing and submitted via facsimile. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (Milliman Care Guidelines (MCG) and InterQual)) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Both Plans offer the provider the opportunity for a peer to peer reconsideration. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM NQTL results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an inter-rater reliability testing process. To address any potential variability, the State plans to establish a mandatory MPS of 90% for inter-rater reliability (IRR) testing. Both Plans review and monitor data such as denial rates, average length of stay, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient Behavioral Health Inpatient Facility Electro-convulsive treatment provided in an inpatient setting Behavioral Health Residential Facility
	M/S: Skilled Nursing Facility Acute Inpatient Rehab (AIR) Facility Long Term Acute Care Acute Inpatient Admissions Hospice Care (Inpatient)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is that the costs of services used to diagnose or treat conditions is high relative to commonly used alternative services.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD plan reports using utilization and service rate data to support the application of UM strategies.	Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.

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Comparability and Stringency of Processes	
MH/SUD	M/S
Provider must obtain PA prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and it is the responsibility of the requesting provider to submit information on the date provided by the Plan after each review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms comprised of a single page in length. BHIF documentation is more extensive to support longer lengths of stay and family involvement. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 4 days (hospital) and 30 days for behavioral health inpatient facilities for persons under the age of 21. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, InterQual, using ALOS benchmarks. Emergency Services do not require PA per federal requirement. If the information does not support the request, the UR staff reaches out for additional information to support medical necessity. Only Medical Directors (MDs) re authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit clinical documentation by completing the mandatory fields within the provider portal or completing the designated PA form with all mandatory fields completed. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Chief Medical Officer reviews authorization criteria at least annually to ensure it meets all applicable federal and state requirements, as well as best practices. Analysis includes PA decision outcomes and the rationale for requiring PA for types of services which are high dollar, high-risk, or may identify members in need of care management. PA requirements are approved by Medical Management (MM) Committee and submitted to State as part of MM/UM plan. HCIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS and readmissions on a quarterly basis. Additionally, IRR is within three months of hire and annually thereafter for all UR staff.	The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans reported using service rate, claims data and utilization data to identify high cost services subject to UM strategies. For both Plans, all services in the inpatient classification are subject to UM strategies, demonstrating comparability in approach and application. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (Milliman Care Guidelines (MCG) and InterQual)) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM NQTL results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an inter-rater reliability (IRR) testing process. To address any potential variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	**MH/SUD:** All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S: Planned Inpatient Procedures/Surgeries

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The M/S plan cites the need for the prior authorization (PA) and concurrent review to ensure the appropriateness of the service and to ascertain if there is an appropriate lower level of care or alternate to hospital based services. The M/S Plan reviews retrospective services to asses if there are meeting regulatory guidelines, assess for potential quality of care and fraud, waste and abuse concerns, and to assess for inappropriate coding and over utilization based on evidence based guidelines.

Comparability of Evidence

MH/SUD	M/S
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.	The M/S plan reports using utilization and cost data to support the application of the UM strategies.

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Comparability and Stringency of Processes

MH/SUD	M/S
Provider must obtain PA prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit the admitting an ICD-10 diagnosis code and other member demographic information. Additional behavioral health specific information must also be included, and, per the Plan, is a variation allowed due to recognized clinically appropriate standards of care permitting such a difference. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to accessing the services by requests initiated via telephone or facsimile. Concurrent review must be conducted prior to the expiration of the authorization and can be completed via telephone, on-site and/or by fax. The service authorization request must be complete with hospital name, reason for the admission, procedure (applicable CPT code) and diagnosis code (ICD-10). Supporting documentation includes correlating medical progress notes, and if applicable, lab and diagnostic test results, consultant notes, and any other medical documentation from the medical record pertinent to the service being requested. Care1st follows the federal timeframe requirements for prior authorization - three business days for expedited service authorization request and up to 14 calendar days for routine requests. The Plan uses DRGs and thus does not establish a length of authorization upfront. The concurrent review process would assess for outliers to the ALOS once admitted. Emergency and maternity triage services do not require prior authorization.

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	The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. The provider has the opportunity for a peer to peer reconsideration. Reviewers utilize nationally-recognized medical necessity guidelines, inter-rater reliability (MCG). Only Medical Directors (MDs) are authorized to exercise discretion in the application of UM strategies to particular cases. In the event that the Plan determines that the service does not meet medical necessity through PA, concurrent review or retrospective review, the outcome would be a denial of payment. For retrospective review, inpatient claims are reviewed, including claims under investigation for fraud or abuse or claims under review for medical necessity (pended for review), or retro eligibility of the member post inpatient admission or discharge. The Hospital electric medical record is accessed or medical records are requested to support the claim. If the clinical data is not received and PA was not obtained, the claim is allowed to be denied.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability (IRR) testing and various quality metrics to assess the effectiveness of the NQTL.	The UM guidelines are reviewed at least annually to review and add new CPT codes and to assess if there are changes required due to new evidence based guidelines or changes to standard of practice. The plan utilizes an IRR testing process with a minimum performance threshold of 85%. Denial rates, average length of stay and readmissions are tracked and monitored by the Plan to assess the effectiveness of the UM strategies.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit prior authorization and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. The M/S Plan offers the provider the opportunity for a peer to peer reconsideration. The State will require for all Plans, that when a Plan notifies a provider that a requested service has been denied, the Plan must inform the provider of the option to request a peer to peer discussion with the Contractor's MD. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. The MH/SUD Plan permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member, whereas the M/S Plan restricts retrospective review for purposes of FWA reviews. In this case, the NQTL is applied to MH/SUD less restrictively. Length of authorization is tied to evidence-based guidelines when such guidelines are present for the service. Variations between MH/SUD and M/S lengths of stay appear to be tied to the type of service as opposed to comparability or stringency of approach. Both plans utilize an IRR testing process. To address this potential variability, the State plans to establish a uniform mandatory MPS for IRR testing for all plans. There is a review and monitoring of utilization data, denial rates, average length of stay (Aloes), readmissions and other quality metrics to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S: All inpatient services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is that the costs of services used to diagnose or treat conditions are high relative to commonly used alternative services.

Comparability of Evidence

MH/SUD	M/S
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance and claims data for cost.	To support the UM strategies related to PA, concurrent review and retrospective review, the Plan utilizes a nationally-recognized, medical necessity guidelines (InterQual).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain PA prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit the admitting an ICD-10 diagnosis code and other member demographic information. Additional behavioral health specific information must also be included, and, per the Plan, is a variation allowed due to recognized clinically appropriate standards of care permitting such a difference. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain PA prior to admission by requests initiated via telephone or facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit clinical documentation by completing the mandatory fields within the provider portal or completing the designated PA form with all mandatory fields completed. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed healthcare professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with guidelines distributed to network providers that include, but are not limited to, nationally recognized MN guidelines, InterQual, developed by professional medical associations. An exception to PA is emergency services, which can be reviewed retrospectively. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine eligibility or coverage for the member. The Plan did not identify any discretion that is applied to the UM strategies. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability (IRR) testing and various quality metrics to assess the effectiveness of the NQTL.	UM strategies are reviewed annually or with any changes that Arizona Health Care Cost Containment System (AHCCCS) has implemented. Additionally, when a denial results in either a claim dispute or a grievance, a review of the UM strategy may occur to ensure accordance with best practices. Overturned appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for IRR. Grievance and complaints as well as appeals will also at times trigger a review of the criteria to determine if they are too stringent.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit prior authorization and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Length of authorization is tied to evidence-based guidelines when such guidelines are present for the service. Variations between MH/SUD and M/S lengths of stay appear to be tied to the type of service as opposed to comparability or stringency of approach. Both plans utilize an IRR testing process. To address potential variability, the State plans to establish a mandatory uniform MPS for IRR testing for all Plans. There is a review and monitoring of utilization data, appeals data and grievances to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	**MH/SUD:** All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S: Inpatient stay Hospital Skilled Nursing Facility Acute rehabilitation Long Term Acute Care

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is to ensure that services are provided as necessary and managed efficiently and not over utilized. Services are high cost services and should be applied to symptoms that will benefit from the application of the service.

Comparability of Evidence

MH/SUD	M/S
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.	Plan tracks and trends utilization and spending thresholds. Evidence reported by the Plan indicates these are high risk/high cost services.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain PA prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit the admitting an ICD-10 diagnosis code and other member demographic information. Additional behavioral health specific information must also be included, and, per the Plan, is a variation allowed due to recognized clinically appropriate standards of care permitting such a difference. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile. The requesting provider must submit the PA with supporting clinical documentation required per MCG guidelines. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request.UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The medical director (MD) and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability (IRR) testing and various quality metrics to assess the effectiveness of the NQTL.	Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into considering before changes are made. Arizona Health Care Cost Containment System (AHCCCS) guidelines, policy updates, Milliman Care Guidelines (MCG) annual updates, Aetna clinical policy guidelines and monthly updates are also considered and may prompt a review more frequent than annually. The Plan relies on claims data, provider utilization data, readmission rates, and predictive analytics. IRR testing is required annually for all existing staff and within 90 days of hire for new staff.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. The M/S Plan offers the provider the opportunity for a peer to peer reconsideration. The State will require for all Plans, that when a Plan notifies a provider that a requested service has been denied, the Plan must inform the provider of the option to request a peer to peer discussion with the Contractor's Medical Director (MD). For both Plans, the failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Length of authorization is tied to evidence-based guidelines when such guidelines are present for the service. Both plans utilize an inter-rater reliability (IRR) testing process, however, the M/S Plan did not report the MPS for IRR testing. Regardless, to address any potential variability, the State plans to establish a mandatory uniform MPS for IRR testing for all Plans. To assess the impact/stringency of the UM strategies, there is a review of claims data, provider utilization data, readmission rates, and predictive analytics. As a result the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S: Skilled Nursing Facility Acute Inpatient Rehab (AIR) Facility Long Term Acute Care Acute Inpatient Admissions Hospice Care (Inpatient)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is that the costs of services used to diagnose or treat conditions is high relative to commonly used alternative services.

Comparability of Evidence

MH/SUD	M/S

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<table>
<tr><td>Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance and claims data for cost.</td><td>Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance and claims data for cost.</td></tr>
<tr><th colspan="2">Comparability and Stringency of Processes</th></tr>
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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The medical director (MD) and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.	The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability (IRR) testing and various quality metrics to assess the effectiveness of the NQTL.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Length of authorization is tied to evidence-based guidelines when such guidelines are present for the service. Variations between MH/SUD and M/S lengths of stay appear to be tied to the type of service as opposed to comparability or stringency of approach. Both plans utilize an IRR testing process. To address this potential variability, the State plans to establish a mandatory uniform MPS for IRR testing for all Plans. There is a review and monitoring of utilization data to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Cenpatico Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient BH Inpatient Facility ECT provided in an inpatient setting BH Residential Facility
	M/S (LTSS): All benefits in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
The MH/SUD plan subjects these services to prior authorization (PA) and concurrent review due to associated high costs and to ensure it is the most appropriate care to meet the member's need. Retrospective review is in place to address circumstances in which the provider failed to notify the health plan of the member's admission within 72 hours of admission or the member became eligible for services after discharge (prior period coverage).	The Plan cites the need for the PA and concurrent review due to high costs and to ensure that services provided are appropriate and timely for the member's needs. The Plan reviews retrospective services in the event that the initial request for the clinical review occurs after the member is discharged and a retrospective review is requested.

Comparability of Evidence

MH/SUD	M/S (LTSS)
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	PA is required for all services as they are based in the individual service plan (ISP) as required by state rules. ISP's are renewed at a minimum annually per contract with the State at which time authorizations and services are also reviewed.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
Providers must obtain PA prior to admission by requests initiated via facsimile, telephone or through a provider portal. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a scheduled telephonic review. The information required is based on the level of service being requested. For the Arizona State Hospital, the provider fills out a specific form. For emergency hospitalization, the provider notifies Cenpatico of the admission and supplies the CON and other clinical documents. For a BHRF admission coming from a hospital, the provider provides notice of admission and supporting clinical documentation. For BHRF admissions from the community, a PA is required and an out-of-home packet (form) is filled out. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 -5 days (hospital) and 14 days for behavioral health residential facilities.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilizes McKesson, InterQual Criteria and American Society of Addiction Medicines (ASAM) Criteria. Emergency Services do not require PA per federal requirement. The medical director (MD) will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only MDs are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. Inter-rater reliability (IRR) testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of procedure that may need to be enhanced or removed. Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the Medical Management Committee. The audits assess timeliness and appropriateness of authorization. The Plan conducts annual IRR testing for utilization review staff.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit prior authorization requests to be initiated via multiple options. The MH/SUD Plan only allows concurrent reviews to be conducted telephonically. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decisions are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. The MH/SUD Plan permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member, whereas the M/S Plan restricts retrospective review for purposes of FWA reviews. In this case, the NQTL is applied to MH/SUD less restrictively. Variations between MH/SUD and M/S lengths of stay appear to be tied to the type of service as opposed to comparability or stringency of approach. Both plans utilize an IRR testing process. The State plans to establish a mandatory uniform MPS of 90% for IRR testing for all Plans to reduce variation across contractors. Both Plans review and monitor data such as denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Health Choice Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	**MH/SUD:** Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient Behavioral Health Inpatient Facility Electro-convulsive treatment provided in an inpatient setting Behavioral Health Residential Facility
	M/S (LTSS): All benefits in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The Plan cites the need for the PA and concurrent review due to high costs and to ensure that services provided are appropriate and timely for the member's needs. The Plan reviews retrospective services in the event that the initial request for authorization occurs after the member is discharged and a retrospective review is requested.

Comparability of Evidence

MH/SUD	M/S (LTSS)
The MH/SUD plan reports using utilization and service rate data to support the application of UM strategies.	PA is required for all services as they are based in the individual service plan (ISP) as required by state rules. ISP's are renewed at a minimum annually per contract with the State at which time authorizations and services are also reviewed.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
Provider must obtain PA prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and it is the responsibility of the requesting provider to submit information on the date provided by the Plan after each review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms comprised of a single page in length. BHIF documentation is more extensive to support longer lengths of stay and family involvement. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, InterQual, using average length of stay (ALOS) benchmarks. Emergency Services do not require PA per federal requirement. If the information does not support the request, the utilization review (UR) staff reaches out for additional information to support medical necessity. Only Medical Directors (MDs) are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
The Chief Medical Officer reviews authorization criteria at least annually to ensure it meets all applicable federal and state requirements, as well as best practices. Analysis includes PA decision outcomes and the rationale for requiring PA for types of services which are high dollar, high-risk, or may identify members in need of care management. PA requirements are approved by Medical Management (MM) Committee and submitted to State as part of MM/UM plan. HCIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS and readmissions on a quarterly basis. Additionally, IRR is within three months of hire and annually thereafter for all UR staff.	PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of procedure that may need to be enhanced or removed. Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the Medical Management Committee. The audits assess timeliness and appropriateness of authorization. The Plan conducts annual IRR testing for UR staff.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services and manage under and over utilization, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans reported using service rate and utilization data to identify high cost services subject to UM strategies. For both Plans, all services in the inpatient classification are subject to UM strategies, demonstrating comparability in approach and application. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods, though the M/S plan restricts PA requests to facsimile only. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (InterQual) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM NQTL results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an inter-rater reliability (IRR) testing process. To address any potential variability, the State plans to establish a mandatory uniform MPS of 90% for IRR testing for all Plans. Both Plans review and monitor data such as denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Mercy Maricopa Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient Behavioral Health Inpatient Facility Electro-convulsive treatment provided in an inpatient setting Behavioral Health Residential Facility Home care training to home care client
	M/S (LTSS): All benefits in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The Plan cites the need for the PA and concurrent review due to high costs and to ensure that services provided are appropriate and timely for the member's needs. The Plan reviews retrospective services in the event that the initial request for the clinical review occurs after the member is discharged and a retrospective review is requested.

Comparability of Evidence

MH/SUD	M/S (LTSS)
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	PA is required for all services as they are based in the individual service plan (ISP) as required by state rules. ISP's are renewed at a minimum annually per contract with the State at which time authorizations and services are also reviewed.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
Provider must obtain PA prior to admission by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a telephonic review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms ranging from three to eleven pages (for BH residential) in length. Requests for PA re reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 days (hospital) and 30 days for behavioral health inpatient facilities for persons under the age of 21. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, using ALOS benchmarks. Emergency Services do not require PA per federal requirement. The medical director (MD) will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only MDs are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of procedure that may need to be enhanced or removed. Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the Medical Management Committee. The audits assess timeliness and appropriateness of authorization. The Plan conducts annual IRR testing for UR staff.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S (LTSS) Plan allows for three options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For both Plans, the failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both plans utilize an inter-rater reliability (IRR) testing process. To address any potential variability, the State plans to establish a mandatory uniform MPS for IRR testing for all Plans. The Plans review and monitor data such as results of audits, denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and United Healthcare Community Plan (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S (LTSS): All benefits in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The Plan cites the need for the PA and concurrent review due to high costs and to ensure that services provided are appropriate and timely for the member's needs. The Plan reviews retrospective services in the event that the initial request for authorization occurs after the member is discharged and a retrospective review is requested.

Comparability of Evidence

MH/SUD	M/S (LTSS)
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.	PA is required for all services as they are based in the individual service plan (ISP) as required by state rules. ISP's are renewed at a minimum annually per contract with the State at which time authorizations and services are also reviewed.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
Provider must obtain PA prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit the admitting an ICD-10 diagnosis code and other member demographic information. Additional behavioral health specific information must also be included, and, per the Plan, is a variation allowed due to recognized clinically appropriate standards of care permitting such a difference. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The medical director (MD) and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability (IRR) testing and various quality metrics to assess the effectiveness of the NQTL.	PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of procedure that may need to be enhanced or removed. Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the Medical Management Committee. The audits assess timeliness and appropriateness of authorization. The Plan conducts annual IRR testing for UR staff.

Findings

All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to UM strategies. The strategies and evidentiary support appear to be comparable.

Both Plans require providers to secure authorization prior to the delivery of the IP service, unless the service is provided emergently. Both Plans permit prior authorization and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member.

Both plans utilize an IRR testing process. To address this potential variability, the State plans to establish a mandatory uniform MPS for IRR testing for all Plans. There is a review and monitoring of utilization data, denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S])and Cenpatico Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient BH Inpatient Facility ECT provided in an inpatient setting BH Residential Facility
	M/S: For non-Indian Health Services (IHS)/638 providers: Non-emergency and elective admissions Elective surgery Hospital stay following an emergent admission if the stay is greater than 72 hours Acute Rehabilitation Facility admissions Skilled Nursing Facility SNF admissions Organ and Tissue Transplant Services (Transplants)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA) and concurrent review due to associated high costs and to ensure it is the most appropriate care to meet the member's need. Retrospective review is in place to address circumstances in which the provider failed to notify the health plan of the member's admission within 72 hours of admission or the member became eligible for services after discharge (prior period coverage).	The AIHP cites the need for the PA, concurrent review and retrospective review due to medical appropriateness, cost effectiveness and quality of care.

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Comparability of Evidence	
MH/SUD	**M/S**
The MH/SUD plan reports using utilization and cost data to support the application of utilization management (UM) strategies.	Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.
Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via facsimile, telephone or through a provider portal. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a scheduled telephonic review. The information required is based on the level of service being requested. For the Arizona State Hospital, the provider fills out a specific form. For emergency hospitalization, the provider notifies Cenpatico of the admission and supplies the certificate of need (CON) and other clinical documents. For a BHRF admission coming from a hospital, the provider provides notice of admission and supporting clinical documentation. For BHRF admissions from the community, a PA is required and an out-of-home packet (form) is filled out. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 -5 days (hospital) and 14 days for behavioral health residential facilities.	Providers must obtain PA prior to admission by requests initiated via online submission portal, telephone or by facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsimile request. A Request form and supporting clinical documentation is required to support the medical necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the chief medical officer (CMO) or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the MD or Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilizes McKesson, InterQual Criteria and average length of stay (ASAM) Criteria. Emergency Services do not require PA per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only MDs are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. Inter-rater reliability (IRR) testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.

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Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA requests to be initiated via multiple options. The MH/SUD Plan only allows concurrent reviews to be conducted telephonically. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decisions are the same for the MH/SUD and M/S Plan . Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans ermit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both Plans review and monitor data such as denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S])and Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient Behavioral Health Inpatient Facility Electro-convulsive treatment provided in an inpatient setting Behavioral Health Residential Facility
	M/S: For non-Indian Health Services (IHS)/638 providers: Non-emergency and elective admissions Elective surgery Hospital stay following an emergent admission if the stay is greater than 72 hours Acute Rehabilitation Facility admissions Skilled Nursing Facility SNF admissions Organ and Tissue Transplant Services (Transplants)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The AIHP cites the need for PA, concurrent review and retrospective review due to medical appropriateness, cost effectiveness, and quality of care.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD plan reports using utilization and service rate data to support the application of utilization management (UM) strategies.	Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.

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Comparability and Stringency of Processes	
MH/SUD	M/S
Provider must obtain PA prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and it is the responsibility of the requesting provider to submit information on the date provided by the Plan after each review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms comprised of a single page in length. BHIF documentation is more extensive to support longer lengths of stay and family involvement. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, InterQual, using average length of stay (ALOS) benchmarks. Emergency Services do not require PA per federal requirement. If the information does not support the request, the UR staff reaches out for additional information to support medical necessity. Only Medical Directors (MDs) are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain PA prior to admission by requests initiated via online submission portal, telephone or by facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsimile request. A Request form and supporting clinical documentation is required to support the medical necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the chief medical officer (CMO) or MD reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the MD or Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The CMO reviews authorization criteria at least annually to ensure it meets all applicable federal and state requirements, as well as best practices. Analysis includes PA decision outcomes and the rationale for requiring PA for types of services which are high dollar, high-risk, or may identify members in need of care management. PA requirements are approved by Medical Management (MM) Committee and submitted to State as part of MM/UM plan. HCIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS and readmissions on a quarterly basis. Additionally, IRR is within three months of hire and annually thereafter for all utilization review staff.	AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the MM Meetings and include all reviewed service categories.

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Findings
All non-emergent MH/SUD and M/S inpatient (IP) admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services and manage under and over utilization, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans reported using service rate and utilization data to identify high cost services subject to UM strategies, demonstrating comparability in approach and application. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S are consistent with State requirements. For each Plan, failure to meet the requirement of the UM NQTL results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Both Plans review and monitor data such as denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S])and Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Inpatient Psychiatric Acute Inpatient Hospital Subacute/Inpatient Behavioral Health Inpatient Facility Electro-convulsive treatment provided in an inpatient setting Behavioral Health Residential Facility Home care training to home care client
	M/S: For non-Indian Health Services (IHS)/638 providers: Non-emergency and elective admissions Elective surgery Hospital stay following an emergent admission if the stay is greater than 72 hours Acute Rehabilitation Facility admissions Skilled Nursing Facility SNF admissions Organ and Tissue Transplant Services (Transplants)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to associated high costs and to ensure it is the most appropriate care to meet the member's need.	The AIHP cites the need for the PA, concurrent review and retrospective review due to medical appropriateness, cost effectiveness and quality of care.

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Comparability of Evidence	
MH/SUD	**M/S**
The MH/SUD plan reports using utilization and cost data to support the application of UM strategies.	Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain PA prior to admission by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a telephonic review. The information and supporting documentation necessary depends upon the service under review, with service authorization request forms ranging from three to eleven pages (for BH residential) in length. Requests for PA are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The average length of authorization for concurrent review of inpatient services is 3 days (hospital) and 30 days for behavioral health inpatient facilities for persons under the age of 21. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, Milliman Care Guidelines (MCG), using average length of stay (ALOS) benchmarks. Emergency Services do not require prior authorization per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Only Medical Directors are authorized to exercise discretion in the application of UM strategies to particular cases. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain PA prior to admission by requests initiated via online submission portal, telephone or by facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsimile request. A Request form and supporting clinical documentation is required to support the medical necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the chief medical officer (CMO) or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the MD or Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions to assess the stringency of the NQTL. Inter-rater reliability (IRR) testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.

Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. The MH/SUD Plan only permits PA and concurrent review requests to be initiated via one method, while the M/S Plan allows for three options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S consistent with State requirements. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For both Plans, the failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The Plans review and monitor data such as results of audits, denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S])and United Health Care Community Plan (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S: For non-Indian Health Services (IHS)/638 providers: Non-emergency and elective admissions Elective surgery Hospital stay following an emergent admission if the stay is greater than 72 hours Acute Rehabilitation Facility admissions Skilled Nursing Facility SNF admissions Organ and Tissue Transplant Services (Transplants)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The AIHP cites the need for the PA, concurrent review and retrospective review due to medical appropriateness, cost effectiveness and quality of care.

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Comparability of Evidence	
MH/SUD	**M/S**
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.	Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain PA prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit the admitting an ICD-10 diagnosis code and other member demographic information. Additional behavioral health specific information must also be included, and, per the Plan, is a variation allowed due to recognized clinically appropriate standards of care permitting such a difference. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain PA prior to admission by requests initiated via online submission portal, telephone or by facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsimile request. A Request form and supporting clinical documentation is required to support the medical necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the chief medical officer (CMO) or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the MD or Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing (IRR) and various quality metrics to assess the	AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.

Findings

All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. The strategies and evidentiary support appear to be comparable.

Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S consistent with State requirements. The M/S Plan offers the provider the opportunity for a peer to peer reconsideration. The State will require for all Plans, that when a Plan notifies a provider that a requested service has been denied, the Plan must inform the provider of the option to request a peer to peer discussion with the Contractor's MD. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member.

Variations between MH/SUD and M/S lengths of stay appear to be tied to the type of service as opposed to comparability or stringency of approach. There is a review and monitoring of utilization data, denial rates, ALOS, readmissions and other quality metrics to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Mental Health/Substance Use Disorder [MH/SUD] and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility Behavioral Health Inpatient Facility Inpatient Detox Facility Residential Treatment Center (RTC) Out of State Placements
	M/S: Planned Inpatient Procedures/Surgeries

Comparability of Strategy

MH/SUD	M/S
The AIHP cites the need for the prior authorization (PA), concurrent review and retrospective review due to medical appropriateness, cost effectiveness, and quality of care.	The M/S plan cites the need for the prior authorization (PA) and concurrent review to ensure the appropriateness of the service and to ascertain if there is an appropriate lower level of care or alternate to hospital based services. The M/S Plan reviews retrospective services to asses if there are meeting regulatory guidelines, assess for potential quality of care and fraud, waste and abuse concerns, and to assess for inappropriate coding and over utilization based on evidence based guidelines.

Comparability of Evidence

MH/SUD	M/S
Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.	The M/S plan reports using utilization and cost data to support the application of the UM strategies.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via online submission portal, telephone or by facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsimile request. A Request form and supporting clinical documentation is required to support the medical necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the Chief Medical Officer or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the MD or Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to accessing the services by requests initiated via telephone or facsimile. Concurrent review must be conducted prior to the expiration of the authorization and can be completed via telephone, on-site and/or by fax. The service authorization request must be complete with hospital name, reason for the admission, procedure (applicable CPT code) and diagnosis code (ICD-10). Supporting documentation includes correlating medical progress notes, and if applicable, lab and diagnostic test results, consultant notes, and any other medical documentation from the medical record pertinent to the service being requested. Care1st follows the federal timeframe requirements for prior authorization - three business days for expedited service authorization request and up to 14 calendar days for routine requests. The Plan uses DRGs and thus does not establish a length of authorization upfront. The concurrent review process would assess for outliers to the ALOS once admitted. Emergency and maternity triage services do not require prior authorization.

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The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. The provider has the opportunity for a peer to peer reconsideration. Reviewers utilize nationally-recognized medical necessity guidelines, MCG. Only Medical Directors are authorized to exercise discretion in the application of UM strategies to particular cases. In the event that the Plan determines that the service does not meet medical necessity through PA, concurrent review or retrospective review, the outcome would be a denial of payment. For retrospective review, inpatient claims are reviewed, including claims under investigation for fraud or abuse or claims under review for medical necessity (pended for review), or retro eligibility of the member post inpatient admission or discharge. The Hospital EMR is accessed or medical records are requested to support the claim. If the clinical data is not received and prior authorization was not obtained, the claim is allowed to be denied.	

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.	The UM guidelines are reviewed at least annually to review and add new CPT codes and to assess if there are changes required due to new evidence based guidelines or changes to standard of practice. The plan utilizes an inter-rater reliability testing process with a minimum performance threshold of 85%. Denial rates, average length of stay and readmissions are tracked and monitored by the Plan to assess the effectiveness of the UM strategies.

Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use nationally-recognized medical necessity criteria to determine coverage of inpatient services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit prior authorization and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S consistent with State requirements. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The Plans review and monitor data such as denial rates, average length of stay, readmissions and complaints to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Mental Health/Substance Use Disorder [MH/SUD] and Health Choice (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility Behavioral Health Inpatient Facility Inpatient Detox Facility Residential Treatment Center (RTC) Out of State Placements
	M/S: All admissions to the following inpatient levels of care: acute, sub-acute, observation are subject to prior authorization concurrent review.

Comparability of Strategy

MH/SUD	M/S
The AIHP cites the need for the prior authorization (PA), concurrent review and retrospective review due to medical appropriateness, cost effectiveness, and quality of care.	The Plan reports that the rationale for applying PA and concurrent review is to manage over- and under-utilization of inpatient services to ensure members care and treatment is managed and delivered timely at the right level of care. Retrospective review ensures care was at the appropriate level and based on medical necessity.

Comparability of Evidence

MH/SUD	M/S
Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.	The health plan determines which inpatient services require pre-service authorization based on utilization data, cost, and/or proclivity for over-utilization. For retrospective review, evidenced based guidelines are used to determine medical necessity. InterQual is the primary guideline.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via online submission portal, telephone or by facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsimile request. A Request form and supporting clinical documentation is required to support the medical necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the MS or Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a facsimile or telephonically. The requesting provider must submit clinical documentation by submitting the designated one page PA form with all mandatory fields completed. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The length of the authorization is determined by adherence to InterQual criteria. Average lengths of authorization for PA are 90 days. Concurrent reviews continue at a minimum of every 3 days. The Plan utilizes licensed healthcare professionals to render authorization decisions while a physician is required to deny a PA request. If further review is needed a Medical Director will review for medical necessity and make a final determination. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan indicated that an MD can exercise discretion when applying the UM strategies based on the member's needs. Retrospective reviews are conducted when the Plan is made aware of inpatient service utilization either by late notification, when a claim is submitted, or when a provider disputes a claim payment/denial. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.	Health Choice utilizes claims data to monitor, track and trend practice patterns, analyzes services rendered to determine and manage what services require PA. This data is reviewed annually or if noted spikes/trends in utilization changes throughout the year. The data is reviewed and analyzed, then presented to Senior and Clinical Health Plan Leadership. The plan utilizes several metrics to measure the efficacy of PA such as: IRR to ensure accuracy and consistently of criteria, denial trends, over- and under-utilization data, grievance and appeals reports, benefit changes.

Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services for high cost services and manage under and over utilization, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. For both Plans, all services in the inpatient classification are subject to UM strategies, demonstrating comparability in approach and application. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods, though the M/S plan restricts PA requests to facsimile only. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S consistent with State requirements. For each Plan, failure to meet the requirement of the UM NQTL results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The Plans review and monitor data such as denial rates, complaints and utilization data to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Mental Health/Substance Use Disorder [MH/SUD] and Health Net (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility Behavioral Health Inpatient Facility Inpatient Detox Facility Residential Treatment Center (RTC) Out of State Placements
	M/S: Inpatient Services including acute hospital, acute rehab, skilled nursing facility (SNF), long term acute care hospital (LTACH).

Comparability of Strategy

MH/SUD	M/S
The AIHP cites the need for the prior authorization (PA), concurrent review and retrospective review due to medical appropriateness, cost effectiveness, and quality of care.	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is to ensure that the quality and type of service is appropriate to the member's needs.

Comparability of Evidence

MH/SUD	M/S
Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.	To support the UM strategies related to PA, concurrent review and retrospective review, the Plan utilizes a nationally recognized industry guideline for the determination of medical necessity (MCG and InterQual).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via online submission portal, telephone or by facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsimile request. A Request form and supporting clinical documentation is required to support the medical necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the Chief Medical Officer (CMO) or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the MD Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain PA prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit clinical documentation by completing the mandatory fields within the provider portal or completing the designated PA form with all mandatory fields completed. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed healthcare professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.	The CMO or designee performs an annual review of all existing clinical policies to determine continued applicability and appropriateness. In connection with this annual review, the CMO or designee is responsible for identifying which policies require revisions. The Plan requires annual IRR, reviews denial rates, readmission rates and grievances to assess the application and stringency of the UM strategies.

Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use nationally-recognized medical necessity criteria to determine coverage of inpatient services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S consistent with State requirements. The MH/SUD Plan offers the provider the opportunity for a peer to peer reconsideration. The State will require for all Plans, that when a Plan notifies a provider that a requested service has been denied, the Plan must inform the provider of the option to request a peer to peer discussion with the Contractor's MD. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The Plans review and monitor data such as denial rates, readmissions and complaints to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Mental Health/Substance Use Disorder [MH/SUD] and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility Behavioral Health Inpatient Facility Inpatient Detox Facility Residential Treatment Center (RTC) Out of State Placements
	M/S: Inpatient stay Hospital Skilled Nursing Facility Acute rehabilitation Long Term Acute Care

Comparability of Strategy

MH/SUD	M/S
The AIHP cites the need for the prior authorization (PA), concurrent review and retrospective review due to medical appropriateness, cost effectiveness, and quality of care.	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is to ensure that services are provided as necessary and managed efficiently and not over utilized. Services are high cost services and should be applied to symptoms that will benefit from the application of the service.

Comparability of Evidence

MH/SUD	M/S
Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.	Plan tracks and trends utilization and spending thresholds. Evidence reported by the Plan indicates these are high risk/high cost services.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via online submission portal, telephone or by facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsimile request. A Request form and supporting clinical documentation is required to support the medical necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the Chief Medical Officer (CMO) or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the MD or Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile. The requesting provider must submit the PA with supporting clinical documentation required per MCG guidelines. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request.UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.	Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into considering before changes are made. AHCCCS guidelines, policy updates, MCG annual updates, Aetna clinical policy guidelines and monthly updates are also considered and may prompt a review more frequent than annually. The Plan relies on claims data, provider utilization data, readmission rates, and predictive analytics. IRR testing is required annually for all existing staff and within 90 days of hire for new staff.

Findings
All non-emergent MH/SUD and M/S IP admissions require PA. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use nationally-recognized medical necessity criteria to determine coverage of inpatient services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S consistent with State requirements. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The Plans review and monitor data such as denial rates, utilization data, readmissions and complaints to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Mental Health/Substance Use Disorder [MH/SUD] and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility Behavioral Health Inpatient Facility Inpatient Detox Facility Residential Treatment Center (RTC) Out of State Placements
	M/S: Elective hospitalizations, skilled nursing facilities and inpatient rehabilitation services

Comparability of Strategy

MH/SUD	**M/S**
The AIHP cites the need for the prior authorization (PA), concurrent review and retrospective review due to medical appropriateness, cost effectiveness, and quality of care.	The Plan reports that the rationale for applying PA and concurrent review is because of high cost. The purpose for retrospective review is to assure through audit, that the correct billing for the appropriate services of patient care performed match the reimbursement at the most affordable level of cost effectiveness.

Comparability of Evidence

MH/SUD	**M/S**
Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.	To support the UM strategies related to PA, concurrent review and retrospective review, the Plan utilizes national, state, and health plan utilization and cost data.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via online submission portal, telephone or by facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsimile request. A Request form and supporting clinical documentation is required to support the medical necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the Chief Medical Officer (CMO) or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the MD Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated in writing via facsimile. Prior authorization must be conducted prior to accessing the service. Concurrent review is initiated by the contractual obligation of the IP facility to notify the Plan of the admission via facsimile. A one page form is required as part of the PA request. Concurrent review nurses gather information on members in inpatient facilities by themselves with the assistance of facility staff. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Medical directors are able to use their clinical expertise when exceptions are warranted before or after peer to peer discussion with the treating provider. Other exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan allows discretion to be applied to the UM strategies by medical directors when considering the best interest of the member. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.	The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The Plan uses Interrater reliability results and tracks overturn rates of appeals. Utilization rates are also monitored to oversee proper application of these reviews. For retrospective reviews, the Plan uses budgeted versus actual audits and compares prior year performance with current year performance. The Plan also utilizes encounter data (paid claims) with failed encounters being a determinate of a system or manual process issue in paying the claim correctly.

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Findings
All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use nationally-recognized medical necessity criteria to determine coverage of inpatient services subject to UM strategies. The strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit PA and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S consistent with State requirements. The MH/SUD Plan offers the provider the opportunity for a peer to peer reconsideration. The State will require for all Plans, that when a Plan notifies a provider that a requested service has been denied, the Plan must inform the provider of the option to request a peer to peer discussion with the Contractor's MD. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The Plans review and monitor data such as denial rates, overturned appeals and complaints to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Mental Health/Substance Use Disorder [MH/SUD] and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility Behavioral Health Inpatient Facility Inpatient Detox Facility Residential Treatment Center (RTC) Out of State Placements
	M/S: Skilled Nursing Facility Acute Inpatient Rehab (AIR) Facility Long Term Acute Care Acute Inpatient Admissions Hospice Care (Inpatient)

Comparability of Strategy

MH/SUD	**M/S**
The AIHP cites the need for the prior authorization (PA), concurrent review and retrospective review due to medical appropriateness, cost effectiveness, and quality of care.	The Plan reports that the rationale for applying PA, concurrent review and retrospective review is that the costs of services used to diagnose or treat conditions is high relative to commonly used alternative services.

Comparability of Evidence

MH/SUD	**M/S**
Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.	Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Providers must obtain PA prior to admission by requests initiated via online submission portal, telephone or by facsimile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsimile request. A Request form and supporting clinical documentation is required to support the medical necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the Chief Medical Officer or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the MD or Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain PA prior to admission by requests initiated via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal. The requesting provider must submit clinical documentation by completing the mandatory fields within the provider portal or completing the designated PA form with all mandatory fields completed. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.	The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.

Findings

All non-emergent MH/SUD and M/S IP admissions require prior authorization. Both Plans use UM strategies (i.e., PA, concurrent review, retrospective review) to ensure the appropriateness of services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use nationally-recognized medical necessity criteria to determine coverage of inpatient services subject to UM strategies. The strategies and evidentiary support appear to be comparable.

Both Plans require providers to secure authorization prior to the delivery of the inpatient service, unless the service is provided emergently. Both Plans permit prior authorization and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S consistent with State requirements. The MH/SUD Plan offers the provider the opportunity for a peer to peer reconsideration. The State will require for all Plans, that when a Plan notifies a provider that a requested service has been denied, the Plan must inform the provider of the option to request a peer to peer discussion with the Contractor's MD. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans permit a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member.

The Plans review and monitor data such as denial rates, readmissions and complaints to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S inpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Electro-convulsive treatment Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency Out-of-Network Single Case Agreements Home care training to home care client
	M/S: A variety of services/procedures including: Diagnostic Testing Dialysis Outpatient Procedures Radiology Specialists Transportation

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan applies the UM strategy (prior authorization and concurrent review) due to the high costs associated with the services. The Plan does not apply retrospective review.	The M/S plan cites the need for UM strategies (PA only) to ensure the appropriateness and cost-effectiveness of the services. The Plan applies retrospective review for purposes of determining FWA.

Comparability of Evidence

MH/SUD	M/S
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	The Plan uses data, such as utilization data, that identifies services that are likely to be over utilized or costly, that indicate high-volume use.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via fax. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG. Emergency Services do not require prior authorization per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. The Plan does not apply retrospective review to outpatient services. In the event that prior authorization or concurrent review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to delivering the services by requests initiated via telephone or facsmile. Requests for continued authorization of that particular service are treated as a request for PA. Emergent Outpatient Services do not require prior authorization per federal requirement. The PA form contains supporting documentation demonstrating medical necessity, including ICD-10 and CPT codes, and the requesting provider's office fax and phone number. Supporting documentation includes correlating medical progress notes, and if applicable, lab and diagnostic test results, consultant notes, and any other medical documentation from the medical record pertinent to the service being requested. Care1st follows the federal timeframe requirements for prior authorization - three business days for expedited service authorization request and up to 14 calendar days for routine requests. The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, when such guidelines are available. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. The Plan conducts retrospective review of outlier trends for purposes of detecting FWA. In the event that the Plan determines that the service does not meet medical necessity through PA or retrospective review, the outcome would be a denial of payment/non-coverage.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, and grievances to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	UM strategies are reviewed annually or with any changes that the Arizona Health Care Cost Containment System has implemented. Additionally, when a denial results in either a claim dispute or a grievance, a review of the UM strategy may occur to ensure accordance with best practices. Overturned appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter-rater reliability. Grievance and complaints as well as appeals will also at times trigger a review of the criteria to determine if they are too stringent.

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Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. The MH/SUD Plan does not apply retrospective review, whereas the M/S Plan reports using retrospective review for purposes of detecting FWA. Given that the M/S Plan's use of this strategy is for purpose of reviewing coverage that has already been extended as opposed to offering an exception to allow a provider to obtain coverage who failed to secure authorization as required, the MH/SUD Plan's approach is less stringent. Accordingly, the strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for two options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested (e.g., the M/S Plan reported things like medical progress notes, labs, medical consultations and diagnostic test results, whereas the MH/SUD Plan requires a request form to be completed summarizing clinical, functional and demographic information for MH/SUD services, with supporting documentation based upon the nature of the service). Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process, though the M/S minimum threshold was not shared, which could lead to greater variation in the applicaion of medical necessity criteria. To address this variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Electro-convulsive treatment Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency Out-of-Network Single Case Agreements Home care training to home care client
	M/S: Physical Therapy Occupational Therapy Speech Therapy Outpatient Surgeries Orthodontia Chemotherapy

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan applies the UM strategy (prior authorization and concurrent review) due to the high costs associated with the services. The Plan does not apply retrospective review.	The M/S plan reports that the UM strategies (prior authorization and concurrent review) helps ensure that services are cost effective, meet the needs of members and to avoid overutilization for high volume services. The Plan reports allowing retrospective review when the provider fails to secure the necessary authorization.

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Comparability of Evidence	
MH/SUD	**M/S**
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	To support the UM strategies related to PA, concurrent review and retrospective review, analyzes member utilization data.
Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via fax. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG. Emergency Services do not require prior authorization per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. The Plan does not apply retrospective review to outpatient services. In the event that prior authorization or concurrent review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to delivering the services by requests initiated via telephone or facsmile. Requests for continued authorization of that particular service are treated as a request for PA. Emergent Outpatient Services do not require prior authorization per federal requirement. The PA form contains supporting documentation demonstrating medical necessity, including ICD-10 and CPT codes, and the requesting provider's office fax and phone number. Supporting documentation includes correlating medical progress notes, and if applicable, lab and diagnostic test results, consultant notes, and any other medical documentation from the medical record pertinent to the service being requested. Care1st follows the federal timeframe requirements for prior authorization - three business days for expedited service authorization request and up to 14 calendar days for routine requests. The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, when such guidelines are available. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. The Plan conducts retrospective review of outlier trends for purposes of detecting FWA. In the event that the Plan determines that the service does not meet medical necessity through PA or retrospective review, the outcome would be a denial of payment/non-coverage.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, and grievances to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	UM strategies are reviewed annually or with any changes that the Arizona Health Care Cost Containment System has implemented. Additionally, when a denial results in either a claim dispute or a grievance, a review of the UM strategy may occur to ensure accordance with best practices. Overturned appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter-rater reliability. Grievance and complaints as well as appeals will also at times trigger a review of the criteria to determine if they are too stringent.

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Findings
Both Plans select a subset of outpatient services subject to UM reviews - PA and concurrent review. Both Plans apply these processes to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use utilization data to identify high cost services subject to UM strategies. The MH/SUD Plan does not conduct retrospective review, while the M/S Plan uses retrospective review when the provider has failed to secure the necessary authorizations. While the strategies and evidentiary support appear to be comparable for PA and concurrent review, the MH/SUD Plan does not permit retrospective review in the event the provider failed to obtain the necessary authorization, which is more stringent than the M/S Plan, which allows such an exception. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for three options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG and Interqual) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process, though the M/S Plan did not provide a minimum threshold which could lead to greater variation in the applicaion of medical necessity criteria. To address this variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. With the exception of the M/S Plan offering retrospective review to providers as an exception to securing authorization, based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Net (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	**MH/SUD:** Electro-convulsive treatment Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency Out-of-Network Single Case Agreements Home care training to home care client
	M/S: Physical Therapy (Occupational Therapy/Speech Therapy not covered outpatient over age 21) for children Occupational Therapy/Physical Therapy/Speech Therapy require prior authorization (PA), Skilled Nursing Medical Supplies, Medical Foods, Prosthetics, Orthotics, Durable Medical Equipment, Private Duty Nursing, non-emergent transportation, total parenteral nutrition, Radiology and Medical Imaging, Chiropractic Services (<21), Dental under 21 and Adult limited M/S by a dentist age 21 and older for transplant patients and certain emergency situations, Hospice.

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan applies the UM strategy (prior authorization and concurrent review) due to the high costs associated with the services. The Plan does not apply retrospective review.	The Plan applies PA to ensure that the quality and type of service is appropriate to the member's needs. The Plan does not apply concurrent review to outpatient services. Plan applies retrospective review process to ensure a consistent and standard approach services delivered without PA and timely notification.

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Comparability of Evidence	
MH/SUD	**M/S**
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	The M/S plan cites InterQual Milliman Care Guideline criteria and State requirements as the evidence that supports applying the UM strategies (PA, retrospective review) to the designated services.
Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via fax. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG. Emergency Services do not require prior authorization per federal requirement. The Plan does not apply retrospective review to outpatient services. In the event that prior authorization or concurrent review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile or telephone. Requests for continued authorization of that particular service are treated as a request for PA. The requesting provider must submit supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed healthcare professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (Interqual). Exceptions to PA include emergency services and services for which the provider failed to secure prior authorization time, which can be reviewed retrospectively. The Plan did not identify any discretion that is applied to the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, and grievances to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	The Chief Medical Officer (CMO) or designee performs an annual review of all existing clinical policies to determine continued applicability and appropriateness. In connection with this annual review, the CMO or designee is responsible for identifying which policies require revisions. The CMO or designee shall send any such policies to the Comprehensive Primary Care to oversee the revision process and for subsequent re-approval. The Plan requires annual IRR, reviews denial rates and grievances to assess the effectiveness of the UM strategies.

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Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to PA. The MH/SUD Plan does not conduct retrospective review, while the M/S Plan uses retrospective review when the provider has failed to secure the necessary authorizations. While the strategies and evidentiary support appear to be comparable for PA and concurrent review, the MH/SUD Plan does not permit retrospective review in the event the provider failed to obtain the necessary authorization, which is more stringent than the M/S Plan, which allows such an exception. Both Plans require providers to secure authorization prior to the delivery of the outpatient service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for two options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process, though the M/S minimum threshold was not shared, which could lead to greater variation in the applicaion of medical necessity criteria. To address this variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. With the exception of the M/S Plan offering retrospective review to providers as an exception to securing authorization, based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Electro-convulsive treatment Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency Out-of-Network Single Case Agreements Home care training to home care client
	M/S: Radiology Lab (other than Sonora Quest Laboratories) Outpatient Surgery

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan applies the UM strategy (prior authorization and concurrent review) due to the high costs associated with the services. The Plan does not apply retrospective review.	The M/S plan cites the need for the PA to ensure the appropriateness of the service, managed efficiently and not over utilized. Retrospective review is used for purposes of identifying FWA.

Comparability of Evidence

MH/SUD	M/S
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	The M/S Plan tracks and trends utilization patterns and high cost services to identify services that are subject to PA.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via fax. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG. Emergency Services do not require prior authorization per federal requirement. The Plan does not apply retrospective review to outpatient services. In the event that prior authorization or concurrent review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to the delivery of the service by requests initiated via facsimile or telephone. Requests for continued authorization of that particular service are treated as a request for PA. The requesting provider must submit the PA with supporting clinical documentation required per MCG guidelines. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request.UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. Retrospective review for cases in which FWA is suspected. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, and grievances to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into considering before changes are made. Arizona Health Care Cost Containment System guidelines, policy updates, MCG annual updates, Aetna clinical policy guidelines and monthly updates are also considered and may prompt a review more frequent than annually. The Plan review denial rates and IRR annual testing for consistency of applied practice guidelines.

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Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage utilization and cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use utilization data to identify high cost services subject to PA. The MH/SUD Plan does not apply retrospective review, whereas the M/S Plan reports using retrospective review for purposes of detecting FWA. Given that the M/S Plan's use of this strategy is for purpose of reviewing coverage that has already been extended as opposed to offering an exception to allow a provider to obtain coverage who failed to secure authorization as required, the MH/SUD Plan's approach is less stringent. Accordingly, the strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for two options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested (e.g., the M/S Plan reported things like medical progress notes, labs, medical consultations and diagnostic test results, whereas the MH/SUD Plan requires a request form to be completed summarizing clinical, functional and demographic information for MH/SUD services, with supporting documentation based upon the nature of the service. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process, though the M/S minimum threshold was not shared, which could lead to greater variation in the applicaion of medical necessity criteria. To address this variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	**MH/SUD:** Electro-convulsive treatment Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency Out-of-Network Single Case Agreements Home care training to home care client

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Services	M/S:
	Abdominal Paracentesis Bariatric Surgery Bone Growth Stimulator BRACA Genetic Testing Cardiology* Cardiovascular* Carpal Tunnel Surgery* Cataract Surgery* Chemotherapy Chiropractic Care Circumcisions Cochlear and other Auditory Implants Colonoscopy* Cosmetic and Reconstructive Procedures* Dental Services Diabetic Supplies* Durable Medical Equipment >$500.00 Ear, Nose, and Throat Procedures* Enteral/Parenteral/Oral Services Experimental and Investigative Eye Care Femoroacetabular Impingement Syndrome Functional Endoscopic Sinus Surgery Genetic Testing Gynecologic Procedures Hearing Services

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Comparability of Strategy	
MH/SUD	**M/S**
The MH/SUD Plan applies the UM strategy (prior authorization and concurrent review) due to the high costs associated with the services. The Plan does not apply retrospective review.	The Plan reports that the rationale for applying PA is that the costs of services used to diagnose or treat conditions is high relative to commonly used alternative services. Retrospective Review is used when PA could not be conducted (e.g., weekend or holiday).

Comparability of Evidence	
MH/SUD	**M/S**
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	The M/S plan reports using claims data to support the application of UM strategies.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via fax. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG. Emergency Services do not require prior authorization per federal requirement. The Plan does not apply retrospective review to outpatient services. In the event that prior authorization or concurrent review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to providing the service by requests initiated via facsimile, telephone or provider portal. Requests for continued authorization of that particular service are treated as a request for PA. Retrospective review is conducted in the event that the PA process occured on a weekend or holiday. The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, and grievances to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	The health plan reviews and evaluates the services subjected to the UM strategies and compares to the latest evidence-based scientific evidence, state requirements, specialty society guidance and claims data to guide coverage decisions. The reviews are conducted on an quarterly basis and ad hoc per regulator updates. The plan utilizes an IRR testing and various quality metrics to assess the effectiveness of the NQTL.

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Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to PA. The MH/SUD Plan does not apply retrospective review, whereas the M/S Plan reports using retrospective review in lieu of PA when PA was not available for the provider, such as on a weekend or holiday. In that instance, while the timing of the process (prior to service delivery, versus after service delivery has begun), the strategy and evidentiary standards are comparable. Accordingly, for all UM NQTLs used by both Plans, the strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for three options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process, though the M/S minimum threshold was not shared, which could lead to greater variation in the applicaion of medical necessity criteria. To address this variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Non-Emergency Services Outside the Contracted Network BH Supportive Home/BHTH HCTC ECT (Electroconvulsive Therapy) Neuropsychological Testing Confirmatory Labs
	M/S: A variety of services/procedures in the outpatient classification including: Diagnostic Testing Dialysis Outpatient Procedures Radiology Specialists Transportation

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan applies the UM strategy (prior authorization (PA), concurrent review)) due to the high costs associated with the services. Retrospective review is applied because there is potential for billing inappropriately for the actual services received in order to receive a higher payment and when prior authorization is not obtained prior to the member accessing the service.	The M/S plan cites the need for UM strategies (PA only) to ensure the appropriateness and cost-effectiveness of the services. The Plan applies retrospective review for purposes of determining FWA.

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Comparability of Evidence	
MH/SUD	**M/S**
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	The Plan uses data, such as utilization data, that identifies services that are likely to be over utilized or costly, that indicate high-volume use.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile, provider portal or telephonically. Concurrent review must be conducted prior to the expiration of the authorization and can be completed telephonically or requested via fax or a provider portal. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines (McKesson, InterQual Criteria and ASAM Criteria). Emergency Services do not require prior authorization per federal requirement. The Plan will conduct a retrospective review if the provider failed to submit a prior authorization for services prior to the services being initiated or member's AHCCCS eligibility being determined (PPC) and/or if there is potential for billing inappropriately for the actual services received in order to receive a higher payment. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to delivering the services by requests initiated via telephone or facsimile. Requests for continued authorization of that particular service are treated as a request for PA. Emergent Outpatient Services do not require prior authorization per federal requirement. The PA form contains supporting documentation demonstrating medical necessity, including ICD-10 and CPT codes, and the requesting provider's office fax and phone number. Supporting documentation includes correlating medical progress notes, and if applicable, lab and diagnostic test results, consultant notes, and any other medical documentation from the medical record pertinent to the service being requested. Care1st follows the federal timeframe requirements for prior authorization - three business days for expedited service authorization request and up to 14 calendar days for routine requests. The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, when such guidelines are available. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. The Plan conducts retrospective review of outlier trends for purposes of detecting FWA. In the event that the Plan determines that the service does not meet medical necessity through PA or retrospective review, the outcome would be a denial of payment/non-coverage.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. IRR testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	UM strategies are reviewed annually or with any changes that the Arizona Health Care Cost Containment System has implemented. Additionally, when a denial results in either a claim dispute or a grievance, a review of the UM strategy may occur to ensure accordance with best practices. Overturned appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter-rater reliability. Grievance and complaints as well as appeals will also at times trigger a review of the criteria to determine if they are too stringent.

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Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. Both Plans apply retrospective review for purposes of detecting FWA, though the MH/SUD Plan will also conduct retrospective review in circumstances in which the provider did not obtain prior approval for a prior authorized service. Accordingly, the strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested (e.g., the M/S Plan reported things like medical progress notes, labs, medical consultations and diagnostic test results, whereas the MH/SUD Plan requires an out-of-home packet to be completed summarizing clinical, functional and demographic information for MH/SUD services, with supporting documentation based upon the nature of the service). Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. The M/S Plan offers the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process. The State plans to establish a mandatory MPS for IRR testing to reduce variation across contractors. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Non-Emergency Services Outside the Contracted Network BH Supportive Home/BHTH HCTC ECT (Electroconvulsive Therapy) Neuropsychological Testing Confirmatory Labs
	M/S: Physical Therapy Occupational Therapy Speech Therapy Outpatient Surgeries Orthodontia Chemotherapy

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan applies the UM strategy (prior authorization (PA), concurrent review)) due to the high costs associated with the services. Retrospective review is applied because there is potential for billing inappropriately for the actual services received in order to receive a higher payment and when prior authorization is not obtained prior to the member accessing the service.	The M/S plan reports that the UM strategies (prior authorization and concurrent review) helps ensure that services are cost effective, meet the needs of members and to avoid overutilization for high volume services. The Plan reports allowing retrospective review when the provider fails to secure the necessary authorization.

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Comparability of Evidence	
MH/SUD	**M/S**
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	To support the UM strategies related to PA, concurrent review and retrospective review, the M/S Plan analyzes member utilization data.
Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile, provider portal or telephonically. Concurrent review must be conducted prior to the expiration of the authorization and can be completed telephonically or requested via fax or a provider portal. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines (McKesson, InterQual Criteria and ASAM Criteria). Emergency Services do not require prior authorization per federal requirement. The Plan will conduct a retrospective review if the provider failed to submit a prior authorization for services prior to the services being initiated or member's AHCCCS eligibility being determined (PPC) and/or if there is potential for billing inappropriately for the actual services received in order to receive a higher payment. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to delivering the services by requests initiated via telephone or facsimile. Requests for continued authorization of that particular service are treated as a request for PA. Emergent Outpatient Services do not require prior authorization per federal requirement. The PA form contains supporting documentation demonstrating medical necessity, including ICD-10 and CPT codes, and the requesting provider's office fax and phone number. Supporting documentation includes correlating medical progress notes, and if applicable, lab and diagnostic test results, consultant notes, and any other medical documentation from the medical record pertinent to the service being requested. Care1st follows the federal timeframe requirements for prior authorization - three business days for expedited service authorization request and up to 14 calendar days for routine requests. The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, when such guidelines are available. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. The Plan conducts retrospective review of outlier trends for purposes of detecting FWA. In the event that the Plan determines that the service does not meet medical necessity through PA or retrospective review, the outcome would be a denial of payment/non-coverage.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. IRR testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	UM strategies are reviewed annually or with any changes that the Arizona Health Care Cost Containment System has implemented. Additionally, when a denial results in either a claim dispute or a grievance, a review of the UM strategy may occur to ensure accordance with best practices. Overturned appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter-rater reliability. Grievance and complaints as well as appeals will also at times trigger a review of the criteria to determine if they are too stringent.

Findings
Both Plans select a subset of outpatient services subject to UM reviews - PA and concurrent review. Both Plans apply these processes to ensure the appropriateness of services for high cost services, and applying UM strategies offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use utilization data to identify high cost services subject to UM strategies. Both Plans use retrospective review when the provider has failed to secure the necessary authorizations. As such, the strategies and evidentiary support appear to be comparable for PA, concurrent review and retrospective review. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG and Interqual) and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process. To address potential variability, the State plans to establish a mandatory MPS for IRR testing. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

<table>
<tr><td rowspan="2">Services</td><td>MH/SUD:
Non-Emergency Services Outside the Contracted Network
BH Supportive Home/BHTH
HCTC
ECT (Electroconvulsive Therapy)
Neuropsychological Testing
Confirmatory Labs</td></tr>
<tr><td>M/S:
Elective procedures that will be done in an acute inpatient setting require pre-certification/prior authorization.</td></tr>
</table>

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan applies the UM strategy (prior authorization (PA), concurrent review)) due to the high costs associated with the services. Retrospective review is applied because there is potential for billing inappropriately for the actual services received in order to receive a higher payment and when prior authorization is not obtained prior to the member accessing the service.	To manage over and under utilization of inpatient services to ensure members care and treatment is managed and delivered timely at the right level of care. The Plan does not apply retrospective review to outpatient services.

Comparability of Evidence

MH/SUD	M/S
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	The M/S plan determines which inpatient services require pre-service authorization based on utilization data, cost, and/or proclivity for over-utilization.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile, provider portal or telephonically. Concurrent review must be conducted prior to the expiration of the authorization and can be completed telephonically or requested via fax or a provider portal. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines (McKesson, InterQual Criteria and ASAM Criteria). Emergency Services do not require prior authorization per federal requirement. The Plan will conduct a retrospective review if the provider failed to submit a prior authorization for services prior to the services being initiated or member's AHCCCS eligibility being determined (PPC) and/or if there is potential for billing inappropriately for the actual services received in order to receive a higher payment. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to delivering the services by requests initiated via facsimile only. Requests for continued authorization of that particular service are treated as a request for PA. Emergent Outpatient Services do not require prior authorization per federal requirement. The Plan utilizes a single page PA form and requires supporting medical documentation from the requesting provider. The Plan follows the federal timeframe requirements for prior authorization - three business days for expedited service authorization request and up to 14 calendar days for routine requests. The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, InterQual, when such guidelines are available. The Plan does not conduct retrospective review of outpatient services. In the event that the Plan determines that the service does not meet medical necessity through PA, the outcome would be a denial of payment/non-coverage.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. IRR testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	Health Choice utilizes claims data to monitor, track and trend practice patterns, and services rendered to determine and manage what services require PA. This data is reviewed annually or if noted spikes/trends in utilization changes throughout the year. The data is reviewed and analyzed, then presented to Senior and Clinical Health Plan Leadership. The Plan utilizes several metrics to measure the efficacy of PA such as: IRR to ensure accuracy and consistently of criteria, denial trends, over- and under-utilization data, grievance and appeals reports, benefit changes.

Findings

Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. The MH/SUD Plan applies retrospective review for purposes of detecting FWA and in circumstances in which the provider did not obtain prior approval for a prior authorized service, offering additional opportunities for service coverage. The M/S Plan does not apply retrospective review to outpatient services.

Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. The MH/SUD Plan permits prior authorization and concurrent review requests to be initiated via multiple methods. The M/S Plan only allows PA requests to be initiated via facsimile. The M/S Plan does not conduct concurrent review for outpatient services. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment.

Both plans utilize an inter-rater reliability testing process. The State plans to establish a mandatory MPS for IRR testing to reduce variation across contractors. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Non-Emergency Services Outside the Contracted Network BH Supportive Home/BHTH HCTC ECT (Electroconvulsive Therapy) Neuropsychological Testing Confirmatory Labs
	M/S: Radiology Lab (other than Sonora Quest Laboratories) Outpatient Surgery

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan applies the UM strategy (prior authorization (PA), concurrent review)) due to the high costs associated with the services. Retrospective review is applied because there is potential for billing inappropriately for the actual services received in order to receive a higher payment and when prior authorization is not obtained prior to the member accessing the service.	The M/S plan cites the need for the PA to ensure the appropriateness of the service, managed efficiently and not over utilized. Retrospective review is used for purposes of identifying FWA.

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Comparability of Evidence	
MH/SUD	**M/S**
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	The M/S Plan tracks and trends utilization patterns and high cost services to identify services that are subject to PA.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile, provider portal or telephonically. Concurrent review must be conducted prior to the expiration of the authorization and can be completed telephonically or requested via fax or a provider portal. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines (McKesson, InterQual Criteria and ASAM Criteria). Emergency Services do not require prior authorization per federal requirement. The Plan will conduct a retrospective review if the provider failed to submit a prior authorization for services prior to the services being initiated or member's AHCCCS eligibility being determined (PPC) and/or if there is potential for billing inappropriately for the actual services received in order to receive a higher payment. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to the delivery of the service by requests initiated via facsimile or telephone. Requests for continued authorization of that particular service are treated as a request for PA. The requesting provider must submit the PA with supporting clinical documentation required per MCG guidelines. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request.UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. Retrospective review for cases in which FWA is suspected. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. IRR testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into considering before changes are made. Arizona Health Care Cost Containment System guidelines, policy updates, MCG annual updates, Aetna clinical policy guidelines and monthly updates are also considered and may prompt a review more frequent than annually. The Plan review denial rates and IRR annual testing for consistency of applied practice guidelines.

Findings

Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage utilization and cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use utilization data to identify high cost services subject to PA. The MH/SUD Plan applies retrospective review to allow a provider to obtain coverage who failed to secure authorization as required, whereas the M/S Plan reports using retrospective review for purposes of detecting FWA. Despite the variability with the application of retrospective review, the strategies and evidentiary support appear to be comparable.

Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. The MH/SUD Plan permits prior authorization and concurrent review requests to be initiated via three methods, while the M/S Plan allows for two options. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested (e.g., the M/S Plan reported things like medical progress notes, labs, medical consultations and diagnostic test results, whereas the MH/SUD Plan requires a request out-of-home packet to be completed summarizing clinical, functional and demographic information for MH/SUD services, with supporting documentation based upon the nature of the service). Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment.

Both plans utilize an inter-rater reliability testing process. To address potential variability, the State plans to establish a mandatory MPS for IRR testing. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
Services	**MH/SUD:** Non-Emergency Services Outside the Contracted Network BH Supportive Home/BHTH HCTC ECT (Electroconvulsive Therapy) Neuropsychological Testing Confirmatory Labs
	M/S: Fmri brain by tech Fmri brain by phys/psych Psychiatric diagnostic evaluation Electroconvulsive therapy (includes necessary monitoring) Unlisted psychiatric service or procedure Unlisted special service, procedure or report Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1) Ambulance service, basic life support, nonemergency transport (BLS)

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Comparability of Strategy	
MH/SUD	**M/S**
The MH/SUD Plan applies the UM strategy (prior authorization (PA), concurrent review)) due to the high costs associated with the services. Retrospective review is applied because there is potential for billing inappropriately for the actual services received in order to receive a higher payment and when prior authorization is not obtained prior to the member accessing the service.	The M/S Plan applies the UM strategy to ensure cost-effectiveness and consistency of services. The Plan does not apply retrospective review to outpatient services.
Comparability of Evidence	
MH/SUD	**M/S**
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	The M/S Plan cited Milliman Care Guidelines along with Hayes criteria and published studies in peer reviewed journals as the evidence to support the UM strategies.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile, provider portal or telephonically. Concurrent review must be conducted prior to the expiration of the authorization and can be completed telephonically or requested via fax or a provider portal. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines (McKesson, InterQual Criteria and ASAM Criteria). Emergency Services do not require prior authorization per federal requirement. The Plan will conduct a retrospective review if the provider failed to submit a prior authorization for services prior to the services being initiated or member's AHCCCS eligibility being determined (PPC) and/or if there is potential for billing inappropriately for the actual services received in order to receive a higher payment. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	The provider must obtain prior authorization prior to the delivery of the service by requests initiated via facsimile, on-line and, for same day requests, the Plan offers a dedicated telephone line. Requests for continued authorization of that particular service are treated as a request for PA. PA requests must be in writing and the M/S Plan requires a one page form and pertinent medical records to support the review. The requested ICD-10 DX codes are used to request the outpatient surgery as described by the surgical CPT code. The clinical reviewer may require additional clinical records to support the request, but it is not requisite that clinical records be submitted. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). Medical directors review all requests not meeting criteria and are able to use clinical discretion with or without dialoguing with the treating provider in a peer to peer discussion. Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. IRR testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	PA updates are done once per fiscal year. The M/S Plan reviews new CPT code additions/deletions communicated by CMS for the upcoming year as well as HCPCS level II codes. IRR testing occurs annually and ensures nurses and MDs apply review criteria consistently. Frequency of requests and associated denial rates are monitored. Provider grievances regarding the Plan's application of criteria are monitored and used to trigger review of criteria when necessary in between the scheduled annual reviews.

Findings

Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage utilization and cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. The MH/SUD Plan applies retrospective review to allow a provider to obtain coverage who failed to secure authorization as required, expanding the opportunity for coverage. In contracts, the M/S Plan does not apply retrospective review to outpatient services.

Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permits prior authorization to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment.

Both plans utilize an inter-rater reliability testing process. To address potential variability, the State plans to establish a mandatory MPS for IRR testing. Both Plans review and monitor data such as denial rates, appeals and grievances to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION	
Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult	
Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])	
Non-quantitative treatment limit (NQTL): Utilization Management (UM)	
Classification: Outpatient	
Services	**MH/SUD:** Non-Emergency Services Outside the Contracted Network BH Supportive Home/BHTH HCTC ECT (Electroconvulsive Therapy) Neuropsychological Testing Confirmatory Labs

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Services	M/S: Abdominal Paracentesis Bariatric Surgery Bone Growth Stimulator BRACA Genetic Testing Cardiology* Cardiovascular* Carpal Tunnel Surgery* Cataract Surgery* Chemotherapy Chiropractic Care Circumcisions Cochlear and other Auditory Implants Colonoscopy* Cosmetic and Reconstructive Procedures* Dental Services Diabetic Supplies* Durable Medical Equipment >$500.00 Ear, Nose, and Throat Procedures* Enteral/Parenteral/Oral Services Experimental and Investigative Eye Care Femoroacetabular Impingement Syndrome Functional Endoscopic Sinus Surgery Genetic Testing Gynecologic Procedures Hearing Services

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Comparability of Strategy	
MH/SUD	**M/S**
The MH/SUD Plan applies the UM strategy (prior authorization (PA), concurrent review)) due to the high costs associated with the services. Retrospective review is applied because there is potential for billing inappropriately for the actual services received in order to receive a higher payment and when prior authorization is not obtained prior to the member accessing the service.	The Plan reports that the rationale for applying PA is that the costs of services used to diagnose or treat conditions is high relative to commonly used alternative services. Retrospective Review is used when PA could not be conducted (e.g., weekend or holiday).
Comparability of Evidence	
MH/SUD	**M/S**
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	The M/S plan reports using claims data to support the application of UM strategies.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile, provider portal or telephonically. Concurrent review must be conducted prior to the expiration of the authorization and can be completed telephonically or requested via fax or a provider portal. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines (McKesson, InterQual Criteria and ASAM Criteria). Emergency Services do not require prior authorization per federal requirement. The Plan will conduct a retrospective review if the provider failed to submit a prior authorization for services prior to the services being initiated or member's AHCCCS eligibility being determined (PPC) and/or if there is potential for billing inappropriately for the actual services received in order to receive a higher payment. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to providing the service by requests initiated via facsimile, telephone or provider portal. Requests for continued authorization of that particular service are treated as a request for PA. Retrospective review is conducted in the event that the PA process was not available because, for example, it occurred on a weekend or holiday. The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. IRR testing annually. Staff not meeting minimum performance score (MPS) are	The health plan reviews and evaluates the services subjected to the UM strategies and compares to the latest evidence-based scientific evidence, state requirements, specialty society guidance and claims data to guide coverage decisions. The reviews are conducted on an quarterly basis and ad hoc per regulator updates. The plan utilizes an IRR testing and various quality metrics to assess the effectiveness of the

Findings

Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost services subject to PA. Both Plans use retrospective review when the provider has failed to secure the necessary authorizations. Accordingly, for all UM NQTLs used by both Plans, the strategies and evidentiary support appear to be comparable.

Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment.

Both plans utilize an inter-rater reliability testing process. To address potential variability, the State plans to establish a mandatory MPS for IRR testing. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	**MH/SUD:** Intensive Outpatient Program Treatment Outpatient Electro-Convulsive Treatment Psychological Testing Methadone Maintenance Extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management
	M/S: A variety of services/procedures including: Diagnostic Testing Dialysis Outpatient Procedures Radiology Specialists Transportation

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The M/S plan cites the need for UM strategies (PA only) to ensure the appropriateness and cost-effectiveness of the services. The Plan applies retrospective review for purposes of determining FWA.

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Comparability of Evidence	
MH/SUD	**M/S**
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.	The Plan uses data, such as utilization data, that identifies services that are likely to be over utilized or costly, that indicate high-volume use.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to providing the service by requests initiated via facsimile, telephone or provider portal. Requests for continued authorization of that particular service are treated as a request for PA. Retrospective review is conducted in the event that the PA process occurred on a weekend or holiday. The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to delivering the services by requests initiated via telephone or facsimile. Requests for continued authorization of that particular service are treated as a request for PA. Emergent Outpatient Services do not require prior authorization per federal requirement. The PA form contains supporting documentation demonstrating medical necessity, including ICD-10 and CPT codes, and the requesting provider's office fax and phone number. Supporting documentation includes correlating medical progress notes, and if applicable, lab and diagnostic test results, consultant notes, and any other medical documentation from the medical record pertinent to the service being requested. Care1st follows the federal timeframe requirements for prior authorization - three business days for expedited service authorization request and up to 14 calendar days for routine requests. The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, when such guidelines are available. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. The Plan conducts retrospective review of outlier trends for purposes of detecting FWA. In the event that the Plan determines that the service does not meet medical necessity through PA or retrospective review, the outcome would be a denial of payment/non-coverage.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.	UM strategies are reviewed annually or with any changes that the Arizona Health Care Cost Containment System has implemented. Additionally, when a denial results in either a claim dispute or a grievance, a review of the UM strategy may occur to ensure accordance with best practices. Overturned appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter-rater reliability. Grievance and complaints as well as appeals will also at times trigger a review of the criteria to determine if they are too stringent.

Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. Both Plans apply retrospective review for purposes of detecting FWA. Accordingly, the strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process. To address potential variability, the State plans to establish a mandatory uniform MPS for IRR testing for all Plans. The Plans review utilization data, appeals and grievances to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Intensive Outpatient Program Treatment Outpatient Electro-Convulsive Treatment Psychological Testing Methadone Maintenance Extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management
	M/S: Physical Therapy Occupational Therapy Speech Therapy Outpatient Surgeries Chemotherapy Orthodontia

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The M/S plan reports that the UM strategies (prior authorization and concurrent review) helps ensure that services are cost effective, meet the needs of members and to avoid overutilization for high volume services. The Plan reports allowing retrospective review when the provider fails to secure the necessary authorization.

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Comparability of Evidence	
MH/SUD	**M/S**
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.	To support the UM strategies related to PA, concurrent review and retrospective review, analyzes member utilization data.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to providing the service by requests initiated via facsimile, telephone or provider portal. Requests for continued authorization of that particular service are treated as a request for PA. Retrospective review is conducted in the event that the PA process occurred on a weekend or holiday. The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to delivering the services by requests initiated via telephone or facsimile. Requests for continued authorization of that particular service are treated as a request for PA. Emergent Outpatient Services do not require prior authorization per federal requirement. The PA form contains supporting documentation demonstrating medical necessity, including ICD-10 and CPT codes, and the requesting provider's office fax and phone number. Supporting documentation includes correlating medical progress notes, and if applicable, lab and diagnostic test results, consultant notes, and any other medical documentation from the medical record pertinent to the service being requested. Care1st follows the federal timeframe requirements for prior authorization - three business days for expedited service authorization request and up to 14 calendar days for routine requests. The plan utilizes licensed health care professionals to render authorization decisions, requiring a physician review to deny a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG, when such guidelines are available. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. The Plan conducts retrospective review of outlier trends for purposes of detecting FWA. In the event that the Plan determines that the service does not meet medical necessity through PA or retrospective review, the outcome would be a denial of payment/non-coverage.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.	UM strategies are reviewed annually or with any changes that the Arizona Health Care Cost Containment System has implemented. Additionally, when a denial results in either a claim dispute or a grievance, a review of the UM strategy may occur to ensure accordance with best practices. Overturned appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter-rater reliability. Grievance and complaints as well as appeals will also at times trigger a review of the criteria to determine if they are too stringent.

Findings

Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. Both Plans apply retrospective review for purposes of detecting FWA and when a prior authorized service is not prior authorized prior to the member accessing the service. Accordingly, the strategies and evidentiary support appear to be comparable.

Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment.

Both plans utilize an inter-rater reliability testing process. To address potential variability, the State plans to establish a mandatory uniform MPS for IRR testing for all Plans. The Plans review utilization data, appeals and grievances to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	**MH/SUD:** Intensive Outpatient Program Treatment Outpatient Electro-Convulsive Treatment Psychological Testing Methadone Maintenance Extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management
	M/S: Radiology Lab (other than Sonora Quest Laboratories) Outpatient Surgery

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The M/S plan cites the need for the PA to ensure the appropriateness of the service, managed efficiently and not over utilized. Retrospective review is used for purposes of identifying FWA.

Comparability of Evidence

MH/SUD	M/S
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.	The M/S Plan tracks and trends utilization patterns and high cost services to identify services that are subject to PA.

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Comparability and Stringency of Processes	
MH/SUD	M/S
Provider must obtain prior authorization prior to providing the service by requests initiated via facsimile, telephone or provider portal. Requests for continued authorization of that particular service are treated as a request for PA. Retrospective review is conducted in the event that the PA process was not accessed prior to the member accessing the service. The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to the delivery of the service by requests initiated via facsimile or telephone. Requests for continued authorization of that particular service are treated as a request for PA. The requesting provider must submit the PA with supporting clinical documentation required per MCG guidelines. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request.UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. Retrospective review for cases in which FWA is suspected. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.	Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into considering before changes are made. Arizona Health Care Cost Containment System guidelines, policy updates, MCG annual updates, Aetna clinical policy guidelines and monthly updates are also considered and may prompt a review more frequent than annually. The Plan review denial rates and IRR annual testing for consistency of applied practice guidelines.

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Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. Both Plans apply retrospective review for purposes of detecting FWA. The MH/SUD Plan will also conduct a retrospective review when a prior authorized service is not prior authorized prior to the member accessing the service. Accordingly, the strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. The M/S Plan will offer a peer to peer discussion prior to issuing a adverse authorization decision. The State will require for all Plans, that when a Plan notifies a provider that a requested service has been denied, the Plan must inform the provider of the option to request a peer to peer discussion with the Contractor's Medical Director. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process. To address potential variability, the State plans to establish a mandatory uniform MPS for IRR testing for all Plans. The Plans review utilization data and denial rates to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Intensive Outpatient Program Treatment Outpatient Electro-Convulsive Treatment Psychological Testing Methadone Maintenance Extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management
	M/S: Abdominal Paracentesis Bariatric Surgery Bone Growth Stimulator BRACA Genetic Testing Cardiology* Cardiovascular*

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The Plan reports that the rationale for applying PA is that the costs of services used to diagnose or treat conditions is high relative to commonly used alternative services. Retrospective Review is used when PA could not be conducted (e.g., weekend or holiday).

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Comparability of Evidence	
MH/SUD	**M/S**
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.	The M/S plan reports using claims data to support the application of UM strategies.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to providing the service by requests initiated via facsimile, telephone or provider portal. Requests for continued authorization of that particular service are treated as a request for PA. Retrospective review is conducted in the event that the PA process occurred on a weekend or holiday. The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Provider must obtain prior authorization prior to providing the service by requests initiated via facsimile, telephone or provider portal. Requests for continued authorization of that particular service are treated as a request for PA. Retrospective review is conducted in the event that the PA process occurred on a weekend or holiday. The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.	The health plan reviews and evaluates the services subjected to the UM strategies and compares to the latest evidence-based scientific evidence, state requirements, specialty society guidance and claims data to guide coverage decisions. The reviews are conducted on an quarterly basis and ad hoc per regulator updates. The plan utilizes an IRR testing and various quality metrics to assess the effectiveness of the NQTL.

Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. Both Plans apply retrospective review for purposes of detecting FWA and when the a prior authorized service is not prior authorized prior to the member accessing the service. Accordingly, the strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process. To address potential variability, the State plans to establish a mandatory uniform MPS for IRR testing for all Plans. The Plans review utilization data to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Cenpatico Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Non-Emergency Services Outside the Contracted Network BH Supportive Home/BHTH HCTC ECT (Electroconvulsive Therapy) Neuropsychological Testing Confirmatory Labs
	M/S (LTSS): All benefits in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
The MH/SUD Plan applies the UM strategy (prior authorization (PA), concurrent review)) due to the high costs associated with the services. Retrospective review is applied because there is potential for billing inappropriately for the actual services received in order to receive a higher payment.	The Plan cites the need for the prior authorization (PA) and concurrent review due to high costs and to ensure that services provided are appropriate and timely for the member's needs. The Plan reviews retrospective services in the event that the initial request for the clinical review occurs after the member is discharged and a retrospective review is requested.

Comparability of Evidence

MH/SUD	M/S (LTSS)
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	Prior authorization is required for all services as they are based in the ISP as required by state rules. ISP's are renewed at a minimum annually per contract with the State at which time authorizations and services are also reviewed.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile, provider portal or telephonically. Concurrent review must be conducted prior to the expiration of the authorization and can be completed telephonically or requested via fax or a provider portal. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines (McKesson, InterQual Criteria and ASAM Criteria). Emergency Services do not require prior authorization per federal requirement. The Plan will conduct a retrospective review if the provider failed to submit a prior authorization for services prior to the services being initiated or member's AHCCCS eligibility being determined (PPC). In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. IRR testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of procedure that may need to be enhanced or removed. Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the Medical Management Committee. The audits assess timeliness and appropriateness of authorization. The Plan conducts annual IRR testing for UR staff.

Findings

Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. Both Plans conduct retrospective review in circumstances in which the provider did not obtain prior approval for a prior authorized service. Accordingly, the strategies and evidentiary support appear to be comparable.

Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. The M/S Plan offers the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment.

Both plans utilize an inter-rater reliability testing process. The State plans to establish a mandatory MPS for IRR testing to reduce variation across contractors. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Mercy Maricopa Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Electro-convulsive treatment Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency Out-of-Network Single Case Agreements Home care training to home care client
	M/S (LTSS): All benefits in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
The MH/SUD Plan applies the UM strategy (prior authorization and concurrent review) due to the high costs associated with the services. The Plan does not apply retrospective review.	The Plan cites the need for the prior authorization (PA) and concurrent review due to high costs and to ensure that services provided are appropriate and timely for the member's needs. The Plan reviews retrospective services in the event that the initial request for the clinical review occurs after the member is discharged and a retrospective review is requested.

Comparability of Evidence

MH/SUD	M/S (LTSS)
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	Prior authorization is required for all services as they are based in the ISP as required by state rules. ISP's are renewed at a minimum annually per contract with the State at which time authorizations and services are also reviewed.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via fax. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG. Emergency Services do not require prior authorization per federal requirement. The MD will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. The Plan does not apply retrospective review to outpatient services. In the event that prior authorization or concurrent review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
The Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, and grievances to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of procedure that may need to be enhanced or removed. Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the Medical Management Committee. The audits assess timeliness and appropriateness of authorization. The Plan conducts annual IRR testing for UR staff.

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Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. The MH/SUD Plan does not apply retrospective review, whereas the M/S Plan reports using retrospective review when a prior authorized service is not prior authorized prior to the member accessing the service. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for two options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process, though the M/S minimum threshold was not shared, which could lead to greater variation in the application of medical necessity criteria. To address this variability, the State plans to establish a mandatory MPS of 90% for IRR testing. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and United Healthcare Community Plan (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	M/S: Radiology Lab (other than Sonora Quest Laboratories) Outpatient Surgery
	M/S (LTSS): All benefits in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The Plan cites the need for the prior authorization (PA) and concurrent review due to high costs and to ensure that services provided are appropriate and timely for the member's needs. The Plan reviews retrospective services in the event that the initial request for the clinical review occurs after the member is discharged and a retrospective review is requested.

Comparability of Evidence

MH/SUD	M/S (LTSS)
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.	Prior authorization is required for all services as they are based in the ISP as required by state rules. ISP's are renewed at a minimum annually per contract with the State at which time authorizations and services are also reviewed.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
Provider must obtain prior authorization prior to providing the service by requests initiated via facsimile, telephone or provider portal. Requests for continued authorization of that particular service are treated as a request for PA. Retrospective review is conducted in the event that the PA process was not accessed prior to the member accessing the service. The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.	PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of procedure that may need to be enhanced or removed. Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the Medical Management Committee. The audits assess timeliness and appropriateness of authorization. The Plan conducts annual IRR testing for UR staff.

Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. Both Plans conduct a retrospective review when a prior authorized service is not prior authorized prior to the member accessing the service. Accordingly, the strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. The M/S Plan will offer a peer to peer discussion prior to issuing a adverse authorization decision. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both plans utilize an inter-rater reliability testing process. To address potential variability, the State plans to establish a mandatory MPS for IRR testing. The Plans review utilization data and denial rates to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Progam (AIHP) (Medical/Surgical [M/S])and Cenpatico Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Non-Emergency Services Outside the Contracted Network BH Supportive Home/BHTH HCTC ECT (Electroconvulsive Therapy) Neuropsychological Testing Confirmatory Labs
	M/S: Elective surgery Home Health visits not within the first five visits following an acute stay Home Infusion Hospice services Medical Equipment over $300 and all rentals Medical Supplies over $100 Nutritional Supplements

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan applies the UM strategy (prior authorization (PA), concurrent review)) due to the high costs associated with the services. Retrospective review is applied because there is potential for billing inappropriately for the actual services received in order to receive a higher payment and when prior authorization is not obtained prior to the member accessing the service.	The AIHP cites the need for the prior authorization (PA), concurrent review and retrospective review to determine medical appropriateness, cost effectiveness, and quality of care.

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Comparability of Evidence	
MH/SUD	**M/S**
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services.
Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile, provider portal or telephonically. Concurrent review must be conducted prior to the expiration of the authorization and can be completed telephonically or requested via fax or a provider portal. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines (McKesson, InterQual Criteria and ASAM Criteria). Emergency Services do not require prior authorization per federal requirement. The Plan will conduct a retrospective review if the provider failed to submit a prior authorization for services prior to the services being initiated or member's AHCCCS eligibility being determined (PPC) and/or if there is potential for billing inappropriately for the actual services received in order to receive a higher payment. In the event that prior authorization, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via online submission portal, telephone or by facsmile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsmile request. A Request form and supporting clinical documentation is required to support the medicl necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. Individual criteria sets would be reviewed as necessary if clinical practice changes. CIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, grievances, ALOS, and readmissions. IRR testing annually. Staff not meeting minimum performance score (MPS) are retrained/retested.	AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.

Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans conduct retrospective review in circumstances in which the provider did not obtain prior approval for a prior authorized service. Accordingly, the strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization and concurrent review requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S consistent with State requirements. The M/S Plan offers the provider the opportunity for a peer to peer reconsideration. The State will require for all Plans, that when a Plan notifies a provider that a requested service has been denied, the Plan must inform the provider of the option to request a peer to peer discussion with the Contractor's Medical Director.For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. Based upon the planned changes identified by the State as noted, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Progam (AIHP) (Medical/Surgical [M/S])and Mercy Maricopa Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	**MH/SUD:** Electro-convulsive treatment Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency Out-of-Network Single Case Agreements Home care training to home care client
	M/S: Elective surgery Home Health visits not within the first five visits following an acute stay Home Infusion Hospice services Medical Equipment over $300 and all rentals Medical Supplies over $100 Nutritional Supplements

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan applies the UM strategy (prior authorization and concurrent review) due to the high costs associated with the services. The Plan does not apply retrospective review.	The AIHP cites the need for the prior authorization (PA), concurrent review and retrospective review to determine medical appropriateness, cost effectiveness, and quality of care.

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Comparability of Evidence	
MH/SUD	**M/S**
Cost data, utilization trends and claims payment requirements serve as evidence to support the UM strategies.	Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to service delivery by requests initiated via facsimile only. Concurrent review must be conducted prior to the expiration of the authorization and is completed via fax. The information and supporting documentation necessary depends upon the service under review. Requests for prior authorization are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The plan utilizes licensed health care professionals to render authorization decisions and requires a physician review prior to the denial of a service authorization request. Reviewers utilize nationally-recognized medical necessity guidelines, MCG. Emergency Services do not require prior authorization per federal requirement. The Plan does not apply retrospective review to outpatient services. In the event that prior authorization or concurrent review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via online submission portal, telephone or by facsmile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsmile request. A Request form and supporting clinical documentation is required to support the medicl necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Plan reviews Medical necessity criteria and UM processes annually. If there are changes, criteria is reviewed by MDs, the criteria is then reviewed by the MM/UM committee for their approval prior to adoption. MMIC monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, and grievances to assess the stringency of the NQTL. IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter.	AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.

Findings
Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Accordingly, the strategies and evidentiary support appear to be comparable. Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. The MH/SUD Plan only permits prior authorization and concurrent review requests to be initiated via one method, while the M/S Plan allows for multiple options. The State plans to require all Plans to offer providers more than one method to initiate a request for authorization. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S consistent with State requirements. Both Plans offer the provider the opportunity for a peer to peer reconsideration. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment. Both Plans review and monitor data such as denial rates, appeals and other quality metrics to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Progam (AIHP) (Medical/Surgical [M/S])and United Health Care Community Plan (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Utilization Management (UM)

Classification: Outpatient

Services	
	MH/SUD: Intensive Outpatient Program Treatment Outpatient Electro-Convulsive Treatment Psychological Testing Methadone Maintenance Extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management
	M/S: Elective surgery Home Health visits not within the first five visits following an acute stay Home Infusion Hospice services Medical Equipment over $300 and all rentals Medical Supplies over $100 Nutritional Supplements

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan subjects these services to prior authorization (PA), concurrent review and retrospective review due to the cost of a service used to diagnose or treat a behavioral health condition is high relative to commonly used alternative services.	The AIHP cites the need for the prior authorization (PA), concurrent review and retrospective review to determine medical appropriateness, cost effectiveness, and quality of care.

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Comparability of Evidence	
MH/SUD	**M/S**
Reviews are based on state requirements, evidence-based scientific evidence, specialty society guidance, and claims data for cost.	Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered services. 9 A.A.C. 22.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Provider must obtain prior authorization prior to providing the service by requests initiated via facsimile, telephone or provider portal. Requests for continued authorization of that particular service are treated as a request for PA. Retrospective review is conducted in the event that the PA process was not accessed prior to the member accessing the service. The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). Exceptions to PA include emergency services. Only the Medical Director may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.	Providers must obtain prior authorization prior to admission by requests initiated via online submission portal, telephone or by facsmile. Concurrent review must be conducted prior to the expiration of the authorization and is completed via the online submission portal or by facsmile request. A Request form and supporting clinical documentation is required to support the medicl necessity review. If a determination is unable to be made, or if there is a lack of supporting evidence, the PA nurse will place the authorization in the "pended" status and the additional documentation is requested from the provider. When the PA is not met, the CMO or Medical Director (MD) reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. Requests are reviewed within required federal timeframes - 14 days for standard requests, three days for an expedited requests. The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. UM authorization decisions are consistent with nationally-recognized medical necessity guidelines. Exceptions to PA include emergency services, which can be reviewed retrospectively. Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The State contract requires the Plan to conduct a review of all UM processes at least annually. The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. The plan utilizes an inter-rater reliability testing and various quality metrics to assess the effectiveness of the NQTL.	AIHP rates of denials, grievances, complaints are presented at the COQOC meetings and the SQMC meetings. AIHP authorization rates are reviewed quarterly at the Medical Management Meetings and include all reviewed service categories.

Findings

Both Plans apply authorization requirements to selected non-emergent MH/SUD and M/S OP services based upon the need to manage cost by making sure the appropriateness of services. Applying authorization requirements to these services offers an opportunity to prevent unnecessary costs and ensure that services are medically necessary. Both Plans use cost and utilization data to identify high cost outpatient services subject to PA. Both Plans conduct a retrospective review when a prior authorized service is not prior authorized prior to the member accessing the service. Accordingly, the strategies and evidentiary support appear to be comparable.

Both Plans require providers to secure authorization prior to the delivery of the service, unless the service is provided emergently. Both Plans permit prior authorization requests to be initiated via multiple methods. Both Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines when applicable to the selected service and, if indicated, refer potential service denial decisions to a physician for review. Based upon the service under review, both Plans require the submission of demographic information and clinical documentation to support the authorization of the service. Variability in the documentation required corresponds to the type of service being requested. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. The M/S Plan will offer a peer to peer discussion prior to issuing a adverse authorization decision. The State will require for all Plans, that when a Plan notifies a provider that a requested service has been denied, the Plan must inform the provider of the option to request a peer to peer discussion with the Contractor's Medical Director. For each Plan, failure to meet the requirement of the UM strategy results in a denial of payment.

The Plans review utilization data and denial rates to assess the impact/stringency of the UM strategies. As a result, the processes, strategies and evidentiary standards used in applying utilization management to MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
1) Compliance with contractual requirements from Arizona Health Care Cost Containment System (AHCCCS) through the implementation of the preferred drug list. 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines.	Per AHCCCS: To cover all medically necessary, clinically appropriate and cost-effective medications that are federally and state reimbursable.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for preferred agents that a require a clinical review will be reviewed against the approved PA Guideline. If a non-preferred agent is requested, the clinical pharmacists will first validate the members pharmacy claim history and/or the provided medical record that the member has tried and failed the preferred agents. If the member pharmacy history and/or prescriber documentation does not support validation of trial and failure of a preferred drug; but based on information provided the request meets approval of a non-preferred agent, the clinical pharmacists will pend the request to reach out to the prescriber to request information to confirm trial and failure of the preferred agents. If the prescriber supplies the necessary information the request will be approved and restricted to the established quantity limit; if the additional trial and failure information is not provided, the request would be forward to the medical director (MD) with recommendation for denial. Urgent request 72 hours, Standard Request - 14 calendar days.	♦ Technician reviews for clinical appropriateness and complete information received ♦ Technician will reach out to provider for additional information as needed ♦ Tech provides an "opinion" on decision to (Registered Pharmacist (RPH) ♦ RPH makes decision ♦ Potential denials are sent to the MD for the final decision ♦ Currently allowance is 72 hours for STAT requests and up to 14 days for routine with the possibility of extending for an additional 14 days if appropriate. (This is changing to 24 hours for all requests with allowance of holding a STAT request for 3 days and Routine for 7 days if additional information is required).

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Monitoring of the formulary set up to include utilization management edits is completed through a variety of analysis and reports. This would include but not limited to: - claims files and reports to include paid and rejected claims - daily and monthly PA Summary reports with details on approved and denial requests - Adhoc reports to identify claims for medications that require PA and validate appropriateness of PA versus pharmacy benefit. 7.9% of the behavioral health drugs have some type of formulary edit associated with them vs. 27.2% of the physical health drugs. Note: some drugs may have multiple edits applied.	♦ Technician reviews for clinical appropriateness and complete information received ♦ Technician will reach out to provider for additional info as needed ♦ Tech provides an "opinion" on decision to RPH ♦ RPH makes decision ♦ Potential denials are sent to the medical director for the final decision ♦ Currently allowance is 72 hours for STAT requests and up to 14 days for routine with the possibility of extending for an additional 14 days if appropriate. (This is changing to 24 hours for all requests with allowance of holding a STAT request for 3 days and Routine for 7 days if additional information is required).

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Findings
Both MMIC and Care 1st use PA to ensure clinically appropriate drug therapy. They both use nationally based evidentiary standards that include FDA guidelines, published medical literature and other nationally recognized evidence to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="3">Benefit Package(s): Child</td></tr>
<tr><td colspan="3">Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="3">Non-quantitative treatment limit (NQTL): Prior Authorization (PA)</td></tr>
<tr><td colspan="3">Classification: Prescription Drugs</td></tr>
<tr><td rowspan="2">Services</td><td colspan="2">MH/SUD:
Medications</td></tr>
<tr><td colspan="2">M/S:
Medications</td></tr>
<tr><td colspan="3">Comparability of Strategy</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">1) Compliance with contractual requirements from Arizona Health Care Cost Containment System (AHCCCS) through the implementation of the preferred drug list.
2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines.</td><td>To adhere to the AHCCCS Preferred Drug List (PDL) - as AHCCCS receives rebates on meds the plans are mandated to use the meds on the AHCCCS PDL. To ensure the appropriate use of medications.</td></tr>
</table>

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Comparability of Evidence	
MH/SUD	**M/S**
Food and Drug Administration (FDA)-approved drug monographs and the following medical pharmacy information sources: American Medical Hospital Formulary Service – Drug Information Drug Facts and Comparisons American Medical Association Drug Evaluations United States Pharmacopoeia – Drug Information Clinical Pharmacology Published practice guidelines and treatment protocols Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for preferred agents that a require a clinical review will be reviewed against the approved PA Guideline. If a non-preferred agent is requested, the clinical pharmacists will first validate the members pharmacy claim history and/or the provided medical record that the member has tried and failed the preferred agents. If the member pharmacy history and/or prescriber documentation does not support validation of trial and failure of a preferred drug; but based on information provided the request meets approval of a non-preferred agent, the clinical pharmacists will pend the request to reach out to the prescriber to request information to confirm trial and failure of the preferred agents. If the prescriber supplies the necessary information the request will be approved and restricted to the established quantity limit; if the additional trial and failure information is not provided, the request would be forward to the medical director with recommendation for denial.	The Pharmacy Benefit Manager receives the medication PA and enters into their system. Their team reviews the PA with guidelines when applicable to see if it meets medical necessity criteria. If it does not or they do not have guidelines for a specific medication the PA is electronically sent to CMDP via a web portal shared between med impact and CMDP. A CMDP nurse checks the web portal inbox numerous times in a day and retrieves the PA. Based on the first letter of the last name of the member will determine which nurse will work the PA. The nurse will review the documents submitted and "work" the case. That may include requesting for additional information, researching medication history for the member or calling the members Department of Child Safety worker for clarification if needed. Once all information is obtained, a decision can be made. If a nurse cannot approve the PA, the request will go to a medical director (MD) for a decision: only the CMDP MD can deny a PA. Once the decision is made, the nurse will input the decision and needed actions back into the web portal to close out the PA. If a routine request then 14 calendar days from date of receipt. If an urgent request, then effective 10/1/17 within 24 hours of receipt. Currently, CMDP processes urgent requests within 3 business days.

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<table>
<tr><th colspan="2">Stringency of Strategy and Evidence</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>Monitoring of the formulary set up to include utilization management edits is completed through a variety of analysis and reports. This would include but not limited to :
- claims files and reports to include paid and rejected claims
- daily and monthly PA Summary reports with details on approved and denial requests
- Adhoc reports to identify claims for medications that require PA and validate appropriateness of PA versus pharmacy benefit. 7.9% of the behavioral health drugs have some type of formulary edit associated with them vs. 27.2% of the physical health drugs. Note: some drugs may have multiple edits applied</td><td>Overturned on appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter rater reliability. Grievance and complaints as well as Appeals will also at times trigger a review of the criteria to determine if they are too stringent. CMDP had no PA appeals.</td></tr>
<tr><th colspan="2">Findings</th></tr>
<tr><td colspan="2">Both MMIC and CMDP use PA to ensure clinically appropriate drug therapy. They both use nationally based evidentiary standards that include FDA guidelines, published medical literature and other nationally recognized drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.</td></tr>
</table>

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Health Net (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
1) Compliance with contractual requirements from Arizona Health Care Cost Containment System (AHCCCS) through the implementation of the preferred drug list. 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines.	Managing financial costs, safety monitoring, control of inappropriate utilizations and many other reasons.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for preferred agents that a require a clinical review will be reviewed against the approved PA Guideline. If a non-preferred agent is requested, the clinical pharmacists will first validate the members pharmacy claim history and/or the provided medical record that the member has tried and failed the preferred agents. If the member pharmacy history and/or prescriber documentation does not support validation of trial and failure of a preferred drug; but based on information provided the request meets approval of a non-preferred agent, the clinical pharmacists will pend the request to reach out to the prescriber to request information to confirm trial and failure of the preferred agents. If the prescriber supplies the necessary information the request will be approved and restricted to the established quantity limit; if the additional trial and failure information is not provided, the request would be forward to the medical director (MD) with recommendation for denial.	When the request is received by the Pharmacy Dept., the drug is reviewed by a technician for approval. If the request is not approvable, the request is sent to the Pharmacist for clinical review. If the pharmacist believes the request should be denied, the request is sent to the Medical Director for final decision. Requests are processed within 72 hours for urgent and 14 days for non-urgent. Only a MD can disapprove a PA request.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Monitoring of the formulary set up to include utilization management edits is completed through a variety of analysis and reports. This would include but not limited to : - claims files and reports to include paid and rejected claims - daily and monthly PA Summary reports with details on approved and denial requests - Adhoc reports to identify claims for medications that require PA and validate appropriateness of PA versus pharmacy benefit. 7.9% of the behavioral health drugs have some type of formulary edit associated with them vs. 27.2% of the physical health drugs. Note: some drugs may have multiple edits applied.	The denial rate for 1/1/17-6/30/17 was 21%. The appeal over turn rate was 37% for those PAs that we received an appeal request for. (This equated to an overall 4.2% overturn rate for all M/S denials). Approximately 10% of M/S medications require a PA).

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Findings
Both MMIC and Health Net use PA to ensure appropriate drug therapies that meet nationally recognized therapeutic guidelines to manage financial costs, monitory safety and control inappropriate utilizations. These nationally recognized guidelines include FDA guidelines, published medical literature, pharmacopoeia and other nationally recognized evidentiary standards to base their PA criteria. The processes and procedures to obtain a PA are appear to be the same and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and within 14 days in normal processing. Only a MD can deny a PA request. The processes, strategies and evidentiary standards used in PA criteria for MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
1) Compliance with contractual requirements from Arizona Health Care Cost Containment System (AHCCCS) through the implementation of the preferred drug list. 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines.	1) Compliance with contractual requirements from AHCCCS through the implementation of the preferred drug list. 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for preferred agents that a require a clinical review will be reviewed against the approved PA Guideline. If a non-preferred agent is requested, the clinical pharmacists will first validate the members pharmacy claim history and/or the provided medical record that the member has tried and failed the preferred agents. If the member pharmacy history and/or prescriber documentation does not support validation of trial and failure of a preferred drug; but based on information provided the request meets approval of a non-preferred agent, the clinical pharmacists will pend the request to reach out to the prescriber to request information to confirm trial and failure of the preferred agents. If the prescriber supplies the necessary information the request will be approved and restricted to the established quantity limit; if the additional trial and failure information is not provided, the request would be forward to the medical director (MD) with recommendation for denial.	- Medication request is denied at point of sale if a PA is required - Prescriber must fill out a PA form and submit - Pharmacy Tech reviews, then Pharmacist, if question about medical necessity, then MD reviews

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Monitoring of the formulary set up to include utilization management (UM) edits is completed through a variety of analysis and reports. This would include but not limited to : - claims files and reports to include paid and rejected claims - daily and monthly PA Summary reports with details on approved and denial requests - Adhoc reports to identify claims for medications that require PA and validate appropriateness of PA versus pharmacy benefit. 7.9% of the behavioral health drugs have some type of formulary edit associated with them vs. 27.2% of the physical health drugs. Note: some drugs may have multiple edits applied.	Track and trend formulary limitations and restrictions to include PA, QLL, Age restriction to determine the % approval/denial rate by drug as well as application of the PA Guideline used in the process. This information is used to evaluate the effectiveness of the UM edit and if changes need to be made to the review criterion or removal of the restriction.

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Findings
Both MMIC and Mercy Care Plan use PA to ensure appropriate drug therapies that meet nationally recognized therapeutic guidelines. These nationally recognized guidelines include FDA guidelines, published medical literature, pharmacopoeia and other nationally recognized evidentiary standards to base their PA criteria. The processes and procedures to obtain a PA are appear to be the same and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and within 14 days in normal processing. Only a MD can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Use Disorder [MH/SUD]) and United Health Care (UHC) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
1) Compliance with contractual requirements from Arizona Health Care Cost Containment System (AHCCCS) through the implementation of the preferred drug list. 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines.	Ensure rational, clinically appropriate, safe and cost-effective drug therapy.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for preferred agents that a require a clinical review will be reviewed against the approved PA Guideline. If a non-preferred agent is requested, the clinical pharmacists will first validate the members pharmacy claim history and/or the provided medical record that the member has tried and failed the preferred agents. If the member pharmacy history and/or prescriber documentation does not support validation of trial and failure of a preferred drug; but based on information provided the request meets approval of a non-preferred agent, the clinical pharmacists will pend the request to reach out to the prescriber to request information to confirm trial and failure of the preferred agents. If the prescriber supplies the necessary information the request will be approved and restricted to the established quantity limit; if the additional trial and failure information is not provided, the request would be forward to the medical director with recommendation for denial.	The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. • The PA request is received 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. • If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language. • 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.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Monitoring of the formulary set up to include utilization management edits is completed through a variety of analysis and reports. This would include but not limited to : - claims files and reports to include paid and rejected claims - daily and monthly PA Summary reports with details on approved and denial requests - Adhoc reports to identify claims for medications that require PA and validate appropriateness of PA versus pharmacy benefit. 7.9% of the behavioral health drugs have some type of formulary edit associated with them vs. 27.2% of the physical health drugs. Note: some drugs may have multiple edits applied.	61.8% of M/S drugs have PA requirements (60.5% have non-formulary PA requirements and 1.3% have clinical PA requirements). The denial rate for M/S drug PA requests received from January-June 2017 was 52.9%. Of the overturned appeals cases from this time 86% of the overturns were for M/S drugs.

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Findings
Both MMIC and UHC use PA to ensure clinically appropriate drug therapy. They both use nationally based evidentiary standards that include FDA guidelines, published medical literature and other nationally recognized evidence to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
MH/SUD: Medications	
M/S: Medications	

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Per AHCCCS: To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC staff retrieve PA requests and prepare for review by a pharmacist. A pharmacist will approve or refer to a medical director (MD) for denial. PA requests are processed in 72 hours for an expedited request and up to 14 calendar days for a standard request. PA turn-around times generally average 24 hours unless additional information is required.	♦ Technician reviews for clinical appropriateness and complete information received ♦ Technician will reach out to provider for additional info as needed ♦ Tech provides an "opinion" on decision to Registered Pharmacist (RPH) ♦ RPH makes decision ♦ Potential denials are sent to the MD for the final decision ♦ Currently allowance is 72 hours for STAT requests and up to 14 days for routine with the possibility of extending for an additional 14 days if appropriate. (This is changing to 24 hours for all requests with allowance of holding a STAT request for 3 days and Routine for 7 days if additional information is required).
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Denial Rate related to PAs for the period January-June 2017 is 28%. Appeal over turn rates during this period is 18%. There are 216 MH/SUD line items on our drug list. 12 (5.6%) require PA and are aligned with the AHCCCS PA required medications on the behavioral health drug list.	Rigors have been put into place due to concerns with fraud, waste, abuse and member safety. For example Opioids, the state required a 7-DAY SUPPLY LIMIT FOR SHORT-ACTING OPIOIDS. **Care 1st states that Pharmacy does not handle appeals in the department. This data will need to come from the Appeals department.
Findings	
Both CIC and Care 1st use PA to ensure clinically appropriate drug therapy. They both use nationally based evidentiary standards that include FDA indications, published medical literature and other nationally recognized evidence to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	To adhere to the AHCCCS Preferred Drug List (PDL) - as AHCCCS receives rebates on meds the plans are mandated to use the meds on the AHCCCS PDL. To ensure the appropriate use of medications.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA) approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC staff retrieve PA requests and prepare for review by a pharmacist. A pharmacist will approve or refer to a medical director (MD) for denial. PA requests are processed in 72 hours for an expedited request and up to 14 calendar days for a standard request. PA turn-around times generally average 24 hours unless additional information is required.	The Pharmacy Benefit Manager receives the medication PA and enters into their system. Their team reviews the PA with guidelines when applicable to see if it meets medical necessity criteria. If it does not or they do not have guidelines for a specific medication the PA is electronically sent to CMDP via a web portal shared between med impact and CMDP. A CMDP nurse checks the web portal inbox numerous times in a day and retrieves the PA. Based on the first letter of the last name of the member will determine which nurse will work the PA. The nurse will review the documents submitted and "work" the case. That may include requesting for additional information, researching medication history for the member or calling the members Department of Child Safety worker for clarification if needed. Once all information is obtained, a decision can be made. If a nurse cannot approve the PA, the request will go to a medical director for a decision: only the CMDP MD can deny a PA. Once the decision is made, the nurse will input the decision and needed actions back into the web portal to close out the PA. If a routine request then 14 calendar days from date of receipt. If an urgent request, then effective 10/1/17 within 24 hours of receipt. Currently, CMDP processes urgent requests within 3 business days.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Denial Rate related to PAs for the period January-June 2017 is 28%. Appeal over turn rates during this period is 18%. There are 216 MH/SUD line items on our drug list. 12 (5.6%) require PA and are aligned with the AHCCCS PA required medications on the behavioral health drug list.	Overturned on appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter rater reliability. Grievance and complaints as well as Appeals will also at times trigger a review of the criteria to determine if they are too stringent. CMDP had no PA appeals.

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Findings
Both CIC and CMDP use PA to ensure clinically appropriate drug therapy. They both use nationally based evidentiary standards that include FDA guidelines, published medical literature and other nationally recognized drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	To encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC staff retrieve PA requests and prepare for review by a pharmacist. A pharmacist will approve or refer to a medical director (MD) for denial. PA requests are processed in 72 hours for an expedited request and up to 14 calendar days for a standard request. PA turn-around times generally average 24 hours unless additional information is required.	All corresponding supporting documentation to satisfy the prior authorization criteria must accompany the request at the time the prescriber submits to the Plan. Health Choice is then responsible for evaluating the prior authorization request based upon scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of the prescription drug.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Denial Rate related to PAs for the period January-June 2017 is 28%. Appeal over turn rates during this period is 18%. There are 216 MH/SUD line items on our drug list. 12 (5.6%) require PA and are aligned with the AHCCCS PA required medications on the behavioral health drug list.	Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products and mail order medications
Findings	
Both CIC and Health Choice use PA to ensure clinically appropriate and cost effective drug therapy. They both use nationally based evidentiary standards that include FDA guidelines, published medical literature and other nationally recognized drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. The processes, strategies and evidentiary standards used in PA criteria for MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	1) Compliance with contractual requirements from AHCCCS through the implementation of the preferred drug list. 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC staff retrieve PA requests and prepare for review by a pharmacist. A pharmacist will approve or refer to a medical director (MD) for denial. PA requests are processed in 72 hours for an expedited request and up to 14 calendar days for a standard request. PA turn-around times generally average 24 hours unless additional information is required.	Medication request is denied at point of sale if a PA is required Prescriber must fill out a PA form and submit Pharmacy Tech reviews, then Pharmacist, if question about medical necessity, then MD reviews
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Denial Rate related to PAs for the period January-June 2017 is 28%. Appeal over turn rates during this period is 18%. There are 216 MH/SUD line items on our drug list. 12 (5.6%) require PA and are aligned with the AHCCCS PA required medications on the behavioral health drug list.	Track and trend formulary limitations and restrictions to include PA, QLL, Age restriction to determine the % approval/denial rate by drug as well as application of the PA Guideline used in the process. This information used to evaluate the effectiveness of the UM edit and if changes need to be made to the review criterion or removal of the restriction.
Findings	
Both CIC and Mercy Care use PA to ensure clinically appropriate drug therapy. They both use nationally based evidentiary standards that include FDA guidelines, published medical literature and other nationally recognized drug reference resources to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria for MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Ensure cost-effectiveness and consistency with national guidelines.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Utilization Management NQTL - Prescription Drug Classification

Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC staff retrieve PA requests and prepare for review by a pharmacist. A pharmacist will approve or refer to a medical director for denial. PA requests are processed in 72 hours for an expedited request and up to 14 calendar days for a standard request. PA turn-around times generally average 24 hours unless additional information is required.	1) request received and processed by pharmacy technician with check of member eligibility, formulary status, utilization management criteria, pharmacy claims rejections; 2) if criteria are available for drug, pharmacy technician makes decision and sends to pharmacist for review. If no criteria available, request sent to pharmacist for review. It takes 3 business days for an expedited request, 14 calendar days for a standard request to process. Decisions are made by a Pharmacist with final review by Medical Director (MD); pharmacy technician with review by pharmacist and final review by MD.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Denial Rate related to PAs for the period January-June 2017 is 28%. Appeal over turn rates during this period is 18%. There are 216 MH/SUD line items on our drug list. 12 (5.6%) require PA and are aligned with the AHCCCS PA required medications on the behavioral health drug list.	There were a total of 30 appeals with 13 denials that were overturned, 12 for receipt of additional information received that was requested but not received with the original request. PA required for 387/3448 drugs (11.2%). Appeal overturns and regulatory requirements are monitored.
Findings	
Both CIC and University Family Care use PA to ensure cost effective drug therapy. They both use nationally based evidentiary standards that include FDA guidelines, peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies and other nationally recognized drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only the MD can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals, and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria for MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and United Health Care (UHC) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Ensure rational, clinically appropriate, safe and cost-effective drug therapy.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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<table>
<tr><th colspan="2">Comparability and Stringency of Processes</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>CIC staff retrieve PA requests and prepare for review by a pharmacist. A pharmacist will approve or refer to a medical director for denial.
PA requests are processed in 72 hours for an expedited request and up to 14 calendar days for a standard request. PA turn-around times generally average 24 hours unless additional information is required.</td><td>The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity.
• The PA is received 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.
• If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language.
• 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.</td></tr>
<tr><th colspan="2">Stringency of Strategy and Evidence</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>Denial Rate related to PAs for the period January-June 2017 is 28%. Appeal over turn rates during this period is 18%.

There are 216 MH/SUD line items on our drug list. 12 (5.6%) require prior authorization and are aligned with the AHCCCS PA required medications on the behavioral health drug list.</td><td>61.8% of M/S drugs have PA requirements (60.5% have non-formulary PA requirements and 1.3% have clinical PA requirements). The denial rate for M/S drug PA requests received from January-June 2017 was 52.9%. Of the overturned appeals cases from this time 86% of the overturns were for M/S drugs.</td></tr>
</table>

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Findings
Both CIC and UHC use PA to ensure clinically appropriate and cost effective drug therapy. They both use nationally based evidentiary standards that include FDA guidelines, published medical literature and other nationally recognized drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria for MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CDMP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
To encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.	To adhere to the Arizona Health Care Cost Containment System (AHCCCS) Preferred Drug List (PDL) - as AHCCCS receives rebates on meds the plans are mandated to use the meds on the AHCCCS PDL. To ensure the

Comparability of Evidence

MH/SUD	M/S
Criteria based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following: i. Food and Drug Administration (FDA) approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-date)(e.g. FDA guidelines.	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
A prescriber can request a PA on formulary that require a PA and non-formulary medications. Prescribers can retrieve the Pharmacy PA form from the Health Choice Arizona website at healthchoiceaz.com or request a form by calling the Health Choice Pharmacy at 1-800-322-8670. Prescribers are to fill out a PA and fax the completed form to the Health Choice Pharmacy at 877-422-8130. The turnaround time is depended upon the urgency in which the prescriber selects. Expedited requests have a turnaround time of 72 hours. Standard requests have a turnaround time of 14 calendar days. All corresponding supporting documentation to satisfy the PA criteria must accompany the request at the time the prescriber submits to the Plan. Health Choice is then responsible for evaluating the PA request based upon scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of the prescription drug. The required qualifications/training requirements for persons implementing the NQTL are as follows, the person must be a licensed Pharmacy technician or Pharmacists. Only Medical Directors (MDs) can issue a prior authorization denial. All staff receive training on prior authorization processes during new hire orientation.	The PBM receives the medication PA and enters into their system. Their team reviews the PA with guidelines when applicable to see if it meets medical necessity criteria. If it does not or they do not have guidelines for a specific medication the PA is electronically sent to CMDP via a web portal shared between med impact and CMDP. A CMDP nurse checks the web portal inbox numerous times in a day and retrieves the PA. Based on the first letter of the last name of the member will determine which nurse will work the PA. The nurse will review the documents submitted and "work" the case. That may include requesting for additional information, researching medication history for the member or calling the members Department of Child Safety (DCS) worker for clarification if needed. Once all information is obtained, a decision can be made. If a nurse cannot approve the PA, the request will go to a medical director for a decision: only the CMDP Medical Director can deny a PA. Once the decision is made, the nurse will input the decision and needed actions back into the web portal to close out the PA. If a routine request then 14 calendar days from date of receipt. If an urgent request, then effective 10/1/17 within 24 hours of receipt. Currently, CMDP processes urgent requests within 3 business days.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications. Both categories are approximately 4% of all claims.	Overturned on appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter rater reliability. Grievance and complaints as well as Appeals will also at times trigger a review of the criteria to determine if they are too stringent. CMDP had no PA appeals.

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Findings
Both HCIC and CMDP use PA to ensure clinically appropriate drug therapy. They both use nationally based evidentiary standards that include FDA-approved indications, published medical literature, national practice guidelines and other nationally recognized evidence to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
To encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.	To encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
A prescriber can request a PA on formulary that require a prior authorization and non-formulary medications. Prescribers can retrieve the Pharmacy PAform from the Health Choice Arizona website at healthchoiceaz.com or request a form by calling the Health Choice Pharmacy at 1-800-322-8670. Prescribers are to fill out a PA form and fax the completed form to the Health Choice Pharmacy at 877-422-8130. The turnaround time is depended upon the urgency in which the prescriber selects. Expedited requests have a turnaround time of 72 hours. Standard requests have a turnaround time of 14 calendar days. All corresponding supporting documentation to satisfy the PA criteria must accompany the request at the time the prescriber submits to the Plan. Health Choice is then responsible for evaluating the prior authorization request based upon scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of the prescription drug. The required qualifications/training requirements for persons implementing the NQTL are as follows, the person must be a licensed Pharmacy technician or Pharmacists. Only Medical Directors (MDs) can issue a PA denial. All staff receive training on PA processes during new hire orientation.	All corresponding supporting documentation to satisfy the prior authorization criteria must accompany the request at the time the prescriber submits to the Plan. Health Choice is then responsible for evaluating the prior authorization request based upon scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of the prescription drug.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications. Both categories are approximately 4% of all claims.	Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications.

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Findings
Both HCIC and Health Choice use PA to ensure safe, cost effective, and clinically appropriate drug therapy. They both use nationally based evidentiary standards that include FDA-approved indications, published medical literature, national practice guidelines and other nationally recognized evidence to base their PA criteria. The processes and procedures to obtain a PA are similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals, and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Use Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
To encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.	Ensure cost-effectiveness and consistency with national guidelines.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
A prescriber can request a PA on formulary that require a PA and non-formulary medications. Prescribers can retrieve the Pharmacy PA form from the Health Choice Arizona website at healthchoiceaz.com or request a form by calling the Health Choice Pharmacy at 1-800-322-8670. Prescribers are to fill out a PA form and fax the completed form to the Health Choice Pharmacy at 877-422-8130. The turnaround time is depended upon the urgency in which the prescriber selects. Expedited requests have a turnaround time of 72 hours. Standard requests have a turnaround time of 14 calendar days. All corresponding supporting documentation to satisfy the PA criteria must accompany the request at the time the prescriber submits to the Plan. Health Choice is then responsible for evaluating the PA request based upon scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of the prescription drug. The required qualifications/training requirements for persons implementing the NQTL are as follows, the person must be a licensed Pharmacy technician or Pharmacists. Only Medical Directors (MDs) can issue a PA denial. All staff receive training on PA processes during new hire orientation.	1) request received and processed by pharmacy technician with check of member eligibility, formulary status, Utilization management criteria, pharmacy claims rejections; 2) if criteria are available for drug, pharmacy technician makes decision and sends to pharmacist for review. If no criteria available, request sent to pharmacist for review. It takes 3 business days for an expedited request, 14 calendar days for a standard request to process. Decisions are made by a Pharmacist with final review by MD; pharmacy technician with review by pharmacist and final review by MD.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications. Both categories are approximately 4% of all claims.	There were a total of 30 appeals with 13 denials that were overturned, 12 for receipt of additional information received that was requested but not received with the original request. PA required for 387/3448 drugs (11.2%). Appeal overturns and regulatory requirements are monitored.

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Findings
Both HCIC and University Family Care use PA to ensure cost effective drug therapy. They both use nationally based evidentiary standards that include FDA guidelines, peer-reviewed medical literature, published practice guidelines and treatment protocols, and other nationally recognized drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only the MD can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals, and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria for MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Use Disorder [MH/SUD]) and United Health Care (UHC) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
To encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.	Ensure rational, clinically appropriate, safe and cost-effective drug therapy.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
A prescriber can request a PAon formulary that require a PA and non-formulary medications. Prescribers can retrieve the Pharmacy PA form from the Health Choice Arizona website at healthchoiceaz.com or request a form by calling the Health Choice Pharmacy at 1-800-322-8670. Prescribers are to fill out a PA form and fax the completed form to the Health Choice Pharmacy at 877-422-8130. The turnaround time is depended upon the urgency in which the prescriber selects. Expedited requests have a turnaround time of 72 hours. Standard requests have a turnaround time of 14 calendar days. All corresponding supporting documentation to satisfy the PA criteria must accompany the request at the time the prescriber submits to the Plan. Health Choice is then responsible for evaluating the PA request based upon scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of the prescription drug. The required qualifications/training requirements for persons implementing the NQTL are as follows, the person must be a licensed Pharmacy technician or Pharmacists. Only Medical Directors (MDs) can issue a prior authorization denial. All staff receive training on PA processes during new hire orientation.	The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. • The PA request is received 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. • If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language. • 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.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications. Both categories are approximately 4% of all claims.	61.8% of M/S drugs have PA requirements (60.5% have non-formulary PA requirements and 1.3% have clinical PA requirements). The denial rate for M/S drug PA requests received from January-June 2017 was 52.9%. Of the overturned appeals cases from this time 86% of the overturns were for M/S drugs.

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Findings
Both HCIC and UHC use PA to ensure safe, cost effective, and clinically appropriate drug therapy. They both use nationally based evidentiary standards that includes published medical literature, national clinical guidelines and other nationally recognized evidence to base their PA criteria. The processes and procedures to obtain a PA are similar and appear to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals, and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications. .

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: United Health Care (UHC) - CRS Partially Integrated (Mental Health/Substance Use Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Per AHCCCS: To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
1. 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. a. If the provider has advance knowledge of the PA process, they can submit a PA request prior to the pharmacy running a claim for the medication; b. If the provider is not aware of the PA the requirement, when the pharmacy submits a claim for the medication it will be with a message that PA is required; c. 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 PA submission and urgent review. 2. The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. The request can be submitted either over the phone, via fax form, or on the provider portal. 3. The PA request is received by pharmacy PA 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.	♦Technician reviews for clinical appropriateness and complete information received ♦Technician will reach out to provider for additional info as needed ♦ Tech provides an "opinion" on decision to RPH ♦ RPH makes decision ♦ Potential denials are sent to the medical director for the final decision ♦ Currently allowance is 72 hours for STAT requests and up to 14 days for routine with the possibility of extending for an additional 14 days if appropriate. (This is changing to 24 hours for all requests with allowance of holding a STAT request for 3 days and Routine for 7 days if additional information is required.

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MH/SUD	M/S
4. 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. Currently the timelines for processing PA requests are as follows: 1) Urgent requests must be completed in 3 business days, 2) Standard requests must be completed in 14 calendar days. Effective 10/1/17, all authorization requests require a decision within 24 hours. A request for additional information is sent to the prescriber by telephone, fax, electronically or other telecommunication devise within 24 hours of the submitted request when the prior authorization request for a medication lacks sufficient information to render a decision. A final decision shall be rendered within seven (7) business days from the initial date of the request and a decision.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial rate for behavioral health (BH0 medications in the CRS-BH population for the period January-July 2017 is 20.0% The overturn rate for the same time period is 33.3%. 30.6% of BH medications require PA.	Rigors have been put into place due to concerns with FWA and member safety for example Opioids, the state required a 7-DAY SUPPLY LIMIT FOR SHORT-ACTING OPIOIDS **Care 1st states that Pharmacy does not handle appeals in the department. This data will need to come from the Appeals department.

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Findings
Both UHC-CRS Partially Integrated plan and Care 1st use PA to ensure clinically appropriate drug therapy. They both use nationally based evidentiary standards that include FDA indications, published medical literature and other nationally recognized evidence to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals, and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: United Health Care (UHC) - CRS Partially Integrated (Mental Health/Substance Use Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CDMP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	To adhere to the AHCCCS Preferred Drug List (PDL) - as AHCCCS receives rebates on meds the plans are mandated to use the meds on the AHCCCS PDL. To ensure the appropriate use of medications.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	M/S
1. 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. a. 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. b. If the provider is not aware of the PA the requirement, when the pharmacy submits a claim for the medication it will be with a message that PA is required. c. 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 PA submission and urgent review. 2. The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. The request can be submitted either over the phone, via fax form, or on the provider portal. 3. The PA request is received by pharmacy PA 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. 4. 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.	The Pharmacy Benefit Manager receives the medication PA and enters into their system. Their team reviews the PA with guidelines when applicable to see if it meets medical necessity criteria. If it does not or they do not have guidelines for a specific medication the PA is electronically sent to CMDP via a web portal shared between med impact and CMDP. A CMDP nurse checks the web portal inbox numerous times in a day and retrieves the PA. Based on the first letter of the last name of the member will determine which nurse will work the PA. The nurse will review the documents submitted and "work" the case. That may include requesting for additional information, researching medication history for the member or calling the members Department of Child Safety worker for clarification if needed. Once all information is obtained, a decision can be made. If a nurse cannot approve the PA, the request will go to a medical director (MD) for a decision: only the CMDP MD can deny a PA. Once the decision is made, the nurse will input the decision and needed actions back into the web portal to close out the PA. If a routine request then 14 calendar days from date of receipt. If an urgent request, then effective 10/1/17 within 24 hours of receipt. Currently, CMDP processes urgent requests within 3 business days.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial rate for behavioral health (BH) medications in the CRS-BH population for the period January-July 2017 is 20.0% The overturn rate for the same time period is 33.3%. 30.6% of BH medications require PA.	Overturned on appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter rater reliability. Grievance and complaints as well as Appeals will also at times trigger a review of the criteria to determine if they are too stringent. CMDP had no PA appeals.

Findings
Both UHC-CRS Partially Integrated plan and CMDP use PA to ensure clinically appropriate drug therapy. They both use nationally based evidentiary standards that include FDA guidelines, published medical literature and other nationally recognized drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to base their PA criteria. The processes and procedures to obtain a PA appear to be similar and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: United Health Care (UHC) - CRS Partially Integrated (Mental Health/Substance Use Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	1) Compliance with contractual requirements from AHCCCS through the implementation of the preferred drug list 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	M/S
1. 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. a. 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; b. 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; c. 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. 2. 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, via fax form, or on the provider portal. 3. 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. 4. 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.	Medication request is denied at point of sale if a PA is required Prescriber must fill out a PA form and submit Pharmacy Tech reviews, then Pharmacist, if question about medical necessity, then Medical Director reviews

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Currently the timelines for processing PA requests are as follows: 1) Urgent requests must be completed in 3 business days, 2) Standard requests must be completed in 14 calendar days. Effective 10/1/17, all authorization requests require a decision within 24 hours. A request for additional information is sent to the prescriber by telephone, fax, electronically or other telecommunication devise within 24 hours of the submitted request when the prior authorization request for a medication lacks sufficient information to render a decision. A final decision shall be rendered within seven (7) business days from the initial date of the request and a decision.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial rate for behavorial health (BH) medications in the CRS-BH population for the period January-July 2017 is 20.0% The overturn rate for the same time period is 33.3%. 30.6% of BH medications require PA.	Track and trend formulary limitations and restrictions to include PA, QLL, Age restriction to determine the % approval/denial rate by drug as well as application of the PA Guideline used in the process. This information used to evaluate the effectiveness of the utilization management edit and if changes need to be made to the review criterion or removal of the restriction.
Findings	
Both UHC-CRS Partially Integrated plan and Mercy Care Plan use prior authorization to ensure appropriate drug therapies that meet nationally recognized therapeutic guidelines. These nationally recognized guidelines include FDA guidelines, published medical literature, pharmacopoeia and other nationally recognized evidentiary standards to base their PA criteria. The processes and procedures to obtain a PA are appear to be the same and seem to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made. Only a medical director can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals, and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: United Health Care (UHC)- CRS Partially Integrated (Mental Health/Substance Use Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Prior Authorization (PA)

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Ensure rational, clinically appropriate, safe and cost-effective drug therapy.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
1. 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. a. If the provider has advance knowledge of the prior authorization process, they can submit a PA request prior to the pharmacy running a claim for the medication. b. If the provider is not aware of the PA the requirement, when the pharmacy submits a claim for the medication it will be with a message that PA is required. c. 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. 2. The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. The request can be submitted either over the phone, via fax form, or on the provider portal. 3. The PA request is received by pharmacy PA 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. 4. 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.	The provider completes and submits a prior authorization request form along with relevant clinical documentation to support medical necessity. • The PA request is received 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. • If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language. • 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.

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MH/SUD	M/S
Currently the timelines for processing PA requests are as follows: 1) Urgent requests must be completed in 3 business days, 2) Standard requests must be completed in 14 calendar days. Effective 10/1/17, all authorization requests require a decision within 24 hours. A request for additional information is sent to the prescriber by telephone, fax, electronically or other telecommunication devise within 24 hours of the submitted request when the prior authorization request for a medication lacks sufficient information to render a decision. A final decision shall be rendered within seven (7) business days from the initial date of the request and a decision.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial rate for behavioral health (BH) medications in the CRS-BH population for the period January-July 2017 is 20.0% The overturn rate for the same time period is 33.3%. 30.6% of BH medications require PA.	61.8% of Medical/Surgical drugs have PA requirements (60.5% have non-formulary PA requirements and 1.3% have clinical PA requirements). The denial rate for M/S drug PA requests received from January-June 2017 was 52.9%. Of the overturned appeals cases from this time 86% of the overturns were for M/S drugs.
Findings	
Both UHC-CRS Partially Integrated plan and UHC use PA to ensure safe, cost effective, and clinically appropriate drug therapy. They both use nationally based evidentiary standards that includes published medical literature, national clinical guidelines and other nationally recognized evidence to base their PA criteria. The processes and procedures to obtain a PA are similar and appear to be applied no more stringently to MH/SUD as they are applied to M/S. The PA request is submitted with supporting medical documentation and decisions are made within 3 days for urgent cases and 14 days in normal processing. Only a medical doctor can deny a PA request. The stringency of the criteria is assessed via utilization data, denials, appeals, and overturn appeals. As a result, the processes, strategies and evidentiary standards used in PA criteria to MH/SUD medications appear to be comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying PA criteria to M/S medications. .	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Electroconvulsive Therapy Admission to the Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility
	M/S: Inpatient Procedures/Surgeries

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The M/S plan reports that the purpose of developing medical necessity criteria is to assess for new evidence-based recommendations, changes to community practice standards, assess new technology (new codes) and solicit local provider input.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care Cost Containment System, Hayes™ and other approved criteria when available.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care Cost Containment System, Hayes™ and other approved criteria when available. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is reviewed annually and updated throughout the year as necessary with rationale noted. Updates to Prior Authorization Guidelines (PAG) are reviewed by the Chief Medical Officer (CMO) who researches the medical and pharmacy codes and updates based on changes to coverage status. Prior to being used to support utilization decisions, criteria is reviewed by applicable medical directors and affiliated health professionals and approved for use by the a designated committee.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	The Plan reviews reports that are queried by current procedural terminology codes to assess and analyze by denial and approval rates to assess for low denials rate and decrease in utilization trends and variations. Review is done on the current PAG for potential additions or deletions based on under/over utilization trends, claims trends including cost, provider feedback, and evidence based guideline changes, low denial rates and emerging technology.

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via utilization data, denial rates and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="3">Benefit Package(s): Child</td></tr>
<tr><td colspan="3">Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="3">Non-quantitative treatment limit (NQTL): Medical Necessity Criteria</td></tr>
<tr><td colspan="3">Classification: Inpatient</td></tr>
<tr><td rowspan="2">Services</td><td colspan="2">MH/SUD:
Electroconvulsive Therapy
Admission to the Arizona State Hospital
Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility
Behavioral Health Residential Facility</td></tr>
<tr><td colspan="2">M/S:
All inpatient services</td></tr>
<tr><td colspan="3">Comparability of Strategy</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">To ensure that the quality and type and duration of service is appropriate to the member's needs.</td><td>The M/S plan reports that the rationale for identifying and developing medical necessity criteria is to identify best practice and to ensure those best practices are reflected in policy and guidelines.</td></tr>
<tr><td colspan="3">Comparability of Evidence</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.</td><td>The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines.</td></tr>
</table>

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is developed and modified by the Plan as needed or at a minimum on an annual basis. A round table discussion led by the Plan's medical services staff is available for provider input during a quarterly Quality Management Performance Improvement meeting where outside stakeholders are invited to attend.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	Research is done by a medical services staff member to identify best practices and to ensure that those best practices are reflected in policy and guidelines. Nationally accredited sources are utilized to identify best practice and this includes but is not limited to Centers for Medicare & Medicaid Services and American Academy of Pediatrics. When reputable sources are found, the material is reviewed in a weekly meeting with the Plan's nursing staff and the MD. Implications of the material is then discussed and embedded into practice when applicable. The Plan monitors trends among denials, claims disputes, or provider suggestions.

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via denial rates and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for applying prior authorization, concurrent review and retrospective review to M/S inpatient services, in writing and or in operation. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Net (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Electroconvulsive Therapy Admission to the Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility
	M/S: Inpatient Admissions

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The Plan utilizes medical necessity criteria for consistent medical management decision-making to support member's clinical circumstances and needs.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	The M/S plan utilizes MCG Guidelines, InterQual and State policies.

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Comparability and Stringency of Processes	
MH/SUD	M/S
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The M/S plan utilizes MCG Guidelines, InterQual and State policies. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria and UM processes are reviewed on at least an annual basis and approved through the Plan's UM Committee structure. The M/S Plan's Corporate Director of Clinical Policy oversees the Clinical Policy Department which is tasked with the responsibilities in connection with the development and approval of clinical policies. The Clinical Policy Committee is chaired by the Corporate Chief Medical Officer (CMO) and is composed of physicians and other medical and operational representatives, as appropriate, from Centene Corporate and each Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	The Plan has established criteria and guidelines for medical necessity decisions and utilizes a variety of sources in developing these guidelines which include, Medicare, Medicaid and other plan specific coverage policy statements; evidence in the peer-reviewed published medical literature; technology assessments and structured evidence reviews; evidence-based consensus statements; expert opinions of healthcare providers; evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies. On a six-month basis, the medical policy department analyzes an appeals report to identify patterns of overturns to determine the need to re -evaluate the Plan's policy where there are consistent overturns.

Findings
Both Plans target appropriate member care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals and nationally accredited sources. The stringency of the criteria by both Plans is assessed via data, including: utilization data, appeals data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illiness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Electroconvulsive Therapy Admission to the Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility
	M/S: Inpatient stay Hospital Skilled Nursing Facilities Long-Term Care Facilities

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The M/S Plan uses nationally recognized evidence-based criteria to support authorization decisions for medical necessity.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines.

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Comparability and Stringency of Processes	
MH/SUD	M/S
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. All new and revised clinical practice guidelines are reviewed by Aetna's Quality Advisory Committees, composed of practicing clinicians who participate in Aetna medical plans. The Plan designates the review of medical necessity criteria to Aetna's Clinical Policy Council that includes external practicing clinicians. Approval of the criteria is completed by Aetna's Chief Medical Officer (CMO) or his/her designee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	As required by the State, criteria sets are reviewed annually for appropriateness to Mercy Care Plan needs and changed as applicable. The changes occur when there's a change to the code, change to Aetna Policy or Aetna Medicaid. The medical necessity criteria review may occur either prior to or after publication of the clinical practice guidelines (CPG) on Aetna's websites. Recommendations from Aetna's Quality Advisory Committees are sent to the Clinical Policy Research and Development Team for review. The Clinical Policy Research and Development Team prepares a response to each of the Quality Assurance Committee recommendations and may draft further revisions to the CPG as appropriate for consideration by Aetna's Clinical Policy Council. The Plan relies on provider and member feedback and/or appeals or grievances to assess the ongoing effectiveness of the criteria.

Findings
Both Plans develop MN criteria to ensure appropriate, medically necessary member care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Provider feedback is obtained by both Plans and considered in the development of criteria. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals and nationally accredited sources. The stringency of the criteria by both Plans is assessed via data, including: utilization data, grievance and appeals data and member feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	**MH/SUD:** Electroconvulsive Therapy Admission to the Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility
	M/S: Acute Inpatient Facility Skilled Nursing Facility (SNF) Acute Inpatient Rehab (AIR) Facility Hospice Care (Inpatient)

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The M/S Plan reports that criteria are developed to help decide whether a given health service is medically necessary and therefore covered.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	The medical plan uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The M/S plan reports using MCG and other nationally recognized clinical guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, on an annual basis, the medical necessity criteria is assessed internally as part of the Plan's continual review of releases of new national practice guidelines from specialty organizations, and following recommendations from the Plan's Medical Technology Assessment Committee (MTAC).

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee).

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via denial rates, appeals, and length of stay data. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Licensed Hospital Facility/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility Continued Stay in a Behavioral Health Residential Facility for Substance Use Disorder Treatment after 14 days Out of State Placement
	M/S: Inpatient Procedures/Surgeries

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The M/S plan reports that the purpose of developing medical necessity criteria is to assess for new evidence-based recommendations, changes to community practice standards, assess new technology (new codes) and solicit local provider input.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care Cost Containment System, Hayes™ and other approved criteria when available.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care Cost Containment System, Hayes™ and other approved criteria when available. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is reviewed annually and updated throughout the year as necessary with rationale noted. Updates to Prior Authorization Guidelines (PAG) are reviewed by the Chief Medical Officer (CMO) who researches the medical and pharmacy codes and updates based on changes to coverage status. Prior to being used to support utilization decisions, criteria is reviewed by applicable medical directors and affiliated health professionals and approved for use by the a designated committee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	The Plan reviews reports that are queried by current procedural terminology codes to assess and analyze by denial and approval rates to assess for low denials rate and decrease in utilization trends and variations. Review is done on the current PAG for potential additions or deletions based on under/over utilization trends, claims trends including cost, provider feedback, and evidence based guideline changes, low denial rates and emerging technology.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via utilization data, denial rates and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="2">Benefit Package(s): Child</td></tr>
<tr><td colspan="2">Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="2">Non-quantitative treatment limit (NQTL): Medical Necessity Criteria</td></tr>
<tr><td colspan="2">Classification: Inpatient</td></tr>
<tr><td rowspan="2">Services</td><td>MH/SUD:
Arizona State Hospital
Licensed Hospital Facility/Sub-Acute Facility/Behavioral Health Inpatient Facility
Behavioral Health Residential Facility
Continued Stay in a Behavioral Health Residential Facility for Substance Use Disorder Treatment after 14 days
Out of State Placement</td></tr>
<tr><td>M/S:
All inpatient services</td></tr>
</table>

<table>
<tr><th colspan="2">Comparability of Strategy</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.</td><td>The M/S plan reports that the rationale for identifying and developing medical necessity criteria is to identify best practice and to ensure those best practices are reflected in policy and guidelines.</td></tr>
<tr><th colspan="2">Comparability of Evidence</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions.</td><td>The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines.</td></tr>
</table>

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is developed and modified by the Plan as needed or at a minimum on an annual basis. A round table discussion led by the Plan's medical services staff is available for provider input during a quarterly Quality Management Performance Improvement meeting where outside stakeholders are invited to attend.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	Research is done by a medical services staff member to identify best practices and to ensure that those best practices are reflected in policy and guidelines. Nationally accredited sources are utilized to identify best practice and this includes but is not limited to Centers for Medicare & Medicaid Services and American Academy of Pediatrics. When reputable sources are found, the material is reviewed in a weekly meeting with the Plan's nursing staff and the MD. Implications of the material is then discussed and embedded into practice when applicable. The Plan monitors trends among denials, claims disputes, or provider suggestions.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via utilization data, denial rates, claims disputes and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Licensed Hospital Facility/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility Continued Stay in a Behavioral Health Residential Facility for Substance Use Disorder Treatment after 14 days Out of State Placement
	M/S: All admissions to the following levels of care: acute, sub-acute, observation.

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The M/S plan reports developing and utilizing medical necessity criteria to determine what is a covered service during medical reviews. Criteria is developed when a service is identified as being over or under utilized, requires prior authorization oversight, or

Comparability of Evidence

MH/SUD	M/S
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions.	The M/S Plan adheres to utilizing nationally recognized, evidenced based criteria for all clinical determinations.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan utilizes nationally recognized criteria such as: Internal Clinical Guidelines, InterQual, Local and National Coverage Determination Guidelines (LCD/NCD), National Institute of Health (NIH) resources, and Hayes Knowledge Center. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is developed and modified by the Plan as needed or at a minimum on an annual basis. Clinical criteria is reviewed annually or as needed by the clinical leadership and physicians who are specialist in that field to ensure criteria is relevant and appropriate.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	Health Choice reviews and updates clinical guidelines annually and as needed to adhere to regulatory changes, new technology, added benefits, and recommendations from committees such as; Medical and Quality Management. This allows for input from a variety of sources to maximize input and feedback. All clinical policies and criteria are reviewed by physicians and approved through Medical and Quality Management Committees. Health Choice uses claims and authorization data to monitor and manage medical necessity criteria.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via claims data, outcomes data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for applying prior authorization, concurrent review and retrospective review to M/S inpatient services, in writing and or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Licensed Hospital Facility/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility Continued Stay in a Behavioral Health Residential Facility for Substance Use Disorder Treatment after 14 days Out of State Placement
	M/S: Inpatient stay Hospital Skilled Nursing Facilities Long-Term Care Facilities

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The M/S Plan uses nationally recognized evidence-based criteria to support authorization decisions for medical necessity.

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Comparability of Evidence	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. All new and revised clinical practice guidelines are reviewed by Aetna's Quality Advisory Committees, composed of practicing clinicians who participate in Aetna medical plans. The Plan designates the review of medical necessity criteria to Aetna's Clinical Policy Council that includes external practicing clinicians. Approval of the criteria is completed by Aetna's Chief Medical Officer (CMO) or his/her designee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	As required by the State, criteria sets are reviewed annually for appropriateness to Mercy Care Plan needs and changed as applicable. The changes occur when there's a change to the code, change to Aetna Policy or Aetna Medicaid. The medical necessity criteria review may occur either prior to or after publication of the clinical practice guidelines (CPG) on Aetna's websites. Recommendations from Aetna's Quality Advisory Committees are sent to the Clinical Policy Research and Development Team for review. The Clinical Policy Research and Development Team prepares a response to each of the Quality Assurance Committee recommendations and may draft further revisions to the CPG as appropriate for consideration by Aetna's Clinical Policy Council. The Plan relies on provider and member feedback and/or appeals or grievances to assess the ongoing effectiveness of the criteria.

Findings
Both Plans develop MN criteria to ensure appropriate, medically necessary member care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Provider feedback is obtained by both Plans and considered in the development of criteria. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals and nationally accredited sources. The stringency of the criteria by both Plans is assessed via data, including: utilization data, grievance and appeals data and member feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Licensed Hospital Facility/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility Continued Stay in a Behavioral Health Residential Facility for Substance Use Disorder Treatment after 14 days Out of State Placement
	M/S: Acute Hospitals Skilled Nursing Facilities Inpatient Rehabilitation

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The Plan reports that the rationale for applying medical necessity criteria is to ensure services are cost-effective, consistent with national standards of care and are able to meet the member's needs.

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Comparability of Evidence	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions.	The M/S Plan utilizes MCG criteria.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan utilizes nationally recognized, evidence-based criteria (MCG©). The Plan does not utilize Plan-specific evidenced based criteria but relies on outside nationally accepted criteria. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is reviewed annually and updated throughout the year as necessary with rationale noted. Guidelines are modified at least annually and when new evidence dictates a major change in review criteria. This is done by Milliman as part of MCG annual updates, internally as part of the plan's continual review of the release of new national practice guidelines from specialty organizations, and following recommendations of the Plan's Technology Assessment Committee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	The criteria are reviewed annually through the Plan's Technology Assessment Committee. Provider input is not used to develop and design the criteria. Frequency of requests and associated denial rates are monitored. Provider grievances regarding our application of criteria are monitored and used to trigger review of the criteria when necessary in between the scheduled annual reviews.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via utilization data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Licensed Hospital Facility/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility Continued Stay in a Behavioral Health Residential Facility for Substance Use Disorder Treatment after 14 days Out of State Placement
	M/S: Acute Inpatient Facility Skilled Nursing Facility (SNF) Acute Inpatient Rehab (AIR) Facility Hospice Care (Inpatient)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The M/S Plan reports that criteria are developed to help decide whether a given health service is medically necessary and therefore covered.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions.	The medical plan uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The M/S plan reports using MCG and other nationally recognized clinical guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, on an annual basis, the medical necessity criteria is assessed internally as part of the Plan's continual review of releases of new national practice guidelines from specialty organizations, and following recommendations from the Plan's Medical Technology Assessment Committee (MTAC).

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee).

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via utilization data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Electroconvulsive Therapy Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility
	M/S: All inpatient services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan reports that the rationale for identifying and developing medical necessity criteria is to ensure services are delivered at the appropriate level of care, frequency and intensity.	The M/S plan reports that the rationale for identifying and developing medical necessity criteria is to identify best practice and to ensure those best practices are reflected in policy and guidelines.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes InterQual and State developed criteria and guidelines.	The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes InterQual criteria, and for certain levels of care, utilizes criteria that was developed by the State. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management Committee which has provider MD level participants.	The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is developed and modified by the Plan as needed or at a minimum on an annual basis. A round table discussion led by the Plan's medical services staff is available for provider input during a quarterly Quality Management Performance Improvement meeting where outside stakeholders are invited to attend.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan's Chief Medical Officer reviews the authorization criteria at least annually to ensure that it meets all applicable federal and state requirements, as well as best practices. The Plan's Medical Management Committee reviews and adopts the criteria on an annual basis. The Plan monitors and reviews average length of stay data, denial rates, the volume of appeals and overturned appeal rates to assess the effectiveness of the criteria.	Research is done by a medical services staff member to identify best practices and to ensure that those best practices are reflected in policy and guidelines. Nationally accredited sources are utilized to identify best practice and this includes but is not limited to Centers for Medicare & Medicaid Services and American Academy of Pediatrics. When reputable sources are found, the material is reviewed in a weekly meeting with the Plan's nursing staff and the MD. Implications of the material is then discussed and embedded into practice when applicable. The Plan monitors trends among denials, claims disputes, or provider suggestions.

Findings
Both Plans strive to identify the care that is most appropriate and effective to treat a particular condition, through the development and application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. The MH/SUD Plan utilizes State developed criteria for some inpatient levels of care. The State will remove policy requirements for the MH/SUD Plan to use State developed clinical decision making criteria for designated inpatient facilities. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via denial rates, appeals, length of stay data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult	
Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])	
Non-quantitative treatment limit (NQTL): Medical Necessity Criteria	
Classification: Inpatient	
Services	**MH/SUD:** Electroconvulsive Therapy Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility
	M/S: All admissions to the following levels of care: acute, sub-acute, observation.

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan reports that the rationale for identifying and developing medical necessity criteria is to ensure services are delivered at the appropriate level of care, frequency and intensity.	The M/S plan reports developing and utilizing medical necessity criteria to determine what is a covered service during medical reviews. Criteria is developed when a service is identified as being over or under utilized, requires prior authorization oversight, or as required by regulatory agencies.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes InterQual and State developed criteria and guidelines.	The M/S Plan adheres to utilizing nationally recognized, evidenced based criteria for all clinical determinations.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes InterQual criteria, and for certain levels of care, utilizes criteria that was developed by the State. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management Committee which has provider MD level participants.	The Plan utilizes nationally recognized criteria such as: Internal Clinical Guidelines, InterQual, Local and National Coverage Determination Guidelines (LCD/NCD), National Institute of Health (NIH) resources, and Hayes Knowledge Center. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is developed and modified by the Plan as needed or at a minimum on an annual basis. Clinical criteria is reviewed annually or as needed by the clinical leadership and physicians who are specialist in that field to ensure criteria is relevant and appropriate.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan's Chief Medical Officer reviews the authorization criteria at least annually to ensure that it meets all applicable federal and state requirements, as well as best practices. The Plan's Medical Management Committee reviews and adopts the criteria on an annual basis. The Plan monitors and reviews average length of stay data, denial rates, the volume of appeals and overturned appeal rates to assess the effectiveness of the criteria.	Health Choice reviews and updates clinical guidelines annually and as needed to adhere to regulatory changes, new technology, added benefits, and recommendations from committees such as; Medical and Quality Management. This allows for input from a variety of sources to maximize input and feedback. All clinical policies and criteria are reviewed by physicians and approved through Medical and Quality Management Committees. Health Choice uses claims and authorization data to monitor and manage medical necessity criteria.

Findings
Both Plans strive to identify the care that is most appropriate and effective to treat a particular condition, through the development and application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. The MH/SUD Plan utilizes State developed criteria for some inpatient levels of care. The State will remove policy requirements for the MH/SUD Plan to use State developed clinical decision making criteria for designated inpatient facilities.Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via denial rates, appeals, length of stay data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and or in operation.

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<table>
<tr><th colspan="3">COMPLIANCE DETERMINATION</th></tr>
<tr><td colspan="3">Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult</td></tr>
<tr><td colspan="3">Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="3">Non-quantitative treatment limit (NQTL): Medical Necessity Criteria</td></tr>
<tr><td colspan="3">Classification: Inpatient</td></tr>
<tr><td rowspan="2">Services</td><td colspan="2">MH/SUD:
Electroconvulsive Therapy
Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility</td></tr>
<tr><td colspan="2">M/S:
Acute hospitals
Skilled Nursing Facilities
Inpatient Rehabilitation</td></tr>
<tr><td colspan="3">Comparability of Strategy</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">The MH/SUD Plan reports that the rationale for identifying and developing medical necessity criteria is to ensure services are delivered at the appropriate level of care, frequency and intensity.</td><td>The Plan reports that the rationale for applying medical necessity criteria is to ensure services are cost-effective, consistent with national standards of care and are able to meet the members' needs.</td></tr>
</table>

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Comparability of Evidence	
MH/SUD	**M/S**
The Plan utilizes InterQual and State developed criteria and guidelines.	The M/S plan reports using MCG.
Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes InterQual criteria, and for certain levels of care, utilizes criteria that was developed by the State. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management Committee which has provider MD level participants.	The M/S plan reports using MCG. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, on an annual basis, the medical necessity criteria is assessed internally as part of the Plan's continual review of releases of new national practice guidelines from specialty organizations, and following recommendations from the Plan's Technology Assessment Committee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan's Chief Medical Officer reviews the authorization criteria at least annually to ensure that it meets all applicable federal and state requirements, as well as best practices. The Plan's Medical Management Committee reviews and adopts the criteria on an annual basis. The Plan monitors and reviews average length of stay data, denial rates, the volume of appeals and overturned appeal rates to assess the effectiveness of the criteria.	Guidelines are modified at least annually and when new evidence dictates a major change in review criteria. This is done by Milliman as part of their MCG annual updates, internally as part of our continual review of release of new national practice guidelines from specialty organizations, and following recommendations of the Plan's Technology Assessment Committee. Frequency of requests and associated denial rates are monitored. Provider grievances regarding the Plan's application of criteria are monitored and used to trigger review of criteria when necessary in between the scheduled annual reviews.

Findings
Both Plans strive to identify the care that is most appropriate and effective to treat a particular condition, through the development and application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. The MH/SUD Plan utilizes State developed criteria for some inpatient levels of care. The State will remove policy requirements for the MH/SUD Plan to use State developed clinical decision making criteria for designated inpatient facilities. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via denial rates, appeals, length of stay data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Electroconvulsive Therapy Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility
	M/S: Acute Inpatient Facility Skilled Nursing Facility (SNF) Acute Inpatient Rehab (AIR) Facility Hospice Care (Inpatient)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan reports that the rationale for identifying and developing medical necessity criteria is to ensure services are delivered at the appropriate level of care, frequency and intensity.	The M/S Plan reports that criteria are developed to help decide whether a given health service is medically necessary and therefore covered.

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Comparability of Evidence	
MH/SUD	**M/S**
The Plan utilizes InterQual and State developed criteria and guidelines.	The medical plan uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines.
Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes InterQual criteria, and for certain levels of care, utilizes criteria that was developed by the State. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management Committee which has provider MD level participants.	The M/S plan reports using MCG and other nationally recognized clinical guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, on an annual basis, the medical necessity criteria is assessed internally as part of the Plan's continual review of releases of new national practice guidelines from specialty organizations, and following recommendations from the Plan's Medical Technology Assessment Committee (MTAC).

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan's Chief Medical Officer reviews the authorization criteria at least annually to ensure that it meets all applicable federal and state requirements, as well as best practices. The Plan's Medical Management Committee reviews and adopts the criteria on an annual basis. The Plan monitors and reviews average length of stay data, denial rates, the volume of appeals and overturned appeal rates to assess the effectiveness of the criteria.	The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee).

Findings
Both Plans strive to identify the care that is most appropriate and effective to treat a particular condition, through the development and application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. The MH/SUD Plan utilizes State developed criteria for some inpatient levels of care. The State will remove policy requirements for the MH/SUD Plan to use State developed clinical decision making criteria for designated inpatient facilities. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via denial rates, appeals, length of stay data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabiliative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S: Inpatient Procedures/Surgeries

Comparability of Strategy

MH/SUD	M/S
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff. The Plan reports that criteria are developed to help decide whether a given health service is medically necessary and therefore covered. All inpatient	The M/S plan reports that the purpose of developing medical necessity criteria is to assess for new evidence-based recommendations, changes to community practice standards, assess new technology (new codes) and solicit local provider input.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes MCG criteria, and internally develops medical necessity criteria and level of care guidelines for services in which nationally recognized, evidence-based criteria is not available.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care Cost Containment System, Hayes™ and other approved criteria when available.

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Comparability and Stringency of Processes	
MH/SUD	M/S
The Plan utilizes nationally recognized, evidence-based criteria, MCG©. The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care Cost Containment System, Hayes™ and other approved criteria when available. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is reviewed annually and updated throughout the year as necessary with rationale noted. Updates to Prior Authorization Guidelines (PAG) are reviewed by the Chief Medical Officer (CMO) who researches the medical and pharmacy codes and updates based on changes to coverage status. Prior to being used to support utilization decisions, criteria is reviewed by applicable medical directors and affiliated health professionals and approved for use by the a designated committee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the Medical Directors can compare the Milliman (MCG) criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to UnitedHealthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	The Plan reviews reports that are queried by current procedural terminology codes to assess and analyze by denial and approval rates to assess for low denials rate and decrease in utilization trends and variations. Review is done on the current PAG for potential additions or deletions based on under/over utilization trends, claims trends including cost, provider feedback, and evidence based guideline changes, low denial rates and emerging technology.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via network changes, utilization data, denial rates and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabiliative Services (CRS)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	**MH/SUD:** All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S: All inpatient services

Comparability of Strategy

MH/SUD	M/S
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff.	The M/S plan reports that the rationale for identifying and developing medical necessity criteria is to identify best practice and to ensure those best practices are reflected in policy and guidelines.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes MCG criteria, and internally develops medical necessity criteria and level of care guidelines for services in which nationally recognized, evidence-based criteria is not available.	The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan utilizes nationally recognized, evidence-based criteria, MCG©. The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is developed and modified by the Plan as needed or at a minimum on an annual basis. A round table discussion led by the Plan's medical services staff is available for provider input during a quarterly Quality Management Performance Improvement meeting where outside stakeholders are invited to attend.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the Medical Directors can compare the Milliman (MCG) criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to UnitedHealthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	Research is done by a medical services staff member to identify best practices and to ensure that those best practices are reflected in policy and guidelines. Nationally accredited sources are utilized to identify best practice and this includes but is not limited to Centers for Medicare & Medicaid Services and American Academy of Pediatrics. When reputable sources are found, the material is reviewed in a weekly meeting with the Plan's nursing staff and the MD. Implications of the material is then discussed and embedded into practice when applicable. The Plan monitors trends among denials, claims disputes, or provider suggestions.

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via network changes, denial rates, claims disputes and provider suggestions. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabiliative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S: Inpatient stay Hospital Skilled Nursing Facilities Long-Term Care Facilities

Comparability of Strategy

MH/SUD	M/S
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff.	`

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes MCG criteria, and internally develops medical necessity criteria and level of care guidelines for services in which nationally recognized, evidence-based criteria is not available.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan utilizes nationally recognized, evidence-based criteria, MCG©. The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. All new and revised clinical practice guidelines are reviewed by Aetna's Quality Advisory Committees, composed of practicing clinicians who participate in Aetna medical plans. The Plan designates the review of medical necessity criteria to Aetna's Clinical Policy Council that includes external practicing clinicians. Approval of the criteria is completed by Aetna's Chief Medical Officer (CMO) or his/her designee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the Medical Directors can compare the Milliman (MCG) criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to UnitedHealthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	As required by the State, criteria sets are reviewed annually for appropriateness to Mercy Care Plan needs and changed as applicable. The changes occur when there's a change to the code, change to Aetna Policy or Aetna Medicaid. The medical necessity criteria review may occur either prior to or after publication of the clinical practice guidelines (CPG) on Aetna's websites. Recommendations from Aetna's Quality Advisory Committees are sent to the Clinical Policy Research and Development Team for review. The Clinical Policy Research and Development Team prepares a response to each of the Quality Assurance Committee recommendations and may draft further revisions to the CPG as appropriate for consideration by Aetna's Clinical Policy Council. The Plan relies on provider and member feedback and/or appeals or grievances to assess the ongoing effectiveness of the criteria.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via network changes, grievances and member and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabiliative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S: Acute Inpatient Facility Skilled Nursing Facility (SNF) Acute Inpatient Rehab (AIR) Facility Hospice Care (Inpatient)

Comparability of Strategy

MH/SUD	M/S
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff.	The M/S Plan reports that criteria are developed to help decide whether a given health service is medically necessary and therefore covered.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes MCG criteria, and internally develops medical necessity criteria and level of care guidelines for services in which nationally recognized, evidence-based criteria is not available.	The medical plan uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan utilizes nationally recognized, evidence-based criteria, MCG©. The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The M/S plan reports using MCG and other nationally recognized clinical guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, on an annual basis, the medical necessity criteria is assessed internally as part of the Plan's continual review of releases of new national practice guidelines from specialty organizations, and following recommendations from the Plan's Medical Technology Assessment Committee (MTAC).
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the Medical Directors can compare the Milliman (MCG) criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to UnitedHealthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee).

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via network changes and comparative reviews led by clinical leadership. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Cenpatico Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Arizona State Hospital Licensed Hospital Facility/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility Continued Stay in a Behavioral Health Residential Facility for Substance Use Disorder Treatment after 14 days Out of State Placement
	M/S (LTSS): All benefits that are subject to prior authorization, concurrent review and/or retrospective review in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The Plan reports that medical necessity criteria is intended to optimize decision-making by emphasizing the use of evidence from well-designed and well conducted research.

Comparability of Evidence

MH/SUD	M/S (LTSS)
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions.	The M/S (LTSS) Plan utilizes Division policy and InterQual criteria as the standard for evidence-based clinical decision support.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The M/S (LTSS) Plan utilizes Division clinical policy and InterQual criteria. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	As part of the annual review process, the M/S (LTSS) Plan reports that services or items considered too rigorous or out of date, as well as unintended outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team would result in changes to the level of evidence as reviewed and updated by the CMO or designee (Medical Director) as well as other members of the Division's Health Care Services Unit.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via adverse incident investigations, utilization data, outcomes data and provider complaints. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Health Choice Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Electroconvulsive Therapy Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility
	M/S (LTSS): All benefits that are subject to prior authorization, concurrent review and/or retrospective review in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
The MH/SUD Plan reports that the rationale for identifying and developing medical necessity criteria is to ensure services are delivered at the appropriate level of care, frequency and intensity.	The Plan reports that medical necessity criteria is intended to optimize decision-making by emphasizing the use of evidence from well-designed and well conducted research.

Comparability of Evidence

MH/SUD	M/S (LTSS)
The Plan utilizes InterQual and State developed criteria and guidelines.	The M/S (LTSS) Plan utilizes Division policy and InterQual criteria as the standard for evidence-based clinical decision support.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
The MH/SUD Plan utilizes InterQual criteria. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management Committee which has provider MD level participants.	The M/S (LTSS) Plan utilizes Division clinical policy and InterQual criteria. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.
Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
The Plan's Chief Medical Officer reviews the authorization criteria at least annually to ensure that it meets all applicable federal and state requirements, as well as best practices. The Plan's Medical Management Committee reviews and adopts the criteria on an annual basis. The Plan monitors and reviews average length of stay data, denial rates, the volume of appeals and overturned appeals rates to assess the effectiveness of the criteria.	As part of the annual review process, the M/S (LTSS) Plan reports that services or items considered too rigorous or out of date, as well as unintended outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team would result in changes to the level of evidence as reviewed and updated by the CMO or designee (Medical Director) as well as other members of the Division's Health Care Services Unit.

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via adverse incident investigations, denial rates, overturned appeal rates, and average length of stay data. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Mercy Maricopa Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Electroconvulsive Therapy Admission to the Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility
	M/S (LTSS): All benefits that are subject to prior authorization, concurrent review and/or retrospective review in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The Plan reports that medical necessity criteria is intended to optimize decision-making by emphasizing the use of evidence from well-designed and well conducted research.

Comparability of Evidence

MH/SUD	M/S (LTSS)
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	The M/S (LTSS) Plan utilizes Division policy and InterQual criteria as the standard for evidence-based clinical decision support.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The M/S (LTSS) Plan utilizes Division clinical policy and InterQual criteria. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.

Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	As part of the annual review process, the M/S (LTSS) Plan reports that services or items considered too rigorous or out of date, as well as unintended outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team would result in changes to the level of evidence as reviewed and updated by the CMO or designee (Medical Director) as well as other members of the Division's Health Care Services Unit.

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via adverse incident investigations and utilization data. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and United Healthcare Community Plan (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S (LTSS): All benefits that are subject to prior authorization, concurrent review and/or retrospective review in this classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S (LTSS)
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff.	The Plan reports that medical necessity criteria is intended to optimize decision-making by emphasizing the use of evidence from well-designed and well conducted research.

Comparability of Evidence

MH/SUD	M/S (LTSS)
The Plan utilizes MCG criteria and medical necessity criteria based on level of care guidelines developed internally for services in which nationally recognized, evidence-based criteria is not available.	The M/S (LTSS) Plan utilizes Division policy and InterQual criteria as the standard for evidence-based clinical decision support.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The M/S (LTSS) Plan utilizes Division clinical policy and InterQual criteria. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the Medical Directors can compare the Milliman (MCG) criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to United Healthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	As part of the annual review process, the M/S (LTSS) Plan reports that services or items considered too rigorous or out of date, as well as unintended outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team would result in changes to the level of evidence as reviewed and updated by the CMO or designee (Medical Director) as well as other members of the Division's Health Care Services Unit.

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via adverse incident investigations, utilization data and clinical review. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S]) and Cenpatico Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	**MH/SUD:** Arizona State Hospital Licensed Hospital Facility/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility Continued Stay in a Behavioral Health Residential Facility for Substance Use Disorder Treatment after 14 days Out of State Placement
	M/S: All benefits assigned to the inpatient classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The Plan reports that medical necessity criteria is intended to establish clinical criteria for coverage determinations.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions.	AIHP utilizes clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM, Inpatient sets guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The AIHP utilizes clinical guidelines and policies. When developing or adopting medical necessity criteria, AIHP considers the mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services; the types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services; the frequency with which the service has been performed in the past; whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits, the reputation and experience of the authors and/or specialists and their record in related areas, the extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future; and whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's medical directors (MDs). Committees within the agency may meet monthly, quarterly, and on an ad hoc basis, as required, to review services for coverage inclusion.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	The committees consider current clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable. Providers may submit requests for reconsideration of services for coverage by the AHCCCS Committees/CMO.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via adverse data analyses, utilization data, outcomes data and provider complaints. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S]) and Health Choice Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Electroconvulsive Therapy Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility
	M/S: All benefits assigned to the inpatient classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan reports that the rationale for identifying and developing medical necessity criteria is to ensure services are delivered at the appropriate level of care, frequency and intensity.	The Plan reports that medical necessity criteria is intended to establish clinical criteria for coverage determinations.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes InterQual and State developed criteria and guidelines.	AIHP utilizes clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes InterQual criteria, and for certain levels of care, utilizes criteria that was developed by the State. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management Committee which has provider MD level participants.	The AIHP utilizes clinical guidelines and policies. When developing or adopting medical necessity criteria, AIHP considers the mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services; the types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services; the frequency with which the service has been performed in the past; whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits, the reputation and experience of the authors and/or specialists and their record in related areas, the extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future; and whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's medical directors (MDs). Committees within the agency may meet monthly, quarterly, and on an ad hoc basis, as required, to review services for coverage inclusion.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan's Chief Medical Officer reviews the authorization criteria at least annually to ensure that it meets all applicable federal and state requirements, as well as best practices. The Plan's Medical Management Committee reviews and adopts the criteria on an annual basis. The Plan monitors and reviews average length of stay data, denial rates, the volume of appeals and overturned appeal rates to assess the effectiveness of the criteria.	The committees consider current clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable. Providers may submit requests for reconsideration of services for coverage by the AHCCCS Committees/CMO.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. The MH/SUD Plan utilizes State developed criteria for some inpatient levels of care. The State will remove policy requirements for the MH/SUD Plan to use State developed clinical decision making criteria for designated inpatient facilities. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via data analyses, denial rates, overturned appeal rates, and average length of stay data. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S]) and Mercy Maricopa Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: Electroconvulsive Therapy Admission to the Arizona State Hospital Inpatient Psychiatric Acute Hospital/Sub-Acute Facility/Behavioral Health Inpatient Facility Behavioral Health Residential Facility
	M/S: All benefits assigned to the inpatient classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The Plan reports that medical necessity criteria is intended to establish clinical criteria for coverage determinations.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	AIHP utilizes clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The AIHP utilizes clinical guidelines and policies. When developing or adopting medical necessity criteria, AIHP considers the mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services; the types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services; the frequency with which the service has been performed in the past; whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits, the reputation and experience of the authors and/or specialists and their record in related areas, the extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future; and whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's medical directors (MDs). Committees within the agency may meet monthly, quarterly, and on an ad hoc basis, as required, to review services for coverage inclusion.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	The committees consider current clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable. Providers may submit requests for reconsideration of services for coverage by the AHCCCS Committees/CMO.

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Findings
Both Plans develop MN criteria to ensure appropriate, medically necessary member care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals and nationally accredited sources. The stringency of the criteria by both Plans is assessed via data, including: utilization data and other data analyses. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S]) and United Health Care Community Plan (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Inpatient

Services	
	MH/SUD: All Inpatient Residential Partial Hospitalization Inpatient Detoxification
	M/S: All benefits assigned to the inpatient classification are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff.	The Plan reports that medical necessity criteria is intended to establish clinical criteria for coverage determinations.

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Comparability of Evidence	
MH/SUD	**M/S**
The Plan utilizes MCG criteria and medical necessity criteria based on level of care guidelines developed internally for services in which nationally recognized, evidence-based criteria is not available.	AIHP utilizes clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The AIHP utilizes clinical guidelines and policies. When developing or adopting medical necessity criteria, AIHP considers the mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services; the types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services; the frequency with which the service has been performed in the past; whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits, the reputation and experience of the authors and/or specialists and their record in related areas, the extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future; and whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's medical directors (MDs). Committees within the agency may meet monthly, quarterly, and on an ad hoc basis, as required, to review services for coverage inclusion.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the Medical Directors can compare the Milliman (MCG) criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to United Healthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	The committees consider current clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable. Providers may submit requests for reconsideration of services for coverage by the AHCCCS Committees/CMO.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via data analyses and clinical review. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
Services	**MH/SUD:** Electroconvulsive Therapy Home Care Training to Home Care Client Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency, Out of Network Single Case Agreements
	M/S: All Services in the Outpatient Classification that are subject to utilization management (UM) strategies (prior authorization (PA), retrospective review))

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The M/S plan reports that the review allows the Plan to assess for new evidence-based recommendations, changes to community practice standards, assess new technology (new codes) and solicit local provider input.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care and Cost Containment System, Hayes™ and other approved criteria when available.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. As required by State policy, all clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/UM Committee which has provider MD level participants.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care Cost Containment System, Hayes™ and other approved criteria when available. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is reviewed annually and updated throughout the year as necessary with rationale noted. Updates to Prior Authorization Guidelines (PAG) are reviewed by the Chief Medical Officer (CMO) who researches the medical and pharmacy codes and updates based on changes to coverage status. Prior to being used to support utilization decisions, criteria is reviewed by applicable medical directors and affiliated health professionals and approved for use by the a designated committee.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	The Plan reviews reports that are queried by current procedural terminology codes to assess and analyze by denial and approval rates to assess for low denials rate and decrease in utilization trends and variations. Review is done on the current PAG or potential additions or deletions based on under/over utilization trends, claims trends including cost, provider feedback, and evidence based guideline changes, low denial rates and emerging technology.

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via utilization data, denial rates and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: Electroconvulsive Therapy Home Care Training to Home Care Client Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency, Out of Network Single Case Agreements
	M/S: All Services in the Outpatient Classification that are subject to UM strategies (prior authorization (PA), concurrent review, retrospective review))

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The M/S plan reports that the rationale for identifying and developing medical necessity criteria is to identify best practice and to ensure those best practices are reflected in policy and guidelines.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	The Plan utilizes InterQual criteria, Arizona Health Care and Cost Containment System, policy and guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is developed and modified by the Plan as needed or at a minimum on an annual basis. A round table discussion led by the Plan's medical services staff is available for provider input during a quarterly Quality Management Performance Improvement meeting where outside stakeholders are invited to attend.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	Research is done by a medical services staff member to identify best practices and to ensure that those best practices are reflected in policy and guidelines. Nationally accredited sources are utilized to identify best practice and this includes but is not limited to Centers for Medicare & Medicaid Services and AAP. When reputable sources are found, the material is reviewed in a weekly meeting with the Plan's nursing staff and the medical director. Implications of the material is then discussed and embedded into practice when applicable. The Plan monitors trends among denials, claims disputes, or provider suggestions.

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via denial rates and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Net (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	**MH/SUD:** Electroconvulsive Therapy Home Care Training to Home Care Client Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency, Out of Network Single Case Agreements
	M/S: All Services in the Outpatient Classification that are subject to utilization management (UM) strategies (prior authorization (PA), retrospective review))

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The M/S Plan reports that criteria are developed to help decide whether a given health service is medically necessary and therefore covered.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	The M/S plan reports using MCG.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The M/S plan reports using MCG. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, on an annual basis, the medical necessity criteria is assessed internally as part of the Plan's continual review of releases of new national practice guidelines from specialty organizations, and following recommendations from the Plan's Technology Assessment Committee. Provider input is not used to develop and design the criteria.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	The Plan has established criteria and guidelines for medical necessity decisions and utilizes a variety of sources in developing these guidelines which include, Medicare, Medicaid and other plan specific coverage policy statements; evidence in the peer-reviewed published medical literature; technology assessments and structured evidence reviews; evidence-based consensus statements; expert opinions of healthcare providers; evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies. On a six-month basis, the medical policy department analyzes an appeals report to identify patterns of overturns to determine the need to re-evaluate the Plan's policy where there are consistent overturns.

Findings
Both Plans target appropriate member care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals and nationally accredited sources. The stringency of the criteria by both Plans is assessed via data, including: utilization data, appeals data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	**MH/SUD:** Electroconvulsive Therapy Home Care Training to Home Care Client Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency, Out of Network Single Case Agreements
	M/S: Radiology Lab Equipment Prosthetics Referral Management

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The M/S Plan applies medical necessity criteria based on the needs of individual members and characteristics of the local delivery system.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG® as primary decision support guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. All new and revised clinical practice guidelines are reviewed by Aetna's Quality Advisory Committees, composed of practicing clinicians who participate in Aetna medical plans. The Plan designates the review of medical necessity criteria to Aetna's Clinical Policy Council that includes external practicing clinicians. Approval of the criteria is completed by Aetna's Chief Medical Officer (CMO) or his/her designee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	Criteria sets are reviewed annually for appropriateness to MCP needs and changed as applicable. The changes occur when there's a change to the code, change to Aetna Policy or Aetna Medicaid. The medical necessity criteria review may occur either prior to or after publication of the clinical practice guidelines (CPG) on Aetna's websites. Recommendations from Aetna's Quality Advisory Committees are sent to the Clinical Policy Research and Development Team for review. The Clinical Policy Research and Development Team prepares a response to each of the Quality Assurance Committee recommendations and may draft further revisions to the CPG as appropriate for consideration by Aetna's Clinical Policy Council. The Plan relies on provider and member feedback and/or appeals or grievances to assess the ongoing effectiveness of the criteria.

Findings
Both Plans develop MN criteria to ensure appropriate, medically necessary member care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Provider feedback is obtained by both Plans and considered in the development of criteria. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals and nationally accredited sources. The stringency of the criteria by both Plans is assessed via data, including: utilization data, grievance and appeals data and member feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: Electroconvulsive Therapy Home Care Training to Home Care Client Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency, Out of Network Single Case Agreements
	M/S: Abdominal Paracentesis Bariatric Surgery

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The M/S Plan reports that medical necessity criteria are developed to help decide whether a given health service is medically necessary.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	The M/S plan reports using MCG.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
All clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The Plan does not utilize it's own evidenced based criteria but relies on outside nationally accepted criteria. On an annual basis, the medical necessity criteria is assessed internally as part of the Plan's continual review of releases of new national practice guidelines from specialty organizations, and following recommendations from the Plan's Technology Assessment Committee. Provider input is not used to develop and design the criteria.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	Guidelines are modified at least annually and when new evidence dictates a major change in review criteria. This is done by Milliman as part of their MCG annual updates. The Plan monitors the frequency of requests and associated denial rates. Provider grievances regarding the Plan's application of the medical necessity criteria are also monitored and used to trigger a review of the criteria when necessary in between the scheduled annual reviews.
Findings	
Both Plans apply nationally based medical necessity criteria to ensure medically necessary and appropriate member care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. The MH/SUD Plan includes proactive provider representation, whereas the M/S Plan obtains "provider feedback" only through its review of provider grievances. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals and nationally accredited sources. The stringency of the criteria is assessed via utilization data denial rates and provider grievances. The processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	**MH/SUD:** Home Care Training to Home Care Client (HCTC) Behavioral Health Supportive Home/Behavioral Health Therapeutic Home Flex Fund Services Domestic Violence Offender Treatment Non-Emergency Services Outside the Contracted Network
	M/S: All Services in the Outpatient Classification that are subject to utilization management (UM) strategies (prior authorization (PA), retrospective review))

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The M/S plan reports that the review allows the Plan to assess for new evidence-based recommendations, changes to community practice standards, assess new technology (new codes) and solicit local provider input.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. For HCTC, the Plan utilizes Plan-specific criteria that is based on State developed criteria.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care and Cost Containment System, Hayes™ and other approved criteria when available.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care Cost Containment System, Hayes™ and other approved criteria when available. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is reviewed annually and updated throughout the year as necessary with rationale noted. Updates to Prior Authorization Guidelines (PAG) are reviewed by the Chief Medical Officer (CMO) who researches the medical and pharmacy codes and updates based on changes to coverage status. Prior to being used to support utilization decisions, criteria is reviewed by applicable medical directors and affiliated health professionals and approved for use by the a designated committee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	The Plan reviews reports that are queried by current procedural terminology codes to assess and analyze by denial and approval rates to assess for low denials rate and decrease in utilization trends and variations. Review is done on the current PAG or potential additions or deletions based on under/over utilization trends, claims trends including cost, provider feedback, and evidence based guideline changes, low denial rates and emerging technology.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO and includes provider representation. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via utilization data, denial rates and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: Home Care Training to Home Care Client (HCTC) Behavioral Health Supportive Home/Behavioral Health Therapeutic Home Flex Fund Services Non-Emergency Transportation Services Domestic Violence Offender Treatment Non-Emergency Services Outside the Contracted Network
	M/S: All Services in the Outpatient Classification that are subject to UM strategies (prior authorization (PA), concurrent review, retrospective

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The M/S plan reports that the rationale for identifying and developing medical necessity criteria is to identify best practice and to ensure those best practices are reflected in policy and guidelines.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. For HCTC, the Plan utilizes Plan-specific criteria that is based on State developed criteria.	The Plan utilizes InterQual criteria, Arizona Health Care and Cost Containment System, policy and guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is developed and modified by the Plan as needed or at a minimum on an annual basis. A round table discussion led by the Plan's medical services staff is available for provider input during a quarterly Quality Management Performance Improvement meeting where outside stakeholders are invited to attend.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	Research is done by a medical services staff member to identify best practices and to ensure that those best practices are reflected in policy and guidelines. Nationally accredited sources are utilized to identify best practice and this includes but is not limited to Centers for Medicare & Medicaid Services and AAP. When reputable sources are found, the material is reviewed in a weekly meeting with the Plan's nursing staff and the medical director. Implications of the material is then discussed and embedded into practice when applicable. The Plan monitors trends among denials, claims disputes, or provider suggestions.
Findings	
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee (MH/SUD Plan includes provider representation) that is led by the CMO. Provider input is solicited by the M/S Plan during a quarterly quality management/performance improvement meeting. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via utilization data, denial rates, claims disputes and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	**MH/SUD:** Home Care Training to Home Care Client (HCTC) Behavioral Health Supportive Home/Behavioral Health Therapeutic Home Flex Fund Services Non-Emergency Transportation Services Domestic Violence Offender Treatment Non-Emergency Services Outside the Contracted Network
	M/S: Outpatient services subject to MN reviews

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The M/S plan reports developing and utilizing medical necessity criteria to determine what is a covered service during medical reviews. Criteria is developed when a service is identified as being over or under utilized, requires prior authorization oversight, or

Comparability of Evidence

MH/SUD	M/S
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. For HCTC, the Plan utilizes Plan-specific criteria that is based on State developed criteria.	The M/S Plan adheres to utilizing nationally recognized, evidenced based criteria for all clinical determinations.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan utilizes nationally recognized criteria such as: Internal Clinical Guidelines, InterQual, Local and National Coverage Determination Guidelines (LCD/NCD), National Institute of Health (NIH) resources, and Hayes Knowledge Center. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is developed and modified by the Plan as needed or at a minimum on an annual basis. Clinical criteria is reviewed annually or as needed by the clinical leadership and physicians who are specialist in that field to ensure criteria is relevant and appropriate.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	Health Choice reviews and updates clinical guidelines annually and as needed to adhere to regulatory changes, new technology, added benefits, and recommendations from committees such as; Medical and Quality Management. This allows for input from a variety of sources to maximize input and feedback. All clinical policies and criteria are reviewed by physicians and approved through Medical and Quality Management Committees. Health Choice uses claims and authorization data to monitor and manage medical necessity criteria.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via claims data, outcomes data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for applying prior authorization, concurrent review and retrospective review to M/S outpatient services, in writing and or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: Home Care Training to Home Care Client (HCTC) Behavioral Health Supportive Home/Behavioral Health Therapeutic Home Flex Fund Services Non-Emergency Transportation Services Domestic Violence Offender Treatment Non-Emergency Services Outside the Contracted Network
	M/S: Radiology Lab Equipment Prosthetics Referral Management

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The M/S Plan applies medical necessity criteria based on the needs of individual members and characteristics of the local delivery system.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. For HCTC, the Plan utilizes Plan-specific criteria that is based on State developed criteria.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG® as primary decision support guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. All new and revised clinical practice guidelines are reviewed by Aetna's Quality Advisory Committees, composed of practicing clinicians who participate in Aetna medical plans. The Plan designates the review of medical necessity criteria to Aetna's Clinical Policy Council that includes external practicing clinicians. Approval of the criteria is completed by Aetna's Chief Medical Officer (CMO) or his/her designee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	Criteria sets are reviewed annually for appropriateness to MCP needs and changed as applicable. The changes occur when there's a change to the code, change to Aetna Policy or Aetna Medicaid. The medical necessity criteria review may occur either prior to or after publication of the clinical practice guidelines (CPG) on Aetna's websites. Recommendations from Aetna's Quality Advisory Committees are sent to the Clinical Policy Research and Development Team for review. The Clinical Policy Research and Development Team prepares a response to each of the Quality Assurance Committee recommendations and may draft further revisions to the CPG as appropriate for consideration by Aetna's Clinical Policy Council. The Plan relies on provider and

Findings
Both Plans develop MN criteria to ensure appropriate, medically necessary member care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Provider feedback is obtained by both Plans and considered in the development of criteria. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals and nationally accredited sources. The stringency of the criteria by both Plans is assessed via data, including: utilization data, grievance and appeals data and member feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: Home Care Training to Home Care Client (HCTC) Behavioral Health Supportive Home/Behavioral Health Therapeutic Home Flex Fund Services Non-Emergency Transportation Services Domestic Violence Offender Treatment Non-Emergency Services Outside the Contracted Network
	M/S: Fmri brain by tech Fmri brain by phys/psych Unlisted special service, procedure or report Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1) Ambulance service, basic life support, nonemergency transport (BLS)

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The Plan reports that the rationale for applying medical necessity criteria is to ensure services are cost-effective, consistent with national standards of care and are able to meet the member's needs.

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Comparability of Evidence	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. For HCTC, the Plan utilizes Plan-specific criteria that is based on State developed criteria.	The M/S Plan utilizes MCG criteria.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan utilizes nationally recognized, evidence-based criteria (MCG©). The Plan does not utilize Plan-specific evidenced based criteria but relies on outside nationally accepted criteria. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is reviewed annually and updated throughout the year as necessary with rationale noted. Guidelines are modified at least annually and when new evidence dictates a major change in review criteria. This is done by Milliman as part of MCG annual updates, internally as part of our continual review of the release of new national practice guidelines from specialty organizations, and following recommendations of the Plan's Technology Assessment Committee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	The criteria are reviewed annually through the Plan's Technology Assessment Committee. Provider input is not used to develop and design the criteria. Frequency of requests and associated denial rates are monitored. Provider grievances regarding our application of criteria are monitored and used to trigger review of the criteria when necessary in between the scheduled annual reviews.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via utilization data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: Home Care Training to Home Care Client (HCTC) Behavioral Health Supportive Home/Behavioral Health Therapeutic Home Flex Fund Services Non-Emergency Transportation Services Domestic Violence Offender Treatment Non-Emergency Services Outside the Contracted Network
	M/S: Abdominal Paracentesis Bariatric Surgery Bone Growth Stimulator BRACA Genetic Testing Cardiology *

Comparability of Strategy

MH/SUD	**M/S**
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The M/S Plan reports that medical necessity criteria are developed to help decide whether a given health service is medically necessary.

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Comparability of Evidence	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. For HCTC, the Plan utilizes Plan-specific criteria that is based on State developed criteria.	The M/S plan reports using MCG.

Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. The Arizona State Hospital has developed specific criteria that are used to determine medical necessity for that facility. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior Medical Director and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The Plan does not utilize it's own evidenced based criteria but relies on outside nationally accepted criteria. On an annual basis, the medical necessity criteria is assessed internally as part of the Plan's continual review of releases of new national practice guidelines from specialty organizations, and following recommendations from the Plan's Technology Assessment Committee. Provider input is not used to develop and design the criteria.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	Guidelines are modified at least annually and when new evidence dictates a major change in review criteria. This is done by Milliman as part of their MCG annual updates. The Plan monitors the frequency of requests and associated denial rates. Provider grievances regarding the Plan's application of the medical necessity criteria are also monitored and used to trigger a review of the criteria when necessary in between the scheduled annual reviews.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via utilization data and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: All outpatient care when authorization is required
	M/S: All Services in the Outpatient Classification that are subject to utilization management (UM) strategies (prior authorization (PA), retrospective review))

Comparability of Strategy

MH/SUD	M/S
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff. The Plan reports that criteria are developed to help decide whether a given health service is medically necessary and therefore covered. All inpatient	The M/S plan reports that the review allows the Plan to assess for new evidence-based recommendations, changes to community practice standards, assess new technology (new codes) and solicit local provider input.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes MCG criteria, and internally develops medical necessity criteria and level of care guidelines for services in which nationally recognized, evidence-based criteria is not available.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care and Cost Containment System, Hayes™ and other approved criteria when available.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan utilizes nationally recognized, evidence-based criteria, MCG©. The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The Plan utilizes nationally recognized, evidence-based criteria such as MCG©, Centers for Medicare & Medicaid Services, Arizona Health Care Cost Containment System, Hayes™ and other approved criteria when available. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is reviewed annually and updated throughout the year as necessary with rationale noted. Updates to Prior Authorization Guidelines (PAG) are reviewed by the Chief Medical Officer (CMO) who researches the medical and pharmacy codes and updates based on changes to coverage status. Prior to being used to support utilization decisions, criteria is reviewed by applicable medical directors and affiliated health professionals and approved for use by the a designated committee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the Medical Directors can compare the Milliman (MCG) criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to United Healthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	The Plan reviews reports that are queried by current procedural terminology codes to assess and analyze by denial and approval rates to assess for low denials rate and decrease in utilization trends and variations. Review is done on the current PAG or potential additions or deletions based on under/over utilization trends, claims trends including cost, provider feedback, and evidence based guideline changes, low denial rates and emerging technology.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via network changes, utilization data, denial rates and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: All outpatient care when authorization is required
	M/S: All Services in the Outpatient Classification that are subject to UM strategies (prior authorization (PA), concurrent review, retrospective review))

Comparability of Strategy

MH/SUD	M/S
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff.	The M/S plan reports that the rationale for identifying and developing medical necessity criteria is to identify best practice and to ensure those best practices are reflected in policy and guidelines.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes MCG criteria, and internally develops medical necessity criteria and level of care guidelines for services in which nationally recognized, evidence-based criteria is not available.	The Plan utilizes InterQual criteria, Arizona Health Care and Cost Containment System, policy and guidelines.

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Medical Necessity Criteria NQTL - Outpatient Classification

Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan utilizes nationally recognized, evidence-based criteria, MCG©. The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The Plan utilizes InterQual criteria, Arizona Health Care Cost Containment System policy and guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, medical necessity criteria is developed and modified by the Plan as needed or at a minimum on an annual basis. A round table discussion led by the Plan's medical services staff is available for provider input during a quarterly Quality Management Performance Improvement meeting where outside stakeholders are invited to attend.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the Medical Directors can compare the Milliman (MCG) criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to United Healthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	Research is done by a medical services staff member to identify best practices and to ensure that those best practices are reflected in policy and guidelines. Nationally accredited sources are utilized to identify best practice and this includes but is not limited to Centers for Medicare & Medicaid Services and AAP. When reputable sources are found, the material is reviewed in a weekly meeting with the Plan's nursing staff and the medical director. Implications of the material is then discussed and embedded into practice when applicable. The Plan monitors trends among denials, claims disputes, or provider suggestions.

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via network changes, denial rates, claims disputes and provider suggestions. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: All outpatient care when authorization is required
	M/S: Radiology Lab Equipment Prosthetics Referral Management

Comparability of Strategy

MH/SUD	M/S
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff.	The M/S Plan applies medical necessity criteria based on the needs of individual members and characteristics of the local delivery system.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes MCG criteria, and internally develops medical necessity criteria and level of care guidelines for services in which nationally recognized, evidence-based criteria is not available.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG® as primary decision support guidelines.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan utilizes nationally recognized, evidence-based criteria, MCG©. The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. All new and revised clinical practice guidelines are reviewed by Aetna's Quality Advisory Committees, composed of practicing clinicians who participate in Aetna medical plans. The Plan designates the review of medical necessity criteria to Aetna's Clinical Policy Council that includes external practicing clinicians. Approval of the criteria is completed by Aetna's Chief Medical Officer (CMO) or his/her designee.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the Medical Directors can compare the Milliman (MCG) criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to United Healthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	Criteria sets are reviewed annually for appropriateness to MCP needs and changed as applicable. The changes occur when there's a change to the code, change to Aetna Policy or Aetna Medicaid. The medical necessity criteria review may occur either prior to or after publication of the clinical practice guidelines (CPG) on Aetna's websites. Recommendations from Aetna's Quality Advisory Committees are sent to the Clinical Policy Research and Development Team for review. The Clinical Policy Research and Development Team prepares a response to each of the Quality Assurance Committee recommendations and may draft further revisions to the CPG as appropriate for consideration by Aetna's Clinical Policy Council. The Plan relies on provider and member feedback and/or appeals or grievances to assess the ongoing effectiveness of the criteria.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via network changes, grievances and member and provider feedback. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	**MH/SUD:** All outpatient care when authorization is required
	M/S: Abdominal Paracentesis Bariatric Surgery Bone Growth Stimulator BRACA Genetic Testing Cardiology * Cardiovascular * Carpal Tunnel Surgery * Cataract Surgery * Chemotherapy Chiropractic Care Circumcisions Cochlear & other Auditory Implants Colonoscopy * Cosmetic & Reconstructive Procedures * Dental Services Diabetic Supplies * Durable Medical Equipment >$500.00 Ear, Nose, & Throat Procedures * Enteral/Parenteral/Oral Services Experimental & Investigative Eye Care

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	M/S: Femoracetabular Impingement Syndrome Functional Endoscopic Sinus Surgery (FESS) Genetic Testing Gynecologic Procedures Hearing Services Tonsillectomy & Adenoidectomy * Transplant Services Upper Gastrointestinal Endoscopy * Urologic Procedures * Vagus Nerve Stimulation Implant Vein Procedures Ventricular Assist Devices Wound Vac Note: Prior Authorization Requirements marked with (*) Site of Service Requirement- Prior Authorization is required if performed in an outpatient hospital setting.

Comparability of Strategy

MH/SUD	M/S
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff.	The M/S Plan reports that medical necessity criteria are developed to help decide whether a given health service is medically necessary.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes MCG criteria, and internally develops medical necessity criteria and level of care guidelines for services in which nationally recognized, evidence-based criteria is not available.	The M/S plan reports using MCG.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan utilizes nationally recognized, evidence-based criteria, MCG©. The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The Plan does not utilize it's own evidenced based criteria but relies on outside nationally accepted criteria. On an annual basis, the medical necessity criteria is assessed internally as part of the Plan's continual review of releases of new national practice guidelines from specialty organizations, and following recommendations from the Plan's Technology Assessment Committee. Provider input is not used to develop and design the criteria.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the Medical Directors can compare the Milliman (MCG) criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to United Healthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	Guidelines are modified at least annually and when new evidence dictates a major change in review criteria. This is done by Milliman as part of their MCG annual updates. The Plan monitors the frequency of requests and associated denial rates. Provider grievances regarding the Plan's application of the medical necessity criteria are also monitored and used to trigger a review of the criteria when necessary in between the scheduled annual reviews.

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Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via network changes and comparative reviews led by clinical leadership. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD outpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S outpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S]) and Cenpatico Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: Home Care Training to Home Care Client (HCTC) Behavioral Health Supportive Home/Behavioral Health Therapeutic Home Flex Fund Services Non-Emergency Transportation Services Domestic Violence Offender Treatment Non-Emergency Services Outside the Contracted Network
	M/S: All benefits assigned to the outpatient classification that require authorization are subject to the NQTL

Comparability of Strategy

MH/SUD	**M/S**
The MH/SUD Plan adopts medical necessity criteria to ensure consistency when rendering medical necessity determinations.	The Plan reports that medical necessity criteria is intended to establish clinical criteria for coverage determinations.

Comparability of Evidence

MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. For HCTC, the Plan utilizes Plan-specific criteria that is based on State developed criteria.	AIHP utilizes clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes McKesson InterQual Criteria and ASAM to guide approval/denial decisions. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review is done by the CMO, Senior MD and VP of Medical Management - recommendations for adoption, approval or deletion of criteria are presented to the Medical Management Committee who then vote on approval/non-approval of the recommendation.	The AIHP utilizes clinical guidelines and policies. When developing or adopting medical necessity criteria, AIHP considers the mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services; the types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services; the frequency with which the service has been performed in the past; whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits, the reputation and experience of the authors and/or specialists and their record in related areas, the extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future; and whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's MDs. Committees within the agency may meet monthly, quarterly, and on an ad hoc basis, as required, to review services for coverage inclusion.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The criteria are reviewed annually or based on feedback from providers or internal experience applying the criteria. A review of utilization data may also prompt a change to prior authorization criteria. The MH/SUD Plan has provider representation on the Medical Management Committee. Providers may also contact the Chief Medical Officer (CMO) or other CIC staff at any time to provide feedback. The Plan reviews utilization data, outcomes and provider complaints to assess the stringency of the medical necessity criteria.	The committees consider current clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable. Providers may submit requests for reconsideration of services for coverage by the Arizona Health Care Cost Containment System (AHCCCS) Committees/CMO.

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via adverse data analyses, utilization data, outcomes data and provider complaints. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S]) and Mercy Maricopa Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: Electroconvulsive Therapy Home Care Training to Home Care Client Non-Emergency Services Outside the Geographic Service Area Non-Emergency Services Outside the Contracted Network Psychological, Psychosexual and Neuropsychological Testing Non-Emergency, Out of Network Single Case Agreements
	M/S: All benefits assigned to the outpatient classification that require authorization are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S
To ensure that the quality and type and duration of service is appropriate to the member's needs.	The Plan reports that medical necessity criteria is intended to establish clinical criteria for coverage determinations.

Comparability of Evidence

MH/SUD	M/S
The MH/SUD utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines.	AIHP utilizes clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The MH/SUD Plan utilizes MCG©, including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	The AIHP utilizes clinical guidelines and policies. When developing or adopting medical necessity criteria, AIHP considers the mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services; the types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services; the frequency with which the service has been performed in the past; whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits, the reputation and experience of the authors and/or specialists and their record in related areas, the extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future; and whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's MDs. Committees within the agency may meet monthly, quarterly, and on an ad hoc basis, as required, to review services for coverage inclusion.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria. The Plan monitors and reviews utilization data to assess the effectiveness of the criteria.	The committees consider current clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable. Providers may submit requests for reconsideration of services for coverage by the Arizona Health Care Cost Containment System (AHCCCS) Committees/Chief Medical Officer (CMO).

Findings
Both Plans develop MN criteria to ensure appropriate, medically necessary member care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plan's ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals and nationally accredited sources. The stringency of the criteria is assessed via data, including: utilization data and other data analyses. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): American Indian Adults & Children

Contractors: American Indian Health Program (AIHP) (Medical/Surgical [M/S]) and United Health Care Community Plan (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Outpatient

Services	
	MH/SUD: All outpatient care when authorization is required
	M/S: All benefits assigned to the outpatient classification that require authorization are subject to the NQTL

Comparability of Strategy

MH/SUD	M/S
Medical Necessity Criteria is developed to improve the quality, appropriateness, and the cost effectiveness of healthcare for the member and serve as a valuable educational tool for the providers and staff.	The Plan reports that medical necessity criteria is intended to establish clinical criteria for coverage determinations.

Comparability of Evidence

MH/SUD	M/S
The Plan utilizes Milliman Care Guidelines (MCG) criteria, and internally develops medical necessity criteria and level of care guidelines for services in which nationally recognized, evidence-based criteria is not available.	AIHP utilizes clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan utilizes nationally recognized, evidence-based criteria, MCG©. The criteria to determine medical necessity are embedded in the Level of Care Guidelines (LOC). The LOC Guidelines were developed utilizing literature reviews as well as input solicited from providers, Medical Directors (MDs) and other clinical staff, members, and regulators. The evidence-base for the LOC Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The LOC Guidelines are annually updated to reflect changes to the network, regulatory requirements, significant advances in service delivery, current research, and other opportunities to improve its quality.	The AIHP utilizes clinical guidelines and policies. When developing or adopting medical necessity criteria, AIHP considers the mortality rate and survival rate of the service as compared to the rates for alternative non-experimental services; the types, severity, and frequency of complications associated with the services as compared with the complications associated with alternative non-experimental services; the frequency with which the service has been performed in the past; whether there is sufficient historical information regarding the service to provide reliable data regarding risks and benefits, the reputation and experience of the authors and/or specialists and their record in related areas, the extent to which medical science in the area develops rapidly and the probability that more definite data will be available in the foreseeable future; and whether the peer reviewed article describes a random controlled trial or an anecdotal clinical case study. Consistent with State requirements, all such clinical criteria is reviewed and updated annually by the Plan's MDs. Committees within the agency may meet monthly, quarterly, and on an ad hoc basis, as required, to review services for coverage inclusion.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The clinical review criteria are reviewed, evaluated, and approved on an annual basis with updates monthly and approves as applicable to the Medicaid line of business in the Healthcare Quality Utilization Management (HQUM) Committee (Medical Management Committee). The measurement is the MDs can compare the MCG criteria to UHC Medical Policies and Medical Benefit Drug Policies and the AHCCCS Policies or submit to United Healthcare Medical Technology Assessment Committee (MTAC) for questions and evidence-base research materials.	The committees consider current clinical guidelines, policies, expert opinion, national and community standards of care, data analyses, and other pertinent information, as applicable. Providers may submit requests for reconsideration of services for coverage by the Arizona Health Care Cost Containment System (AHCCCS) Committees/Chief Medical Officer (CMO).

Findings
Both Plans strive to ensure high quality care through the application of nationally-recognized, evidence based, investigated and peer reviewed medical necessity criteria, as required by State policy. Both Plans review the criteria annually via a designated Plan committee that is led by the CMO. Both Plans ensure that any revisions or additions to the medical necessity criteria are based on the consensus of qualified health care professionals. The stringency of the criteria is assessed via data analyses and clinical review. As a result, the processes, strategies and evidentiary standards used in developing medical necessity criteria for MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in developing medical necessity criteria for M/S inpatient services, in writing and in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult		
Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])		
Non-quantitative treatment limit (NQTL): Medical Necessity Criteria		
Classification: Prescription Drugs		
Services	**MH/SUD:** Medications	
	M/S: Medications	

Comparability of Strategy

MH/SUD	M/S
1) Compliance with contractual requirements from Arizona Health Care Cost Containment System through the implementation of the preferred drug list (PDL) 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines	Clinical application of the standards of practice and national guidelines.

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Comparability of Evidence	
MH/SUD	**M/S**
Food and Drug Administration (FDA)-approved drug monographs and the following medical pharmacy information sources: - American Medical Hospital Formulary Service – Drug Information - Drug Facts and Comparisons - American Medical Association Drug Evaluations - United States Pharmacopoeia – Drug Information - Clinical Pharmacology - Published practice guidelines and treatment protocols, - Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, - Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.	FDA-approved indications and limits. If a non-FDA approved medication for a specific diagnosis or condition or dosage it is considered when all formulary plus FDA-approved non-formulary medications have been tried and failed with any of the following supporting documentation: i. Published practice guidelines and treatment protocols ii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes iii. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for preferred agents that a require a clinical review due to requiring prior authorization (PA), not meeting the age limit, step therapy is not met or the drug exceeds quantity level limits, the request will be reviewed against the approved health plan PA Guidelines. If a non-preferred/non-formulary medication is requested, the request will be reviewed against the global/non formulary medication guideline. If the pharmacy technician is not able to approve the request due to the criteria not being me the request will be sent to a clinical pharmacist. The clinical pharmacy will review the information submitted with the request and the member's pharmacy claims history. If there is not enough information to approve the request the clinical pharmacist will reach out to the provider via fax to obtain additional information. The request will be pended and if additional information is not received then the request will be sent to a medical director (MD) with a recommendation to deny. The MD will make the final decision to approve or deny the medication.	Criteria would be written by Pharmacy Director and/or formulary team and brought to Pharmacy and Therapeutics (P&T) committee for review and approval. These criteria are updated as needed based on new guidelines or medications.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Monitoring of the formulary set up to include utilization management edits is completed through a variety of analysis and reports. This would include but not limited to : - Claims files and reports to include paid and rejected claims - Daily and monthly PA Summary reports with details on approved and denial requests - Adhoc reports to identify claims for medications that require PA and validate appropriateness of PA versus pharmacy benefit.	Overall the company has a approximately 45% denial percentage for Medicaid with the majority of denials being for alternatives on the PDL. The Pharmacy team does participate in the Annual inter-rater reliability a MPS of 85%.

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Findings
MMIC and Care 1st use medical necessity criteria (MNC) to ensure the appropriate use of drug therapies per standards of practice and national guidelines. Both plans use FDA-approved indications and limits, national clinical guidelines, peer-reviewed medical literature that includes randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The criteria is used primarily for PA determinations and is developed by the P&T committee. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
1) Compliance with contractual requirements from AHCCCS through the implementation of the preferred drug list 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines	To adhere to the Arizona Health Care Cost Containment System (AHCCCS) Preferred Drug List (PDL) - as AHCCCS receives rebates on meds the plans are mandated to use the meds on the AHCCCS PDL. To ensure the appropriate use of medications.

Comparability of Evidence

MH/SUD	M/S
Food and Drug Administration (FDA)-approved drug monographs and the following medical pharmacy information sources: American Medical Hospital Formulary Service – Drug Information Drug Facts and Comparisons American Medical Association Drug Evaluations United States Pharmacopoeia – Drug Information Clinical Pharmacology Published practice guidelines and treatment protocols, Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for preferred agents that a require a clinical review due to requiring prior authorization (PA), not meeting the age limit, step therapy is not met or the drug exceeds quantity level limits, the request will be reviewed against the approved health plan PA Guidelines. If a non-preferred/non-formulary medication is requested, the request will be reviewed against the global/non formulary medication guideline. If the pharmacy technician is not able to approve the request due to the criteria not being me the request will be sent to a clinical pharmacist. The clinical pharmacy will review the information submitted with the request and the member's pharmacy claims history. If there is not enough information to approve the request the clinical pharmacist will reach out to the provider via fax to obtain additional information. The request will be pended and if additional information is not received then the request will be sent to a medical director with a recommendation to deny. The Medical Director (MD) will make the final decision to approve or deny the medication.	For all medical necessity criteria (MNC), review is done by registered nurses and medical directors (MDs) annually. Best practice and Evidence based practice articles are referenced and implemented when applicable by national accredited organizations.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Monitoring of the formulary set up to include utilization management edits is completed through a variety of analysis and reports. This would include but not limited to : - Claims files and reports to include paid and rejected claims - Daily and monthly PA Summary reports with details on approved and denial requests - Adhoc reports to identify claims for medications that require PA and validate appropriateness of PA versus pharmacy benefit.	Overturned on appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter rater reliability. Grievance and complaints as well as Appeals will also at times trigger a review of the criteria to determine if they are too stringent. CMDP had zero denial and appeal over turns during this time period.

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Findings
MMIC and CMDP use MNC to ensure the appropriate use of drug therapies per standards of practice and national guidelines. Both plans use FDA-approved indications and limits, national clinical guidelines, peer-reviewed medical literature that includes randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Health Net (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
1) Compliance with contractual requirements from Arizona Health Care Cost Containment System (AHCCCS) through the implementation of the preferred drug list 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines	Per AHCCCS: To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.

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Comparability of Evidence	
MH/SUD	**M/S**
Food and Drug Administration (FDA)-approved drug monographs and the following medical pharmacy information sources: - American Medical Hospital Formulary Service – Drug Information - Drug Facts and Comparisons - American Medical Association Drug Evaluations - United States Pharmacopoeia – Drug Information - Clinical Pharmacology - Published practice guidelines and treatment protocols, - Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, - Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for preferred agents that a require a clinical review due to requiring prior authorization (PA), not meeting the age limit, step therapy is not met or the drug exceeds quantity level limits, the request will be reviewed against the approved health plan PA Guidelines. If a non-preferred/non-formulary medication is requested, the request will be reviewed against the global/non formulary medication guideline. If the pharmacy technician is not able to approve the request due to the criteria not being me the request will be sent to a clinical pharmacist. The clinical pharmacy will review the information submitted with the request and the member's pharmacy claims history. If there is not enough information to approve the request the clinical pharmacist will reach out to the provider via fax to obtain additional information. The request will be pended and if additional information is not received then the request will be sent to a medical director (MD) with a recommendation to deny. The MD will make the final decision to approve or deny the medication.	Specific Criteria are developed by a clinical pharmacist and reviewed by a clinical team that includes pharmacists and providers. Approval/denial authority is contained by Regional and National Pharmacy and Therapeutics (P&T) committee. M/S medications follow the same process pharmacy drugs follow. The drug is reviewed by an internal clinical group and draft criteria are created. The drug is then reviewed at regional P&T and national P&T. Once approved, the criteria is finalized and implemented. Timeline for this is 3-6 months. If criteria are needed more timely, the process is expedited.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Monitoring of the formulary set up to include utilization management edits is completed through a variety of analysis and reports. This would include but not limited to : - Claims files and reports to include paid and rejected claims - Daily and monthly PA Summary reports with details on approved and denial requests - Adhoc reports to identify claims for medications that require PA and validate appropriateness of PA versus pharmacy benefit.	Criteria are reviewed on at least an annual basis to ensure accuracy and update any guideline changes. For M/S medications related to MNC for the period January-June 2017, the denial rate was 21% and appeal overturn rate was 37%.

Findings
MMIC and Health Net use medical necessity criteria (MNC) to ensure the appropriate use of drug therapies. Both plans use FDA approved drug indications, published practice guidelines and treatment protocols, and other information that includes peer-reviewed medical literature that has randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The criteria is primarily used for PA determinations and is developed by the P&T Committee. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	1) Compliance with contractual requirements from AHCCCS through the implementation of the preferred drug list 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guideline

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	FDA-approved drug monographs and the following medical pharmacy information sources: - American Medical Hospital Formulary Service - Drug Facts and Comparisons - United States Pharmacopoeia (Drug Information) - Clinical Pharmacology - Published practice guidelines and treatment protocols, - Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, - Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC Pharmacists and Medical Directors (MD) develop medical necessity criteria (MNC). All criteria is reviewed at our quarterly Pharmacy and Therapeutics (P&T) Committee meeting and updated at least annually. Approval requires voting results from committee members. The MNC is used by CIC staff to process prior authorization (PA) requests, which a pharmacist will approve or refer to a MD for denial.	Medication request is denied at point of sale if a PA is required Prescriber must fill out a PA form and submit Pharmacy Tech reviews, then Pharmacist, if question about medical necessity, then MD reviews
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial and appeal rate for MH/SUD medications related to MNC for the period January-June 2017 is 23%, and the appeal over turn rates during this period is 18%.	Track and trend formulary limitations and restrictions to include PA, QLL, Age restriction to determine the % approval/denial rate by drug as well as application of the PA Guideline used in the process. This information used to evaluate the effectiveness of the UM edit and if changes need to be made to the review criterion or removal of the restriction.
Findings	
CIC and Mercy Care Plan use MNC to ensure the appropriate use of drug therapies. Both plans use FDA-approved drug indications, peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The criteria is used primarily for PA determinations and is developed by the P&T Committee. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Use Disorder [MH/SUD]) and United Health Care (UHC) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
1) Compliance with contractual requirements from Arizona Health Care Cost Containment System (AHCCCS) through the implementation of the preferred drug list 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines	Ensure rational, clinically appropriate, safe and cost-effective drug therapy.

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Comparability of Evidence	
MH/SUD	**M/S**
- Food and Drug Administration (FDA)-approved drug monographs and the following medical pharmacy information sources: - American Medical Hospital Formulary Service – Drug Information - Drug Facts and Comparisons - American Medical Association Drug Evaluations - United States Pharmacopoeia – Drug Information - Clinical Pharmacology - Published practice guidelines and treatment protocols, - Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, - Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for preferred agents that a require a clinical review due to requiring prior authorization (PA), not meeting the age limit, step therapy is not met or the drug exceeds quantity level limits, the request will be reviewed against the approved health plan PA Guidelines. If a non-preferred/non-formulary medication is requested, the request will be reviewed against the global/non formulary medication guideline. If the pharmacy technician is not able to approve the request due to the criteria not being me the request will be sent to a clinical pharmacist. The clinical pharmacy will review the information submitted with the request and the member's pharmacy claims history. If there is not enough information to approve the request the clinical pharmacist will reach out to the provider via fax to obtain additional information. The request will be pended and if additional information is not received then the request will be sent to a medical director (MD) with a recommendation to deny. The MD will make the final decision to approve or deny the medication.	The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. • The PA request is received 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. • If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language. • 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.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Monitoring of the formulary set up to include utilization management edits is completed through a variety of analysis and reports. This would include but not limited to : - Claims files and reports to include paid and rejected claims - Daily and monthly PA Summary reports with details on approved and denial requests - Adhoc reports to identify claims for medications that require PA and validate appropriateness of PA versus pharmacy benefit.	61.8% of M/S drugs have PA requirements (60.5% have non-formulary PA requirements and 1.3% have clinical PA requirements). The denial rate for M/S drug PA requests received from January-June 2017 was 52.9%. Of the overturned appeals cases from this time 86% of the overturns were for M/S drugs.

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Findings
MMIC and UHC use medical necessity criteria (MNC) to ensure the appropriate use of drug therapies. Both plans use national clinical guidelines, peer-reviewed medical literature that includes randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. If a non-preferred/non-formulary medication is requested, a PA request is submitted along with supporting documentation, the supporting documentation will be reviewed against MNC and a decision made on coverage; only a medical doctor can deny a medication. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Clinical application of the standards of practice and national guidelines.

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Comparability of Evidence	
MH/SUD	**M/S**
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	FDA-approved indications and limits. If a non-FDA approved medication for a specific diagnosis or condition or dosage it is considered when all formulary plus FDA-approved non-formulary medications have been tried and failed with any of the following supporting documentation: i. Published practice guidelines and treatment protocols ii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes iii. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.
Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC Pharmacists and Medical Directors (MD) develop medical necessity criteria (MNC). All criteria is reviewed at our quarterly Pharmacy and Therapeutics (P&T) Committee meeting and updated at least annually. Approval requires voting results from committee members. The MNC is used by CIC staff to process prior authorization (PA) requests, which a pharmacist will approve or refer to a MD for denial.	Criteria would be written by Pharmacy Director and/or formulary team and brought to P&T committee or review and approval. These criteria are updated as needed based on new guidelines or medications.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial and appeal rate for MH/SUD medications related to MNC for the period January-June 2017 is 23%, and the appeal over turn rates during this period is 18%.	Overall the company has a approximately 45% denial percentage for Medicaid with the majority of denials being for alternatives on the Preferred Drug List. The Pharmacy team does participate in the Annual inter-rater reliability with a MPS of 85%.

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Findings
CIC and Care 1st use MNC to ensure the appropriate use of drug therapies per standards of practice and national guidelines. Both plans use FDA-approved indications and limits, national clinical guidelines, peer-reviewed medical literature that includes randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The criteria is used primarily for PA determinations and is developed by the P&T committee. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	To adhere to the AHCCCS Product Drug List (PDL) - as AHCCCS receives rebates on meds the plans are mandated to use the meds on the AHCCCS PDL. To ensure the appropriate use of medications.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC Pharmacists and Medical Directors (MDs) develop medical necessity criteria (MNC). All criteria is reviewed at our quarterly Pharmacy and Therapeutics Committee meeting and updated at least annually. Approval requires voting results from committee members. The MNC is used by CIC staff to process prior authorization requests, which a pharmacist will approve or refer to a medical director (MD) for denial.	For all MNC, review is done by registered nurses and MD's annually. Best practice and Evidence based practice articles are referenced and implemented when applicable by national accredited organizations.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial and appeal rate for MH/SUD medications related to MNC for the period January-June 2017 is 23%, and the appeal over turn rates during this period is 18%.	Overturned on appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter rater reliability. Grievance and complaints as well as Appeals will also at times trigger a review of the criteria to determine if they are too stringent. CMDP had zero denial and appeal over turns during this time period.
Findings	
CIC and CMDP use MNC to ensure the appropriate use of drug therapies per standards of practice and national guidelines. Both plans use FDA-approved indications and limits, national clinical guidelines, peer-reviewed medical literature that includes randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	To encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	FDA-approved indications and limits, published practice guidelines and treatment protocols, comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC Pharmacists and Medical Directors (MD) develop medical necessity criteria (MNC). All criteria is reviewed at our quarterly Pharmacy and Therapeutics (P&T) Committee meeting and updated at least annually. Approval requires voting results from committee members. The MNC is used by CIC staff to process PA requests, which a pharmacist will approve or refer to a medical director for denial.	All corresponding supporting documentation to satisfy the prior authorization criteria must accompany the request at the time the prescriber submits to the Plan. Health Choice is then responsible for evaluating the PA request based upon scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of the prescription drug.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial and appeal rate for MH/SUD medications related to MNC for the period January-June 2017 is 23%, and the appeal over turn rates during this period is 18%.	Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications.
Findings	
CIC and Mercy Care Plan use MNC to ensure the clinically appropriate and cost effective use of drug therapies. Both plans use FDA-approved drug indications, peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The criteria is used primarily for prior authorization determinations and is developed by the P&T Committee. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and United Health Care (UHC) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Ensure rational, clinically appropriate, safe and cost-effective drug therapy.

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Comparability of Evidence	
MH/SUD	**M/S**
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC Pharmacists and Medical Directors (MDs) develop medical necessity criteria (MNC). All criteria is reviewed at our quarterly Pharmacy and Therapeutics (P&T) Committee meeting and updated at least annually. Approval requires voting results from committee members. The MNC is used by CIC staff to process prior authorization (PA) requests, which a pharmacist will approve or refer to a MD for denial.	The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. • The PA request is received 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. • If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language. • 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.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial and appeal rate for MH/SUD medications related to MNC for the period January-June 2017 is 23%, and the appeal over turn rates during this period is 18%.	61.8% of M/S drugs have PA requirements (60.5% have non-formulary PA requirements and 1.3% have clinical PA requirements). The denial rate for M/S drug PA requests received from January-June 2017 was 52.9%. Of the overturned appeals cases from this time 86% of the overturns were for M/S drugs.

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Findings
CIC and UHC use MNC to ensure the clinically appropriate and cost effective use of drug therapies. Both use FDA-approved indications and limits, published practice guidelines and treatment protocols, peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to develop its MNC. The criteria is used primarily for PA determinations and is developed by the P&T Committee. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Ensure cost-effectiveness and consistency with national guidelines.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA) approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC Pharmacists and Medical Directors develop medical necessity criteria (MNC). All criteria is reviewed at our quarterly Pharmacy and Therapeutics (P&T) Committee meeting and updated at least annually. Approval requires voting results from committee members. The MNC is used by CIC staff to process PA requests, which a pharmacist will approve or refer to a medical director (MD) for denial.	Scientific literature is reviewed along with studies submitted to regulatory agencies as part of the review process. Criteria are developed by Doctorate level pharmacists with input from the MDs as well as community providers as indicated. Not all drugs have criteria, only those that are deemed to be high risk, high cost, or at risk for inappropriate use and are used frequently. General guidelines is that drug must be FDA-approved or have a compendia indication or have adequate randomized, controlled trials to support use.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial and appeal rate for MH/SUD medications related to MNC for the period January-June 2017 is 23%, and the appeal over turn rates during this period is 18%.	PA required for 387/3448 drugs (11.2%). Appeal overturns and regulatory requirements are monitored: none were submitted during the January-June 2017 period.

Findings
CIC and University Family Care both use MNC to ensure cost effective use of drug therapies. Both use FDA-approved indications and limits, published practice guidelines and treatment protocols, peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to develop its MNC. The criteria is used primarily for prior authorization determinations and is developed by the Pharmacists and MD. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="3">Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult</td></tr>
<tr><td colspan="3">Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Use Disorder [MH/SUD]) and United Health Care (UHC) (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="3">Non-quantitative treatment limit (NQTL): Medical Necessity Criteria</td></tr>
<tr><td colspan="3">Classification: Prescription Drugs</td></tr>
<tr><td rowspan="2">Services</td><td colspan="2">MH/SUD:
Medications</td></tr>
<tr><td colspan="2">M/S:
Medications</td></tr>
<tr><td colspan="3">Comparability of Strategy</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">Per Arizona Health Care Cost Containment System (AHCCCS):
To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.</td><td>Ensure rational, clinically appropriate, safe and cost-effective drug therapy.</td></tr>
<tr><td colspan="3">Comparability of Evidence</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">Per AHCCCS 310-V Policy:
i. Food and Drug Administration (FDA)-approved indications and limits,
ii. Published practice guidelines and treatment protocols,
iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes,
iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and
v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).</td><td>Per AHCCCS 310-V Policy:
i. FDA-approved indications and limits,
ii. Published practice guidelines and treatment protocols,
iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes,
iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and
v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).</td></tr>
</table>

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
CIC Pharmacists and Medical Directors (MDs) develop medical necessity criteria (MNC). All criteria is reviewed at our quarterly Pharmacy and Therapeutics (P&T) Committee meeting and updated at least annually. Approval requires voting results from committee members. The MNC is used by CIC staff to process prior authorization (PA) requests, which a pharmacist will approve or refer to a MD for denial.	The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. • The PA request is received 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. • If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language. • 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.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial and appeal rate for MH/SUD medications related to MNC for the period January-June 2017 is 23%, and the appeal over turn rates during this period is 18%.	61.8% of M/S drugs have PA requirements (60.5% have non-formulary PA requirements and 1.3% have clinical PA requirements). The denial rate for M/S drug PA requests received from January-June 2017 was 52.9%. Of the overturned appeals cases from this time 86% of the overturns were for M/S drugs.

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Findings
CIC and UHC use MNC to ensure the clinically appropriate and cost effective use of drug therapies. Both use FDA-approved indications and limits, published practice guidelines and treatment protocols, peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to develop its MNC. The criteria is used primarily for PA determinations and is developed by the P&T Committee. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	To adhere to the Arizona Health Care Cost Containment System (AHCCCS) Preferred Drug List (PDL) - as AHCCCS receives rebates on meds the plans are mandated to use the meds on the AHCCCS PDL. To ensure the appropriate use of medications.

Comparability of Evidence

MH/SUD	M/S
Medical Necessity Criteria (MNC) are based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Medically necessary, cost-effective, and federally and state reimbursable medications prescribed by a physician, physician's assistant, nurse practitioner, dentist, or other AHCCCS registered practitioner and dispensed by an AHCCCS registered licensed pharmacy are covered for members consistent with 9 A.A.C. 22 Article 2, 9 A.A.C. 28 Article 2, and 9 A.A.C. 31 Article 2 and for persons who have a diagnosis of Serious Mental Illness. The advisory committee to the AHCCCS Administration, which is responsible for developing, managing, updating, and administering the AHCCCS Drug List and AHCCCS Behavioral Health (BH) Drug List. The Pharmacy and Therapeutics Committee is primarily comprised of physicians, pharmacists, nurses, and other health care professionals.	For all MNC, review is done by registered nurses and medical directors (MDs) annually. Best practice and Evidence based practice articles are referenced and implemented when applicable by national accredited organizations.
Prior Authorization (PA) Criteria for BH drugs: HCIC must apply the AHCCCS PA criteria as those specified on the AHCCCS website for medications listed on the AHCCCS BH Drug List that require PA prior to dispensing the medication. When a medication on the AHCCCS BH Drug List is subject to PA but no PA criteria is specified, HCIC may elect to establish PA criteria based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following: • FDA-approved indications and limits, • Published practice guidelines and treatment protocols, • Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, • Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacy-economic studies, and • Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-date). HCIC PM Chapter 2, Section 2.7, Pharmacy Management.	

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications.	Overturned on appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter rater reliability. Grievance and complaints as well as Appeals will also at times trigger a review of the criteria to determine if they are too stringent. CMDP had zero denial and appeal over turns during this time period.

Findings
HCIC and CMDP use MNC to ensure the appropriate use of drug therapies per standards of practice and national guidelines. Both plans use FDA-approved indications and limits, national clinical guidelines, peer-reviewed medical literature that includes randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Use Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	To encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.

Comparability of Evidence

MH/SUD	M/S
Medical Necessity Criteria (MNC) are based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-date).	FDA-approved indications and limits, published practice guidelines and treatment protocols, comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Medically necessary, cost-effective, and federally and state reimbursable medications prescribed by a physician, physician's assistant, nurse practitioner, dentist, or other AHCCCS registered practitioner and dispensed by an AHCCCS registered licensed pharmacy are covered for members consistent with 9 A.A.C. 22 Article 2, 9 A.A.C. 28 Article 2, and 9 A.A.C. 31 Article 2 and for persons who have a diagnosis of Serious Mental Illness. The advisory committee to the AHCCCS Administration, which is responsible for developing, managing, updating, and administering the AHCCCS Drug List and AHCCCS Behavioral Health Drug List. The Pharmacy and Therapeutics Committee is primarily comprised of physicians, pharmacists, nurses, and other health care professionals.	All corresponding supporting documentation to satisfy the prior authorization (PA) criteria must accompany the request at the time the prescriber submits to the Plan. Health Choice is then responsible for evaluating the PA request based upon scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of the prescription drug.
PA Criteria for Behavioral Health Drugs: HCIC must apply the AHCCCS PA criteria as those specified on the AHCCCS website for medications listed on the AHCCCS Behavioral Health Drug List that require prior authorization prior to dispensing the medication. When a medication on the AHCCCS Behavioral Health Drug List is subject to PA but no PA criteria is specified, HCIC may elect to establish PA criteria based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following: • FDA-approved indications and limits, • Published practice guidelines and treatment protocols, • Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, • Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacy-economic studies, and • Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, UpToDate). HCIC PM Chapter 2, Section 2.7, Pharmacy Management.	

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications.	Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications.

Findings
HCIC and Health Choice use MNC to ensure the cost effective and clinically appropriate use of drug therapies. Both plans use FDA-indications, national clinical guidelines, published medical literature, research data and pharmacoeconomic studies to base their MNC. The Pharmacy and Therapeutics Committee, which is primarily comprised of physicians, pharmacists, nurses, and other health care professionals, makes MNC determinations. If a non-preferred/non-formulary medication is requested, a PA request is submitted along with supporting documentation, the supporting documentation will be reviewed against MNC and a decision made on coverage; only a medical doctor can deny a medication. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Use Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Ensure cost-effectiveness and consistency with national guidelines.

Comparability of Evidence

MH/SUD	M/S
Medical Necessity Criteria (MNC) are based on clinical appropriateness,	Per Arizona Health Care Cost Containment System (AHCCCS) 310-V Policy:

Comparability and Stringency of Processes

MH/SUD	M/S
Medically necessary, cost-effective, and federally and state reimbursable medications prescribed by a physician, physician's assistant, nurse practitioner, dentist, or other AHCCCS registered practitioner and dispensed by an AHCCCS registered licensed pharmacy are covered for members consistent with 9 A.A.C. 22 Article 2, 9 A.A.C. 28 Article 2, and 9 A.A.C. 31 Article 2 and for persons who have a diagnosis of Serious Mental Illness. The advisory committee to the AHCCCS Administration, which is responsible for developing, managing, updating, and administering the AHCCCS Drug List and AHCCCS Behavioral Health Drug List. The Pharmacy and Therapeutics (P&T) Committee is primarily comprised of physicians, pharmacists, nurses, and other health care professionals.	Scientific literature is reviewed along with studies submitted to regulatory agencies as part of the review process. Criteria are developed by Doctorate level pharmacists with input from the Medical Directors (MDs) as well as community providers as indicated. Not all drugs have criteria, only those that are deemed to be high risk, high cost, or at risk for inappropriate use and are used frequently. General guidelines is that drug must be FDA-approved or have a compendia indication or have adequate randomized, controlled trials to support use.

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Prior Authorization (PA) Criteria for Behavioral Health Drugs: HCIC must apply the AHCCCS PA criteria as those specified on the AHCCCS website for medications listed on the AHCCCS Behavioral Health Drug List that require PA prior to dispensing the medication. When a medication on the AHCCCS Behavioral Health Drug List is subject to PA but no PA criteria is specified, HCIC may elect to establish PA criteria based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following: • FDA-approved indications and limits, • Published practice guidelines and treatment protocols, • Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, • Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmaco-economic studies, and • Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, UpToDate). • HCIC PM Chapter 2, Section 2.7, Pharmacy Management.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications.	PA required for 387/3448 drugs (11.2%). Appeal overturns and regulatory requirements are monitored: none were submitted during the January-June 2017 period.

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Findings
HCIC and University Family Care both use MNC to ensure cost effective use of drug therapies. Both use FDA-approved indications and limits, published practice guidelines and treatment protocols, peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to develop its MNC. The criteria is used primarily for prior authorization determinations and is developed by the Pharmacists and MDs. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Use Disorder [MH/SUD]) and United Health Care (UHC) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Ensure rational, clinically appropriate, safe and cost-effective drug therapy.

Comparability of Evidence

MH/SUD	M/S
Medical Necessity Criteria (MNC) are based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following: i. Food and Drug Administration (FDA)-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-date).	Per Arizona Health Care Cost Containment System (AHCCCS) 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Medically necessary, cost-effective, and federally and state reimbursable medications prescribed by a physician, physician's assistant, nurse practitioner, dentist, or other AHCCCS registered practitioner and dispensed by an AHCCCS registered licensed pharmacy are covered for members consistent with 9 A.A.C. 22 Article 2, 9 A.A.C. 28 Article 2, and 9 A.A.C. 31 Article 2 and for persons who have a diagnosis of Serious Mental Illness. The advisory committee to the AHCCCS Administration, which is responsible for developing, managing, updating, and administering the AHCCCS Drug List and AHCCCS Behavioral Health Drug List. The Pharmacy and Therapeutics Committee is primarily comprised of physicians, pharmacists, nurses, and other health care professionals.	The provider completes and submits a prior authorization (PA) request form along with relevant clinical documentation to support medical necessity. • The PA request is received 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. • If the clinical information submitted with the prior authorization request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language. • 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.

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PA Criteria for Behavioral Health Drugs: HCIC must apply the AHCCCS PA criteria as those specified on the AHCCCS website for medications listed on the AHCCCS Behavioral Health Drug List that require prior authorization prior to dispensing the medication. When a medication on the AHCCCS Behavioral Health Drug List is subject to PA but no PA criteria is specified, HCIC may elect to establish PA criteria based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following: • FDA-approved indications and limits, • Published practice guidelines and treatment protocols, • Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, • Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacy-economic studies, and • Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, UpToDate). HCIC PM Chapter 2, Section 2.7, Pharmacy Management.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
Perform pattern analyses that evaluate clinical appropriateness, over and underutilization, therapeutic duplications, contraindications, drug interactions, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail order medications.	61.8% of M/S drugs have PA requirements (60.5% have non-formulary PA requirements and 1.3% have clinical PA requirements). The denial rate for M/S drug PA requests received from January-June 2017 was 52.9%. Of the overturned appeals cases from this time 86% of the overturns were for M/S drugs.

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Findings
HCIC and UHC use MNC to ensure the cost effective and clinically appropriate use of drug therapies. Both plans use national clinical guidelines, published medical literature, research data and pharmacoeconomic studies to base their MNC. The Pharmacy and Therapeutics Committee, which is primarily comprised of physicians, pharmacists, nurses, and other health care professionals, makes MNC determinations. If a non-preferred/non-formulary medication is requested, a PA request is submitted along with supporting documentation, the supporting documentation will be reviewed against MNC and a decision made on coverage; only a medical doctor can deny a medication. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: United Health Care (UHC) - CRS Partially Integrated (Mental Health/Substance Use Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Per AHCCCS: To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA) approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	• Care1st Prior Authorization (PA) Guidelines when available • Standards of practice and National Guidelines • FDA-approved indications and limits • A non-FDA approved medication for a specific diagnosis or condition or dosage is considered when all formulary plus FDA approved non-formulary medications have been tried and failed with any of the following supporting documentation: i. Published practice guidelines and treatment protocols ii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes iii. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.

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Comparability and Stringency of Processes	
MH/SUD	M/S
1. Development of Criteria a. The process is generally initiated by the approval of a medication by the FDA. Once approved by the FDA the medication will be reviewed for inclusion in the preferred drug list. As part of the review medical necessity/appropriateness criteria for use may be drafted if deemed appropriate by the review. b. When drafting the medical necessity/appropriateness criteria the following are considered: review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. c. Criteria development will consider the likely impact of a drug product on patient compliance when compared to alternative products. d. The criteria will be presented to the UHC Utilization Management Committee and UHC Pharmacy and Therapeutics (P&T) Committee	Criteria would be written by Pharmacy Director and/or formulary team and brought to Pharmacy and Therapeutics (P&T) committee for review and approval. These criteria are updated as needed based on new guidelines or medications.

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<table>
<tr><td>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 (MDs), 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.</td><td></td></tr>
<tr><th colspan="2">Stringency of Strategy and Evidence</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>The denial rate for behavioral health (BH) medications related to medical necessity criteria (MNC) in the CRS-BH population for the period January-June 2017 is 18.5%; the overturn rate for the same time period is 33.3%.</td><td>Overall the company has a approximately 45% denial percentage for Medicaid with the majority of denials being for alternatives on the Preferred Drug List. The Pharmacy team does participate in the Annual IRR with a MPS of 85%.</td></tr>
<tr><th colspan="2">Findings</th></tr>
<tr><td colspan="2">UHC - CRS Partially Integrated and Care 1st use MNC to ensure the appropriate use of drug therapies per standards of practice and national guidelines. Both plans use FDA-approved indications and limits, national clinical guidelines, peer-reviewed medical literature that includes randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The criteria is used primarily for PA determinations and is developed by the P&T Committee. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.</td></tr>
</table>

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: United Health Care (UHC) - CRS Partially Integrated (Mental Health/Substance Use Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	To adhere to the AHCCCS Preferred Drug List (PDL) - as AHCCCS receives rebates on meds the plans are mandated to use the meds on the AHCCCS PDL. To ensure the appropriate use of medications.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA) approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	M/S
1. Development of Criteria a. The process is generally initiated by the approval of a medication by the FDA. Once approved by the FDA the medication will be reviewed for inclusion in the PDL. As part of the review medical necessity/appropriateness criteria for use may be drafted if deemed appropriate by the review. b. When drafting the medical necessity/appropriateness criteria the following are considered: review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. c. Criteria development will consider the likely impact of a drug product on patient compliance when compared to alternative products. d. The criteria will be presented to the UHC Utilization Management (UM) Committee and UHC P&T Committee	For all medical necessity criteria, review is done by RN's and MD's annually. Best practice and Evidence based practice articles are referenced and implemented when applicable by national accredited organizations.

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<table>
<tr><td>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.</td><td></td></tr>
<tr><th colspan="2">Stringency of Strategy and Evidence</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>The denial rate for BH medications related to MNC in the CRS-BH population for the period Jan-June 2017 is 18.5%; the overturn rate for the same time period is 33.3%.</td><td>Overturned on appeals are reviewed to determine if the standards in place need to be revised, or to determine retraining for inter rater reliability. Grievance and complaints as well as Appeals will also at times trigger a review of the criteria to determine if they are too stringent. CMDP had zero denial and appeal over turns during this time period.</td></tr>
<tr><th colspan="2">Findings</th></tr>
<tr><td colspan="2">UHC - CRS Partially Integrated and CMDP use medical necessity criteria (MNC) to ensure the appropriate use of drug therapies per standards of practice and national guidelines. Both plans use FDA-approved indications and limits, national clinical guidelines, peer-reviewed medical literature that includes randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.</td></tr>
</table>

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: United Health Care (UHC) - CRS Partially Integrated (Mental Health/Substance Use Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	1) Compliance with contractual requirements from AHCCCS through the implementation of the preferred drug list 2) Member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA) approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	FDA-approved drug monographs and the following medical pharmacy information sources: - American Medical Hospital Formulary Service - Drug Facts and Comparisons - United States Pharmacopoeia (Drug Information) - Clinical Pharmacology - Published practice guidelines and treatment protocols, - Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, - Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies.

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Comparability and Stringency of Processes	
MH/SUD	M/S
1. Development of Criteria a. The process is generally initiated by the approval of a medication by the FDA. Once approved by the FDA the medication will be reviewed for inclusion in the preferred drug list (PDL). As part of the review medical necessity/appropriateness criteria for use may be drafted if deemed appropriate by the review. b. When drafting the medical necessity/appropriateness criteria the following are considered: review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. c. Criteria development will consider the likely impact of a drug product on patient compliance when compared to alternative products. d. The criteria will be presented to the UHC Utilization Management (UM) Committee and UHC Pharmacy and Therapeutics (P&T) Committee.	Medication request is denied at point of sale if a prior authorization (PA) is required Prescriber must fill out a PA form and submit Pharmacy Tech reviews, then Pharmacist, if question about medical necessity, then Medical Director (MD) reviews

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<table>
<tr><td>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 MDs, 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.</td><td></td></tr>
<tr><th colspan="2">Stringency of Strategy and Evidence</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>The denial rate for behavioral (BH) medications related to MNC in the CRS-BH population for the period Jan-June 2017 is 18.5%; the overturn rate for the same time period is 33.3%.</td><td>Track and trend formulary limitations and restrictions to include PA, QLL, Age restriction to determine the % approval/denial rate by drug as well as application of the PA Guideline used in the process. This information used to evaluate the effectiveness of the UM edit and if changes need to be made to the review criterion or removal of the restriction.</td></tr>
<tr><th colspan="2">Findings</th></tr>
<tr><td colspan="2">UHC - CRS Partially Integrated and Mercy Care Plan use medical necessity criteria (MNC) to ensure the appropriate use of drug therapies. Both plans use FDA-approved drug indications, comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, and other information that includes peer-reviewed medical literature that includes randomized clinical trials, outcomes, research data and pharmacoeconomic studies to base its MNC. The criteria is used primarily for PA determinations. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.</td></tr>
</table>

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: United Health Care (UHC) - CRS Partially Integrated (Mental Health/Substance Use Disorder [MH/SUD]) and United Health Care (UHC) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Medical Necessity Criteria

Classification: Prescription Drugs

Services	
	MH/SUD: Medications
	M/S: Medications

Comparability of Strategy

MH/SUD	M/S
Per Arizona Health Care Cost Containment System (AHCCCS): To cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable.	Ensure rational, clinically appropriate, safe and cost-effective drug therapy.

Comparability of Evidence

MH/SUD	M/S
Per AHCCCS 310-V Policy: i. Food and Drug Administration (FDA) approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).	Per AHCCCS 310-V Policy: i. FDA-approved indications and limits, ii. Published practice guidelines and treatment protocols, iii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, iv. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and v. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date).

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
1. Development of Criteria a. The process is generally initiated by the approval of a medication by the FDA. Once approved by the FDA the medication will be reviewed for inclusion in the preferred drug list (PDL). As part of the review medical necessity/appropriateness criteria for use may be drafted if deemed appropriate by the review. b. When drafting the medical necessity/appropriateness criteria the following are considered: review of FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. c. Criteria development will consider the likely impact of a drug product on patient compliance when compared to alternative products. d. The criteria will be presented to the UHC Utilization Management (UM) Committee and UHC Pharmacy and Therapeutics (P&T) Committee.	The provider completes and submits a prior authorization (PA) request form along with relevant clinical documentation to support medical necessity. • The PA request is received 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. • If the clinical information submitted with the prior authorization request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language. • 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.

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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 MDs, 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.	
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The denial rate for behavioral health (BH) medications related to MNC in the CRS-BH population for the period January-June 2017 is 18.5%; the overturn rate for the same time period is 33.3%.	61.8% of M/S drugs have PA requirements (60.5% have non-formulary PA requirements and 1.3% have clinical PA requirements). The denial rate for M/S drug PA requests received from January-June 2017 was 52.9%. Of the overturned appeals cases from this time 86% of the overturns were for M/S drugs.
Findings	
UHC - CRS Partially Integrated and UHC use medical necessity criteria (MNC) to ensure the clinically appropriate and cost effective use of drug therapies. Both use FDA-approved indications and limits, published practice guidelines and treatment protocols, peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-Date) to develop their criteria. The criteria is used primarily for PA determinations. The processes, strategies and evidentiary standards used in MNC application to MH/SUD medications seem comparable to, and appear to be applied no more stringently than, the processes, strategies and evidentiary standards used in applying MNC to M/S medications.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy

MH/SUD	M/S
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence

MH/SUD	M/S
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Members may be able to begin services without the appropriate documentation, but those services will not be able to continue without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	NQTL is not applicable to M/S Plan.

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy

MH/SUD	M/S
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence

MH/SUD	M/S
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Members may be able to begin services without the appropriate documentation, but those services will not be able to continue without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	NQTL is not applicable to M/S Plan.

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="2">Benefit Package(s): Child</td></tr>
<tr><td colspan="2">Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Net (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="2">Non-quantitative treatment limit (NQTL): Documentation Requirements</td></tr>
<tr><td colspan="2">Classification: Inpatient and Outpatient</td></tr>
<tr><td rowspan="2">Services</td><td>MH/SUD:
All Inpatient and Outpatient Services</td></tr>
<tr><td>M/S:
NQTL is not applicable to M/S Plan</td></tr>
</table>

Comparability of Strategy	
MH/SUD	**M/S**
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence	
MH/SUD	**M/S**
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Members may be able to begin services without the appropriate documentation, but those services will not be able to continue without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	NQTL is not applicable to M/S Plan

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy

MH/SUD	M/S
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence

MH/SUD	M/S
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Members may be able to begin services without the appropriate documentation, but those services will not be able to continue without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	NQTL is not applicable to M/S Plan.

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy

MH/SUD	M/S
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence

MH/SUD	M/S
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Members may be able to begin services without the appropriate documentation, but those services will not be able to continue without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	NQTL is not applicable to M/S Plan.

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child	
Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])	
Non-quantitative treatment limit (NQTL): Documentation Requirements	
Classification: Inpatient and Outpatient	
Services	**MH/SUD:** All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy	
MH/SUD	**M/S**
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.
Comparability of Evidence	
MH/SUD	**M/S**
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan reports that designated services that require prior authorization and provider types that are not subject to State licensing requirements must include the appropriate documentation for members to access those services. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through the Plan's Quality Management Department which performs medical record audits of assessments and ISPs that must meet minimum performance standards or the provider will be subject to corrective action.	NQTL is not applicable to M/S Plan.

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP)

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy

MH/SUD	M/S
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence

MH/SUD	M/S
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan reports that designated services that require prior authorization and provider types that are not subject to State licensing requirements must include the appropriate documentation for members to access those services. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through the Plan's Quality Management Department which performs medical record audits of assessments and ISPs that must meet minimum performance standards or the provider will be subject to corrective action.	NQTL is not applicable to M/S Plan.

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy

MH/SUD	M/S
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence

MH/SUD	M/S
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan reports that designated services that require prior authorization and provider types that are not subject to State licensing requirements must include the appropriate documentation for members to access those services. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through the Plan's Quality Management Department which performs medical record audits of assessments and ISPs that must meet minimum performance standards or the provider will be subject to corrective action.	NQTL is not applicable to M/S Plan.

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child	
Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])	
Non-quantitative treatment limit (NQTL): Documentation Requirements	
Classification: Inpatient and Outpatient	
Services	**MH/SUD:** All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy	
MH/SUD	**M/S**
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.
Comparability of Evidence	
MH/SUD	**M/S**
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan reports that designated services that require prior authorization and provider types that are not subject to State licensing requirements must include the appropriate documentation for members to access those services. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through the Plan's Quality Management Department which performs medical record audits of assessments and ISPs that must meet minimum performance standards or the provider will be subject to corrective action.	NQTL is not applicable to M/S Plan.

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy

MH/SUD	**M/S**
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence

MH/SUD	**M/S**
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan reports that designated services that require prior authorization and provider types that are not subject to State licensing requirements must include the appropriate documentation for members to access those services. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through the Plan's Quality Management Department which performs medical record audits of assessments and ISPs that must meet minimum performance standards or the provider will be subject to corrective action.	NQTL is not applicable to M/S Plan.

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy

MH/SUD	M/S
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence

MH/SUD	M/S
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
The Plan reports that designated services that require prior authorization and provider types that are not subject to State licensing requirements must include the appropriate documentation for members to access those services. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through the Plan's Quality Management Department which performs medical record audits of assessments and ISPs that must meet minimum performance standards or the provider will be subject to corrective action.	NQTL is not applicable to M/S Plan.

Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the Plan reports that while members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. Failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="3">Benefit Package(s): Child</td></tr>
<tr><td colspan="3">Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="3">Non-quantitative treatment limit (NQTL): Documentation Requirements</td></tr>
<tr><td colspan="3">Classification: Inpatient and Outpatient</td></tr>
<tr><td rowspan="2">Services</td><td colspan="2">MH/SUD:
All Inpatient and Outpatient Services</td></tr>
<tr><td colspan="2">M/S:
NQTL is not applicable to M/S Plan</td></tr>
<tr><td colspan="3">Comparability of Strategy</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.</td><td>NQTL is not applicable to M/S Plan.</td></tr>
<tr><td colspan="3">Comparability of Evidence</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">State policy requires the Plan to implement assessment and service planning requirements for both classifications.</td><td>NQTL is not applicable to M/S Plan.</td></tr>
</table>

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Members may access services without the appropriate documentation and HCIC indicated that this process is concurrent to accessing services and will not result in the denial of coverage or access without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	NQTL is not applicable to M/S Plan.

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Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. Since this strategy does not result in restrictions to the member's coverage or access to covered services, the child and family team approach to service planning is not considered an NQTL.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy

MH/SUD	M/S
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence

MH/SUD	M/S
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Members may access services without the appropriate documentation and HCIC indicated that this process is concurrent to accessing services and will not result in the denial of coverage or access without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	NQTL is not applicable to M/S Plan.

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Findings
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. Since this strategy does not result in restrictions to the member's coverage or access to covered services, the child and family team approach to service planning is not considered an NQTL.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child	
Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])	
Non-quantitative treatment limit (NQTL): Documentation Requirements	
Classification: Inpatient and Outpatient	
Services	**MH/SUD:** All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy	
MH/SUD	**M/S**
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence	
MH/SUD	**M/S**
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Documentation Requirements NQTL –
Inpatient and Outpatient Classifications

Comparability and Stringency of Processes	
MH/SUD	**M/S**
Members may access services without the appropriate documentation and HCIC indicated that this process is concurrent to accessing services and will not result in the denial of coverage or access without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	NQTL is not applicable to M/S Plan.
Findings	
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. Since this strategy does not result in restrictions to the member's coverage or access to covered services, the child and family team approach to service planning is not considered an NQTL.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S: NQTL is not applicable to M/S Plan

Comparability of Strategy

MH/SUD	M/S
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	NQTL is not applicable to M/S Plan.

Comparability of Evidence

MH/SUD	M/S
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Members may access services without the appropriate documentation and HCIC indicated that this process is concurrent to accessing services and will not result in the denial of coverage or access without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. At a minimum, the assessment and an individual service plan are updated on an annual basis.	NQTL is not applicable to M/S Plan.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	NQTL is not applicable to M/S Plan.
Findings	
The MH/SUD Plan's requirements of developing an assessment and service plan by a multi-disciplinary team (Child and Family Teams) are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. Since this strategy does not result in restrictions to the member's coverage or access to covered services, the child and family team approach to service planning is not considered an NQTL.	

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COMPLIANCE DETERMINATION

Benefit Package(s): Child members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Cenpatico Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S (LTSS): All Inpatient and Outpatient Services

Comparability of Strategy

MH/SUD	M/S (LTSS)
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.

Comparability of Evidence

MH/SUD	M/S (LTSS)
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	State policy requires the Plan to implement assessment and service planning requirements for both classifications.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
The Plan reports that designated services that require prior authorization and provider types that are not subject to State licensing requirements must include the appropriate documentation for members to access those services. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	Service planning begins within 10 days of eligibility and every 90 days following. During service planning appropriate services are placed in the ISP. Referrals for services are made following the ISP process and are required to be in place with a service provider (vendor) within 30 days for a new service and 14 days for an existing service. Individuals responsible for coordinating this are support coordinators hired by DDD. All services are accessed through this process. Member must attend the planning process and, with the assistance of a support coordinator, determine their needs and the services that will be needed to assist them. Member must then work with the support coordinator to determine which qualified vendor they want to work with for each service. The planning and referral process always occurs unless the family or member is unwilling to participate in the process which could lead to loss of benefits due to nonparticipation. In-person participation is necessary for the planning process. The support Coordinator fills out all pages requiring only the signature of the member.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through the Plan's Quality Management Department which performs medical record audits of assessments and ISPs that must meet minimum performance standards or the provider will be	As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, provider monitoring and grievance and appeal data.

Findings
The MH/SUD and the M/S (LTSS) Plans' requirements of developing an assessment and service plan by a multi-disciplinary team are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the MH/SUD Plan reports that members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. For both Plans, the failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD and LTSS services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Health Choice Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
Services	**MH/SUD:** All Inpatient and Outpatient Services
	M/S (LTSS): All Inpatient and Outpatient Services

Comparability of Strategy

MH/SUD	M/S (LTSS)
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.

Comparability of Evidence

MH/SUD	M/S (LTSS)
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	State policy requires the Plan to implement assessment and service planning requirements for both classifications.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
Members may access services without the appropriate documentation and HCIC indicated that this process is concurrent to accessing services and will not result in the denial of coverage or access without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. At a minimum, the assessment and an individual service plan are updated on an annual basis.	Service planning begins within 10 days of eligibility and every 90 days following. During service planning appropriate services are placed in the ISP. Referrals for services are made following the ISP process and are required to be in place with a service provider (vendor) within 30 days for a new service and 14 days for an existing service. Individuals responsible for coordinating this are support coordinators hired by DDD. All services are accessed through this process. Member must attend the planning process and, with the assistance of a support coordinator, determine their needs and the services that will be needed to assist them. Member must then work with the support coordinator to determine which qualified vendor they want to work with for each service. The planning and referral process always occurs unless the family or member is unwilling to participate in the process which could lead to loss of benefits due to nonparticipation. In-person participation is necessary for the planning process. The support Coordinator fills out all pages requiring only the signature of the member.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, provider monitoring and grievance and appeal data.

Findings
The MH/SUD and the M/S (LTSS) Plans' requirements of developing an assessment and service plan by a multi-disciplinary team are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the MH/SUD Plan reports that members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. For both Plans, the failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD and LTSS services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Mercy Maricopa Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Documentation Requirements

Classification: Inpatient and Outpatient

Services	
	MH/SUD: All Inpatient and Outpatient Services
	M/S (LTSS): All Inpatient and Outpatient Services

Comparability of Strategy

MH/SUD	M/S (LTSS)
The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.	The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. In addition, this process includes a determination of medical necessity for identified services.

Comparability of Evidence

MH/SUD	M/S (LTSS)
State policy requires the Plan to implement assessment and service planning requirements for both classifications.	NQTL is not applicable to M/S Plan.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
Members may be able to begin services without the appropriate documentation, but those services will not be able to continue without the appropriate documentation. The initial and annual assessment must be completed by a behavioral health professional (BHP). If an assessment is conducted and documented by a Behavioral Health Technician (BHT), a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. A complete service plan must be completed no later than 90 days after the initial appointment. Child and Family teams (composed of multi-disciplinary members and the member/guardian) are involved with the assessment and service planning after the initial assessment. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services, should services be rendered without documentation of an assessment and treatment plan. At a minimum, the assessment and an individual service plan are updated on an annual basis.	Service planning begins within 10 days of eligibility and every 90 days following. During service planning appropriate services are placed in the ISP. Referrals for services are made following the ISP process and are required to be in place with a service provider (vendor) within 30 days for a new service and 14 days for an existing service. Individuals responsible for coordinating this are support coordinators hired by DDD. All services are accessed through this process. Member must attend the planning process and, with the assistance of a support coordinator, determine their needs and the services that will be needed to assist them. Member must then work with the support coordinator to determine which qualified vendor they want to work with for each service. The planning and referral process always occurs unless the family or member is unwilling to participate in the process which could lead to loss of benefits due to nonparticipation. In-person participation is necessary for the planning process. The support Coordinator fills out all pages requiring only the signature of the member.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, the provider monitoring tool (CMRRT), and grievance and appeal data.	As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. Documentation requirements are evaluated through access to care addressing timeliness of service, provider monitoring and grievance and appeal data.

Findings
The MH/SUD and the M/S (LTSS) Plans' requirements of developing an assessment and service plan by a multi-disciplinary team are to ensure that members are afforded the opportunity to provide choice in the identification and selection of services, to ensure coordination of care and to determine medical necessity for the identified services. While the MH/SUD Plan reports that members may access services initially without completing the assessment and service plan, this NQTL ultimately is necessary for service coverage/access. For both Plans, the failure to complete the assessment and service planning results in the inability to access the service or potential for recoupment for services delivered without this documentation to support it. This strategy is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. While this level of service assessment and planning has been identified as necessary for this population for their MH/SUD and LTSS services, there has not been a similar determination of the need to apply this to the assessment and planning for M/S benefits for this population (consider, for example, individuals with development disabilities or CRS conditions wherein the member's M/S condition may require additional requirements for assessment and service planning). The requirement is supported by State policy and protocols, and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multisystemic involvement.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage

Classification: Inpatient and Outpatient Services

Services	
	MH/SUD: All out-of-network (non-emergent) services
	M/S: All out-of-network (non-emergent) services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan reports that the NQTL that limits coverage to network providers supports oversight of the quality of care, while approval for out of network providers ensures network adequacy by making services available to members (e.g., specialized care).	The Plan reports that the strategy of limiting coverage when possible to network providers is used to ensure member safety and the quality of the care rendered by service providers.

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as MMIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
To initiate a request for out of network coverage or out-of-state placement, a provider contacts the MH/SUD's Utilization Management Department. A member could also initiate a request via the Plan's Customer Service Department or through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. The MH/SUD Plan requests the medical record and MCG or other State generated medical necessity criteria are applied to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The MH/SUD Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. Once the request is approved, the MH/SUD Plan requests the provider's Medicaid identification number, W-9 form and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a single case agreement.	An out of network coverage or out-of-state placement request is initiated by a provider or a member. OON coverage and planned out-of-state placement requests require prior authorization. The Plan verifies that a participating provider is not available to provide the requested service. MCG criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved the M/S Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The M/S Plan is required to notify the State when a member is authorized for an out-of-state placement. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a letter of agreement.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The MH/SUD Plan regularly reviews trended claims data, grievances, complaints and the volume and type of out of network requests. The information is reviewed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. Out of network coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified.	The M/S Plan states that requirements and processes are reviewed and updated based on network need. Network adequacy is reviewed quarterly along with single case agreements and NON-PAR authorizations. The Plan also reviews and presents reports regarding network adequacy to designated committees. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.

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Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review Network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more strigent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="3">Benefit Package(s): Child</td></tr>
<tr><td colspan="3">Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="3">Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage</td></tr>
<tr><td colspan="3">Classification: Inpatient and Outpatient Services</td></tr>
<tr><td rowspan="2">Services</td><td colspan="2">MH/SUD:
All OON (non-emergent) services</td></tr>
<tr><td colspan="2">M/S:
Out-of-State Placements</td></tr>
<tr><td colspan="3">Comparability of Strategy</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">The MH/SUD Plan reports that the NQTL that limits coverage to network providers supports oversight of the quality of care, while approval for out of network providers ensures network adequacy by making services available to members (e.g., specialized care).</td><td>The M/S Plan may approve an out-of-state placement in order to make medically necessary covered services available to members (e.g., specialized care).</td></tr>
</table>

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as MMIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	The M/S Plan is statutorily required to extend coverage to any AHCCCS registered provider and does not maintain a contracted provider network. A provider may be identified as prefered by the Plan based on established quality metrics (readmissions, grievances, high claims volume), but an eligible member can receive services from any AHCCCS Medicaid registered provider.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
To initiate a request for out of network coverage or out-of-state placement, a provider contacts the MH/SUD's Utilization Management Department. A member could also initiate a request via the Plan's Customer Service Department or through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. The MH/SUD Plan requests the medical record and MCG or other State generated medical necessity criteria are applied to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The MH/SUD Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. Once the request is approved, the MH/SUD Plan requests the provider's Medicaid identification number, W-9 form and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a single case agreement.	An out-of-state placement request is initiated by a provider or a member. Planned out-of-state placement requests require prior authorization. InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The provider must be an AHCCCS registered provider in order to be reimbursed by the Plan for the service. The M/S Plan is required to notify the State when a member is authorized for an out-of-state placement. The provider is offered the standard AHCCCS reimbursement rate.

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Out of Network Coverage/Geographic Area NQTL -
Inpatient and Outpatient Classifications

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The MH/SUD Plan regularly reviews trended claims data, grievances, complaints and the volume and type of out of network requests. The information is reviewed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. Out of network coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified.	The M/S Plan is statutorily required to extend coverage to any AHCCCS registered provider and does not maintain a contracted provider network. A provider may be identified as prefered by the Plan based on established quality metrics (readmissions, grievances, high claims volume), but an eligible member can receive services from any AHCCCS Medicaid registered provider.

Findings
All non-emergent MH/SUD services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. The MH/SUD Plan allows for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. The M/S Plan requires planned out-of-state placements to be prior authorized. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. The MH/SUD Plan utilizes a single case agreement and requires that the provider is AHCCCS registered. The MH/SUD Plan reviews Network adequacy data and evidence to inform their strategy on a regular and frequent basis. The M/S Plan is statutorily required to extend coverage to any AHCCCS registered provider. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more strigent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Net (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage

Classification: Inpatient and Outpatient Services

Services	
	MH/SUD: All OON (non-emergent) services
	M/S: All OON (non-emergent) services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan reports that the NQTL that limits coverage to network providers supports oversight of the quality of care, while approval for out of network providers ensures network adequacy by making services available to members (e.g., specialized care).	The Plan utilizes the strategy to ensure the safety of members and to control the quality of services being provided.

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as MMIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
To initiate a request for out of network coverage or out-of-state placement, a provider contacts the MH/SUD's Utilization Management Department. A member could also initiate a request via the Plan's Customer Service Department or through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. The MH/SUD Plan requests the medical record and MCG or other State generated medical necessity criteria are applied to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The MH/SUD Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. Once the request is approved, the MH/SUD Plan requests the provider's Medicaid identification number, W-9 form and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a single case agreement.	An out network coverage and out-of-state placement requests are initiated by a contracted health home, provider or a member. OON coverage and non-emergent out-of-state placements must be prior authorized by the Plan. The Plan verifies that a participating provider is not available to provide the requested service. MCG, ASAM and InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved, the Plan must notify the State if a member has been authorized for an out-of-state placement. The Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a single case agreement.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The MH/SUD Plan regularly reviews trended claims data, grievances, complaints and the volume and type of out of network requests. The information is reviewed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. Out of network coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified.	The Plan reviews applicable policies annually, but more frequent reviews can be triggered by a change in State requirements. The Plan maintains a record of all out of network coverage requests and out of network service authorizations. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review Network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more strigent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage

Classification: Inpatient and Outpatient Services

Services	
	MH/SUD: All out-of-network (non-emergent) services
	M/S: All out-of-network (non-emergent) services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan reports that the NQTL that limits coverage to network providers supports oversight of the quality of care, while approval for out of network providers ensures network adequacy by making services available to members (e.g., specialized care).	The M/S Plan reports that the NQTL that limits coverage to network providers supports oversight of the quality of care, while approval for out of network providers ensures network adequacy by making services available to members (e.g., specialized care).

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as MMIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements. The Plan requires that there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
To initiate a request for out of network coverage or out-of-state placement, a provider contacts the MH/SUD Plan's Utilization Management Department. A member could also initiate a request via the Plan's Customer Service Department or through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. The MH/SUD Plan requests the medical record and MCG or other State generated medical necessity criteria are applied to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The MH/SUD Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. Once the request is approved, the MH/SUD Plan requests the provider’s Medicaid identification number, W-9 form and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a single case agreement.	To initiate a request for out of network coverage or out-of-state placement, a provider contacts the Plan's Utilization Management Department. A member could also initiate a request via the Plan's Customer Service Department or through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization. The M/S Plan confirms that a participating provider is not available to provide the requested service. The M/S Plan requests the medical record and MCG criteria are applied to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The M/S Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the M/S Plan must notify the State. Once the request is approved by the M/S Plan, the Plan requests the provider’s Medicaid identification number, W-9 form and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a single case agreement.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The MH/SUD Plan regularly reviews trended claims data, grievances, complaints and the volume and type of out of network requests. The information is reviewed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. Out of network coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified.	The MH/SUD Plan reviews trended claims data, grievances, complaints and the volume and type of out of network requests. The information is reviwed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. Out of coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review Network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more strigent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Mercy Maricopa Integrated Care (MMIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage

Classification: Inpatient and Outpatient Services

Services	
	MH/SUD: All out-of-network (non-emergent) services
	M/S: All out-of-network (non-emergent) services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD Plan reports that the NQTL that limits coverage to network providers supports oversight of the quality of care, while approval for out of network providers ensures network adequacy by making services available to members (e.g., specialized care).	The strategy is used when in-network care is not available or not available within geo access or clinical specialty not available in network.

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as MMIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
To initiate a request for out of network coverage or out-of-state placement, a provider contacts the MH/SUD's Utilization Management Department. A member could also initiate a request via the Plan's Customer Service Department or through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. The MH/SUD Plan requests the medical record and MCG or other State generated medical necessity criteria are applied to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The MH/SUD Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. Once the request is approved, the MH/SUD Plan requests the provider's Medicaid identification number, W-9 form and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a single case agreement.	Requests for OON and outside geographic area services is initiated by providers via telephone, fax, or on line portal. In the event that a member initiated the request, the member would be instructed to have their current provider contact the Plan to provide the necessary information to support the request. OON coverage and services outside the geographic services area and out-of-state placements must be prior authorized by the Plan. The PA team will review the request for an OON provider for continuity of care and review the member's history for other PA cases, discharge needs provided after an Inpatient admission, emergency room or Urgent Care services requested by an OON provider, or if the provider in a rural area is willing to accept the Medicaid Fee Schedule. If the provider is not willing to accept the Medicaid rate, a Single Case Agreement (SCA) is required. The level of evidence that the provider should submit with the prior authorization request is an AHCCCS ID and clinical information to support continuity of care, post hospital care, and ED or Urgent Care discharge. If the member is out-of-state; the length of time out-of-state (urgent vs. routine) along with the service request. Timeframes for rendering an authorization decision are expedited (3 business days) and standard (14 calendar days) of receipt of the service request.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The MH/SUD Plan regularly reviews trended claims data, grievances, complaints and the volume and type of out of network requests. The information is reviewed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. Out of network coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified.	The Plan reviews out of network coverage policies annually or more frequently if prompted by AHCCCS changes. The Plan reviews geo-access data, time and distance standards, and the volume of out of network coverage requests. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more strigent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="2">Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult</td></tr>
<tr><td colspan="2">Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="2">Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage</td></tr>
<tr><td colspan="2">Classification: Inpatient and Outpatient Services</td></tr>
<tr><td rowspan="2">Services</td><td>MH/SUD:
All out-of-network (non-emergent) services</td></tr>
<tr><td>M/S:
All out-of-network (non-emergent) services</td></tr>
</table>

Comparability of Strategy	
MH/SUD	**M/S**
The Plan utilizes the strategy to ensure the safety of members and to control the quality of services being provided.	The Plan reports that the strategy of limiting coverage when possible to network providers is used to ensure member safety and the quality of the care rendered by service providers.

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
An out network coverage and out-of-state placement requests are initiated by a contracted health home, provider or a member. Non-emergent OON coverage and out-of-state placements must be prior authorized by the Plan. In addition to the prior authorization process, the Plan verifies that a participating provider is not available to provide the requested service. MCG, ASAM and InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved, the Plan must notify the State if a member has been authorized for an out-of-state placement. The Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a single case agreement.	An out of network coverage or out-of-state placement request is initiated by a provider or a member. Non-emergent OON coverage and planned out-of-state placement requests require prior authorization. In addition to the prior authorization process, the Plan verifies that a participating provider is not available to provide the requested service. MCG criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved the M/S Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The M/S Plan is required to notify the State when a member is authorized for an out-of-state placement. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a letter of agreement.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews applicable policies annually, but more frequent reviews can be triggered by a change in State requirements. The Plan maintains a record of all out of network coverage requests and out of network service authorizations. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The M/S Plan states that requirements and processes are reviewed and updated based on network need. Network adequacy is reviewed quarterly along with single case agreements and NON-PAR authorizations. The Plan also reviews and presents reports regarding network adequacy to designated committees. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider or out of geographic area. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review Network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child	
Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])	
Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage	
Classification: Inpatient and Outpatient Services	
Services	**MH/SUD:** All out-of-network (non-emergent) services
	M/S: Out-of-State Placements

Comparability of Strategy	
MH/SUD	**M/S**
The Plan utilizes the strategy to ensure the safety of members and to control the quality of services being provided.	The M/S Plan may approve an out-of-state placement in order to make medically necessary covered services available to members (e.g., specialized care).

Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery	The M/S Plan is statutorily required to extend coverage to any AHCCCS registered provider and does not maintain a contracted provider network. A provider may be identified as preferred by the Plan based on established quality metrics (readmissions,

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
An out network coverage and out-of-state placement requests are initiated by a contracted health home, provider or a member. Non-emergent OON coverage and out-of-state placements must be prior authorized by the Plan. In addition to the prior authorization process, the Plan verifies that a participating provider is not available to provide the requested service. MCG, ASAM and InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved, the Plan must notify the State if a member has been authorized for an out-of-state placement. The Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a single case agreement.	A non-emergent out-of-state placement request is initiated by a provider or a member. Planned out-of-state placement requests require prior authorization. InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The provider must be an AHCCCS registered provider in order to be reimbursed by the Plan for the service. The M/S Plan is required to notify the State when a member is authorized for an out-of-state placement. The provider is offered the standard AHCCCS reimbursement rate.

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews applicable policies annually, but more frequent reviews can be triggered by a change in State requirements. The Plan maintains a record of all out of network coverage requests and out of network service authorizations. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The M/S Plan is statutorily required to extend coverage to any AHCCCS registered provider and does not maintain a contracted provider network. A provider may be identified as preferred by the Plan based on established quality metrics (readmissions, grievances, high claims volume), but an eligible member can receive services from any AHCCCS Medicaid registered provider.

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Findings
All non-emergent MH/SUD services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider or out of geographic area. The MH/SUD Plan allows for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. The M/S Plan requires planned out-of-state placements to be prior authorized. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. The MH/SUD Plan utilizes a single case agreement and requires that the provider is AHCCCS registered. The MH/SUD Plan reviews Network adequacy data and evidence to inform their strategy on a regular and frequent basis. The M/S Plan is statutorily required to extend coverage to any AHCCCS registered provider. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="3">Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult</td></tr>
<tr><td colspan="3">Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="3">Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage</td></tr>
<tr><td colspan="3">Classification: Inpatient and Outpatient Services</td></tr>
<tr><td rowspan="2">Services</td><td colspan="2">MH/SUD:
All out-of-network (non-emergent) services</td></tr>
<tr><td colspan="2">M/S:
All out-of-network (non-emergent) services</td></tr>
<tr><td colspan="3">Comparability of Strategy</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">The Plan utilizes the strategy to ensure the safety of members and to control the quality of services being provided.</td><td>The M/S Plan reports that the strategy and related processes are available to ensure quality oversight and maintain cost controls when services are needed outside of the contracted network and/or geographic service area.</td></tr>
<tr><td colspan="3">Comparability of Evidence</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery</td><td>State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access</td></tr>
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Comparability and Stringency of Processes	
MH/SUD	**M/S**
An out network coverage and out-of-state placement requests are initiated by a contracted health home, provider or a member. Non-emergent OON coverage and out-of-state placements must be prior authorized by the Plan. In addition to the prior authorization process, the Plan verifies that a participating provider is not available to provide the requested service. MCG, ASAM and InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved, the Plan must notify the State if a member has been authorized for an out-of-state placement. The Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a single case agreement.	An out of network coverage or out-of-state placement request is initiated by a provider or a member. Non-emergent OON coverage and planned out-of-state placement requests require prior authorization. The Plan verifies that a participating provider is not available to provide the requested service. The Plan accepts documentation that supports the need for out of network services and applies internal clinical guidelines, InterQual criteria, local and national coverage determination guidelines, National Institute of Health (NIH) resources, or Hayes Knowledge Center criteria applicable to the requested service through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The M/S Plan is required to notify the State when a member is authorized for an out-of-state placement. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a single case agreement.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews applicable policies annually, but more frequent reviews can be triggered by a change in State requirements. The Plan maintains a record of all out of network coverage requests and out of network service authorizations. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The M/S Plan udpates and revises applicable OON and out-of-state placement protocols no less than annually. State requirement changes, benefit changes and evolution of standards of science may necessitate more frequent reviews. The Plan reviews geo-access data, time and distance standards, utilization data and grievance data to inform the OON process. The data is reviewed monthly through the Plan's Contract Committee.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider or out of geographic area. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

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<tr><td colspan="3">Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])</td></tr>
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All out-of-network (non-emergent) services</td></tr>
<tr><td colspan="3">Comparability of Strategy</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">The Plan utilizes the strategy to ensure the safety of members and to control the quality of services being provided.</td><td>The M/S Plan reports that the NQTL that limits coverage to network providers supports oversight of the quality of care provided to members.</td></tr>
<tr><td colspan="3">Comparability of Evidence</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
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Comparability and Stringency of Processes	
MH/SUD	**M/S**
An out network coverage and out-of-state placement requests are initiated by a contracted health home, provider or a member. Non-emergent OON coverage and out-of-state placements must be prior authorized by the Plan. In addition to the prior authorization process, the Plan verifies that a participating provider is not available to provide the requested service. MCG, ASAM and InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved, the Plan must notify the State if a member has been authorized for an out-of-state placement. The Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a single case agreement.	To initiate a request for out of network coverage or out-of-state placement, a provider contacts the Plan's Utilization Management Department. A member could also initiate a request via the Plan's Customer Service Department or through the member's clinical team. A request for non-emergent OON coverage or a planned out-of-state placement requires prior authorization. The M/S Plan confirms that a participating provider is not available to provide the requested service. The M/S Plan requests the medical record and MCG criteria are applied to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The M/S Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the M/S Plan must notify the State. Once the request is approved by the M/S Plan, the Plan requests the provider's Medicaid identification number, W-9 form and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a single case agreement.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews applicable policies annually, but more frequent reviews can be triggered by a change in State requirements. The Plan maintains a record of all out of network coverage requests and out of network service authorizations. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The Plan reviews trended claims data, grievances, complaints and the volume and type of out of network requests. The information is reviewed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. Out of coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified.

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Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider or out of geographic area. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review Network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

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<tr><td colspan="3">Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="3">Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage</td></tr>
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<tr><td rowspan="2">Services</td><td colspan="2">MH/SUD:
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<tr><td colspan="3">Comparability of Strategy</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">The Plan utilizes the strategy to ensure the safety of members and to control the quality of services being provided.</td><td>The M/S Plan reports that limiting coverage to network providers helps ensure the quality of care provided to members, but the Plan will allow out of network coverage and out-of-state placements when deemed necessary to meet the member's health care needs.</td></tr>
<tr><td colspan="3">Comparability of Evidence</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
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Comparability and Stringency of Processes	
MH/SUD	M/S
An out network coverage and out-of-state placement requests are initiated by a contracted health home, provider or a member. Non-emergent OON coverage and out-of-state placements must be prior authorized by the Plan. In addition to the prior authorization process, the Plan verifies that a participating provider is not available to provide the requested service. MCG, ASAM and InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved, the Plan must notify the State if a member has been authorized for an out-of-state placement. The Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a single case agreement.	To initiate a request for out of network coverage or out-of-state placement, a provider contacts the Plan's Utilization Management Department. A request for non-emergent OON coverage or a planned out-of-state placement requires prior authorization. The M/S Plan confirms that a participating provider is not available to provide the requested service. The M/S Plan requests the medical record and MCG criteria are applied to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The M/S Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the M/S Plan must notify the State.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews applicable policies annually, but more frequent reviews can be triggered by a change in State requirements. The Plan maintains a record of all out of network coverage requests and out of network service authorizations. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The Plan reviews out of network coverage policies annually or more frequently if prompted by AHCCCS changes. The Plan reviews geo-access data, time and distance standards, and the volume of out of network coverage requests and reviews the data with a designated committee each month. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider or out of geographic area. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review Network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Cenpatico Integrated Care (CIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage

Classification: Inpatient and Outpatient Services

Services	
	MH/SUD: All out-of-network (non-emergent) services
	M/S: All out-of-network (non-emergent) services

Comparability of Strategy

MH/SUD	M/S
The Plan utilizes the strategy to ensure the safety of members and to control the quality of services being provided.	The strategy is used when in-network care is not available or not available within geo access or clinical specialty not available in network.

Comparability of Evidence

MH/SUD	M/S
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
An out network coverage and out-of-state placement requests are initiated by a contracted health home, provider or a member. Non-emergent OON coverage and out-of-state placements must be prior authorized by the Plan. In addition to the prior authorization process, the Plan verifies that a participating provider is not available to provide the requested service. MCG, ASAM and InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved, the Plan must notify the State if a member has been authorized for an out-of-state placement. The Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a single case agreement.	Requests for OON and outside geographic area services is initiated by providers via telephone, fax, or on line portal. In the event that a member initiated the request, the member would be instructed to have their current provider contact the Plan to provide the necessary information to support the request. Non-emergent OON coverage and services outside the geographic services area and out-of-state placements must be prior authorized by the Plan. The PA team will review the request for an OON provider for continuity of care and review the member's history for other PA cases, discharge needs provided after an Inpatient admission, emergency room or Urgent Care services requested by an OON provider, or if the provider in a rural area is willing to accept the Medicaid Fee Schedule. If the provider is not willing to accept the Medicaid rate, a Single Case Agreement (SCA) is required. The level of evidence that the provider should submit with the prior authorization request is an AHCCCS ID and clinical information to support continuity of care, post hospital care, and ED or Urgent Care discharge. If the member is out-of-state; the length of time out-of-state (urgent vs. routine) along with the service request. Timeframes for rendering an authorization decision are expedited (3 business days) and standard (14 calendar days) of receipt of the service request.
Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews applicable policies annually, but more frequent reviews can be triggered by a change in State requirements. The Plan maintains a record of all out of network coverage requests and out of network service authorizations. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The Plan reviews out of network coverage policies annually or more frequently if prompted by AHCCCS changes. The Plan reviews geo-access data, time and distance standards, and the volume of out of network coverage requests. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.

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Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider or out of geographic area. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

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<tr><td colspan="3">Benefit Package(s): Child</td></tr>
<tr><td colspan="3">Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])</td></tr>
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All out-of-network (non-emergent) services</td></tr>
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Out-of-State Placements</td></tr>
<tr><td colspan="3">Comparability of Strategy</td></tr>
<tr><td colspan="2">MH/SUD</td><td>M/S</td></tr>
<tr><td colspan="2">The MH/SUD plan permits coverage of services outside the network and geographic area to resolve short-term gaps in the contracted network, allow for flexibility to identify and secure specialty providers and to promote member choice.</td><td>The M/S Plan applies this limitation to meet State' requirements to establish a comprehensive provider network that provides access to all services covered under the contract for all members and to ensure that services are delivered by fully credentialed providers.</td></tr>
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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as HCIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	The M/S Plan is statutorily required to extend coverage to any State registered provider and does not maintain a contracted provider network. A provider may be identified as preferred by the Plan based on established quality metrics (readmissions, grievances, high claims volume), but an eligible member can receive services from any State Medicaid registered provider.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
To initiate a request for out of network coverage or out-of-state placement, a member's assigned health home would make the request to the Plan's utilization management department via the clinical team. A member could also initiate a request through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization if the requested service is required to be prior authorized. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. If the service requires prior authorization, the MH/SUD Plan requests clinical information and applies InterQual or other State generated medical necessity criteria to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. For all other out of network service requests, the MH/SUD Plan requires a one page form that includes the provider type, health home assignment, Medicaid registration identification number, NPI, and contact information. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. The Plan defaults the service reimbursement to 5% above the State rate but will negotiate an alternative rate if necessary and execute a single case agreement.	An out-of-state placement request is initiated by a provider or a member. Planned out-of-state placement requests require prior authorization. InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The provider must be an State registered provider in order to be reimbursed by the Plan for the service. The M/S Plan is required to notify the State when a member is authorized for an out-of-state placement. The provider is offered the standard State reimbursement rate.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The MH/SUD Plan conducts an annual network evaluation. As part of the annual network analysis, the MH/SUD Plan reviews single case agreements, including the type, populations served and the volume. In addition, complaint data collected through the member services department is reviewed quarterly through the Plan's Quality Management Committee.	The M/S Plan is statutorily required to extend coverage to any State registered provider and does not maintain a contracted provider network. A provider may be identified as preferred by the Plan based on established quality metrics (readmissions, grievances, high claims volume), but an eligible member can receive services from any State Medicaid registered provider.

Findings
All non-emergent MH/SUD services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. The MH/SUD Plan allows for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. The M/S Plan requires planned out-of-state placements to be prior authorized. The MH/SUD Plan requires the provider to submit a request if the service is subject to prior authorization, which is reviewed for medical necessity. For all other covered BH services, the decision to secure an OON provider is determined by the member and the member's clinical team. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. The MH/SUD Plan utilizes a single case agreement and requires that the provider is State registered. The MH/SUD Plan reviews network adequacy data and evidence to inform their strategy on a regular and frequent basis. The M/S Plan is statutorily required to extend coverage to any State registered provider. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult	
Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Health Choice (Medical/Surgical [M/S])	
Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage	
Classification: Inpatient and Outpatient Services	
Services	**MH/SUD:** All out-of-network (non-emergent) services
	M/S: All out-of-network (non-emergent) services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan permits coverage of services outside the network and geographic area to resolve short-term gaps in the contracted network, allow for flexibility to identify and secure specialty providers and to promote member choice.	The M/S Plan applies this limitation to meet State' requirements to establish a comprehensive provider network that provides access to all services covered under the contract for all members and to ensure that services are delivered by fully credentialed providers.

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as HCIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
To initiate a request for out of network coverage or out-of-state placement, a member's assigned health home would make the request to the Plan's utilization management department via the clinical team. A member could also initiate a request through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization if the requested service is required to be prior authorized. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. If the service requires prior authorization, the MH/SUD Plan requests clinical information and applies InterQual or other State generated medical necessity criteria to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. For all other out of network service requests, the MH/SUD Plan requires a one page form that includes the provider type, health home assignment, Medicaid registration identification number, NPI, and contact information. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. The Plan defaults the service reimbursement to 5% above the State rate but will negotiate an alternative rate if necessary and execute a single case agreement.	An out of network coverage or out-of-state placement request is initiated by a provider or a member. OON coverage and planned out-of-state placement requests require prior authorization. The Plan verifies that a participating provider is not available to provide the requested service. The Plan accepts documentation that supports the need for out of network services and applies internal clinical guidelines, InterQual criteria, local and national coverage determination guidelines, National Institute of Health (NIH) resources, or Hayes Knowledge Center criteria applicable to the requested service through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The M/S Plan is required to notify the State when a member is authorized for an out-of-state placement. The provider is offered the standard State reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a single case agreement.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The MH/SUD Plan conducts an annual network evaluation. As part of the annual network analysis, the MH/SUD Plan reviews single case agreements, including the type, populations served and the volume. In addition, complaint data collected through the member services department is reviewed quarterly through the Plan's Quality Management Committee.	The M/S Plan udpates and revises applicable OON and out-of-state placement protocols no less than annually. State requirement changes, benefit changes and evolution of standards of science may necessitate more frequent reviews. The Plan reviews geo-access data, time and distance standards, utilization data and grievance data to inform the OON process. The data is reviewed monthly through the Plan's Contract Committee.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is State registered. Both Plans review network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="2">Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult</td></tr>
<tr><td colspan="2">Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and University Family Care (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="2">Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage</td></tr>
<tr><td colspan="2">Classification: Inpatient and Outpatient Services</td></tr>
<tr><td rowspan="2">Services</td><td>MH/SUD:
All out-of-network (non-emergent) services</td></tr>
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<tr><td colspan="2">Comparability of Strategy</td></tr>
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</table>

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as HCIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
To initiate a request for out of network coverage or out-of-state placement, a member's assigned health home would make the request to the Plan's utilization management department via the clinical team. A member could also initiate a request through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization if the requested service is required to be prior authorized. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. If the service requires prior authorization, the MH/SUD Plan requests clinical information and applies InterQual or other State generated medical necessity criteria to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. For all other out of network service requests, the MH/SUD Plan requires a one page form that includes the provider type, health home assignment, Medicaid registration identification number, NPI, and contact information. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. The Plan defaults the service reimbursement to 5% above the State rate but will negotiate an alternative rate if necessary and execute a single case agreement.	Requests for OON and outside geographic area services is initiated by providers via telephone, fax, or on line portal. In the event that a member initiated the request, the member would be instructed to have their current provider contact the Plan to provide the necessary information to support the request. OON coverage and services outside the geographic services area and out-of-state placements must be prior authorized by the Plan. The PA team will review the request for an OON provider for continuity of care and review the member's history for other PA cases, discharge needs provided after an Inpatient admission, emergency room or Urgent Care services requested by an OON provider, or if the provider in a rural area is willing to accept the Medicaid Fee Schedule. If the provider is not willing to accept the Medicaid rate, a Single Case Agreement (SCA) is required. The level of evidence that the provider should submit with the prior authorization request is an State ID and clinical information to support continuity of care, post hospital care, and ED or Urgent Care discharge. If the member is out-of-state; the length of time out-of-state (urgent vs. routine) along with the service request. Timeframes for rendering an authorization decision are expedited (3 business days) and standard (14 calendar days) of receipt of the service request.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The MH/SUD Plan conducts an annual network evaluation. As part of the annual network analysis, the MH/SUD Plan reviews single case agreements, including the type, populations served and the volume. In addition, complaint data collected through the member services department is reviewed quarterly through the Plan's Quality Management Committee.	The Plan reviews out of network coverage policies and protocols annually or more frequently if the State changes criteria or policies. The M/S Plan reviews geo-access data to ensure the sufficiency of designated provider types, time and distance standards, and the volume of out of network coverage requests. The data is reviewed monthly through a designated Plan committee.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is State registered. Both Plans review network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child, non-serious mental illness adult, non-dual eligible adult

Contractors: Health Choice Integrated Care (HCIC) (Mental Health/Substance Abuse Disorder [MH/SUD]) and United Health Care (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage

Classification: Inpatient and Outpatient Services

Services	
	MH/SUD: All out-of-network (non-emergent) services
	M/S: All out-of-network (non-emergent) services

Comparability of Strategy

MH/SUD	M/S
The MH/SUD plan permits coverage of services outside the network and geographic area to resolve short-term gaps in the contracted network, allow for flexibility to identify and secure specialty providers and to promote member choice.	The M/S Plan applies this limitation to meet State' requirements to establish a comprehensive provider network that provides access to all services covered under the contract for all members and to ensure that services are delivered by fully credentialed providers.

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as HCIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
To initiate a request for out of network coverage or out-of-state placement, a member's assigned health home would make the request to the Plan's utilization management department via the clinical team. A member could also initiate a request through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization if the requested service is required to be prior authorized. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. If the service requires prior authorization, the MH/SUD Plan requests clinical information and applies InterQual or other State generated medical necessity criteria to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. For all other out of network service requests, the MH/SUD Plan requires a one page form that includes the provider type, health home assignment, Medicaid registration identification number, NPI, and contact information. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. The Plan defaults the service reimbursement to 5% above the State rate but will negotiate an alternative rate if necessary and execute a single case agreement.	Requests for OON and outside geographic area services is initiated by providers via telephone, fax, or on line portal. In the event that a member initiated the request, the member would be instructed to have their current provider contact the Plan to provide the necessary information to support the request. OON coverage and services outside the geographic services area and out-of-state placements must be prior authorized by the Plan. The PA team will review the request for an OON provider for continuity of care and review the member's history for other PA cases, discharge needs provided after an Inpatient admission, emergency room or Urgent Care services requested by an OON provider, or if the provider in a rural area is willing to accept the Medicaid Fee Schedule. If the provider is not willing to accept the Medicaid rate, a Single Case Agreement (SCA) is required. The level of evidence that the provider should submit with the prior authorization request is an State ID and clinical information to support continuity of care, post hospital care, and ED or Urgent Care discharge. If the member is out-of-state; the length of time out-of-state (urgent vs. routine) along with the service request. Timeframes for rendering an authorization decision are expedited (3 business days) and standard (14 calendar days) of receipt of the service request.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The MH/SUD Plan conducts an annual network evaluation. As part of the annual network analysis, the MH/SUD Plan reviews single case agreements, including the type, populations served and the volume. In addition, complaint data collected through the member services department is reviewed quarterly through the Plan's Quality Management Committee.	The Plan reviews out of network coverage policies annually or more frequently if prompted by State changes. The Plan review geo-access data, time and distance standards, and the volume of out of network coverage requests. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is State registered. Both Plans review network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]	
Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Care 1st (Medical/Surgical [M/S])	
Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage	
Classification: Inpatient and Outpatient Services	
Services	**MH/SUD:** All out-of-network and out-of-geographic area (non-emergent) services
	M/S: All out-of-network and out-of-geographic area (non-emergent) services

Comparability of Strategy

MH/SUD	M/S
The plan limits coverage to in network and offers coverage under this strategy when in-network care is not available or not available within geo access or clinical specialty not available in network.	The Plan reports that the strategy of limiting coverage when possible to network providers is used to ensure member safety and the quality of the care rendered by service providers.

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The MH/SUD Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for non-emergent OON and outside geographic area services is initiated by providers via telephone, fax, or on line portal. In the event that a member initiated the request, the member would be instructed to have their current provider contact the Plan to provide the necessary information to support the request. OON coverage and services outside the geographic services area and out-of-state placements must be prior authorized by the Plan. The PA team will review the request for an OON provider for continuity of care and review the member's history for other PA cases, discharge needs provided after an Inpatient admission, emergency room or Urgent Care services requested by an OON provider, or if the provider in a rural area is willing to accept the Medicaid Fee Schedule. If the provider is not willing to accept the Medicaid rate, a Single Case Agreement (SCA) is required. The level of evidence that the provider should submit with the prior authorization request is an AHCCCS ID (to verify AHCCCS registration) and clinical information to support continuity of care, post hospital care, and ED or Urgent Care discharge. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. If the member is out-of-state; the Plan requests that the provider submit the length of time out-of-state (urgent vs. routine) along with the service request. Timeframes for rendering an authorization decision are expedited (3 business days) and standard (14 calendar days) of receipt of the service request.	A non-emergent, out of network coverage or out-of-state placement request is initiated by a provider or a member. OON coverage and planned out-of-state placement requests require prior authorization. The Plan verifies that a participating provider is not available to provide the requested service. MCG criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved the M/S Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The M/S Plan is required to notify the State when a member is authorized for an out-of-state placement. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a letter of agreement.

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Out of Network/Geographic Area NQTL –
Inpatient and Outpatient Classifications

Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews out of network coverage policies annually or more frequently if prompted by AHCCCS changes. The Plan reviews geo-access data, time and distance standards, and the volume of out of network coverage requests. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The M/S Plan states that requirements and processes are reviewed and updated based on network need. Network adequacy is reviewed quarterly along with single case agreements and NON-PAR authorizations. The Plan also reviews and presents reports regarding network adequacy to designated committees. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made by the Plan to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review Network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS)]

Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Comprehensive Medical and Dental Program (CMDP) (Medical/Surgical [M/S])

Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage

Classification: Inpatient and Outpatient Services

Services	
	MH/SUD: All out-of-network and out-of-geographic area (non-emergent) services
	M/S: All out-of-network and out-of-geographic area (non-emergent) services

Comparability of Strategy

MH/SUD	M/S
The plan limits coverage to in network and offers coverage under this strategy when in-network care is not available or not available within geo access or clinical specialty not available in network.	The M/S Plan may approve an out-of-state placement in order to make medically necessary covered services available to members (e.g., specialized care).

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The MH/SUD Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.	The M/S Plan is statutorily required to extend coverage to any AHCCCS registered provider and does not maintain a contracted provider network. A provider may be identified as preferred by the Plan based on established quality metrics (readmissions, grievances, high claims volume), but an eligible member can receive services from any AHCCCS Medicaid registered provider.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for non-emergent OON and outside geographic area services is initiated by providers via telephone, fax, or on line portal. In the event that a member initiated the request, the member would be instructed to have their current provider contact the Plan to provide the necessary information to support the request. OON coverage and services outside the geographic services area and out-of-state placements must be prior authorized by the Plan. The PA team will review the request for an OON provider for continuity of care and review the member's history for other PA cases, discharge needs provided after an Inpatient admission, emergency room or Urgent Care services requested by an OON provider, or if the provider in a rural area is willing to accept the Medicaid Fee Schedule. If the provider is not willing to accept the Medicaid rate, a Single Case Agreement (SCA) is required. The level of evidence that the provider should submit with the prior authorization request is an AHCCCS ID (to verify AHCCCS registration) and clinical information to support continuity of care, post hospital care, and ED or Urgent Care discharge. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. If the member is out-of-state; the Plan requests that the provider submit the length of time out-of-state (urgent vs. routine) along with the service request. Timeframes for rendering an authorization decision are expedited (3 business days) and standard (14 calendar days) of receipt of the service request.	A non-emergent, out-of-state placement request is initiated by a provider or a member. Planned out-of-state placement requests require prior authorization. InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The provider must be an AHCCCS registered provider in order to be reimbursed by the Plan for the service. The M/S Plan is required to notify the State when a member is authorized for an out-of-state placement. The provider is offered the standard AHCCCS reimbursement rate.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews out of network coverage policies annually or more frequently if prompted by AHCCCS changes. The Plan reviews geo-access data, time and distance standards, and the volume of out of network coverage requests. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The M/S Plan is statutorily required to extend coverage to any AHCCCS registered provider and does not maintain a contracted provider network. A provider may be identified as preferred by the Plan based on established quality metrics (readmissions, grievances, high claims volume), but an eligible member can receive services from any AHCCCS Medicaid registered provider.

Findings
All non-emergent MH/SUD services are restricted to contracted, credentialed network providers unless an exception is made by the Plan to cover an OON provider. The MH/SUD Plan allows for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. The M/S Plan requires planned out-of-state placements to be prior authorized. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. The MH/SUD Plan utilizes a single case agreement and requires that the provider is AHCCCS registered. The MH/SUD Plan reviews Network adequacy data and evidence to inform their strategy on a regular and frequent basis. The M/S Plan is statutorily required to extend coverage to any AHCCCS registered provider. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

<table>
<tr><td colspan="2">Benefit Package(s): Child [Eligible for Children's Rehabilitative Services (CRS) and Arizona Long Term Care System (ALTCS)/Developmental Disabilities (DD)]</td></tr>
<tr><td colspan="2">Contractors: United Health Care Community Plan (UHCCP) (Mental Health/Substance Abuse Disorder [MH/SUD]) and Mercy Care Plan (Medical/Surgical [M/S])</td></tr>
<tr><td colspan="2">Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage</td></tr>
<tr><td colspan="2">Classification: Inpatient and Outpatient Services</td></tr>
<tr><td rowspan="2">Services</td><td>MH/SUD:
All out-of-network and out-of-geographic area (non-emergent) services</td></tr>
<tr><td>M/S:
All out-of-network and out-of-geographic area (non-emergent) services</td></tr>
<tr><td colspan="2">Comparability of Strategy</td></tr>
<tr><td>MH/SUD</td><td>M/S</td></tr>
<tr><td>The plan limits coverage to in network and offers coverage under this strategy when in-network care is not available or not available within geo access or clinical specialty not available in network.</td><td>The M/S Plan reports that the NQTL that limits coverage to network providers supports oversight of the quality of care, while approval for out of network providers ensures network adequacy by making services available to members (e.g., specialized care).</td></tr>
</table>

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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The MH/SUD Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements. The Plan requires that there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for non-emergent OON and outside geographic area services is initiated by providers via telephone, fax, or on line portal. In the event that a member initiated the request, the member would be instructed to have their current provider contact the Plan to provide the necessary information to support the request. OON coverage and services outside the geographic services area and out-of-state placements must be prior authorized by the Plan. The PA team will review the request for an OON provider for continuity of care and review the member's history for other PA cases, discharge needs provided after an Inpatient admission, emergency room or Urgent Care services requested by an OON provider, or if the provider in a rural area is willing to accept the Medicaid Fee Schedule. If the provider is not willing to accept the Medicaid rate, a Single Case Agreement (SCA) is required. The level of evidence that the provider should submit with the prior authorization request is an AHCCCS ID (to verify AHCCCS registration) and clinical information to support continuity of care, post hospital care, and ED or Urgent Care discharge. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. If the member is out-of-state; the Plan requests that the provider submit the length of time out-of-state (urgent vs. routine) along with the service request. Timeframes for rendering an authorization decision are expedited (3 business days) and standard (14 calendar days) of receipt of the service request.	To initiate a request for non-emergent, out of network coverage or out-of-state placement, a provider contacts the Plan's Utilization Management Department. A member could also initiate a request via the Plan's Customer Service Department or through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization. The M/S Plan confirms that a participating provider is not available to provide the requested service. The M/S Plan requests the medical record and MCG criteria are applied to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The M/S Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the M/S Plan must notify the State. Once the request is approved by the M/S Plan, the Plan requests the provider's Medicaid identification number, W-9 form and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a single case agreement.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews out of network coverage policies annually or more frequently if prompted by AHCCCS changes. The Plan reviews geo-access data, time and distance standards, and the volume of out of network coverage requests. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The Plan reviews trended claims data, grievances, complaints and the volume and type of out of network requests. The information is reviewed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. Out of coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made by the Plan to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review Network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

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<table>
<tr><th colspan="2">Comparability of Strategy</th></tr>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>The plan limits coverage to in network and offers coverage under this strategy when in-network care is not available or not available within geo access or clinical specialty not available in network.</td><td>The strategy is used when in-network care is not available or not available within geo access or clinical specialty not available in network.</td></tr>
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Comparability of Evidence	
MH/SUD	**M/S**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The MH/SUD Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.

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Comparability and Stringency of Processes	
MH/SUD	**M/S**
Requests for non-emergent OON and outside geographic area services is initiated by providers via telephone, fax, or on line portal. In the event that a member initiated the request, the member would be instructed to have their current provider contact the Plan to provide the necessary information to support the request. OON coverage and services outside the geographic services area and out-of-state placements must be prior authorized by the Plan. The PA team will review the request for an OON provider for continuity of care and review the member's history for other PA cases, discharge needs provided after an Inpatient admission, emergency room or Urgent Care services requested by an OON provider, or if the provider in a rural area is willing to accept the Medicaid Fee Schedule. If the provider is not willing to accept the Medicaid rate, a Single Case Agreement (SCA) is required. The level of evidence that the provider should submit with the prior authorization request is an AHCCCS ID (to verify AHCCCS registration) and clinical information to support continuity of care, post hospital care, and ED or Urgent Care discharge. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. If the member is out-of-state; the Plan requests that the provider submit the length of time out-of-state (urgent vs. routine) along with the service request. Timeframes for rendering an authorization decision are expedited (3 business days) and standard (14 calendar days) of receipt of the service request.	Requests for non-emergent OON and outside geographic area services is initiated by providers via telephone, fax, or on line portal. In the event that a member initiated the request, the member would be instructed to have their current provider contact the Plan to provide the necessary information to support the request. OON coverage and services outside the geographic services area and out-of-state placements must be prior authorized by the Plan. The PA team will review the request for an OON provider for continuity of care and review the member's history for other PA cases, discharge needs provided after an Inpatient admission, emergency room or Urgent Care services requested by an OON provider, or if the provider in a rural area is willing to accept the Medicaid Fee Schedule. If the provider is not willing to accept the Medicaid rate, a Single Case Agreement (SCA) is required. The level of evidence that the provider should submit with the prior authorization request is an AHCCCS ID and clinical information to support continuity of care, post hospital care, and ED or Urgent Care discharge. If the member is out-of-state; the Plan notifies the State and requests that the provider submit the length of time out-of-state (urgent vs. routine) along with the service request. Timeframes for rendering an authorization decision are expedited (3 business days) and standard (14 calendar days) of receipt of the service request.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews out of network coverage policies annually or more frequently if prompted by AHCCCS changes. The Plan reviews geo-access data, time and distance standards, and the volume of out of network coverage requests. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The Plan reviews out of network coverage policies annually or more frequently if prompted by AHCCCS changes. The Plan reviews geo-access data, time and distance standards, and the volume of out of network coverage requests. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.

Findings
All non-emergent MH/SUD and M/S services are restricted to contracted, credentialed network providers unless an exception is made by the Plan to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. Both Plans require the provider to submit a request, which is then reviewed for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State. To address this potential parity compliance issue, the State plans to amend the current requirement to only require the MH/SUD Plan to provide advanced notification in these circumstances. Both Plans utilize a single case agreement and requires that the provider is AHCCCS registered. Both Plans review network adequacy data and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Cenpatico Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage

Classification: Inpatient and Outpatient Services

Services	
	MH/SUD: All out-of-network (non-emergent) services
	M/S (LTSS): Occupational therapy Speech therapy Physical therapy Nursing Attendant care Homemaker Assisted living Skilled nursing facility

Comparability of Strategy

MH/SUD	M/S (LTSS)
The Plan utilizes the strategy to ensure the safety of members and to control the quality of services being provided.	The Plan reports that the strategies are in place to ensure that the claims may be encountered and that timely services are provided by qualified Out of Network Providers.

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Comparability of Evidence	
MH/SUD	**M/S (LTSS)**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The M/S Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, some contractors must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
An out network coverage and out-of-state placement requests are initiated by a contracted health home, provider or a member. Non-emergent OON coverage and out-of-state placements must be prior authorized by the Plan. In addition to the prior authorization process, the Plan verifies that a participating provider is not available to provide the requested service. MCG, ASAM and InterQual criteria are applied through the Plan's prior authorization process to determine if the service meets medical necessity. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. Once approved, the Plan must notify the State if a member has been authorized for an out-of-state placement. The Plan requires the provider to submit demographic information, a Medicaid registered provider identification number, address, NPI number, tax identification and a W-9 form. The provider is offered the standard AHCCCS reimbursement rate. However, the Plan will negotiate an alternative rate if deemed necessary to secure a needed service for a member through a single case agreement.	A request for out of network coverage or out-of-state placement can be initiated by a member, DES/DDD field staff or a provider. A request for non-emergency OON coverage or a planned out-of-state placement requires prior authorization. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. The member's clinical team determines if the LTSS meet medical necessity criteria to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The MH/SUD Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the M/S (LTSS) Plan must notify the State. Once the request is approved, the Plan requests the provider's Medicaid identification number, NPI and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate and generates a letter of authorization.
Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
The Plan reviews applicable policies annually, but more frequent reviews can be triggered by a change in State requirements. The Plan maintains a record of all out of network coverage requests and out of network service authorizations. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The M/S (LTSS) Plan reviews policies annually, but would only review the OON procedure if changes were deemed necessary, the procedure lacked clarity or it was determined that process steps needed to be reconfigured. The Plan reviews grievance and complaint data, authorization data and tracks the volume and type of OON requests to assess the stringency of the strategy.

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Findings
All non-emergent MH/SUD and M/S (LTSS) services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. The MH/SUD Plan requires the provider to submit a request; while the M/S (LTSS) defers the decision to engage an OON provider to the clinical team. Both Plans review for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State (though some LTSS may require State approval). To address potential parity compliance issues, the State plans to amend the current requirement to only require the MH/SUD Plan and designated LTSS to provide advanced notification in these circumstances. Both Plans utilize a single case agreement or letter of authorization and requires that the provider is AHCCCS registered. Both Plans review network adequacy data (complaints, number and types of OON requests) and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S (LTSS) inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

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<tr><td colspan="2">Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Health Choice Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])</td></tr>
<tr><td colspan="2">Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage</td></tr>
<tr><td colspan="2">Classification: Inpatient and Outpatient Services</td></tr>
<tr><td rowspan="2">Services</td><td>MH/SUD:
All out-of-network (non-emergent) services</td></tr>
<tr><td>M/S (LTSS):
Occupational therapy
Speech therapy
Physical therapy
Nursing
Attendant care
Homemaker
Assisted living
Skilled nursing facility</td></tr>
</table>

<table>
<tr><th colspan="2">Comparability of Strategy</th></tr>
<tr><th>MH/SUD</th><th>M/S (LTSS)</th></tr>
<tr><td>The MH/SUD plan permits coverage of services outside the network and geographic area to resolve short-term gaps in the contracted network, allow for flexibility to identify and secure specialty providers and to promote member choice.</td><td>The Plan reports that the strategies are in place to ensure that the claims may be encountered and that timely services are provided by qualified Out of Network Providers.</td></tr>
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Comparability of Evidence	
MH/SUD	**M/S (LTSS)**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as HCIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, some contractors must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
To initiate a request for out of network coverage or out-of-state placement, a member's assigned health home would make the request to the Plan's utilization management department via the clinical team. A member could also initiate a request through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization if the requested service is required to be prior authorized. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. If the service requires prior authorization, the MH/SUD Plan requests clinical information and applies InterQual or other State generated medical necessity criteria to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. For all other out of network service requests, the MH/SUD Plan requires a one page form that includes the provider type, health home assignment, Medicaid registration identification number, NPI, and contact information. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. The Plan defaults the service reimbursement to 5% above the State rate but will negotiate an alternative rate if necessary and execute a single case agreement.	A request for out of network coverage or out-of-state placement can be initiated by a member, DES/DDD field staff or a provider. A request for non-emergency OON coverage or a planned out-of-state placement requires prior authorization. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. The member's clinical team determines if the LTSS meet medical necessity criteria to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The MH/SUD Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the M/S (LTSS) Plan must notify the State. Once the request is approved, the Plan requests the provider's Medicaid identification number, NPI and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate and generates a letter of authorization.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
The MH/SUD Plan conducts an annual network evaluation. As part of the annual network analysis, the MH/SUD Plan reviews single case agreements, including the type, populations served and the volume. In addition, complaint data collected through the member services department is reviewed quarterly through the Plan's Quality Management Committee.	The M/S (LTSS) Plan reviews policies annually, but would only review the OON procedure if changes were deemed necessary, the procedure lacked clarity or it was determined that process steps needed to be reconfigured. The Plan reviews grievance and complaint data, authorization data and tracks the volume and type of OON requests to assess the stringency of the strategy.

Findings
All non-emergent MH/SUD and M/S (LTSS) services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. The MH/SUD Plan requires the provider to submit a request; while the M/S (LTSS) defers the decision to engage an OON provider to the clinical team. Both Plans review for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State (though some LTSS may require State approval). To address potential parity compliance issues, the State plans to amend the current requirement to only require the MH/SUD Plan and designated LTSS to provide advanced notification in these circumstances. Both Plans utilize a single case agreement or letter of authorization and requires that the provider is AHCCCS registered. Both Plans review network adequacy data (complaints, number and types of OON requests) and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S (LTSS) inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and Mercy Maricopa Integrated Care (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage

Classification: Inpatient and Outpatient Services

Services	
	MH/SUD: All out-of-network (non-emergent) services
	M/S (LTSS): Occupational therapy Speech therapy Physical therapy Nursing Attendant care Homemaker Assisted living Skilled nursing facility

Comparability of Strategy

MH/SUD	M/S (LTSS)
The MH/SUD Plan reports that the NQTL that limits coverage to network providers supports oversight of the quality of care, while approval for out of network providers ensures network adequacy by making services available to members (e.g., specialized care).	The Plan reports that the strategies are in place to ensure that the claims may be encountered and that timely services are provided by qualified Out of Network Providers.

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Comparability of Evidence	
MH/SUD	**M/S (LTSS)**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, RBHA Contractors, such as MMIC, must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, some contractors must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
To initiate a request for out of network coverage or out-of-state placement, a provider contacts the MH/SUD Plan's Utilization Management Department. A member could also initiate a request via the Plan's Customer Service Department or through the member's clinical team. A request for OON coverage or a planned out-of-state placement requires prior authorization. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. The MH/SUD Plan requests the medical record and MCG or other State generated medical necessity criteria are applied to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The MH/SUD Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. Once the request is approved, the MH/SUD Plan requests the provider's Medicaid identification number, W-9 form and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a single case agreement.	A request for out of network coverage or out-of-state placement can be initiated by a member, DES/DDD field staff or a provider. A request for non-emergency OON coverage or a planned out-of-state placement requires prior authorization. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. The member's clinical team determines if the LTSS meet medical necessity criteria to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The MH/SUD Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the M/S (LTSS) Plan must notify the State. Once the request is approved, the Plan requests the provider's Medicaid identification number, NPI and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate and generates a letter of authorization.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S (LTSS)**
The MH/SUD Plan regularly reviews trended claims data, grievances, complaints and the volume and type of out of network requests. The information is reviewed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. Out of network coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified.	The M/S (LTSS) Plan reviews policies annually, but would only review the OON procedure if changes were deemed necessary, the procedure lacked clarity or it was determined that process steps needed to be reconfigured. The Plan reviews grievance and complaint data, authorization data and tracks the volume and type of OON requests to assess the stringency of the strategy.

Findings
All non-emergent MH/SUD and M/S (LTSS) services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. The MH/SUD Plan requires the provider to submit a request; while the M/S (LTSS) defers the decision to engage an OON provider to the clinical team. Both Plans review for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State (though some LTSS may require State approval). To address potential parity compliance issues, the State plans to amend the current requirement to only require the MH/SUD Plan and designated LTSS to provide advanced notification in these circumstances. Both Plans utilize a single case agreement or letter of authorization and requires that the provider is AHCCCS registered. Both Plans review network adequacy data (complaints, number and types of OON requests) and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S (LTSS) inpatient and outpatient services, in writing or in operation.

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COMPLIANCE DETERMINATION

Benefit Package(s): Child and adult members eligible for the Arizona Long-Term Care System (ALTCS)/Developmental Disabilities (DD) Program

Contractors: Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)(Medical/Surgical [M/S]/Long-Term Care Services and Supports [LTSS]) and United Healthcare Community Plan (Mental Health/Substance Abuse Disorder [MH/SUD])

Non-quantitative treatment limit (NQTL): Out of Network (OON)/Geographic Area Coverage

Classification: Inpatient and Outpatient Services

Services	
	MH/SUD: All out-of-network (non-emergent) services
	M/S (LTSS): Occupational therapy Speech therapy Physical therapy Nursing Attendant care Homemaker Assisted living Skilled nursing facility

Comparability of Strategy

MH/SUD	M/S (LTSS)
The plan limits coverage to in network and offers coverage under this strategy when in-network care is not available or not available within geo access or clinical specialty not available in network.	The Plan reports that the strategies are in place to ensure that the claims may be encountered and that timely services are provided by qualified Out of Network Providers.

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Comparability of Evidence	
MH/SUD	**M/S (LTSS)**
State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, the Plan must have a network that provides access so that 90% of the membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain PCP services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The MH/SUD Plan reviews their network to ensure and maintain a provider network that is sufficient to provide all covered services consistent with CMS and State requirements.	State contract and policy requires the Plan to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). OON providers are required if Contractor's network is unable to provide adequate and timely services until a network provider is available. State policy establishes timeliness and distance standards for all Plans. For example, some contractors must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services. The Plan must maintain a defined number of hospitals in the geographic region they serve (the defined number is consistent for both types of Plans within the geographical region). The Plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network.

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Comparability and Stringency of Processes	
MH/SUD	**M/S (LTSS)**
Requests for non-emergent OON and outside geographic area services is initiated by providers via telephone, fax, or on line portal. In the event that a member initiated the request, the member would be instructed to have their current provider contact the Plan to provide the necessary information to support the request. OON coverage and services outside the geographic services area and out-of-state placements must be prior authorized by the Plan. The PA team will review the request for an OON provider for continuity of care and review the member's history for other PA cases, discharge needs provided after an Inpatient admission, emergency room or Urgent Care services requested by an OON provider, or if the provider in a rural area is willing to accept the Medicaid Fee Schedule. If the provider is not willing to accept the Medicaid rate, a Single Case Agreement (SCA) is required. The level of evidence that the provider should submit with the prior authorization request is an AHCCCS ID (to verify AHCCCS registration) and clinical information to support continuity of care, post hospital care, and ED or Urgent Care discharge. For out-of-state placements, the MH/SUD Plan must notify the State and request approval. If the member is out-of-state; the Plan requests that the provider submit the length of time out-of-state (urgent vs. routine) along with the service request. Timeframes for rendering an authorization decision are expedited (3 business days) and standard (14 calendar days) of receipt of the service request.	A request for out of network coverage or out-of-state placement can be initiated by a member, DES/DDD field staff or a provider. A request for non-emergency OON coverage or a planned out-of-state placement requires prior authorization. The MH/SUD Plan confirms that a participating provider is not available to provide the requested service. The member's clinical team determines if the LTSS meet medical necessity criteria to determine if the service will be authorized. The Plan will complete the review within 3 days for expedited requests and 14 days for standard requests. The MH/SUD Plan determines if the out of network provider is actively registered as a Medicaid provider. For out-of-state placements, the M/S (LTSS) Plan must notify the State. Once the request is approved, the Plan requests the provider’s Medicaid identification number, NPI and tax identification number. The Plan defaults the service reimbursement to the AHCCCS rate and generates a letter of authorization.

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Stringency of Strategy and Evidence	
MH/SUD	**M/S**
The Plan reviews out of network coverage policies annually or more frequently if prompted by AHCCCS changes. The Plan reviews geo-access data, time and distance standards, and the volume of out of network coverage requests. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements.	The M/S (LTSS) Plan reviews policies annually, but would only review the OON procedure if changes were deemed necessary, the procedure lacked clarity or it was determined that process steps needed to be reconfigured. The Plan reviews grievance and complaint data, authorization data and tracks the volume and type of OON requests to assess the stringency of the strategy.

Findings
All non-emergent MH/SUD and M/S (LTSS) services are restricted to contracted, credentialed network providers unless an exception is made to cover an OON provider. Both Plans allow for OON and Out of Geographic Area coverage for services provided emergently and when necessary services are not available in network or do not meet network access or distance standards. The MH/SUD Plan requires the provider to submit a request; while the M/S (LTSS) defers the decision to engage an OON provider to the clinical team. Both Plans review for medical necessity (except for emergent services) and must be authorized prior to the member accessing the services. For planned out-of-state placements, the MH/SUD Plan must notify and secure prior approval from the State while the M/S Plan is only required to notify the State (though some LTSS may require State approval). To address potential parity compliance issues, the State plans to amend the current requirement to only require the MH/SUD Plan and designated LTSS to provide advanced notification in these circumstances. Both Plans utilize a single case agreement or letter of authorization and requires that the provider is AHCCCS registered. Both Plans review network adequacy data (complaints, number and types of OON requests) and evidence to inform their strategy on a regular and frequent basis. As a result, the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to MH/SUD inpatient and outpatient services are comparable and no more stringent than the processes, strategies and evidentiary standards used in applying OON/geographic restrictions and exceptions to M/S (LTSS) inpatient and outpatient services, in writing or in operation.

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