Rhode Island Executive Office of Health and Human Services

Behavioral Health Parity Compliance Plan
Report Resubmission to CMS
June 17, 2019

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EXECUTIVE SUMMARY

Background

The Medicaid/CHIP final parity rule applies most provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid and CHIP programs.[1] Under this rule, states are required to do a parity analysis, document their findings, and create a compliance plan to address any necessary follow-up activities. Rhode Island Executive Office of Health and Human Services (EOHHS) initially submitted a Behavioral Health (BH) Parity Compliance Report for "in-plan" benefits to the Center for Medicare and Medicaid Services (CMS) in October 2017. This analysis included a side-by side analysis completed by each of the Medicaid Managed Care Organizations (MCOs), using the Non-Quantitative Treatment Limit (NQTL) Questionnaire Example A, found on page 42 of CMS' Parity Compliance Toolkit. [2]

CMS has requested that EOHHS resubmit the BH Parity Compliance Report with additional information. CMS has requested that the revised report:

- document EOHHS's analysis of the MCO submissions at the benefit package level,
- include findings for each separate required step of the analysis, not just an overall summary, and
- include carved out benefits.

Process

This revised submission is a detailed BH parity analysis and summary of findings. The report details actions taken for each step of CMS's Parity Implementation Roadmap,[3] and provides detailed findings of EOHHS's current BH parity status. EOHHS has reviewed MCO-submitted materials, other MCO material available, State Plan documents, 1115 waiver documents, and MCO contracts. This report includes a detailed analysis on parity compliance for both "in-plan" and "out-of-plan" benefits, including a summary of EOHHS's analysis of each of the MCOs' submissions for each benefit package.

The report documents the review process, findings, and recommendations for both the EOHHS Medicaid Fee-for Service (FFS) program and its contracted MCOs. The report also discusses other ongoing RI regulatory activities conducted by the Office of the Health Insurance Commissioner (OHIC) related to BH Parity compliance in commercial health plans.

Findings

The report finds that both EOHHS and the contracted MCOs are very aware of the BH Parity rules and have incorporated them into their policies and clinical standards. After a comprehensive review, including requesting additional information and clarifications from the

[1] https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of

[2] https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf

[3] https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-roadmap.pdf

MCOs in the spring of 2019, all written policies of the three Medicaid-participating MCOs were found to be fully compliant with federal BH Parity rules. A review of the waiver, MCO contract, and Medicaid State Plan found that EOHHS's Medicaid policies are also fully compliant with BH Parity.

This report completes all CMS requirements for a state Medicaid BH Parity review, with the exception of conducting a review of the comparability and stringency of the actual service approval decision-making process. This last step required is to confirm that EOHHS is compliant at the level of service authorization decisions made by the MCO and EOHHS.

Next Steps

A thorough review of the actual service authorization decision-making process can only be achieved through on-site visits and interviews with the three MCOs and Medicaid's fiscal agent, as well as an adequate random sample review of cases containing service authorization decisions made for BH services, and a companion review of med/surg service authorization cases. EOHHS recognizes that this review is required in order to fully confirm BH parity compliance.

Rhode Island, as a whole, sees value in addressing parity at all levels, systems, and populations. On the commercial side, OHIC recently conducted an analysis of each of RI's four major commercial carriers' compliance with mental health and substance use laws and regulations. For their analysis, OHIC completed a policy review of all issuers as well as an operational/process review by conducting chart audits on a random sample of cases to identify potential areas of non-compliance. This analysis included, but was not limited to, BH parity, obligations relating to emergency services, coverage requirements, access to coverage, and utilization review decision processes. EOHHS is planning to leverage OHIC's experience to identify potential areas of non-compliance that would not be recognized in a review only of MCO written policies and standards.

EOHHS may look to use its external quality review organization (EQRO) vendor to conduct the last step of this compliance review process over the next year. Medicaid programs are required by CMS to have an EQRO vendor conduct clinical quality reviews of Medicaid MCOs each year. EOHHS can choose an area of focus for these required clinical studies and could make BH parity the focus for the next review. In order to leverage OHIC's recent experience, EOHHS and the EQRO vendor would meet with OHIC to learn about best practices that could help inform the review process.

SECTION I: BACKGROUND INFORMATION

CMS Final Medicaid/CHIP Final Parity Rule

Under the final Medicaid/CHIP final parity rule, managed care organizations (MCOs) may not apply any financial requirement or quantitative treatment limitation (QTL) to mental health or substance use disorder ("MH/SUD") benefits that is more restrictive than the predominant financial requirement or QTL of that type applied to substantially all medical/surgical benefits in the same classification.

Also under the rule, an MCO cannot impose a non-quantitative treatment limit (NQTL) on MH/SUD benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to and are applied no more stringently than those used in applying the limitation to medical/surgical benefits in the same classification. NQTLs may include but are not limited to prior, concurrent, and retrospective review and approval; other medical management strategies; formulary design; and network admission standards.

The rule requires states to do a parity analysis on all services for which the following populations are eligible:

- Members in managed care organizations (MCOs). EOHHS contracts with 3 MCOs: Neighborhood Health Plan of RI (NHPRI), UnitedHealthcare of New England, Inc (UHCNE), and Tufts Health Plan (Tufts);
- Members in Alternative Benefit Plans (ABPs), regardless of delivery system; and
- Members in the Children's Health Insurance Program (CHIP), regardless of delivery system.

EOHHS BH Parity Workgroup Description

An interdepartmental group was convened including staff from EOHHS, which includes the Medicaid Program, and from the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), which includes the state's mental health authority. The interdepartmental workgroup met several times to review and comment on materials submitted by the MCOs concerning potential areas of non-compliance. Members of the workgroup are listed in Attachment 1.

The effort for this revised report submission is led by Chantele Rotolo and Melody Lawrence of EOHHS, with consultation from Jerry Fingerut, MD, EOHHS Associate Medical Director, and Brian Daly, MD, Medical Director, BHDDH. The team also has support from Faulkner Consulting Group, which has expertise in this area.

Determination of Benefit Packages Subject to Medicaid BH Parity Rules

EOHHS has two benefit packages containing Mental Health/Substance Use Disorder (MH/SUD) benefits, which are therefore subject to the Medicaid BH Parity rule.[4] Attachment 2 provides a visual description of EOHHS's Medicaid benefit packages and the populations within each benefit package subject to the parity rule. It also provides a description of the populations whose benefit packages are not subject to the federal parity rule.

The following covered populations have access to comprehensive benefits, including MH/SUD services, under the two benefit packages:

1. Populations Eligible for EOHHS Medicaid Comprehensive Benefit Package

- *RIte Care* children and families (including CHIP-eligible children).[5] This group also includes optional waiver populations for pregnant women, children in substitute care and adoption subsidy, and children with special health care needs.
- *Rhody Health*, which is made up of adults with disabilities.
- Affordable Care Act (ACA) *Adult Expansion* Population, for adults under 138% FPL.

The populations above are enrolled in their choice of 3 MCOs and are eligible for the same in-plan and out-of-plan benefits under Medicaid. Their comprehensive Medicaid benefit package is also defined as the "benchmark plan" in the RI Medicaid State Plan. That same benefit package is defined as the Alternative Benefit Package (ABP) in RI's State Plan for the ACA expansion adult population.

This benefit package also encompasses Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which is further described in the next section of this report.

2. Populations Enrolled in both Medicare and Medicaid

Dual eligible enrollees have a choice of enrolling in EOHHS's Medicaid dual demonstration. One MCO, NHPRI, offers this option, where both Medicare and Medicaid benefits are provided seamlessly by the MCO. Dual eligible enrollees are eligible for the same in-plan and out-of-plan benefit package described above, except any benefit covered by Medicare is only covered by Medicaid as the second payor. The other choice for dual eligible population is to remain in Medicaid Fee-for-Service (FFS), where they would be eligible for the same benefit package, delivered by Medicaid FFS as a second payor to Medicare.

[4] In this report, Behavioral Health (BH) is used interchangeably with Mental Health/Substance Use Disorder (MH/SUD).
[5] EOHHS operates CHIP as a Medicaid expansion program, assuring that children eligible for enhanced CHIP matching funds are enrolled in RIte Care, and have access to the same, comprehensive benefit package as the rest of the Medicaid enrolled children.

EOHHS has several additional special waiver populations which are not eligible for the full scope of Medicaid benefits because they do not meet the Medicaid income limits. Since they are eligible only for select individual benefits, these populations are not subject to the BH Parity rule.

An additional waiver population, Extended Family Planning (EFP), is eligible for a set of family-planning related benefits only. This is the only population currently subject to the QTL of point of service cost-sharing. However, this population is not eligible for any MH/SUD benefits under Medicaid, and thus is not subject to the BH parity rule.

EOHHS Definition of Service Classifications

The federal regulation requires states to further categorize benefits into four classifications – Inpatient, Outpatient, Prescription Drugs and Emergency.

EOHHS's Medicaid State Plan defines these service categories as follows:

Emergency Services:

- Emergency Outpatient Hospital Services:
  - No service authorization required
  - No amount, duration or scope limitation
  - Covered both in-state and out-of-state, for emergency services or when authorized by a provider, or in order to assess whether a condition warrants emergency treatment as an emergency service.
- Emergency Transportation Services:
  - No service authorization required
  - No amount, duration or scope limitation
  - Covered both in-state and out-of-state, for emergency services or when authorized by a provider, or in order to assess whether a condition warrants emergency treatment as an emergency service.

Inpatient Hospital Services:

- Inpatient Hospital:
  - Subject to Prior Authorization
  - No limit on amount
  - Duration Limit: Up to 365 days per year based on medical necessity
  - Scope Limit: Payment not made for inpatient hospital services related to elective surgery performed for cosmetic purposes only.
- Maternity:
  - Subject to Prior Authorization
  - No amount, duration or scope limitation

Prescription Drugs:

- Benefit Provided: Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the baseline benchmark.
- Requires authorization by a state licensed provider
- Limits on brand drugs
- Subject to Preferred Drug List
- Subject to other coverage limits (unspecified)
- No limits on number of days supply or number of prescriptions
- The state of Rhode Island's APB prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Outpatient Services

- Outpatient Services were mapped to the "Ambulatory Patient Services" Essential Health Benefit (EHB) category. The source of this information is 1905(a), which includes:
  - Outpatient Hospital
    - Subject to prior authorization
    - No other limits
  - Non-Emergency Transportation
    - Subject to prior authorization
    - No other limits
  - Hospice care
    - Subject to prior authorization
    - No other limits
  - Physician's Services
    - Covered as needed, based on medical necessity, including primary care, specialty care and obstetric care.
    - Prior authorization is required for all surgical procedures of a cosmetic nature which must be performed for a functional purpose.
    - No other limits
  - Personal Care Services
    - Subject to prior authorization
    - No other limits
  - Case management services (including Tuberculosis-related Case Management Services)
    - Subject to prior authorization
    - Some case management services are limited to specific populations or groups of individuals, as detailed in RI's State Plan.
  - Podiatrist Services:
    - Prior authorization is required for x-rays performed for diagnostic evaluation services and molded shoes

- No other limits

In addition to these four service categories, EOHHS'S State Plan defines EPSDT Benefits as follows:

> **EPSDT Benefits**
> EPSDT benefits are provided to all members under 21 and are fully integrated into the comprehensive benefit package, composed of both in-plan and out-of-plan benefits. According to EOHHS's State Plan, EPSDT benefits may:
> - be subject to Prior Authorization
>   - The prior authorization requirements which are applicable to all other medical services and supplies provided in the Rhode Island Medical Assistance Program also apply for EPSDT Benefits
> - have no amount or duration limitation, and
> - be limited in scope to all children and young adults up to age 21.

EOHHS Medical Necessity Definition

EOHHS uses the following policy to define Medical Necessity:

> The term "medical necessity", "medically necessary", or "medically necessary service" means medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of an injury, health related condition, disease or its symptoms including such services necessary to prevent a detrimental change in either medical or mental health status or substance use disorder or services needed to achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity. Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

Definition of MH/SUD Benefits

The federal regulation requires states to categorize benefits as either medical/surgical or MH/SUD. EOHHS uses both the Diagnostic and Statistical Manual for Mental Disorders (DSM) V and the Current Procedural Terminology (CPT) 10 as the bases to define MH/SUD benefits and distinguish them from medical/surgical benefits.

EOHHS MH/SUD Clinical/Evidentiary Standards

EOHHS bases its clinical/evidentiary standards on nationally recognized clinical standards, which serve as a minimum standard for providing MH/SUD services in the appropriate amount, level of care, and duration.[6]

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[6] MEDICAID EVIDENTIARY STANDARD REQUIREMENTS: § 438.236 Practice guidelines.
(a)*Basic rule.* The State must ensure, through its contracts, that each MCO, PIHP, and PAHP meets the requirements of this section.
(b)*Adoption of practice guidelines.* Each MCO and, when applicable, each PIHP and PAHP adopts practice guidelines that meet the following requirements:
(1) Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
(2) Consider the needs of the MCO's, PIHP's, or PAHP's enrollees.

SUD Service Standards

For SUD services, RI's 1115 waiver requires that all MH and SUD diagnosis and treatment need determinations meet the American Society of Addiction Medicine (ASAM) criteria.

The RI State Plan requires Substance Abuse Assessment Services to determine recommended level of care according to ASAM Patient Placement Criteria. [7] This includes Assessment, Outpatient Counseling, and Day Treatment.

EOHHS's contract with the MCOs requires that they use ASAM or comparable policies and procedures for initial and ongoing service authorization for:

- Non-hospital-based inpatient detox
- Residential Substance Abuse Treatment
- Assertive Community Treatment (ACT) Services
- Integrated Health Home (IHH) Services
- Adolescent Substance Abuse Treatment

Mental Health Service Standards

EOHHS developed an "Integrated Health Home Manual" that defines the six major SPMI diagnoses which determine eligibility for:

- Integrated Health Homes (IHH)
- Assertive Community Treatment (ACT), and
- Mental Health Psychiatric Rehabilitative Residence (MHPRR) specialty services.

In addition, EOHHS has adopted the ACT national clinical standards.

EOHHS uses the Daily Living Activities instrument (DLA-20) as an assessment tool that determines service authorization/reauthorization requests.[8] Based on DLA score individuals are triaged as appropriate to either General Outpatient (GOP), IHH, ACT, or MHPRR. Persons are reassessed every 6 months to see if they are appropriate for their placed care level.

(3) Are adopted in consultation with contracting health care professionals.
(4) Are reviewed and updated periodically as appropriate.
(c)*Dissemination of guidelines.* Each MCO, PIHP, and PAHP disseminates the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
(d)*Application of guidelines.* Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

[7] RI State Medicaid Plan page 6.20

[8] https://www.thenationalcouncil.org/areas-of-expertise/dla-20-mental-health-outcomes-measurement

SECTION II: BH PARITY COMPLIANCE DETERMINATION PROCESS

With the submission of this report, EOHHS, in partnership with BHDDH, has completed the policy compliance assessment steps required in accordance with CMS's BH Parity Toolkit. EOHHS has assessed the compliance of policies, strategies and standards for FFS benefits, state policy documents, and MCO policies and standards with federal BH Parity rules. This has essentially been a thorough review of policy documents and clinical standards, not a review of actual processes and practices.

A review of actual processes in use and actual decision-making practices will require a random sample review of MCO case records. Review of policy information does not provide EOHHS with information on whether actual processes and practices follow written policies and standards. EOHHS is committed to doing this in-depth clinical review of processes and practices over the next year, potentially making use of its EQRO vendor. This planned review of processes and practices will be further discussed following this section.

EOHHS has conducted the following process to determine BH Parity compliance of written Policies, Standards and Strategies, for both FFS Medicaid and at the MCOs:

1. In 2017, a BH Parity interagency workgroup was convened, including staff from EOHHS and BHDDH, the state mental health authority. In the follow-up 2019 review, Medical Directors from each agency were also engaged in a consultative role.
2. For the current report, as documented in Section I, EOHHS has done the following:
    a) Determined that two benefit packages are subject to federal BH Parity rules.
    b) Determined which services are defined as Behavioral Health, and which are defined as Medical/Surgical, and provided the national definitional standards used as the basis for the definitions.
    c) Defined inpatient, outpatient (as ambulatory care services), prescription drugs, and emergency services.
    d) Determined the types of clinical/evidentiary standards used by EOHHS.
    e) Provided EOHHS's definition of medical necessity.
3. EOHHS then identified and analyzed all BH QTLs and NQTLs in detail across EOHHS Medicaid MCOs.
    a) In 2017, EOHHS developed a process and template, built on the CMS template, to identify all MH/SUD NQTLs in Medicaid Managed Care. NQTLs specifically listed in the template included:
        - Medical necessity determination
        - Medical appropriateness review
        - Prior authorization
        - Current or retrospective review
        - Admissions standards
        - Provider network standards; tiered networks; out-of-network access standards

- Reimbursement rates
- Fail first requirements
- Facility-related restrictions (e.g. location, type)
- Drug formularies
- Outlier management
- Experimental determinations
- Exclusions
- Any other NQTLs

b) In 2017, EOHHS used the CMS template described above to send a Request for Information to each of the MCOs for each of the two benefit packages. Meetings were held with the MCOs to further explain the request and answer questions.

c) In this 2019 analysis, EOHHS conducted a more detailed review and created written summaries of the completed templates that had been submitted by the MCOs in 2017. This process included identifying all BH NQTLs, identifying med/surg equivalents, and determining whether each MCO is in compliance with BH Parity for each identified MH/SUD NQTL. This was done in order to determine and clearly document for CMS each MCO's BH Parity compliance for each MH/SUD NQTL by comparing to the med/surg benefit.

d) EOHHS determined and documented BH Parity compliance for each NQTL in each MCO for each of the two benefit plans (only one MCO offers two benefit plans).

e) EOHHS requested additional information from the MCOs, as well as clarification of information already provided, for any NQTL which could not be determined compliant due to missing or unclear information.

f) EOHHS conducted a detailed analysis of the additional information provided to complete a compliance summary for each MCO. These summaries are provided in Attachments 5-8.

g) Each MCO will be informed in writing of the results of the policy and standards compliance analysis for their MCO. This correspondence will also inform the MCOs about plans for an upcoming on-site review, which may include random sample medical record audits to determine BH Parity compliance in actual practice.

4. EOHHS reviewed MCO provider manuals, credentialing processes, network adequacy standards and facility participation requirements.

5. EOHHS identified and analyzed all BH QTLs and NQTLs across EOHHS policies and standards.

    a) In this 2019 review, EOHHS built on the CMS template to identify all MH/SUD NQTLs in Medicaid FFS as well as NQTLs that are requirements in the MCO contract. EOHHS identified all such policy-directed MH/SUD NQTLs by

conducting a complete review of the Medicaid State Plan, 1115 waiver, and the MCO contract.

b) EOHHS then determined BH Parity compliance of requirements and policies for each NQTL.
c) A copy of the compliance summary for EOHHS FFS Medicaid and other EOHHS policy documents is provided in Attachment 4.

6. To date, this entire process has been strictly a review of FFS Medicaid and MCO policies and clinical standards. The basis for this BH parity analysis of the MCOs has primarily been the analysis conducted internally by each MCO, as well as EOHHS review of MCO submissions and written policies.

7. EOHHS analysis of FFS Medicaid has been a review of policy documents (State Plan, waiver, MCO contract), and has not included a review of actual processes and practices that take place when a service is requested for prior approval.

8. A detailed analysis of the actual practice of prior of concurrent service authorization will be conducted for each of the MCOs by conducting a detailed review of a random sample of medical records which have included a BH prior authorization or concurrent review. These will be compared to similar med/surg authorizations. A review of prior authorizations in FFS Medicaid for BH services will also be conducted in order to observe the process, timeliness, and appropriateness of the review and authorization decision.

SECTION III: BH PARITY POLICY COMPLIANCE FINDINGS

Financial Requirements, Lifetime or Annual Dollar Limits for MH/SUD

EOHHS has no copays, premiums or dollar limits except for point of service copays in the Extended Family Planning (EFP) program. The EFP benefit package is not subject to the BH parity rule because the EFP waiver population is not eligible for MH/SUD benefits. Therefore, no claims analysis is needed to test parity compliance.

Quantitative Treatment Limits (QTLs) for MH/SUD

EOHHS identified the following QTLs. However, after careful clinical review, EOHHS has determined that it is in parity compliance with QTLs.

- Based on review of MCO policy documentation, EOHHS determined that there are no BH QTLs across all Medicaid benefit plans for NHPRI, UHCNE, and Tufts Health Plan.
- Based on a thorough review of the Medicaid State Plan, EOHHS determined that there are three Children's Behavioral Health services which have suggested quantitative treatment limits within benefit packages subject to BH Parity rules. These services are: Children's Emergency Services (CES), Early Start, and Children and Adolescents Intensive Treatment Services (CAITS). Each of these specified in-plan services have stated suggested duration limits of hours or weeks of service. However, the program policies also state that EPSDT overrides these treatment limits for members under age 21. Since these services are not provided to members over age 21, and EPSDT has no quantitative treatment limits, EOHHS has concluded that the Medicaid State Plan is in compliance with BH Parity rules for these services.

Parity Requirements in MCO Contracts

The Final Medicaid Parity Rule requires states to include contract provisions requiring compliance with parity standards in all applicable Medicaid managed care contracts. EOHHS is in compliance with this requirement, having added the following three sections to all Medicaid MCO contracts:

> ***"MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)***
> *MHPAEA requires MCOs that cover mental health or substance use disorders to offer coverage for those services that is no more restrictive than the coverage for medical/surgical conditions."*
>
> ***"MENTAL HEALTH PARITY***
> *The Contractor will comply with the Mental Health Parity Addiction Equity Act (MHPAEA). Requirements include:*
>
> - *Treatment limitations that are applied to mental health or substance use disorder benefits are no more than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.*

- *There are no separate treatment limitations that apply only to mental health or substance use disorder benefits.*
- *Medical management techniques used by the Contractor must be comparable to and applied no more stringently that the medical techniques that are applied to medical/surgical benefits."*

"BEHAVIORAL HEALTH SERVICES

The Contractor must comply with MHPAEA requirements and establish coverage parity between mental health/substance abuse benefits and medical/surgical benefits. The Contractor will cover mental health or substance use disorders in a manner that is no more restrictive than the coverage for medical/surgical conditions. The Contractor will publish any processes, strategies, evidentiary standards, or other factors used in applying NQTLs to mental health or substance use disorder benefits and ensure that the classifications are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. The Contractor will provide EOHHS with its analysis ensuring parity compliance when: (1) new services are added as an in-plan benefit for members or (2) there are changes to NQTLs. The Contractor will publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence. In the event of a suspected parity violation, the Contractor will direct members through its internal complaint, grievance and appeals process as appropriate. If the matter is still not resolved to the member's satisfaction, the member may file an external appeal (medical review) and/or a State Fair Hearing. The Contractor will track and trend parity complaints, grievances and appeals on the EOHHS approved template at a time and frequency as specified in the EOHHS Managed Care Reporting Calendar and Templates."

Provider Manual

Each of the MCOs has a provider section on their website. The Tufts website includes a provider manual, which includes specific information on covered benefits. UHCNE uses eligibilityLink to provide covered benefits specific to the member's benefit plan. NHPRI has a list of covered benefits within an online member information manual but does not appear to have a streamlined list of covered benefits in the provider section of their website.

The EOHHS medical necessity definition (which includes prevention, unlike other medical necessity definitions) is easily found in both UHCNE's and Tuft's provider manuals. NHPRI does not appear to have EOHHS's definition of medical necessity on their website, although it is difficult to be sure because they don't appear to have a working search function for their website.

All three MCOs have easily accessible clinical practice guidelines within the provider portion of their website, including guidelines for Behavioral Health services. All three MCOs refer to

specific clinical guidelines from well-recognized national provider practice associations such as the American Psychiatric Association and ASAM.

More specific information about each MCO is described below:

UHCNE Provider Information for Medicaid Managed Care

List of Covered Benefits [9]

Care providers use UHCNE's eligibilityLink to quickly check member eligibility and review detailed benefits information. Providers may also use the eligibilityLink tool to find out if referrals, notification and prior authorization are needed for services covered in the member's benefit plan.

Medical Necessity

UHCNE 2018 Care Provider Manual[10] includes the EOHHS definition of Medical Necessity in Chapter 4: Medical Management

Clinical Practice Guidelines [11]

Providers can access nationally recognized clinical practice guidelines that UHCNE uses for the administration of Medicaid benefits. Guidelines are specific for various diagnostic categories. For example, most Mental Health clinical guidelines are from the American Psychiatric Association.

Tufts Health Plan Provider Information for Medicaid Managed Care

List of Covered Benefits [12]

A list of covered benefits for Tufts Medicaid benefit package is easily available online.

Medical Necessity [13]

Tufts Health Public Plans *Provider Manual*, 2019, includes the EOHHS definition of Medical Necessity.

Clinical Practice Guidelines [14]

Providers can access nationally recognized clinical practice guidelines that Tufts uses for the administration of Medicaid benefits. Guidelines are specific for various diagnostic categories. For example, most Mental Health clinical guidelines are from the American Psychiatric Association.

NHPRI Provider Information for Medicaid Managed Care

List of Covered Benefits

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[9] UHCprovider.com/Link

[10] https://www.uhcprovider.com/content/provider/en/viewer.html?file=%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fadmin-guides%2Fcomm-plan%2FRI-UHCCP-Care-Provider-Manual.pdf

[11] https://www.uhcprovider.com/content/provider/en/viewer.html?file=https%3A%2F%2Fwww.uhcprovider.com%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fcommplan%2Fmulti%2Fclinical-guidelines%2F2018-Clinical-Practice-Guidelines-UHCCP.pdf

[12] https://tuftshealthplan.com/documents/providers/benefit-summaries/ritogether-benefit-grids-archive/2018-ritogether-medical-benefit-grid

[13] https://tuftshealthplan.com/documents/providers/provider-manuals/public-plans-manual/thpp-provider-manual

[14] https://tuftshealthplan.com/provider/clinical-practice-guidelines

A list of covered benefits for NHPRI's Medicaid and Medicaid/Medicare products are available for Members within a Member manual on the MCO website. There does not appear to be a streamlined list of covered benefits for providers. The website does not appear to have a working internal search function, so it is difficult to find materials on the provider portion of the website.

Medical Necessity

NHPRI's provider website does not appear to include the EOHHS definition of Medical Necessity.

Clinical Practice Guidelines [15]

Providers can access nationally recognized clinical practice guidelines that NHPRI uses for the administration of Medicaid benefits. Mental Health clinical guidelines are American Academy of Child & Adolescent Psychiatry Practice Parameters or American Psychiatric Association Practice Guidelines. ASAM Criteria are in effect for Substance Use Disorder services.

MCO Provider Credentialing: BH vs. M/S

All three MCOs report uniform credentialing requirements for all benefit products. All MCOs have submitted policies which justify their policy compliance with this requirement.

Medicaid MCOs are required by contractual agreement with EOHHS to have a uniform credentialing and re-credentialing process in compliance with state regulations and current NCQA "Standards and Guidelines for Accreditation of Health MCOs". For facilities, including nursing facilities, hospitals, and Medicare certified home health agencies, the MCO must adopt a uniform credentialing and re-credentialing process in compliance with State Health Care Facility regulations. These requirements are the same across MH/SUD and med/surg providers.

The contract prohibits the MCOs from discriminating against particular providers that serve high-risk populations, such as members who are seriously mentally ill or addicted to drugs or alcohol. Furthermore, the contract prohibits the MCO from discriminating against providers that specialize in treating conditions that require costly treatment, such as residential treatment facilities. This assures that med/surg and MH/SUD providers will be treated non-discriminately as potential network providers.

Network Adequacy Standards: BH vs. M/S

EOHHS reviewed MCO compliance on network adequacy and determined that UHCNE, NHPRI and Tufts Health Plan are all in compliance with federal BH parity rules on network adequacy. Policies at all MCOs have access standards between 20 and 30 minutes for BH prescribers and non-prescribers, primary care providers, and physician specialists. This is well within contractual requirements. EOHHS Medicaid MCO contracts have service accessibility standards by which EOHHS holds the MCOs accountable for providing adequate access to care.

[15] https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/bpg.html

MCOs are required to establish and implement mechanisms to ensure that network providers comply with the access and timely appointment availability requirements detailed in the contract. This includes providing access to medical and behavioral health services to members either directly or through their PCP on a twenty-four (24) hours a day, seven (7) days a week basis. Members must be educated about how to access services after regular business hours and on weekends. All PCPs are required to assume the primary responsibility for 24/7 after hours on-call telephone services.

MCOs are also required to maintain a statewide provider network that is geographically accessible to the population being served. Each member must have access to a provider that meets the specific service accessibility standards below:

PROVIDER TYPE	**TIME AND DISTANCE STANDARD** *PROVIDER OFFICE IS LOCATED WITHIN THE LESSER OF*
PRIMARY CARE	
Primary care, adult and pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
OB/GYN specialty care	Forty-five (45) minutes or thirty (30) miles from the member's home
OUTPATIENT BEHAVIORAL HEALTH-MENTAL HEALTH	
Prescribers-adult	Thirty (30) minutes or thirty (30) miles from the member's home.
Prescribers-pediatric	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Non-prescribers-adult	Twenty (20) minutes or twenty (20) miles from the member's home.
Non-prescribers-pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
OUTPATIENT BEHAVIORAL HEALTH-SUBSTANCE USE	
Prescribers	Thirty (30) minutes or thirty (30) miles from the member's home.
Non-prescribers	Twenty (20) minutes or twenty (20) miles from the member's home.
SPECIALIST	
Top five adult specialties by volume (as identified by MCO)	Thirty (30) minutes or thirty (30) miles from the member's home.
Top five pediatric specialties by volume (as identified by MCO)	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Hospital	Forty-five (45) minutes or thirty (30) miles from the member's home
Pharmacy	Ten (10) minutes or ten (10) miles from the member's home
Imaging	Forty-five (45) minutes or thirty (30) miles from the member's home
Ambulatory Surgery Centers	Forty-five (45) minutes or thirty (30) miles from the member's home
Dialysis	Thirty (30) minutes or thirty (30) miles from the member's home.

The MCOs are required to include a mix of behavioral health providers in their networks to ensure that a broad range of treatment options representing a continuum of care is available to both children and adults. The behavioral health provider network must at least include Psychiatrists, Clinical Psychologists, Psychiatric Nurses, licensed Social Workers, adequate network of buprenorphine-waivered physicians and providers licensed by the Departments of

Children, Youth and Families (DCYF), and the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH).

MCO networks must include providers experienced in serving adults and children, low income populations, subspecialists or specialty providers experienced in sexual abuse, domestic violence, rape, and dual diagnosis (behavioral health and substance use) in sufficient numbers to meet the needs of the population to be served in a timely manner. The composition of the network is required to recognize the multi-lingual, multi-cultural nature of the population to be served and include providers in locations where members are concentrated. MCOs are required to include all BHDDH-licensed Community Mental Health Centers (CMHCs) in their networks.

Service Authorization Information for Members

There are many reasons that an MCO might not approve authorization for a requested service or deny payment for a service. Common reasons are that the benefit is not a covered benefit under the MCO, the provider is not a participating provider, or the member was not enrolled in the MCO on the date the service was performed. Another reason is that the service required prior approval and the MCO has made the determination that the service is not medically necessary.

The three Medicaid MCOs have all implemented a structured process for the approval or denial of services, as required under the contract. This includes, in the instance of denials, formal written notification to the member and the requesting or treating provider of the denial, the basis of the denial, and any applicable appeal rights and procedures.

MCOs are required to make standard prior authorization decisions within fourteen (14) calendar days of the request for authorization. The timeframes for standard authorization decisions may be extended by fourteen (14) calendar days if the member requests an extension or the MCO justifies a need for additional information and can demonstrate how the extension is in the member's interest.

All members receive a member handbook written at not more than a 6^{th} grade reading level. The handbook provides information on amount, duration, scope, and how to access covered services, including behavioral health and long-term services and supports. This information is in sufficient detail to ensure that the member understands the benefits to which they are entitled, how to access them, and any prior authorization requirements. There is also an explanation of how the MCO reviews and authorizes covered services.

Member information is provided regularly to members, including the information above on how to access services. The information is easily available in a user-friendly fashion on each of the MCOs' websites.

NQTL Policy Compliance Analysis Results and Recommendations

State Policy Compliance

EOHHS determined that its Medicaid State Plan FFS policies and MCO contract requirements are in full compliance with the federal BH Parity rule. Attachment 4 provides the basis for this determination.

There are three specific benefits noted where EOHHS is technically in compliance, but which could be stated more clearly in the State Plan. Children's Emergency Services (CES), Early Start, and Children and Adolescents Intensive Treatment Services (CAITS) have suggested duration limits of hours or weeks of service in the Medicaid State Plan. However, the program policies also state that EPSDT overrides these treatment limits for members under age 21. Since these services are not provided to members over age 21, and EPSDT has no quantitative treatment limits, EOHHS concluded that the Medicaid State Plan is in compliance with BH Parity rules for these services. However, EOHHS may wish to more clearly state that the quantitative limits are suggested clinical standards, not service limitations.

The following BH services are also subject to prior or concurrent review according to State Plan or other policy documents, but do not have treatment limits:

- Residential Substance Use Treatment
- Non-hospital based, Inpatient Detoxification
- Adult Day Treatment
- Children's Inpatient Psych

MCO Parity Compliance

For each MCO, EOHHS reviewed the following areas:

- Medical necessity determination
- Medical appropriateness review
- Prior authorization
- Current or retrospective review
- Admissions standards
- Provider network standards; tiered networks; out-of-network access standards
- Reimbursement rates
- Fail first requirements
- Facility-related restrictions (e.g. location, type)
- Drug formularies
- Outlier management
- Experimental determinations
- Exclusions

UHCNE

EOHHS found that UHCNE was in BH Parity compliance in all policy areas. A summary of results can be found in Attachment 5.

The following BH services provided by UHCNE are subject to prior or concurrent review:

- Inpatient hospital
- Partial Hospitalization programs (PHP)
- Intensive outpatient program treatment (IOP)
- Outpatient electro-convulsive treatment (ECT)
- Psychological testing
- Extended outpatient therapy visits 50+ minutes in duration (non-emergent situation)
- Applied Behavioral Analysis (ABA)
- Transcranial Magnetic Stimulation (TMS)

EOHHS found equivalent med/surg services which were subject to the same or stricter levels or frequency of review.

NHPRI

EOHHS found that NHPRI was in BH Parity compliance in all policy areas for both benefit plans that are offered to Medicaid members (one for members covered only by Medicaid, and one for members dually eligible for Medicaid and Medicare). A summary of results can be found in Attachments 6 and 7.

The following BH services provided by NHPRI are subject to prior or concurrent review:

- Inpatient hospital
- Electroconvulsive therapy (ECT) when scheduled as outpatient
- Partial Hospitalization Programs
- Intensive outpatient program treatment
- Psychological testing
- Medication Assisted Treatment
- Transcranial Magnetic Stimulation

EOHHS found equivalent med/surg services which were subject to the same or stricter levels or frequency of review.

EOHHS also found that it was difficult to find certain information on the NHPRI website related to BH benefits. A list of covered benefits for NHPRI Medicaid and Medicaid/Medicare products is not readily available on the MCO's website. A benefit list is available for Members but only within a member manual. In addition, there does not appear to be an easily found list of covered benefits for providers. The NHPRI provider website furthermore does not appear to include the EOHHS definition of medical necessity. These materials may, in fact, be available on the website, but the website did not appear to have a working internal search function, so it was difficult to look for these specific items.

NHPRI was found to be in full compliance. However, CMS requires that the above items are readily available for Members and Providers. EOHHS will inform NHPRI of these needed improvements.

Tufts Health Plan

EOHHS found that Tufts Health Plan was in BH Parity compliance in all policy areas. A summary of results can be found in Attachment 8.

The following BH services provided by Tufts are subject to prior or concurrent review:

- IOP
- Day Treatment
- Psychological and Neuropsychological testing
- Applied Behavioral Analysis (ABA)
- Evidence Based Practices (EBP)
- Home Based Treatment (HBTS)
- Personal Assistance Services & Support (PASS)
- Inpatient h=Hospital
- Emergency Services
- Respite
- IHH
- Level 3.1 (Clinically Managed Low-Intensity Residential)
- Level 3.3 (Short-Term Clinically Managed-Medium Intensity)
- Level 3.5 (Clinically Managed High-Intensity Residential)

EOHHS found equivalent med/surg services which were subject to the same or stricter levels or frequency of review.

Environmental Scan: OHIC Market Conduct Examination of Commercial Insurers

CMS encourages states to actively work with state agencies responsible for regulating commercial health insurance issuers in the state in order to leverage their experience, tools, and learnings. In fact, as a key task in the CMS Roadmap for this BH Parity review, CMS has directed states to leverage the work of state agencies responsible for regulating BH Parity in the commercial insurance market. Three separate Medicaid policy documents make very clear that a major purpose of the Medicaid BH Parity rule is to align Medicaid and commercial insurance in states, and Medicaid agencies are encouraged to partner with insurance regulators in this process:

1. The final Medicaid BH Parity rule is designed to align as much as possible with the approach taken in the final Mental Health Parity and Addiction Act (MHPAEA) regulation to create consistency between the commercial and Medicaid markets. This helps to prevent inequity and promote consistency between beneficiaries who have mental

health or substance use disorder conditions in the commercial market (including the state and federal Marketplace) and Medicaid and CHIP. [16]

2. CMS believes that regulation specific to MHPAEA's application to Medicaid and CHIP is important because the final rules applying MHPAEA to the commercial market did not originally apply to Medicaid and CHIP. The statutory provisions applying specific MHPAEA provisions to Medicaid managed care organizations, Medicaid alternative benefit plans, and CHIP were stated generally and did not originally have significant detailed provisions. CMS believes that adopting these final regulations for Medicaid and CHIP will implement existing statutory provisions and better align regulation of Medicaid and CHIP with commercial product regulation.[17]
3. A key task in the CMS BH Parity Implementation Roadmap encourages state Medicaid agencies to consider existing resources for additional technical support. This can be accomplished by leveraging existing state expertise from commercial issuer parity analysis. State health insurance commissioners may have materials, templates, processes or guidelines developed in preparation for MHPAEA's application to commercial issuers that can inform the state Medicaid agency's approach.[18]

The Office of the Health Insurance Commissioner in RI (OHIC) is the agency responsible for assuring BH Parity compliance in RI's commercial health insurance issuers. In September 2018, OHIC released the first of four reports from its Market Conduct Examinations of the four major commercial health insurers operating in the state. A market conduct exam involves a detailed review of insurer records. The exam process includes a review of a random sample of case records to assess compliance with statutory and regulatory requirements.

OHIC's market conduct examinations provide a superb opportunity for EOHHS to borrow tools, methodologies and learnings from OHIC that could be used by EOHHS to conduct similar examinations in the coming year. EOHHS may look to use its EQRO vendor to conduct such examinations using a random sample of Medicaid member case records.

General Findings and Recommendations

EOHHS analysis of BH policies and standards at all three contracted Medicaid MCOs as well as for Medicaid FFS benefits resulted in a finding of no apparent BH Parity compliance issues. EOHHS found two areas for suggested improvement, but these were not considered to be areas of non-compliance. The first was a recommendation to improve ready access to benefit information at one MCO, and the second was a recommendation to improve clarity for 3 children's behavioral health benefits in the Medicaid State Plan.

CMS requires states to conduct a comparability review of BH and med/surg benefits in the actual stringency of the review process, including a comparison of the frequency, intensity and

[16] https://www.medicaid.gov/medicaid/benefits/downloads/fact-sheet-cms-2333-f.pdf
[17] https://www.medicaid.gov/medicaid/benefits/downloads/faq-cms-2333-f.pdf
[18] https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-roadmap.pdf

rigor of application of policies and standards. In order to fully complete this comparability review, EOHHS plans to conduct random case reviews of BH service approvals for Medicaid managed care enrollees. As well, EOHHS will review the timeliness and appropriateness of Medicaid FFS BH service authorizations.

SECTION IV: NEXT STEPS

CMS has requested that state Medicaid programs test the actual processes and practices used in service decision authorization for MH/SUD services. EOHHS plans to take several actions over the next year to determine the comparability and stringency of actual processes and practices to augment this report on written policies and standards.

A test of the actual processes and practices used in service decision authorization for MH/SUD services in both FFS Medicaid and within each of the MCOs will require a detailed review of the documentation of the process of authorizing services at an appropriate level, duration, and intensity of care to meet medical necessity. This can best be accomplished through:

- A review of a random sample of charts in each MCO for members who have received MH/SUD services. This would include a review of cases involving each of the four service categories, for both MH and SUD.
- A review of the process used by EOHHS's fiscal agent to handle decisions for FFS benefits which are subject to NQTLs as directed by state policy.

EOHHS is planning to move forward with the following next steps in its BH parity review:

- **Strengthen Medicaid MCO Contract**
  EOHHS considers equitable access to care of members within the broader health delivery system to be an important program objective. EOHHS will insert language into the contract with each MCO, to be effective July 1, 2019, which requires the MCOs to apply any MH/SA NQTLs for Medicaid using standards and processes which are equal to or less restrictive than the NQTL standards and processes used for commercial lines of business. Decision processes and standards for Medicaid cannot be applied more stringently or more often than for the MCO's commercial population. This includes policies and procedures for medical necessity determination, prior approval, and concurrent and retrospective review.

- **Conduct an Internal Review of the EOHHS Authorization Process for BH Services**
  EOHHS will be held to the same high standards as the MCOs. EOHHS will ask its fiscal agent to conduct an internal review of processes and practices for any MH/SUD NQTL decisions. This will include a review of the clinical decision-making process for FFS benefits that are subject to review.

  The review will include:
  - Generation and review of a report of timeliness of all BH prior authorizations.
  - Review of standards and policies used for BH service authorizations.
  - Review of qualifications and timely availability of EOHHS BH clinical reviewers.
  - Review of all documentation and decisions for a random sample of past BH service authorization decisions.

Any findings of non-compliance would result in review and correction of internal EOHHS processes and those of its fiscal agent.

- **Conduct a Detailed Review of MCO Authorization Processes for BH Services**
  Building on the learnings of the review process conducted by OHIC, EOHHS may look to its EQRO vendor to conduct a similar process for Medicaid enrollees. This would include chart review to determine if the MCOs are truly in BH parity compliance at the level of clinical decision-making processes for approval of services for individual members based on medical necessity. EOHHS will request the advice of OHIC in determining medical record sampling technique and sample size.

  More specifically, in the next year, EOHHS plans to:

  - Complete the processes and practices portion of CMS's required BH parity review for state Medicaid programs, building on the policy and standards portion in this report.
  - Consider using its EQRO vendor to conduct the processes and practices examination, as this activity aligns with the purpose of Medicaid-required EQRO studies, and the EQRO vendor's expertise.
  - Leverage the results and recommendations in this report to focus efforts in the right direction during the examination.
  - Leverage the work, tools, and findings of OHIC's examinations.
  - Leverage the clinical and program expertise of BHDDH where appropriate.
  - Assure that MCO processes and practices for approval of BH services follow acceptable written policy and evidentiary standards.
  - Assure that the BH care approval process for Medicaid members is not more restrictive or applied more stringently than the approval process for med/surg services.
  - Assure that the BH care approval process for Medicaid MCO managed care members is not more restrictive or applied more stringently than the BH approval processes for MCO commercial members.
  - Assure that any findings of non-compliance result in a corrective action plan.
  - Assure follow-up on corrective action plans and timeliness of completion.

The final report of EOHHS BH compliance will be posted on the EOHHS website.

ATTACHMENTS

Attachment 1: BH Parity Workgroup Members

EOHHS Medicaid
Jason Lyon
Catherine Hunter
Meghan Ruane
Sandra Curtis
Pragati Sellon
Chantele Rotolo
Chris Counihan
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Brian Daly, MD, consultant to Parity workgroup

Attachment 2: Benefit Packages

Two RI Medicaid Comprehensive Benefit Packages with MH/SUD services									
		Benefit Package 1				Benefit Package 2			
		RIte Care Children (including CHiP and CSHCN); families	**Rhody Health**	**Pregnant women 138 - 250% poverty**	**Adult <65 Expansion <138% FPL**	**Dual eligible enrolled in NHPRI**	**Dual eligible enrolled in FFS**	**Extended Family Planning**	**Limited Benefit Waiver Pops (10, 16, 18, 19, 20)**
IN-PLAN SERVICES	**Med/Surg in plan**	ABP equivalent	ABP equivalent	ABP equivalent	ABP	Medicare Advantage	Medicare FFS	Family Planning Only	No
	EPSDT in plan (for <21 only)	ABP equivalent	No <21	ABP equivalent	No <21	No <22	No <23	No	No
	MH/SA in plan	ABP equivalent	ABP equivalent	ABP equivalent	ABP	Medicare Advantage	Medicare FFS	No	No
OUT-OF-PLAN SERVICES in Medicaid FFS		State Plan including APB Out of Plan Services *	State Plan including APB Out of Plan Services *	State Plan including APB Out of Plan Services *	State Plan including APB Out of Plan Services *	Mcare Wrap including ABP in-plan and out-of-plan benefits as secondary payor	Mcare Wrap including ABP in-plan and out-of-plan benefits as secondary payor	No	Selected individual FFS benefits only
Benefit package subject to BH Parity Rule?		Yes	Yes	Yes	Yes	Yes	Yes	No	No

* MH/SUD out-of-plan for members enrolled in in-plan Medicaid APB is limited to new waiver MAT services and DD residential services

Attachment 3: Benefit Plan Compliance Summary

BH Parity Summary of Compliance based on Medicaid and MCO Written Policy						
Standard Type		**RI Medicaid Policy** *State Plan; Waiver; MCO Contract*	**NHPRI** *Medicaid*	**NHPRI** *Medicaid/ Medicare*	**UHCNE** *Medicaid*	**Tufts Health Plan** *Medicaid*
QTLs		yes	yes	yes	yes	yes
Medical management standards	**Medical necessity criteria development**	yes	yes	yes	yes	yes
	Prior authorization: individual services subject to PA	yes	yes	yes	yes	yes
		yes	yes	yes	yes	yes
		yes	yes	yes	yes	yes
		yes	yes	yes	yes	yes
		yes	yes	yes	yes	yes
		yes	yes	yes	yes	yes
		yes	yes	yes	yes	yes
		yes	yes	yes	yes	yes
		yes	yes	yes	yes	yes
	Concurrent review	yes	yes	yes	yes	yes
		yes	yes	yes	yes	yes
	Retrospective review	yes	yes	yes	yes	yes
	Outlier management	yes	yes	yes	yes	yes
	Experimental/ investigational determinations	yes	yes	yes	yes	yes
	Fail first requirements	yes	yes	yes	yes	yes
	Exclusions (e.g., based on a failure to complete treatment)	yes	yes	yes	yes	yes
	Medical appropriateness reviews	yes	yes	yes	yes	
	Practice guideline selection/criteria	yes	yes	yes	yes	yes
	Requirements for lower cost therapies to be tried first	yes	yes	yes	yes	yes
Network standards	**Network Credentialing Standards and Process**	yes	yes	yes	yes	yes
	Network Adequacy Standards	yes			yes	yes
	Reimbursement rates	yes	yes	yes	yes	yes
	Geographic restrictions	yes	yes	yes	yes	yes
	Specialty requirements or exclusions	yes			yes	
	Facility type requirements or additional requirements for certain facility types	yes	yes	yes	yes	yes
	Network tiers	yes	yes	yes	yes	yes
	Out-of-network access standards	yes			yes	yes
Methods for determining usual, customary, and		yes	yes	yes	yes	yes
Prescription Drugs	**Formulary design for prescription drugs**	yes	yes	yes	yes	yes
	Prescription drug benefit tiers	yes	yes	yes	yes	yes
	Generic vs. brand name	yes	yes	yes	yes	yes
	High cost vs. low cost	yes	yes	yes	yes	yes
Other NQTLs		yes	yes	yes	yes	yes

Attachment 4: Summary of BH Parity Rule Compliance Analysis of State Plan FFS Policies, 1115 Waiver Requirements, and MCO Contract Requirements

RI Medicaid-specified MH/SUD QTLs and NQTLs for fee-for-service and MCO services												
Standard Type	NQTL service	NQTL Description for MH/SA Service	State In-Plan Requirements (per MCO contract)	State Waiver/ STC requirements	State FFS Requirements (per state plan)	IP	OP	Rx Drugs	Emergency Care	Medical Service Comparison	MH/SUD Parity Compliance?
QTLs											
Amount and Duration Limits	CAITS	RI State Plan p 6.26: CAITS is available for up to 16 weeks per 12 month period.Individual and Familiy Therapy is limited to 40 hours. Family Training and Support Worker Services are limited to 18 hours. However, the above limits do not apply to EPSDT services			X		X				**The State is in compliance because the services are for children-only and the PA requirement does not apply to children under 21 under EPSDT.**
	Childrens Emergency Services (CES)	RI State Plan p 6.29: CES is available for up to 16 weeks However, the above limit does not apply to EPSDT services			X		X		X		
	Early Start	RI State Plan p 6.30: Early Start is available for up to 24 weeks However, the above limit does not apply to EPSDT services			X		X				
Medical management standards											
Medical necessity criteria development		Medical Necessity Definition is the same for MH/SUD and med/surg								Medical Necessity Definition is the same for MH/SUD and med/surg	**in compliance**
Prior authorization	Residential Substance Use Treatment	Contractor shall have policies and procedures for conducting **utilization review** to authorize residential substance use treatment services. These policies and procedures should allow for the provider to conduct the initial assessment that is utilized to determine **prior authorization, up to, but no greater than, two weeks prior to admission date to the facility**. To ensure adequate duration of care, prior authorizations shall certify that the Member can receive treatment for a minimum of two weeks. This does not preclude Contractor from conducting utilization review during the two-week authorization to determine if the member continues to require residential substance use treatment services based on medical necessity criteria. These policies and procedures are subject to EOHHS review and approval, and should be comparable to criteria established by the American Society of Addiction Medicine (ASAM). For any individual that is in a residential setting for more than 30 days, the provider shall report to the Contractor, BHDDH, and EOHHS on these members for the State to make a determination if this person is still appropriate for this level of service. (Note: STCs limit Medicaid funds to an average 30 day stay)	X				X			State Plan Att 3.1-A, pg 9: All Skilled nursing facility admissions require Prior Authorization	**in compliance**
	Non-hospital based, Inpatient Detoxification	The Contractor shall have policies and procedures for conducting utilization review to authorize non-hospital based detoxification services. These policies and procedures should allow for a **presumptive authorization period of three (3) days for admissions into a detoxification facility.** The provider should seek to obtain **additional authorization for these services during this three (3) day presumptive authorization period**. EOHHS and/or its designee and the Contractor shall monitor the frequency and appropriateness of use of this three (3) day presumptive authorization period and re-assess after the first six (6) months of the effective date of this Agreement. These policies and procedures are subject to EOHHS review and approval and should be should be comparable to criteria established by the **American Society of Addiction Medicine (ASAM).**	X			X				State Plan Att 3.1-A, pg 9: Inpatient Dental Services require prior authorization	**in compliance**
	Adult Day Treatment	The Contractor shall establish a **prior authorization** process for Adult Day Health Services that includes a review of **minimum standards** of eligibility as defined below: 1. The member must have a medical or mental dysfunction that involves one or more physiological systems and indicates a need for nursing care, supervision, therapeutic services, support services, and/or socialization. 2. The member must require services in a structured Adult Day Health Setting. 3. The member must have personal physician that can attest to the member's need. 4. The Contractor shall ensure that its Adult Day Health Service providers complete health assessment for admission; establish an oversight and monitoring process for the program that involves a licensed nurse; and provides standard and ad hoc reporting on this project.	X				X			State Plan Att 3.1-A, pg 10: Home Health Services: Prior Authorization is required for home-based nursing, home health aide, therapy, medical supplies, equipment and appliances.	**in compliance**
	Children's Inpatient Psych	Amount, duration and scope of remedial care and Services provided to the Categorically Needy: 16. Inpatient psychiatric services for individuals under 22 years of age. Provided with Limitations: Prior Authorization is required for all admissions. RI State Medicaid Plan IN # 88-12 effective 7-1-88 (no page #)			X	X				RI State Plan, Alternative benefit Plan page 6: Inpatient hospital requires prior authorization	**in compliance**
	Child and Adolescent Intensive Treatment Services (CAITS)	RI State Plan p 6.26: CAITS requires PA from RI DHS.			X					State Plan Att 3.1-A, pg 10: Home Health Services: Prior Authorization is required for home-based nursing, home health aide, therapy, medical supplies, equipment and appliances.	**in compliance**

RI Medicaid-specified MH/SUD QTLs and NQTLs for fee-for-service and MCO services											
Standard Type	**NQTL service**	**NQTL Description for MH/SA Service**	**State In-Plan Requirements (per MCO contract)**	**State Waiver/ STC requirements**	**State FFS Requirements (per state plan)**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**Medical Service Comparison**	**MH/SUD Parity Compliance?**
Medical management standards, continued											
Concurrent review	**SUD and MH services**	MCO contract: Concurrent and retrospective review are required functions of MCOs under section 2.03.02 of the MCO contract. Under section 2.12.03.02 Utilization Review, the contract specifies that utilization review will be conducted for the following SUD services: non-hospital inpt detox and residential SUD treatment. In that same section the contract specifies that utilization review will be conducted for Adult Day Health, which is a medical service for frail elderly. Waiver STCs: EOHHS and BHDDH currently operate utilization management through a few avenues, including retrospective records-based reviews, which allows for opportunities to provide technical assistance and to monitor appropriate levels of placement. Behavioral Health Organization regulations require all Licensed Behavioral Health programs to screen potential clients for appropriateness and eligibility, and to use a multidimensional biopsychosocial assessment tool to diagnose individuals and identify treatment needs and interim services that meet ASAM level of care criteria. Utilization reviews include mental health as well as SUD programs to ensure that co-occurring disorders are properly diagnosed and treated.		**X**		**X**	**X**			Concurrent and retrospective review are required functions of MCOs under section 2.03.02 of the MCO contract. Under section 2.12.03.02 Utilization Review, the contract specifies that utilization review will be conducted for the following SUD services: non-hospital inpt detox and residential SUD treatment. In that same section the contract specifies that utilization review will be conducted for Adult Day Health, which is a medical service for frail	**in compliance**
Retrospective review	**SUD and MH services**			**X**		**X**	**X**				
Outlier management	**none**										
Experimental/ investigational determinations	**none**										
Fail first requirements	**none**										
Exclusions (e.g., based on a failure to complete treatment)	**none**										
Medical appropriateness reviews	**none**										
Requirements for lower cost therapies to be tried first	**none**										
Network admission standards											
Reimbursement rates	**none**										
Geographic restrictions	**none**										
Specialty requirements or exclusions	**All Benefits**	Contractor agrees that it will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. Complete a comprehensive risk assessment using the standardized tool, DLA, to identify participant.	**X**				**X**			Applies to all providers	**in compliance**
Facility type requirements or additional requirements for certain facility types	**none**										
Network tiers	**none**										
Out-of-network access standards											
Methods for determining usual, customary, and reasonable charges	**none**										
Formulary design for prescription drugs											
Prescription drug benefit tiers	**none**										
Generic vs. brand name		Covers generic only if available, with a process for clinical exceptions	**X**					**X**		Applies to all classes of drugs	**in compliance**
High cost vs. low cost	**none**										
Other NQTLs											
other	none										

Attachment 5: Summary of Analysis of UHCNE's BH Parity Rule Compliance

BH Parity Summary for UHCNE Health Plan										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
QTLs		NONE		NONE						**YES**
Medical management standards	**Medical necessity criteria development**	medical necessity criteria development	similar definition as med/surg. Standards based on Generally Accepted Standards of Medical Practice, ASAM guidelines for SA tx; other national professional standards, or own standards if not available	medical necessity criteria development	similar definition as med/surg. Standards based on Generally Accepted Standards of Medical Practice, ASAM guidelines for SA tx; other national professional standards, or own standards if not available	x	x		x	YES
	Prior authorization	Inpatient (in network and out of network)	Planned inpatient services and treatments for MH/SUD and M/S, require Prior Authorization. The MH/SUD and M/S Prior Authorization requirements for planned Inpatient admissions are comparable because the same criteria (all services and treatments) and no more stringent requirements are applied.	Inpatient (in network and out of network)	Planned inpatient services and treatments for MH/SUD and M/S, require Prior Authorization. The MH/SUD and M/S Prior Authorization requirements for planned Inpatient admissions are comparable because the same criteria (all services and treatments) and no more stringent requirements are applied.	x				yes
		Outpatient	A limited number of MH/SUD Outpatient services do require Prior Authorization (subject to state requirements) Prior Authorization is generally required for the following Outpatient MH/SUD services: • Partial Hospitalization programs (PHP) • Intensive outpatient program treatment (IOP) • Outpatient electro-convulsive treatment (ECT) • Psychological testing • Extended outpatient therapy visits 50+ minutes in duration (non-emergent situation) • Applied Behavioral Analysis (ABA) • Transcranial Magnetic Stimulation (TMS)	Outpatient	Similar to the MH/SUD services methodology, Prior Authorization is required for some Outpatient M/S services. The following list is provided for illustrative purposes, is not exhaustive, and is subject to applicable state law requirements: • Arthroplasty • Arthroscopy • Bariatric Surgery • Bone Growth stimulator • Breast Reconstruction (non-mastectomy) • Cancer Supportive Care • Cardiology • Cartilage Implants • Chemotherapy Services • Clinical Trials • Congenital Heart Disease • Cosmetic and Reconstructive Procedures • Durable Medical Equipment • End-Stage Renal Disease Services • Functional Endoscopic Sinus Surgery • Gender Dysphoria Treatment • Genetic and Molecular Testing including BRCA • Home Care • Hysterectomy • Infertility • Injectable Medications • Intensity Modulated Radiation Therapy • MR-guided Focused Ultrasound • Non-emergent Air Transport • Orthognathic Surgery • Orthotics/Prosthetics :more than $1000 • Out of Network Services • Potentially Unproven Services • Proton Beam Therapy • Radiology • Rhinoplasty /Sinuplasty • Site of Service -Outpatient and office-based • Sleep Apnea procedures and surgeries • Sleep Studies (facility-based) • Spinal Cord Stimulators • Spinal Surgery • Transplant • Vagus Nerve Stimulator • Vein Procedures • Ventricular Assist Devices		x			yes

BH Parity Summary for UHCNE Health Plan										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
	Prior authorization, continued	Pharmacy benefits and services	NQTLs of Prior Authorization is developed and applied in an identical manner for BH and med/surg: Prior Authorization is required when a provider prescribes non-formulary/non-PDL medication or certain formulary medications that have precursor therapies, specific indications, or not routinely covered due to plan Benefit Limitations or Exclusions. Standard of evidence to support approval of drug therapy subject to prior authorization comes from several sources such as pharmaceutical assessments, national clinical guidelines, published medical literature, and data analysis.	Pharmacy benefits and services	NQTLs of Prior Authorization is developed and applied in an identical manner for BH and med/surg: Prior Authorization is required when a provider prescribes non-formulary/non-PDL medication or certain formulary medications that have precursor therapies, specific indications, or not routinely covered due to plan Benefit Limitations or Exclusions. Standard of evidence to support approval of drug therapy subject to prior authorization comes from several sources such as pharmaceutical assessments, national clinical guidelines, published medical literature, and data analysis.			X		yes
Medical management standards, continued	**Concurrent review**	same	For most OP behavioral care, just as with medical, if prior auth is required and additional sessions are needed beyond the initial auth, the provider calls with clinical for more authorizations.	same	For most OP behavioral care, just as with medical, if prior auth is required and additional sessions are needed beyond the initial auth, the provider calls with clinical for more authorizations.		X			YES
		same	Reviews usually begin on the first business day following admission to a program.	same	Reviews usually begin on the first business day following admission to a program.	X				YES
	Retrospective review	same	various points of retrospective review (appeals, didn't get PAed, weekend admissions, etc. appear to be the same of similar to med/surg	same	various points of retrospective review (appeals, didn't get PAed, weekend admits, etc. appear to be the same of similar to BH	x				YES
	Outlier management	similar criteria and use	Can be conducted on high cost, frequesnt services used outside of the norm. used to assure care coordination is in place if needed and to manage provider fraud and abuse.	similar criteria and use	Can be conducted on high cost, frequesnt services used outside of the norm. used to assure care coordination is in place if needed and to manage provider fraud and abuse.	x	x			yes
	Experimental/ investigational determinations	experimental tx	not covered	experimental tx	not covered	x	x	x		yes
	Fail first requirements	plan reports none	same	plan reports none	same	x	x	x		yes
	Exclusions (e.g., based on a failure to complete treatment)	plan reports none	same	plan reports none	same	x	x	x		yes
	Medical appropriateness reviews	plan reports same as medical necessity	same	plan reports same as medical necessity	same	x	x	x		yes
	Medical Management benefit selection criteria	same criteria as med/surg	If the question refers to how it is determined when to apply medical necessity during the review process, services for notification, authorization, and concurrent review based on a variety of strategies, processes, evidentiary standards and other factors, including: 1) Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a) Preference driven b) Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost analysis	same criteria as BH	If the question refers to how it is determined when to apply medical necessity during the review process, services for notification, authorization, and concurrent review based on a variety of strategies, processes, evidentiary standards and other factors, including: 1) Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a) Preference driven b) Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost analysis	x	x			yes
	Practice guidelines / Evidentiary Standards / Criteria used for medical necessity decisions	generally accepted level of care guidelines	no set national standards appear to be used as the basis for Optum's Level of Care Guidelines for MH. ASAM is used for SUD. Level of Care Criteria for MH is developed based on generally accepted standards of care, along with multiple sources of internal and external input. This is all exactly the same as RI Medicaid requirements.	generally accepted level of care guidelines	The medical plan uses MCG™ Care Guidelines to assist clinicians in making informed decisions. As noted previously, these are nationally accepted guidelines based on peer reviewed literature and CMS standards. This includes acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. . All inpatient reviews are based on MCG Care Guidelines unless there are state or federal guidelines in place.	x	x	x		yes
	Requirements for lower cost therapies to be tried first	same criteria as med/surg	Pharmaceutical agents in which a lower risk or more cost effective agent is available to treat a given medical condition.	same criteria as BH	Pharmaceutical agents in which a lower risk or more cost effective agent is available to treat a given medical condition.			x		yes
Network standards	**Network Credentialing Standards and Process**	BH provider credentialing	Contract requires uniform credentialing processes,	Provider credentialing	Contract requires uniform credentialing processes	x	x	x	x	YES
	Network Adequacy Standards	BH prescribers and non prescribers	Contract standards range from 20 to 30 min	Primary care and specialists	Contract standards range from 20 to 30 min	x	x	x	x	YES

BH Parity Summary for UHCNE Health Plan										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
Network standards, continued	**Reimbursement rates**	same	uses RI Medicaid rates and payment methodologies	same	uses RI Medicaid rates and payment methodologies	x	x		x	yes
	Geographic restrictions	BH facilities	in state and some border facilities except for emergencies	med surg facitilites	in state and some border facilities except for emergencies	x				yes
		BH providers	Contract requires the same geographic network standards for all provider types	Med surg providers	Contract requires the same geographic network standards for all provider types		x			YES
	Specialty requirements or exclusions	same	plan reports no exclusions	same	plan reports no exclusions	x	x	x	x	yes
	Facility type requirements or additional requirements for certain facility types	no addl requirements for BH	no addl requirements over med/surg	no addl requirements for BH	The only additional requirements based on Facility type for Credentialing are NPDB query and Medicaid Exclusion Query.	x	x			yes
	Network tiers	none		none						yes
	Out-of-network access standards	BH providers	Contract requires the same out-of-network standards for all provider types	Med surg providers	Contract requires the same out-of-network standards for all provider types	x	x		x	YES
Methods for determining usual, customary, and reasonable charges		same	uses RI Medicaid rates and payment methodologies; The methodology for development and application of UCR rates, is based on: 1) The provider's usual charge for the service(s), 2) Payments are within the customary fees for the geographic area/zip code, 3) Payments are reasonable based on the circumstances	same	uses RI Medicaid rates and payment methodologies; The methodology for development and application of UCR rates, is based on: 1) The provider's usual charge for the service(s), 2) Payments are within the customary fees for the geographic area/zip code, 3) Payments are reasonable based on the circumstances	x	x		x	yes
Prescription Drugs	**Formulary design for prescription drugs**	NA								yes
	Prescription drug benefit tiers	no tiers		no tiers						YES
	Generic vs. brand name	generic MH/SUD drugs		generic med/surg drugs						yes
	High cost vs. low cost									yes
Other NQTLs	**none**									

Attachment 6: Summary of Analysis of NHPRI's Medicaid Benefit Package BH Parity Rule Compliance

BH Parity Summary for NHPRI Health Plan Medicaid Enrollees										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
QTLs		none reported		none reported		x	x	x	x	yes
Medical management standards	**Medical necessity criteria development**	medical necessity criteria development	similar definition as med/surg. Standards based on Generally Accepted Standards of Medical Practice	medical necessity criteria development	similar definition as BH. Standards based on Generally Accepted Standards of Medical Practice	x	x	x	x	yes
	Prior authorization	inpatient	within 3 days	inpatient	within 3 days	x				yes
		Electroconvulsive therapy (ECT) when scheduled as outpatient	PA required	bone growth stimulators	PA required		x			yes
		Partial Hospitalization Programs	PA required	Adult day health enhanced services; Hasbro partial program	PA required		x			yes
		Intensive outpatient program treatment	PA required	Home care	PA required		x			yes
		Psychological testing (5 hours or less only requires notification	PA required	allergen IG E testing	PA required		x			yes
		Medication Assisted Treatment	PA required	Home infusion	PA required		x			yes
		Transcranial Magnetic Stimulation	PA required	Phototherapeutic Keratectomy	PA required		x			yes
	Concurrent review	concurrent review	yes, beginning first business day of admission	concurrent review	yes, within 24 hours	x				yes
		concurrent review	same criteria	concurrent review	same criteria		x			yes
	Retrospective review	retrospective review	within 3 days of inpatient	retrospective review	same	x				yes
	Outlier management	psychotherapy	subject to outlier management	PT and OT	subject to outlier management		x			yes
	Experimental/ investigational determinations	experimental tx/clinical trials	experimental not covered. Therapies which may be exp. tx/clinical trials may be covered with certain criteria and PA	experimental tx/clinical trials	experimental not covered. Therapies which may be exp. tx/clinical trials may be covered with certain criteria and PA	x	x			yes
	Fail first requirements	fail first	some of the plan's MH/SUD review guidelines have what may be considered to be "fail first" or "step therapy" protocols.	fail first	Fail first requirement for the following: Phototherapy and Photochemotherapy for Dermatologic Condition; Hyperbaric Oxygen Therapy; Spinal Cord Stimulator; Breast Reduction/Reconstructive Surgery; and Weight Management	x	x			yes
	Exclusions (e.g., based on a failure to complete treatment)	has none	same	has none	same	x	x	x		yes
	Medical appropriateness reviews	medical appropriateness reviews	The Medical Director and other clinical staff review hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. Same guidelines as med surg for Rx	medical appropriateness reviews	The Medical Director and other clinical staff review hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. Same guidelines as med/surg for Rx	x	x	x		yes

BH Parity Summary for NHPRI Health Plan Medicaid Enrollees										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
	Medical management benefit selection/criteria	same as med/surg	These services/procedures were selected based on the following strategies, processes, evidentiary standards and other factors: 1. Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility. 2. Significant drivers of cost trend. 3. Outlier performance against established benchmarks. 4. Disproportionate Utilization. 5. Preference/System driven care. a.) Preference-driven b.) Supply/demand factors. 6. Gaps in Care that negatively impact cost, quality and/or utilization. 7. Outcome yield from the UM activity/Administrative cost analysis	same	These services/procedures were selected based on the following strategies, processes, evidentiary standards and other factors: 1. Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility. 2. Significant drivers of cost trend. 3. Outlier performance against established benchmarks. 4. Disproportionate Utilization. 5. Preference/System driven care. a.) Preference-driven b.) Supply/demand factors. 6. Gaps in Care that negatively impact cost, quality and/or utilization. 7. Outcome yield from the UM activity/Administrative cost analysis	x	x			yes
	Practice guidelines / Evidentiary standards / Criteria used for medical necessity decisions	medical practice guidelines	Generally accepted standards of medical practice; Based on clinical studies and generally accepted standards, professional org stds. None specified	medical practice guidelines	Generally accepted standards of medical practice; Based on clinical studies and generally accepted standards, professional org stds. None specified	x	x			yes
	Requirements for lower cost therapies to be tried first	same	All Pharmacy UM is the same for BH and med/surg	same	All Pharmacy UM is the same for BH and med/surg			x		yes
Network standards	**Network Credentialing Standards and Process**	credentialing	same credentialing criteria; recredentialing every 3 years	credentialing	same credentialing criteria; recredentialing every 3 years	x	x			yes
	Network Adequacy Standards	same critera	follows contract	same critera	follows contract	x	x	x		yes
	Reimbursement rates	same criteria basis; uses FFS and per diem	Inpatient per diems are negotiated on a facility by facility basis. Several factors are taken into consideration in the rate- setting process, including CMS guidelines, as well as regional market dynamics and current business needs.	same criteria basis; uses FFS, per diem, case rates and DRGs	Inpatient per diems are negotiated on a facility by facility basis. Several factors are taken into consideration in the rate- setting process, including CMS guidelines, as well as regional market dynamics and current business needs.	x	x		x	yes
	Geographic restrictions	geographic restrictions	there are none	geographic restrictions	there are none	x	x			yes
	Specialty requirements or exclusions									
	Facility type requirements or additional requirements for certain facility types	appear to be the same as what med/surg would be	recredentialing every 3 years. participation/credentialing requirements are specified. Appear to be the same that would be required for med/surg. No additional criteria for BH	not provided	recredentialing every 3 years. BH requirements appear to be the same that would be required for med/surg.	x	x			yes
	Network tiers	NA		NA						yes
	Out-of-network access standards	essentially the same		essentially the same		x	x	x	x	yes
Methods for determining usual, customary, and reasonable charges		same criteria basis	Inpatient per diems are negotiated on a facility by facility basis. Several factors are taken into consideration in the rate- setting process, including CMS guidelines, as well as regional market dynamics and current business needs.	same criteria basis	Inpatient per diems are negotiated on a facility by facility basis. Several factors are taken into consideration in the rate- setting process, including CMS guidelines, as well as regional market dynamics and current business needs.	x	x			yes
Prescription Drugs	**Formulary design for prescription drugs**	formulary	The process applied by the plan for BH prescription drug formulary design is the same process as that used for medical/surgical prescription drugs, using the same committee and same factors in design.	formulary	The process applied by the plan for BH prescription drug formulary design is the same process as that used for medical/surgical prescription drugs, using the same committee and same factors in design.			x		yes
	Prescription drug benefit tiers	no tiers		no tiers				x		yes
	Generic vs. brand name	generic first MH/SUD drugs required by contract	same	generic first MH/SUD drugs required by contract	same			x		yes
	High cost vs. low cost							x		yes
Other NQTLs		none reported		none reported						yes

Attachment 7: Summary of Analysis of NHPRI's Medicaid/Medicare Benefit Package BH Parity Rule Compliance

BH Parity Summary for NHPRI Health Plan Integrity Enrollees: Medicaid/Medicare Dual Eligibles										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
QTLs		none reported		none reported		x	x	x	x	yes
Medical management standards	**Medical necessity criteria development**	medical necessity criteria development	similar definition as med/surg. Standards based on Generally Accepted Standards of Medical Practice	medical necessity criteria development	similar definition as BH. Standards based on Generally Accepted Standards of Medical Practice	x	x	x	x	yes
	Prior authorization	inpatient	within 3 days	inpatient	within 3 days	x				yes
		Electroconvulsive therapy (ECT) when scheduled as outpatient	PA required	bone growth stimulators	PA required		x			yes
		Partial Hospitalization Programs	PA required	Adult day health enhanced services; Hasbro partial program	PA required		x			yes
		Intensive outpatient program treatment	PA required	Home care	PA required		x			yes
		Psychological testing (5 hours or less only requires notification	PA required	allergen IG E testing	PA required		x			yes
		Medication Assisted Treatment	PA required	Home infusion	PA required		x			yes
		Transcranial Magnetic Stimulation	PA required	Phototherapeutic Keratectomy	PA required		x			yes
	Concurrent review	concurrent review	yes, beginning first business day of admission	concurrent review	yes, within 24 hours	x				yes
		concurrent review	same criteria	concurrent review	same criteria		x			yes
	Retrospective review	retrospective review	within 3 days of inpatient	retrospective review	same	x				yes
	Outlier management	psychotherapy	subject to outlier management	PT and OT	subject to outlier management		x			yes
	Experimental/ investigational determinations	experimental tx/clinical trials	experimental not covered. Therapies which may be exp. tx/clinical trials may be covered with certain criteria and PA	experimental tx/clinical trials	experimental not covered. Therapies which may be exp. tx/clinical trials may be covered with certain criteria and PA	x	x			yes
	Fail first requirements	fail first	some of the plan's MH/SUD review guidelines have what may be considered to be "fail first" or "step therapy" protocols.	fail first	Fail first requirement for the following: Phototherapy and Photochemotherapy for Dermatologic Condition; Hyperbaric Oxygen Therapy; Spinal Cord Stimulator; Breast Reduction/Reconstructive Surgery; and Weight Management	x	x			yes
	Exclusions (e.g., based on a failure to complete treatment)	has none	same	has none	same	x	x	x		yes
	Medical appropriateness reviews	medical appropriateness reviews	The Medical Director and other clinical staff review hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. Same guidelines as med surg for Rx	medical appropriateness reviews	The Medical Director and other clinical staff review hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. Same guidelines as med/surg for Rx	x	x	x		yes

BH Parity Summary for NHPRI Health Plan Integrity Enrollees: Medicaid/Medicare Dual Eligibles										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
	Medical management benefit selection/criteria	same as med/surg	These services/procedures were selected based on the following strategies, processes, evidentiary standards and other factors: 1. Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility. 2. Significant drivers of cost trend. 3. Outlier performance against established benchmarks. 4. Disproportionate Utilization. 5. Preference/System driven care. a.) Preference-driven b.) Supply/demand factors. 6. Gaps in Care that negatively impact cost, quality and/or utilization. 7. Outcome yield from the UM activity/Administrative cost analysis	same	These services/procedures were selected based on the following strategies, processes, evidentiary standards and other factors: 1. Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility. 2. Significant drivers of cost trend. 3. Outlier performance against established benchmarks. 4. Disproportionate Utilization. 5. Preference/System driven care. a.) Preference-driven b.) Supply/demand factors. 6. Gaps in Care that negatively impact cost, quality and/or utilization. 7. Outcome yield from the UM activity/Administrative cost analysis	**x**	**x**			**yes**
	Practice guidelines / Evidentiary standards / Criteria used for medical necessity decisions	medical practice guidelines	Generally accepted standards of medical practice; Based on clinical studies and generally accepted standards, professional org stds. None specified	medical practice guidelines	Generally accepted standards of medical practice; Based on clinical studies and generally accepted standards, professional org stds. None specified	**x**	**x**			**yes**
	Requirements for lower cost therapies to be tried first	same	All Pharmacy UM is the same for BH and med/surg	same	All Pharmacy UM is the same for BH and med/surg			**x**		**yes**
Network standards	**Network Credentialing Standards and Process**	credentialing	same credentialing criteria; recredentialing every 3 years	credentialing	same credentialing criteria; recredentialing every 3 years	**x**	**x**			**yes**
	Network Adequacy Standards	same critera	follows contract	same critera	follows contract	**x**	**x**	**x**		**yes**
	Reimbursement rates	same criteria basis; uses FFS and per diem	Inpatient per diems are negotiated on a facility by facility basis. Several factors are taken into consideration in the rate- setting process, including CMS guidelines, as well as regional market dynamics and current business needs.	same criteria basis; uses FFS, per diem, case rates and DRGs	Inpatient per diems are negotiated on a facility by facility basis. Several factors are taken into consideration in the rate- setting process, including CMS guidelines, as well as regional market dynamics and current business needs.	**x**	**x**		**x**	**yes**
	Geographic restrictions	geographic restrictions	there are none	geographic restrictions	there are none	**x**	**x**			**yes**
	Specialty requirements or exclusions									
	Facility type requirements or additional requirements for certain facility types	appear to be the same as what med/surg would be	recredentialing every 3 years. participation/credentialing requirements are specified. Appear to be the same that would be required for med/surg. No additional criteria for BH	not provided	recredentialing every 3 years. BH requirements appear to be the same that would be required for med/surg.	**x**	**x**			**yes**
	Network tiers	NA		NA						**yes**
	Out-of-network access standards	essentially the same		essentially the same		**x**	**x**	**x**	**x**	**yes**
Methods for determining usual, customary, and reasonable charges		same criteria basis	Inpatient per diems are negotiated on a facility by facility basis. Several factors are taken into consideration in the rate- setting process, including CMS guidelines, as well as regional market dynamics and current business needs.	same criteria basis	Inpatient per diems are negotiated on a facility by facility basis. Several factors are taken into consideration in the rate- setting process, including CMS guidelines, as well as regional market dynamics and current business needs.	**x**	**x**			**yes**
Prescription Drugs	**Formulary design for prescription drugs**	formulary	The process applied by the plan for BH prescription drug formulary design is the same process as that used for medical/surgical prescription drugs, using the same committee and same factors in design.	formulary	The process applied by the plan for BH prescription drug formulary design is the same process as that used for medical/surgical prescription drugs, using the same committee and same factors in design.			**x**		**yes**
	Prescription drug benefit tiers	no tiers		no tiers				**x**		**yes**
	Generic vs. brand name	generic first MH/SUD drugs required by contract	same	generic first MH/SUD drugs required by contract	same			**x**		**yes**
	High cost vs. low cost							**x**		**yes**
Other NQTLs		none reported		none reported						**yes**

Attachment 8: Summary of Analysis of Tufts Health Plan's BH Parity Rule Compliance

BH Parity Summary for Tufts Health Plan										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
QTLs		MH drugs	various clinical limitations. See attached for antidepressants	other drugs	various clinical limitations. See attached for anticonvulsants. Very similar to antidepressants (slightly different for each drug but does not display a pattern not favoring MH drugs.).			x		YES
Medical management standards	**Medical necessity criteria development**	med necessity definition	same as med/surg	med necessity definition	same	x	x		x	YES
	Prior authorization	IOP	PA	outpatient rehab	PA		x			YES
		Day Tx	PA	day hab	PA		x			YES
		Psychological and Neuropsychological testing	PA	sleep study	PA		x			YES
		Applied Behavioral Tx (ABA)	PA	outpt rehab	PA		x			YES
		Evidence Based Practices (EBP)	PA	Therapies (PT, OT, SHL)	PA		x			YES
		Home Based Treatment (HBTS)	PA	Home infusion therapy	PA		x			YES
		Personal Assistance Services & Support (PASS)	PA	Home health care	PA		x			YES
		inpatient hosp	Information that is requested of a mental health/substance use provider in order to conduct the utilization review of a request for mental health/substance use services are no different from information requested of a medical/surgical provider in order to conduct the utilization review of a request for medical/surgical services.	inpatient hosp	Information that is requested of a mental health/substance use provider in order to conduct the utilization review of a request for mental health/substance use services are no different from information requested of a medical/surgical provider in order to conduct the utilization review of a request for medical/surgical services.	x				YES
		Emergency Services	no authorization required	Emergency Services	no authorization required				x	YES
	Concurrent review	respite	after first 100 hours/annum	Hospice	PA		x			YES
		IHH	at 28 days of inpt stay, PA required	day hab	PA		x			YES
		Level 3.1 (Clinically Managed Low-Intensity Residential)	Yes for 14 days authorized	day hab	PA		x			YES
		Level 3.3 (Short-Term Clinically Managed-Medium Intensity)	Yes for 14 days authorized	day hab	PA		x			YES
		Level 3.5 (Clinically Managed High-Intensity Residential)	Yes, after first 10 visits	day hab	PA		x			YES
		inpatient hosp	Information that is requested of a mental health/substance use provider in order to conduct the utilization review of a request for mental health/substance use services are no different from information requested of a medical/surgical provider in order to conduct the utilization review of a request for medical/surgical services.	inpatient hosp	Information that is requested of a mental health/substance use provider in order to conduct the utilization review of a request for mental health/substance use services are no different from information requested of a medical/surgical provider in order to conduct the utilization review of a request for medical/surgical services.	x				YES
	Retrospective review	inpatient hosp				x				YES

BH Parity Summary for Tufts Health Plan										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
Medical management standards, continued	**Outlier management**	no outlier program	same as med/surg	no outlier program	same as BH	**x**	**x**			**YES**
	Experimental/ investigational determinations	sme	Tufts Health Public Plans restricts coverage to those devices, treatments, or procedures for which the safety and efficacy have been proven, and which are comparable or superior to conventional therapies. Any device, medical treatment, supply or procedure for which safety and efficacy has not been established and proven is considered investigational (unproven) and would be excluded from coverage.	same	Tufts Health Public Plans restricts coverage to those devices, treatments, or procedures for which the safety and efficacy have been proven, and which are comparable or superior to conventional therapies. Any device, medical treatment, supply or procedure for which safety and efficacy has not been established and proven is considered investigational (unproven) and would be excluded from coverage.	**x**	**x**			**yes**
		same as med/surg	The Plan does not cover experimental or investigational drugs, as this is the industry standard for Medicaid. When new drugs are approved by the FDA, they are considered "experimental" or "investigational." The Plan determines that new drugs and procedures are no longer experimental/investigational based on scientific evidence and clinician recommendations and pursuant to our contract with EOHHS	same	The Plan does not cover experimental or investigational drugs, as this is the industry standard for Medicaid. When new drugs are approved by the FDA, they are considered "experimental" or "investigational." The Plan determines that new drugs and procedures are no longer experimental/investigational based on scientific evidence and clinician recommendations and pursuant to our contract with EOHHS			**x**		**yes**
	Fail first requirements	BH drugs	several fail first policies for specific drugs	med-/surg drugs	several fail first policies for specific drugs. Very similar to BH drugs (slightly different for each drug but does not display a pattern not favoring BH drugs.).			**x**		**YES**
	Exclusions (e.g., based on a failure to complete treatment)	same as med/surg	none	same	none	**x**	**x**	**x**		**yes**
	Medical appropriateness reviews	same as med/surg	. Tufts Health Plan develops or adopts medical policies for both mental health and substance use disorder benefits and medical/surgical benefits that are grounded in evidence-based and industry recognized medical literature and professional standards and protocols.	same	Tufts Health Plan develops or adopts medical policies for both mental health and substance use disorder benefits and medical/surgical benefits that are grounded in evidence-based and industry recognized medical literature and professional standards and protocols.	**x**	**x**			**yes**

BH Parity Summary for Tufts Health Plan										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
Medical management standards, continued	**Medical management benefit selection criteria**	same as med/surg	Tufts Health Plan considers a wide array of factors when determining which services (medical/surgical, behavioral health and pharmacy) require medical management techniques such as prior authorization. Those factors may include cost of treatment, high cost growth, variability in cost and quality, provider discretion in determining diagnosis, or type or length of treatment, clinical efficacy of any proposed treatment or service, licensing and accreditation of providers, and probability of fraud. Based on application of these factors in a comparable fashion, prior authorization is required for some (but not all) mental health and substance use disorder benefits and drugs as well as for some (but not all) medical/surgical and pharmacy benefits. Tufts Health Plan does not require prior authorization or concurrent review for emergency room benefits or pharmacy-managed drugs administered during inpatient visits.	same as BH	Tufts Health Plan considers a wide array of factors when determining which services (medical/surgical, behavioral health and pharmacy) require medical management techniques such as prior authorization. Those factors may include cost of treatment, high cost growth, variability in cost and quality, provider discretion in determining diagnosis, or type or length of treatment, clinical efficacy of any proposed treatment or service, licensing and accreditation of providers, and probability of fraud. Based on application of these factors in a comparable fashion, prior authorization is required for some (but not all) mental health and substance use disorder benefits and drugs as well as for some (but not all) medical/surgical and pharmacy benefits. Tufts Health Plan does not require prior authorization or concurrent review for emergency room benefits or pharmacy-managed drugs administered during inpatient visits.	**x**	**x**	**x**		**yes**
		same as med/surg	Tufts Health Plan does not require prior authorization or concurrent review for emergency room benefits.	same as BH	Tufts Health Plan does not require prior authorization or concurrent review for emergency room benefits.				**x**	**yes**
	Practice guidelines / Evidentiary standards /Criteria used for medical necessity decisions	MH/SUD drugs	Criteria are based on package insert, drug studies, and clinical team input. Approved by the P&T Committee;	med/surg drugs	Criteria are based on package insert, drug studies, and clinical team input. Approved by the P&T Committee;			**x**		**YES**
		same as med/surg	Interqual and nationally recognized standards	same	Interqual and nationally recognized standards	**x**	**x**		**x**	**YES**
	Requirements for lower cost therapies to be tried first	see generic drugs below						**x**		**YES**
Network standards	**Network Credentialing Standards and Process**	BH provider credentialing	Contract requires uniform credentialing processes,	Provider credentialing	Contract requires uniform credentialing processes	**x**	**x**	**x**	**x**	**YES**
	Network Adequacy Standards	BH prescribers and non prescribers	Contract standards range from 20 to 30 min	Primary care and specialists	Contract standards range from 20 to 30 min	**x**	**x**			**YES**
	Reimbursement rates	Standard reimbursement fee schedule unless directed by contract, e.g., IHH/ACT		Standard reimbursement fee schedule unless directed by contract, e.g., IHH/ACT		**x**	**x**		**x**	**YES**
	Geographic restrictions	BH providers	Contract requires the same geographic network standards for all provider types	Med surg providers	Contract requires the same geographic network standards for all provider types	**x**	**x**			**YES**

BH Parity Summary for Tufts Health Plan										
Standard Type		**NQTL MH/SUD service**	**NQTL Description for MH/SA Service**	**Equivalent med/surg service**	**NQTL Description for equivalent med/ surg Service**	**IP**	**OP**	**Rx Drugs**	**Emergency Care**	**In Compliance with BH Parity Rule?**
	Specialty requirements or exclusions	same as med/surg	Network providers must meet contracting and credentialing criteria. Additional consideration is also given to geographical access, specialty requirements and the cultural and linguistic needs of members. Tufts Health Public Plans follows applicable State and Federal regulatory requirements for network participation, including, but not limited to, providers accepting RIteCare and providers not being excluded from participation in federal or state health care programs.	same as BH	Network providers must meet contracting and credentialing criteria. Additional consideration is also given to geographical access, specialty requirements and the cultural and linguistic needs of members. Tufts Health Public Plans follows applicable State and Federal regulatory requirements for network participation, including, but not limited to, providers accepting RIteCare and providers not being excluded from participation in federal or state health care programs.	x	x			yes
	Facility type requirements or additional requirements for certain facility types	same as med/surg	licensing and credentialing	same	licensing and credentialing	x				yes
	Network tiers	NA/none		NA/none						yes
	Out-of-network access standards	BH providers	Contract requires the same out-of-network standards for all provider types	Med surg providers	Contract requires the same out-of-network standards for all provider types	x	x		x	YES
Methods for determining usual, customary, and reasonable charges		Standard reimbursement fee schedule unless directed by contract, e.g., IHH/ACT		Standard reimbursement fee schedule unless directed by contract, e.g., IHH/ACT		x	x		x	YES
Prescription Drugs	**Formulary design for prescription drugs**	Step Therapy MH/SUD drugs	same protocol development process for all drugs	Step Therapy med/surg drugs	same protocol development process for all drugs			x		YES
	Prescription drug benefit tiers	no tiers		no tiers				x		YES
	Generic vs. brand name	generic MH/SUD drugs	RI is a generics first state. Generic alternatives (when available) are required prior to approval of a brand agent. In those instances in which one generic is significantly more costly than another but is equal in clinical effectiveness, Members may be required to fail the less costly generic;	generic med/surg drugs	RI is a generics first state. Generic alternatives (when available) are required prior to approval of a brand agent. In those instances in which one generic is significantly more costly than another but is equal in clinical effectiveness, Members may be required to fail the less costly generic;			x		YES
	High cost vs. low cost							x		YES
Other NQTLs		none		none						YES