MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT FINAL REPORT

DECEMBER 30, 2019

Arizona Health Care Cost Containment System (AHCCCS)

CONTENTS

1 EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to provide technical assistance with assessing compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA herein referenced as "Parity"). Mercer has drafted a comprehensive final report that includes the Parity analysis methodology and benefit packages assessed, the standard chosen to define mental health/substance use disorder (MH/SUD) and medical/surgical (M/S) benefits, classification definitions, benefit mapping, review of results of claims-based testing, and the side-by-side analysis relative to each applicable non-quantitative treatment limit (NQTL) and associated final compliance recommendations. Mercer used a team of members with specialized knowledge for pharmacy, financial requirements/quantitative treatment limits (FR/QTLs) and NQTLs to manage and implement AHCCCS' Parity analysis.

Since the initial Parity analysis conducted in 2017[1], a significant change in AHCCCS' service delivery system for Arizona Long Term Care Services for Developmentally Disabled (ALTCS-DD) members, effective October 1, 2019, precipitates the need for reassessing Parity compliance. A summary of the changes is depicted in Table 1 below.

Table 1: ALTCS-DD Service Delivery Changes Effective October 1, 2019

BEFORE OCTOBER 1, 2019	EFFECTIVE OCTOBER 1, 2019
Members received physical health (PH) services through DDD contracted Managed Care Organizations (MCOs).	Members continue to receive PH services through DDD Health Plans.
Members received behavioral health (BH) services through Regional Behavioral Health Authorities (RBHAs).	Members receive BH services through DDD Health Plans.
Members with Children's Rehabilitative Services (CRS) conditions received PH and BH services through a DDD contracted MCO.	Members with CRS conditions receive PH and BH services through DDD Health Plans.
Members with a serious mental illness (SMI) received PH and BH services through a RBHA.	Members with an SMI designation receive PH and BH services through DDD Health Plans.

[1] Final Determination For the Mental Health Parity and ty Act Analysis; https://www.azahcccs.gov/Resources/Downloads/GovernmentalOversight/ArizonaMHPAEAReport.pdf

BEFORE OCTOBER 1, 2019	EFFECTIVE OCTOBER 1, 2019
Members received all Long Term Services and Supports (LTSS) through Department of Economic Security (DES)/DDD.	Members continue to receive all LTSS through DES/DDD, with the exception of nursing facility services, emergency alert system services and habilitative physical therapy for members twenty-one (21) years of age and older.

To complete the Parity analysis, AHCCCS performed and documented the following activities based on October 1, 2019 service delivery changes:

- Reviewed and confirmed benefit packages and service delivery systems included under the AHCCCS program that are subject to parity.
- Reviewed and confirmed the definitions for MH, SUD and M/S benefits consistent with a generally recognized independent standard of current medical practice.
- Reviewed and confirmed assignments of each service to one of four classifications (inpatient (IP), outpatient (OP), emergency care (EC), prescription drugs (PDs)) applying the same reasonable standard to M/S and MH/SUD benefits.
- Reviewed service delivery change impact to applicable FRs, QTLs, and aggregate lifetime and annual dollar limits (AL/ADLs) applied to each classification of identified benefit packages.
- Evaluated each NQTL for compliance applied to MH/SUD and M/S benefits to determine Parity requirements for comparability and stringency.

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

The State must assign each service to one of four classifications (IP, OP, EC and prescription drug) identified in the regulation. In defining the classifications for purposes of determining which benefits are included in each classification, the State is required to apply the same definitions of classifications to M/S and MH/SUD benefits. In general, classification definitions relate to how AHCCCS constructs and manages Medicaid benefits. When determining how to assign benefits to classifications, AHCCCS chose to define classifications based on the setting in which the services are delivered. The same standards for classifying benefits were applied to all M/S and MH/SUD

benefits, including intermediate services and long term care (LTC) services. Applying these standards resulted in services being mapped to more than one classification and a service(s) being classified as both an M/S benefit and an MH/SUD benefit.

In accordance with the Parity rule, FRs, QTLs and AL/ADLs applicable to MH/SUD benefits must be identified and analyzed in each classification of a benefit package. The State defined the benefit packages and benefit classifications consistent with requirements of the Parity rule. Section 7 of this report provides a summary of the findings of AL/ADLs applicable to MH/SUD benefits. As noted in the 2017 report and confirmed as part of this analysis, AHCCCS was able to determine that no AL/ADLs apply to MH/SUD services. Section 8 of this report provides a summary of all identified MH/SUD FRs and QTLs. The analysis found that the FRs that apply to MH/SUD are not applied within any classification of MH/SUD benefits more restrictively than the predominant financial requirement applied to substantially all M/S benefits in the same classification. As noted in the 2017 report and confirmed as part of this analysis, AHCCCS was able to determine that no parity concerns associated with FRs for MH/SUD services. QTLs applied to MH/SUD benefits are expected to be permissible under the Medicaid/Children's Health Insurance Program (CHIP) Parity Rule as the current limits are applied equally to MH/SUD and M/S benefits, or are more often applied to M/S benefits than to MH/SUD benefits. As noted in the 2017 report and confirmed as part of this analysis, AHCCCS was able to determine that no parity concerns associated with QTLs for MH/SUD services.

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

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

- Utilization Management NQTLs (includes prior authorization for PDs).
- Medical Necessity NQTLs.
- Documentation Requirements NQTLs.
- Out-of-Network (OON)/Geographic Area Coverage NQTLs.

Section 9 includes a summary of MH/SUD NQTLs that have been identified for benefit packages to which Parity applies and a brief overview of the findings including comparability and stringency of NQTL strategies, evidentiary standards and processes. Appendix C “NQTL Compliance Determinations”, demonstrates in a side by side analysis, the comparability and stringency for the associated processes, strategies, evidentiary standards and other factors, in writing and in operation, as they apply to M/S and MH/SUD benefits in the same classification. Based on the analysis, AHCCCS was able to determine that there are no parity concerns associated with NQTLs for MH/SUD services.

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INTRODUCTION

In August through December of 2019, AHCCCS conducted an additional Parity analysis for delivery system changes to AHCCCS' ALTCS-DD program effective October 1, 2019. The AHCCCS Parity analysis from 2017 was done to reflect service delivery systems in place at that time and subsequent service delivery changes to the ALTCS-DD program warranted an additional analysis by AHCCCS to confirm Parity compliance.

SERVICE DELIVERY CHANGES

Service delivery system changes to the ALTCS-DD program on October 1, 2019 were initiated as part of AHCCCS' overarching efforts to reduce service delivery fragmentation by building a more cohesive and effective health care system in Arizona. The ALTCS-DD delivery system changes were designed to provide integrated services and supports for members, and simplify and centralize responsibilities for ALTCS-DD services to members.

As of October 1, 2019, DES/DDD subcontracts with two statewide MCO's called "DDD Health Plans" for the provision of physical and behavioral health services, as well as a limited set of LTSS (nursing facility services, emergency alert system services, and habilitative physical therapy for members 21 years of age and older). DES/DDD manages all other LTSS and Case Management services and is responsible for the oversight of DDD Health Plans.

A summary of the changes is captured in Table 2 below.

Table 2: ALTCS-DD Service Delivery Changes Effective October 1, 2019

BEFORE 10/1/19	EFFECTIVE 10/1/19
Members received physical health (PH) services through DDD contracted Managed Care Organizations (MCOs).	Members continue to receive PH services through DDD Health Plans.
Members received behavioral health (BH) services through Regional Behavioral Health Authorities (RBHAs).	Members receive BH services through DDD Health Plans.
Members with Children's Rehabilitative Services (CRS) conditions received PH and BH services through and an AHCCCS contracted MCO.	Members with CRS conditions receive PH and BH services through DDD Health Plans.
Members with a serious mental illness (SMI) received PH and BH services through a RBHA.	Members with an SMI designation receive PH and BH services through DDD Health Plans.

BEFORE 10/1/19	EFFECTIVE 10/1/19
Members received all Long Term Services and Supports (LTSS) through DES/DDD.	Members continue to receive all LTSS through DES/DDD, with the exception of nursing facility services, emergency alert system services and habilitative physical therapy for members twenty-one (21) years of age and older.

2019 ANALYSIS

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

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

- Confirmed benefit packages and service delivery systems included under the AHCCCS program that are subject to parity.
- Defined MH, SUD and M/S benefits consistent with a generally recognized independent standard of current medical practice.
- Assigned each service to one of four classifications (IP, OP, EC, PDs) applying the same reasonable standard to M/S and MH/SUD benefits.
- Reviewed changes since 2017 regarding FRs, QTLs and AL/ADLs in each classification of identified benefit packages.
- Evaluated each NQTL for compliance with Parity requirements for comparability and stringency.

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

The Centers for Medicare & Medicaid Services (CMS) issued a Final Rule that applies requirements of the MHPAEA to MCO members' benefits, Medicaid Alternative Benefit Plans, and CHIP.

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METHODOLOGY

The approach and results of each component of the Parity analysis are discussed in greater detail in later sections of this report. In general, AHCCCS's approach to conducting the Parity analysis followed CMS guidance as outlined in the CMS Parity toolkit, *"Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*"[2] and included the following steps:

1. Identifying all benefit packages to which Parity applies.
2. Determining whether the State or DDD Health Plan is responsible for the Parity analysis (by benefit package).
3. Defining MH/SUD, and M/S services and determining which covered services are MH/SUD and/or M/S services.
4. Defining the four benefit classifications (IP, OP, PD, and EC) and mapping MH/SUD and M/S services to these classifications.
5. Determining whether any aggregate lifetime and annual dollar limits (AL/ADLs) apply to MH/SUD services.
6. Determining whether any FRs or QTLs apply to MH/SUD services in a benefit package and testing the applicable FRs and QTLs for compliance with Parity.
7. Identifying and analyzing NQTLs that apply to MH/SUD services in a benefit package.

[2] Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs. Retrieved from https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf

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MEDICAID/CHIP DELIVERY SYSTEM AND BENEFIT PACKAGES

As of October 1, 2019, members determined eligible for the ALTCS-DD program are assigned to the DES/DDD. ALTCS-DD members receive MH/SUD and M/S benefits from DES/DDD-contracted DDD Health Plans; and receive LTSS (M/S benefits) from DES/DDD.

BENEFIT PACKAGES

AHCCCS' ALTCS-DD program covers MH/SUD benefits in each classification (IP, OP, EC, PDs) in which there is an M/S benefit. Below is a summary of the responsible Health Plan by benefit packages. Please see Appendix A, AHCCCS Benefit Packages, for a summary of service delivery system combinations and benefit package combinations.

Table 3: Integrated Benefit Packages

MH/SUD BENEFITS	M/S BENEFITS
Mercy Care Plan (MCP)	Mercy Care Plan (MCP) DES/DDD (LTSS)
United Health Community Plan (UHCP)	United Health Community Plan (UHCP) DES/DDD (LTSS)

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DEFINITION OF MENTAL HEALTH/SUBSTANCE USE DISORDER SERVICES

GENERALLY RECOGNIZED INDEPENDENT STANDARD

The final regulations that apply Parity to Medicaid and the CHIP generally require that limitations applied to MH/SUD benefits are no more restrictive than the limitations applied to M/S benefits. In order to conduct the Parity analysis, AHCCCS was required to define MH, SUD and M/S benefits. Parity regulations define MH/SUD benefits as benefits for items or services for MH or SUDs, as defined by the State, in accordance with applicable Federal and State law. Any condition/disorder defined by the State as being or as not being a MH or SUD benefit must be defined consistent with generally recognized independent standards of current medical practice.

Based on a review of the available standards and to ensure consistency with the 2017 analysis, AHCCCS defined MH, SUD and M/S benefits consistent with the ICD-10-CM. The ICD-10-CM is a classification of diseases with codes and descriptors arranged within a Tabular List of Diseases. ICD-10-CM is an advantageous choice since AHCCCS already uses ICD as its standard for payment purposes, which avoids the administrative burden associated with selecting a different standard.

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

The ICD-10 includes the following chapters:

1. Certain infectious and parasitic diseases (A00-B99)
2. Neoplasms (C00-D49)
3. Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
4. Endocrine, nutritional and metabolic diseases (E00-E89)
5. **Mental, behavioral and neurodevelopmental disorders (F01-199)**
6. Diseases of the nervous system (G00-G99)
7. Diseases of the eye and adnexa (H00-H59)
8. Diseases of the ear and mastoid process (H60-H95)
9. Diseases of the circulatory system (I00-I99)
10. Diseases of the respiratory system (J00-J99)

11. Diseases of the digestive system (K00-K95)
12. Diseases of the skin and subcutaneous tissue (L00-L99)
13. Diseases of the musculoskeletal system and connective tissue (M00-M99)
14. Diseases of the genitourinary system (N00-N99)
15. Pregnancy, childbirth and the puerperium (O00-O99)
16. Certain conditions originating in the perinatal period (P00-P96)
17. Congenital malformations, deformations and chromosomal abnormalities (Q00-Q9A)
18. Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)
19. Injury, poisoning and certain other consequences of external causes (S00-T88)
20. External causes of morbidity and mortality (V00-Y99.9)
21. **Factors influencing health status and contact with health service (Z00-Z99)**

MH/SUD DEFINITION

AHCCCS defined[3] MH/SUD services as services for the conditions listed in ICD-10-CM, Chapter 5 "Mental, Behavioral, and Neurodevelopmental Disorders" with the exception of:

- The conditions listed in subchapter 1, "Mental disorders due to known physiological conditions" (F01 to F09).
- The conditions listed in subchapter 8, "Intellectual disabilities" (F70 to F79).
- The conditions listed in subchapter 9, "Pervasive and specific developmental disorders" (F80 to F89).

Given these definitions, AHCCCS determined that, because members must meet Intellectual Disability (ID)/DD level of care criteria to participate in the ALTCS/DD program, and an MH/SUD diagnosis is not a qualifying criterion for participation, all ID/DD services are considered M/S services for the purposes of the Parity analysis.

AHCCCS excluded subchapter 1 from the definition of MH/SUD because these mental disorders are due to known physiological conditions (e.g., vascular dementia and delirium due to known physiological condition) and all, except one, require that the physiological condition is coded first, indicating that the physiological (rather than the MH) condition is the focus of services. AHCCCS based this exclusion on the structure of the ICD-10-CM.

[3] Note: The definition of MH/SUD was for purposes of the Parity analysis and ensuring that MH/SUD services are provided in Parity with M/S services. The exclusion of certain conditions from the Parity analysis will not impact eligibility or treatment for conditions excluded from the Parity definition of MH/SUD.

AHCCCS excluded subchapters 8 (IDs) and 9 (DDs) from the definition of MH/SUD consistent with the structure and content of the ICD-10-CM. Chapter 5 of the ICD-10-CM is entitled Mental, Behavioral, and Neurodevelopmental Disorders and is divided into three subsets of disorders; only two of which are Mental and Behavioral. In addition, not including these disorders as MH/SUD disorders is consistent with CMS' definition of "mental disease," in the State Medicaid Manual Section 4390.D, which provides as follows: "…the term 'mental disease' includes diseases listed as mental disorders in the [ICD-9-CM], with the exception of mental retardation, senility, and organic brain syndrome."[4] Also, this definition is consistent with the definition of "Persons with related conditions" in 42 CFR 435.1010: "Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: (a) It is attributable to (1) Cerebral palsy or epilepsy; or (2) Any other condition, other than mental illness, found to be closely related to ID because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons…" (Sections (b) through (d) omitted; emphasis supplied).[5]

EXCLUSION OF Z CODES

AHCCCS also excludes Chapter 21 (bolded above) from the definition of M/S conditions because the ICD does not treat Z codes as either medical or MH/SUD conditions. The ICD-10 states that Z codes "are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00-Y89 are recorded as diagnoses or problems.

AHCCCS chose to exclude Z codes from the definition of M/S conditions and refined the definition to only exclude procedures where a Z code is the primary diagnosis code on the claim. In responding to a question during a Parity webinar about how to classify certain benefits such as newborn screenings or immunizations, (which are included in the Z Code chapter), CMS encouraged states to identify a clear standard and ensure that it is being applied consistently across services. CMS indicated that the state has flexibility to determine what that standard is; however, it must be applied in a reasonable manner.

The result of this exclusion is that costs, FRs, QTLs and NQTLs associated with Z codes are not part of the Parity analysis for FRs, QTLs or NQTLs applicable to MH/SUD benefits. It is important to note that based on discussions with coding experts, there may be instances where a Chapter 21 diagnosis code may accompany another medical diagnosis code to provide informational support.

[4] State Medicaid Manual – Part 4 Services. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R74SMM.pdf
[5] 42 CFR § 435.1010 – Definitions relating to institutional status. Retrieved from https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol4/xml/CFR-2015-title42-vol4-sec435-1010.xml

6
BENEFIT CLASSIFICATIONS

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

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

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

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

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

Outpatient: All covered services or items provided to a member in a setting that does not require an overnight stay, which do not otherwise meet the definition of IP, prescription drug or EC services.

Emergency Care: All covered emergency services or items to treat an emergency medical condition delivered in an emergency department setting.

Prescription Drugs: Covered medications, drugs and associated supplies and services that require a prescription to be dispensed. Includes drugs claimed using the National Council for Prescription Drugs Program (NCPDP) claim forms.

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AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS

In the 2017 analysis, Mercer provided assistance to AHCCCS regarding collecting data regarding AL/ADLs. Mercer and AHCCCS collaborated to help the DDD Health Plans identify any AL/ADLs applied to MH/SUD benefits. Under Parity, an aggregate lifetime dollar limit is a dollar limit on the total amount of specified benefits that may be paid. An aggregate annual dollar limit is a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period.

In accordance with the Medicaid/CHIP Parity rule AL/ADLs applicable to MH/SUD benefits must be analyzed in each classification (i.e., IP, OP, EC and PDs) of a benefit package. For an AL/ADL to be allowable, the limitation must be applied to at least one-third of the costs of M/S benefits across benefit classifications. Note that if an AL/ADL passes the one-third test, the Medicaid/CHIP Parity Rule prescribes additional analyses to determine if the AL/ADL may be applied to MH/SUD benefits.

Since the 2017 analysis, no changes to AL/ADLs have been implemented, and Mercer did not identify any AL/ADL applicable to any MH/SUD services. As a result, no AL/ADL review or testing was necessary.

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FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

FINANCIAL REQUIREMENTS (FR)

FRs are payments made by a member for services received (e.g., copayments). In the 2017 analysis, Mercer provided assistance to AHCCCS regarding collecting data regarding FRs.

Based on Mercer's review of state documentation and survey responses from the DDD Health Plans, the current Medicaid program includes the following copayment requirements (see table below). For purposes of this analysis, it is important to note that, based on the AHCCCS copayment requirements, copayments are not applicable to preventative visits (such as well visits, immunizations, pap smears, colonoscopies and mammograms).

Table 3: Co-Payment Requirements (2017 Analysis)

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

Consistent with AHCCCS definitions of MH/SUD and M/S benefits, Mercer identified that certain PDs and office visits associated with copays may be MH/SUD benefits. Note that OP therapies and non-emergency surgery are primarily M/S services and associated FRs would not need to be tested per the Parity rule.

Based on 42 CFR 438.910(c)(2)(ii), an additional Outpatient – office sub-classification may be used in determining Parity compliance for FRs. Mercer categorized prescriptions in the Prescription Drug category and office visits into the Outpatient – office sub-classification. Mercer was able to determine the results of the two-part test without doing a detailed cost-based analysis. See the table below for the results of the two-part test.

Table 4: Results of the Substantially All and Predominant Level Review (2017 Analysis)

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

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

- Outpatient – office copayment: All OP office visits in all benefit packages require a copay. Because all Outpatient – office visits have the same copayment ($4.00 for TMA and $3.40 for Other Special Populations), it can be concluded without testing that these are the respective predominant limits.

- Prescription Drugs: A copayment applies to all PDs irrespective of whether they are primarily for M/S or MH/SUD conditions. Thus all PDs are assigned a copayment. Because all PDs have the same level of copayment ($2.30), it can be concluded without testing that this is the predominant limit.

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

No additional FRs have been implemented therefore the identified FRs applicable to MH/SUD benefits, remain consistent with Parity requirements.

QUANTITATIVE TREATMENT LIMITATIONS (QTL)

In the 2017 analysis, Mercer reviewed State and DDD Health Plan documentation to compile a list of potential MH/SUD QTLs. Mercer found that no QTLs are applied to MH/SUD benefits in the IP, EC or PD classification of any benefit package. For the OP benefit classification, there were some potential QTLs noted in the table below.

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

Occupational Therapy (OT) hard limit of 15 OT visits is equally applied for members regardless of whether the principle/primary diagnosis is an M/S diagnosis or an MH/SUD diagnosis that necessitates the OT. AHCCCS believes the coverage is equal treatment and should meet the parity requirement. No changes have been made to the OT benefit AHCCCS determined as Parity compliant.

Regarding the annual limit of 600 hours for respite services. CMS clarified through a Frequently Asked Questions publication dated October 11, 2017 that long term supports and services, such as personal care and respite, could be defined as either MH/SUD or M/S, depending on the condition of the member being treated. CMS further clarified that, for these benefits, the state may define the benefit as MH/SUD or M/S for the entire member population using a reasonable method, such as whether the service is most commonly or frequently provided due to an MH/SUD or M/S condition. In the 2017 analysis, AHCCCS evaluated service encounter data during calendar year 2016 across all applicable benefit packages and determined that respite services are more commonly provided due to M/S conditions (i.e., more than 50% of spending on respite care is for beneficiaries who are receiving the service due to M/S conditions). Therefore, AHCCCS has determined that the respite limit is permissible under Parity requirements. No changes have been made to the Respite benefit that AHCCCS has determined as Parity compliant.

9
NON-QUANTITATIVE TREATMENT LIMITATIONS

IDENTIFYING NQTLS AND INFORMATION COLLECTION

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

Based on the illustrative list of NQTLs in the final Medicaid/CHIP Parity rule, the Parity toolkit, written guidance from the Department of Labor[6] regarding the commercial Parity rule (including FAQs, MHPAEA enforcement updates, and a document identifying potential "red flag" NQTLs). AHCCCS prioritized the analysis of four NQTLs (to ensure consistency with the 2017 analysis) that could be applied by the DDD Health Plan or DDD to MH/SUD services. This list included NQTLs related to out of network coverage, documentation requirements for individual service plans, medical necessity criteria, and utilization management (UM), including prior authorization requirements for PDs.

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

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

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[6] Department of Labor Information on Mental Health and Substance Use Disorder Parity: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity

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

NQTL: MEDICAL NECESSITY CRITERIA

The NQTL analysis for medical necessity criteria covered two classifications: IP services and OP services.

Medical Necessity Criteria (Inpatient and Outpatient Classifications)

For the DDD Health Plans and DDD, the adoption and development of medical necessity criteria for both MH/SUD and M/S services (IP and OP) is done to ensure that the quality and type and duration of service is appropriate to the member's needs. Medical necessity criteria is either based upon nationally-recognized criteria (such as MCG, InterQual and ASAM), or complies with AHCCCS policy that criteria be approved by the Plan's Medical Management Committee.

The DDD Health Plans and DDD conduct a review of the medical necessity criteria at least annually which includes physician review and the DDD Health Plans allows an ad hoc review if anyone identifies a potential concern. The DDD Health Plans monitor and review utilization data on an annual basis, per state requirement, to assess the effectiveness of the criteria. DDD also uses quality management data to monitor the effectiveness of the data.

Based upon the analysis, the processes, strategies and evidentiary standards for adopting and developing medical necessity criteria are comparable and no more stringently applied to MH/SUD benefits as compared to M/S benefits for the DDD Health Plans and DDD.

NQTL: UTILIZATION MANAGEMENT

The NQTL analysis for UM covered three classifications: IP services, OP services and prior authorizations for PDs.

Utilization Management (Inpatient Classification)

All non-emergent MH/SUD and M/S IP admissions require PA (notification). In addition, the following services managed by DDD require UM: Acute Inpatient, Skilled Nursing Facility (SNF), Acute Inpatient Rehab Facility, and Inpatient hospice care. All services requiring prior authorization require subsequent concurrent review. If a member is admitted to a MH/SUD or M/S IP facility for an emergency service, the DDD Health Plan and DDD require notification within 24 hours. DDD also

conducts a second level review for the following specific MH/SUD and M/S services: admissions to Arizona State Hospital (AzSH), Behavioral Health Residential Facility (BHRF) and Out of State placements for MH/SUD and enclosed or partially enclosed beds, hysterectomy, out of state placements and transplant of heart, heart/lung or liver on the M/S side.

The DDD Health Plans applies UM to the identified MH/SUD and M/S IP services because of the potential for overutilization and services are high cost and UM provides an opportunity to reduce unnecessary costs through medical necessity review and facilitate transition planning. The DDD Health Plan reviews MH/SUD and M/S cost and utilization data to identify services subject to UM strategies. DDD's strategy for applying UM to IP services is also due to high cost services and medical necessity review offers an opportunity to reduce unnecessary costs. DDD's evidentiary standard for this strategy is a review of claims data to identify high cost services.

DES/DDD's second level review process is supported to ensure compliance with enhanced state requirements (e.g., AMPM Chapter 300) for these particular services, and because these services are being provided to particularly vulnerable populations. The evidentiary standards for the DDD second level reviews includes cost and utilization reports, audits of consent processes/proof of guardianship and verification of network provider credentials and rate negotiations for out-of-state (OOS) placements.

MH/SUD and M/S DDD Health Plan providers must submit notification with supporting clinical documentation of IP admission. Both of the DDD Health Plans allow MH/SUD and M/S providers more than one method to submit notification. The DDD Health Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (i.e., MCG or InterQual) and, if indicated, refer potential service denial decisions to a physician for review. The DDD Health Plans indicated that for planned MH/SUD IP admissions, requests are reviewed within required federal timeframes. One DDD Health Plan reviews expedited requests within three days and Mercer recommends the State confirm with the DDD Health Plan that expedited requests are reviewed within 72 hours per State policy, not three days.

For MH/SUD and M/S IP requests lacking sufficient clinical information, DDD Health Plan providers are given the opportunity to submit necessary information within 24 hours of the second notification. After the second notification, licensed clinical health care professionals can issue an administrative denial. Both MH/SUD and M/S DDD Health Plan providers are offered the opportunity for a peer to peer reconsideration. Failure to meet the requirement of the UM strategy results in a denial of payment. The DDD Health Plans permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain prior authorization due to inability to determine coverage for the member. The DDD Health Plan's UM appeal process only applies if service coverage was denied and the service had not been rendered. The only exception in the application of PA/concurrent review for both MH/SUD and M/S is at the discretion of the Medical Director.

DDD requires providers to obtain prior authorization prior to the admission via fax, email or telephone and does not prescribe a timeframe. Licensed health care professionals apply nationally-recognized medical necessity guidelines (InterQual) and, if indicated, refer potential service denial decisions to a physician for review. When prior authorization is not met, the Chief Medical Officer or Medical Director reviews documentation and may request additional information or will have a peer-to-peer consultation. Requests are reviewed within the required federal timeframes – 14 days for standard requests and three days for expedited requests. DDD permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Members/providers on behalf of the member may request an appeal via phone, fax, mail or email. The only exception in the application of PA/concurrent review for M/S is at the discretion of the Medical Director or Assistant Medical Director.

DDD applies the second level review for all the listed services regardless of approval or denial by the health plans with the exception of BHRF which only requires a second level review if the service was denied by a health plan. Both MH/SUD and M/S services follow the same timeframes per AAC R9-34-206. The processes are the same for letters of extension and expedited requests. All denied second level review are subject to appeal by the member or provider on the member's behalf, and there are no exceptions to the process.

All MH/SUD and M/S IP services are subject to prior authorization. MH/SUD IP services are paid per diem and M/S IP services are paid by diagnosis-related group. The DDD Health Plan reported the average length of authorization for MH/SUD IP and M/S IP is three days. The reported range of MH/SUD IP authorization does not appear more stringent for MH/SUD than M/S. Measures of the stringency and consistency with which UM is conducted include IRR standards. The DDD Health Plan utilizes an IRR testing and requires a 90% pass rate.

DDD reported that 100% of all elective admissions require PA. For members not enrolled in the American Indian Health Program (AIHP), the PA is delegated to the DDD Health Plans. IP hospitalization authorization is provided for 30 days at a time. For an elective procedure, authorization is provided with a 14-day window. Measures of the stringency and consistency with which UM is conducted include IRR standards. The DDD Health Plan utilizes an annual IRR testing and requires a 90% pass rate.

The DDD second level review is supported by AAC R9-34-206 for both MH/SUD and M/S services.

Based upon these findings, it appears that the strategy and evidence are applied to MH/SUD benefits no more stringently than to M/S benefits.

Dependent upon the state ensuring DDD Health Plan review of expedited requests within 72 hours, and as a result of the analysis, the processes, strategies and evidentiary standards used in applying UM to MH/SUD IP services are comparable to, and applied no more stringently than, the processes,

strategies and evidentiary standards used in applying UM to M/S IP services, in writing or in operation.

Utilization Management (Outpatient Classification)

The DDD Health Plans apply UM to certain non-emergent MH/SUD and M/S OP services. In addition, certain OP services managed by DDD require UM. DDD conducts a second level review of specific M/S services (specifically termination of pregnancy and sterilization); no MH/SUD OP services are subject to DDD's second level review. Consequently, additional analysis for second level reviews for OP services is not necessary.

The DDD Health Plans applies UM to the identified MH/SUD and M/S OP services because these services have the potential for overutilization and because the services are high cost and UM provides an opportunity to reduce unnecessary costs through medical necessity review. The DDD Health Plan reviews MH/SUD and M/S cost and utilization data monthly to identify services subject to UM strategies. The strategies and evidentiary support appear to be comparable.

DDD's strategy for applying UM to the identified OP services is because the services are high cost and medical necessity review offers an opportunity to reduce unnecessary costs. The evidentiary standard for this strategy is a review of claims data to identify high cost services. Also, state requirements including AMPM Chapter 300 requires UM. DDD's strategy for the services requiring second level review is also because the services are high risk and high cost, and because the population being served is vulnerable The evidentiary standards for the DDD second level review includes cost and utilization reports, and audits of consent processes/proof of guardianship and verification of network provider credentials.

MH/SUD and M/S DDD Health Plan providers must request prior authorization prior to the delivery of the service. Both of the DDD Health Plans allow MH/SUD and M/S providers to submit notification via two methods. The DDD Health Plans use retrospective review for MH/SUD and M/S for purposes of detecting fraud, waste and abuse. The DDD Health Plans utilize licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) and, if indicated, refer potential service denial decisions to a physician for review. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. The DDD Health Plan offers both MH/SUD and M/S providers the opportunity for a peer to peer discussion if the intention is to deny the services. Failure to meet the requirement of the UM strategy results in a denial of payment. For OP requests lacking sufficient clinical information, providers are given the opportunity to submit the necessary information up to three attempts. The UM appeal process only applies if the services had not been rendered. Once the service has been provided, the provider can request a retrospective review. The only exception in the application of PA/concurrent review for both MH/SUD and M/S is at the discretion of the Medical Director.

DDD requires providers to obtain PA prior to the service via fax, email or telephone. Licensed health care professionals apply nationally-recognized medical necessity guidelines (InterQual) and, if

indicated, refer potential service denial decisions to a physician for review. When PA is not met, the Chief Medical Officer or Medical Director reviews documentation and may request additional information or will have a peer-to-peer consultation. Requests are reviewed within the required federal timeframes – 14 days for standard requests and three days for expedited requests. DDD permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Members/providers on behalf of the member may request an appeal via phone, fax, mail or email. The only exception in the application of PA/concurrent review for M/S is at the discretion of the Medical Director or Assistant Medical Director.

A range of 2% to 6% of MH/SUD and 16% of M/S OP services are subject to PA. The DDD Health Plan reported the average length of authorization for MH/SUD is 60 to 180 days and M/S OP is 60 days. The reported range of MH/SUD OP authorization does not appear more stringent for MH/SUD than M/S. Measures of the stringency and consistency with which UM is conducted include IRR standards. The DDD Health Plan utilizes an IRR testing and requires a 90% pass rate for both MH/SUD and M/S benefits.

DDD reported that 85% of services require PA. All non-emergent physical health services require PA with the exception of members who are under the age of 21. Services may be authorized for 14 days to six months dependent on type of service. Measures of the stringency and consistency with which UM is conducted include IRR standards. The DDD Health Plan utilizes an annual IRR testing and requires a 90% pass rate for M/S benefits.

Based upon these findings, it appears that the strategy and evidence are applied no more stringently to MH/SUD benefits than to M/S benefits.

As a result of the analysis, the processes, strategies and evidentiary standards used in applying UM to MH/SUD OP services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S OP services, in writing or in operation.

Utilization Management – Prior Authorization for Prescription Drugs (Prescription drugs classification)

The DDD Health Plans use the AHCCCS-mandated Preferred Drug List (PDL) which applies PA criteria to certain MH/SUD and M/S drugs to promote the appropriate and cost-effective use of prescription drugs. Evidence used to determine which MH/SUD and M/S drugs are subject to PA includes U.S. Food and Drug Administration (FDA) prescribing guidelines, published practice guidelines and treatment protocols, comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes, peer-reviewed medical literature, including randomized clinical

trials, outcomes, research data and pharmacoeconomic studies, and drug reference resources (e.g., Micromedex, Drug Facts and Comparisons, Up-to-Date).

To obtain PA, for both MH/SUD and M/S drugs, the provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. A clinical review for medical necessity is conducted, with a response within 24 hours of request. If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. Once the review is complete, a notice of action is sent to both the member and provider. If the notice of action is a denial, then the member and provider are advised of their options and appeals rights.

The DDD Health Plans use the AHCCCS-mandated PDL. PDL development and maintenance recommendations are provided regularly by the P&T Committee to the AHCCCS administration. For medications not listed on the AHCCCS PDL, a prior authorization may be submitted for a non-preferred federally and state reimbursable medication. The prior authorization is evaluated for coverage based on medical on medical necessity. On an ongoing basis, the DDD Health Plans monitor approval, denial, and appeal rates.

Based on the analysis, the processes, strategies, and evidentiary standards for prior authorization of MH/SUD prescription drugs appear to be comparable and no more stringently applied, in writing and in operation, to M/S drugs.

NQTL: OUT-OF-NETWORK REQUIREMENTS

Out of Network Requirements (IP and OP classifications)

The DDD Health Plans (MH/SUD and M/S services) and DDD (M/S services) restrict member access to out-of-network and out-of-state (non-emergent) providers in order to comply with federal, State regulation and contract requirements, when in-network care is not available, and to ensure network adequacy for specialty care. The DDD Health Plans and DDD makes exceptions for out-of-network limits for reasons that include: lack of in-network providers, ensuring appointment availability or accessibility, when there is a unique member need and out-of-area emergencies and out-of-area placements.

The DDD Health Plans and DDD use State contract and policy requirements regarding maintaining a sufficient contracted and credentialed network, State policy regarding time and distance standards, and data regarding specialty services unavailable within time and distance standards. Time and distance standards allow easier access to providers for the DDD Health Plan as compared to DDD services.

The DDD Health Plans and DDD require a standard UM review and prior authorization for requests for non-emergency out-of-network benefits. After network providers are confirmed to be unavailable to meet time and distance standards, are medically necessary and the request is approved,

documentation is requested and the provider is verified as actively enrolled as a Medicaid provider. The DDD Health Plans and DDD require both MH/SUD and M/S out-of-network providers to sign a single case agreement.

Delayed or retrospective requests are allowed by the DDD Health Plan and DDD and follow standard UM retrospective review processes and conditions. Members and providers may appeal the denial of out-of-network authorization requests. Discretion in applying out-of-network limits to both MH/SUD and M/S is allowed based on factors including out-of-network providers in process of credentialing, when in-network access and appointment timeliness standards cannot be met, member clinical risk/need, and scarcity of providers.

The DDD Health Plan and DDD review out-of-network policy and procedures for both providers of MH/SUD and M/S services at least annually, and update the policy and procedures when needed. Additionally, the DDD Health Plan and DDD review metrics to ensure out-of-network restrictions and discretion are relevant for both MH/SUD and M/S.

The DDD Health Plan and DDD reviews trended claims data, grievances, complaints and the volume and type of out of network requests on a weekly and bi-weekly basis (depending upon the committee); out of network coverage protocols are reviewed at least annually; and gaps are identified and addressed in the Annual Network Development and Management Plan.

Based on the analysis, the processes, strategies, and evidentiary standards for the application of out-of-network limits to providers of non-emergency MH/SUD, benefits are comparable and no more stringently applied, in writing and in operation, than to providers of non-emergency M/S benefits.

NQTL: DOCUMENTATION REQUIREMENTS

Documentation Requirements for Service Planning (IP and OP classifications)

Only one DDD Health Plan indicated that service planning was an NQTL.

The DDD Health Plan (MH/SUD services) and DDD (M/S services) apply documentation requirements (assessment and service planning, which includes a determination of medical necessity) by a multi-disciplinary team, including the member and family members, to: 1) ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services, and 2) to meet the requirements of State rule, contract and policy.

The requirements for both MH/SUD and M/S services is supported by Arizona Administrative Code (Title 9, Chapter 21, Article 3 and Title 6, Chapter 6, Article 6), DDD Health Plan and DDD contracts and policy. For MH/SUD services for children and adults, documentation requirements are set forth in AMPM Policy 320-O. State requirements for assessment and service planning for MH/SUD and DDD M/S services are recognized best practices for the population to support voice and choice (self-determination) and care coordination for individuals whose conditions necessitate multi-system involvement and collateral supports.

For MH/SUD services, the DDD Health Plan completes an initial and annual assessment by a behavioral health provider (BHP), or by a behavioral health technician (BHT) with BHP oversight. The initial assessment and preliminary service plan are developed as expeditiously as the member need requires, but no later than seven days of the intake appointment that identifies interventions and services. In the event an assessment is conducted and documented by a BHT, a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature.

For DDD M/S services, DDD service planning begins within 10 days of eligibility in which appropriate services are identified and documented in a member's individual service plan (ISP). Referrals for services are made following the ISP process and are required to be in place with a service provider within 30 days for a new service and 14 days for an existing service.

For both MH/SUD and M/S services, service plans are developed by service planning teams. For MH/SUD services for children, the service planning process is conducted by a service planning team called Child and Family Team (CFT), for adults the service planning team is called the Adult Recovery Team (ART). Both teams are composed of multi-disciplinary members and the member and/or guardian, as appropriate to capacity or age. The DDD Health Plan is required to complete a service plan no later than 90 days after the initial appointment with the member which is signed by the member. The length of time to develop the ISP varies based on urgency of needs, availability and member/guardian involvement. DDD also requires members and guardians/family to attend the planning process and, with the assistance of a support coordinator, determine their needs and the services that will be needed to assist them. Members work with their support coordinators to identify providers for approved ISP services as all DDD M/S services are accessed this way and monitored through the ISP. In limited circumstances, such as when the member/guardian is unwilling to participate in the process, the ISP is developed with limited input from the member.

Members may access MH/SUD services without a written assessment and service plan, but coverage for services may be denied without appropriate documentation. Additionally, providers are subject to audits to ensure assessments and ISPs are complete and updated regularly, and are at risk for recoupment in the event services are delivered without appropriate service planning documentation. The DDD Health Plan updated member ISPs on an annual basis or more frequently as necessary. DDD applies service planning more stringently for DDD M/S services, requiring DDD members to have ISPs in order to initiate and access services, including services with referrals. ISPs are updated every 90 days following the initial development.

For both MH/SUD and M/S services, the DDD Health Plan and DDD evaluates the stringency of the NQTL by reviewing access to care data addressing timeliness of service, provider monitoring and grievance and appeal data.

The processes, strategies and evidentiary standards for assessments and ISP development, in writing and in operation, are comparable and no more stringently applied to providers of MH/SUD services than to providers of M/S services.

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CONCLUSION

Following the comprehensive review of the new delivery system for the State's Medicaid/CHIP delivery system, AHCCCS has been determined to be in compliance with the parity requirements in 42 CFR Part 438 for the delivery system changes that came into effect on October 1, 2019.

AHCCCS will post a public report online documenting compliance with the final Medicaid/CHIP Parity rule. AHCCCS will continue to monitor compliance with the final Medicaid/CHIP Parity rule on an ongoing basis and will update this documentation to reflect the additional activities as necessary.

APPENDIX A

BENEFIT PACKAGE AND SERVICES GRID

APPENDIX B

NQTL SIDE BY SIDE ANALYSIS

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AHCCCS
Arizona Health Care Cost Containment System

AZ Parity Summary, Appendix A -
Benefit Package Mapping 2019

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

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Arizona Health Care Cost Containment System

AZ Parity Summary, Appendix A -
Benefit Package Mapping 2019

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

AZ Parity Summary, Appendix A -
Benefit Package Mapping 2019

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

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AZ Parity Summary, Appendix A -
Benefit Package Mapping 2019

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

AZ Parity Summary, Appendix A -
Benefit Package Mapping 2019

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

AZ Parity Summary, Appendix A -
Benefit Package Mapping 2019

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

MERCY CARE PLAN NQTL ANALYSIS

NQTL: Medical Necessity Criteria
Benefit Packages: All benefit packages for ALTCS-DD members
Classification: Inpatient
MCO: Mercy Care Plan (MCP)

1. To which benefits type(s) is the NQTL assigned?

MCO MH/SUD	MCO M/S
MCO: • Arizona State Hospital • Inpatient Psychiatric Acute Hospital • IMD • Sub-Acute Facility • Behavioral Health Inpatient Facility (BHIF/RTC) • Behavioral Health Residential Facility	MCO: • Inpatient M/S services • Hospital • Skilled Nursing Facilities • Long-Term Care Facilities (that provide rehabilitative, restorative, and/or ongoing skilled nursing care) DDD: All benefits that are subject to prior authorization, concurrent review and/or retrospective review in this classification are subject to the NQTL. • Acute Inpatient facility • SNF • Acute Inpatient Rehab (AIR) facility • Inpatient Hospice Care • Intermediate Care Facility

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO:	MCO:

MCO MH/SUD	MCO M/S
• To ensure that the quality (level of care) and type (intensity of service) and duration (length of stay) of service is appropriate to the member's needs.	• To ensure that the quality (level of care) and type (intensity of service) and duration (length of stay) of service is appropriate to the member's needs. DDD: • Medical necessity criteria are intended to optimize decision-making by emphasizing the use of evidence from well-designed and well conducted research.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S
MCO: • AHCCCS/CMS Guidelines and policies (i.e., AMPM 320-V for residential) • DDD Guidelines and policies • The MCO utilizes criteria required by applicable state or federal regulatory agencies and applicable MCG© and ASAM as primary decision support guidelines. If nationally-recognized criteria are not available for new treatments, procedures, medications and/or technology, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. • BHRF MNC guidelines were developed in compliance with AMPM Chaper 1020 and utilize a review of numerous	MCO: • AHCCCS/CMS Guidelines and Polices • DDD Guidelines and Policies • The MCO reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines. If nationally-recognized criteria are not available for new treatments, procedures, medications and/or technology, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. DDD: • Utilizes Division policy and InterQual criteria as the standard for evidence-based clinical decision support. Where nationally-recognized criteria are not available, the State

MCO MH/SUD	MCO M/S
sources including the AAC R9 Article 7 and AMPM 320, CRS Residential facility policies, as well as information from other documents including Nebraska and Louisiana's Office of Behavioral Health Therapeutic Group Home Policies, ASAM criteria, Magellan Clinical Guidelines for Behavioral Residential facilities, Milliman Clinical Guidelines, and RBHA policies. The APA and AMA were also reviewed.	requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO: • All new and revised clinical practice guidelines are reviewed by the MCO's Medical Management and Quality Advisory Committees, composed of practicing clinicians who participate in Aetna medical plans including Mercy Care. The Plan designates the review of medical necessity criteria to Aetna's Clinical Policy Council that includes external practicing clinicians. Approval of the criteria is completed by Aetna's Chief Medical Officer (CMO) or his/her designee. A medical director (MD) may use his/her discretion and professional judgement on behalf of member or provider's special requests.	MCO: • All new and revised clinical practice guidelines are reviewed by the MCO's Medical Management and Quality Advisory Committees, composed of practicing clinicians who participate in Aetna medical plans including Mercy Care. The Plan designates the review of medical necessity criteria to Aetna's Clinical Policy Council that includes external practicing clinicians. Approval of the criteria is completed by Aetna's Chief Medical Officer (CMO) or his/her designee. An MD may use his/her discretion and professional judgement on behalf of special requests. DDD: • Consistent with State requirements, all such clinical criteria are reviewed and updated annually by the Plan's MDs. The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical

MCO MH/SUD	MCO M/S
	Management/Utilization Management Committee which has provider MD level participants. • Any identified trends are further evaluated and may signal a change in current practice and/or medical policy or medical necessity in the evaluation, hospitalization, treatment, and/or discharge planning of members.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO: • As required by the State, criteria sets are reviewed at least annually for appropriateness to Mercy Care needs and changed as applicable. The changes occur when there's a change to the code, clinical practice, state/federal policy and/or change to Aetna or Aetna Medicaid Policy. The medical necessity criteria review may occur either prior to or after publication of the clinical practice guidelines (CPG) on Aetna's websites. Anyone can request a review of the criteria. • The annual and ad hoc review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, reviewing or revising medical necessity criteria. • All updated criteria must be reviewed and approved by Mercy Care's MMUM. • Recommendations from Aetna's Quality Advisory Committees are sent to the Clinical Policy Research and	MCO: • As required by the State, criteria sets are reviewed at least annually for appropriateness to Mercy Care needs and changed as applicable. The changes occur when there's a change to the code, clinical practice, state/federal policy and/or change to Aetna or Aetna Medicaid. The medical necessity criteria review may occur either prior to or after publication of the CPG on Aetna's websites. Anyone can request a review of the criteria. • The annual and ad hoc review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, reviewing or revising medical necessity criteria. • All updated criteria must be reviewed and approved by Mercy Care's MMUM. • Recommendations from Aetna's Quality Advisory Committees are sent to the Clinical Policy Research and Development Team for review. The Clinical Policy Research

MCO MH/SUD	MCO M/S
Development Team for review. The Clinical Policy Research and Development Team prepares a response to each of the Quality Assurance Committee recommendations and may draft further revisions to the CPG as appropriate for consideration by Aetna's Clinical Policy Council.	and Development Team prepares a response to each of the Quality Assurance Committee recommendations and may draft further revisions to the CPG as appropriate for consideration by Aetna's Clinical Policy Council. DDD: • As part of the annual review process, the Plan reports that services or items considered too rigorous or out of date, as well as unintended outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team would result in changes to the level of evidence as reviewed and updated by the CMO or designee (Medical Director) as well as other members of the Division's Health Care Services Unit.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • The Plan monitors and reviews utilization data to assess the effectiveness of the criteria. • The plan monitors clinical outcomes and adverse events to assess effectiveness of applying the criteria. • The plan relies on provider and member feedback and/or appeals and grievances to assess effectiveness.	MCO: • The plan monitors and reviews utilization data to assess the effectiveness of applying the criteria. • The plan monitors clinical outcomes and adverse events to assess effectiveness of applying the criteria. • The Plan relies on provider and member feedback and/or appeals or grievances to assess the ongoing effectiveness of the criteria. DDD:

MCO MH/SUD	MCO M/S
	• Outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team. • Randomized controlled trials or Cochrane are examples of strong evidence based services or items considered for coverage. Items are not excluded from coverage unless they fall outside of the purview what is allowed or required by state law, state rule, and/or contract with AHCCCS.

7. Compliance Determination

Comparability of Strategy and Evidence:

MNC adoption and development for both MH/SUD and M/S services is done to ensure that the quality and type and duration of service is appropriate to the member's needs. For both MH/SUD and M/S services, MNC is either based upon nationally-recognized criteria (such as MCG, Interqual and ASAM), or complies with AHCCCS policy that requires that where nationally-recognized criteria are not available, that the adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Based upon these findings, the strategy and evidence supporting the adoption and development of MNC for MH/SUD and DDD M/S services are comparable.

Comparability and Stringency of Processes:

Both M/S and MH/SUD MCOs utilize independently developed, evidence-based MNC when they are available; MH/SUD uses MCG® and ASAM, M/S uses MCG® and DDD uses Interqual. When nationally recognized criteria are not available, Mercy and DDD requires that any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. MH/SUD, M/S and DDD conduct a review of the MNC at least annually which includes physician review and UHC MH/SUD and M/S allows an ad hoc review if anyone identifies a potential concern. Based upon these findings, the processes supporting the adoption and development of MNC for MH/SUD and DDD M/S services are comparable and no more stringently applies to MH/SUD services.

Stringency of Strategy and Evidence:

The MCO monitors and reviews utilization data on an annual basis, per state requirement, to assess the effectiveness of the criteria. DDD also uses quality management data to monitor the effectiveness of the data. Based upon these findings, the strategy and evidence the adoption and development of MNC for MH/SUD and DDD M/S services are comparable and no more stringently applies to MHSUD services.

Compliance Determination:

Based upon the analysis, the processes, strategies and evidentiary standards for adopting and developing MNC are comparable and no more stringently applied to MH/SUD benefits as compared to M/S benefits for Mercy and DDD.

NQTL: Medical Necessity Criteria
Benefit Package: All benefit packages for ALTCS-DD members
Classification: Outpatient
MCO: Mercy Care Plan (MCP)

1. To which benefits type(s) is the NQTL assigned?

MCO MH/SUD	MCO M/S
MCO: • Non-Emergency Services Outside the Geographic Service Area • Non-Emergency Services Outside the Contracted Network • Non-Emergency, Out of Network Single Case Agreements • Therapeutic group home	MCO: • Radiology • Lab (other than Sonora Quest laboratories) • OP surgery DDD • All benefits OP benefits are subject to prior authorization, concurrent review and/or retrospective review in this classification are subject to the NQTL.

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO • To ensure that the quality and type and duration of service is appropriate to the member's needs.	MCO: • The MCO applies medical necessity criteria based on the needs of individual members and characteristics of the local delivery system. DDD: • Medical necessity criteria are intended to optimize decision-making by emphasizing the use of evidence from well-designed and well conducted research.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S
MCO: • The MCO utilizes Milliman Care Guidelines (MCG©), including Chronic Care Guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.	MCO: • The Plan reports using criteria required by applicable state or federal regulatory agencies and applicable MCG© as primary decision support guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. All new and revised clinical practice guidelines are reviewed by Aetna's Quality Advisory Committees, composed of practicing clinicians who participate in Aetna medical plans. DDD: • Utilizes Division clinical policy and InterQual criteria for both IP and OP LTSS. The Division also follows AMPM chapter 300. AMPM 430 is used for EPSDT services which includes vision and dental up to age 21, Dental EPSDT AMPM 431, ALTCS dental age 21+ or older including AIHP AMPM 310D2. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include

MCO MH/SUD	MCO M/S
	positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO: • Consistent with State requirements, all such clinical criteria are reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria are completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants.	MCO: • The Plan designates the review of medical necessity criteria to Aetna's Clinical Policy Council that includes external practicing clinicians. Approval of the criteria is completed by Aetna's Chief Medical Officer (CMO) or his/her designee. An MD may use his/her discretion and professional judgement on behalf of special requests. DDD: • Consistent with State requirements, all such clinical criteria are reviewed and updated annually by the Plan's MDs. The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants. • Any identified trends are further evaluated and may signal a change in current practice and/or medical policy or medical necessity in the evaluation, hospitalization, treatment, and/or discharge planning of members.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO:	MCO:

MCO MH/SUD	MCO M/S
• The annual review process consists of an evaluation of the existing criteria, issuing of any recommendations or changes needed, final acknowledgment or acceptance of the criteria and involvement of appropriate practitioners in developing, adopting, or reviewing criteria.	• Criteria sets are reviewed annually for appropriateness to MCP needs and changed as applicable. The changes occur when there's a change to the code, change to Aetna Policy or Aetna Medicaid. The medical necessity criteria review may occur either prior to or after publication of the clinical practice guidelines (CPG) on Aetna's websites. Recommendations from Aetna's Quality Advisory Committees are sent to the Clinical Policy Research and Development Team for review. The Clinical Policy Research and Development Team prepares a response to each of the Quality Assurance Committee recommendations and may draft further revisions to the CPG as appropriate for consideration by Aetna's Clinical Policy Council. DDD: • As part of the annual review process, the Plan reports that services or items considered too rigorous or out of date, as well as unintended outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team would result in changes to the level of evidence as reviewed and updated by the CMO or designee (Medical Director) as well as other members of the Division's Health Care Services Unit.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • The Plan relies on provider and member feedback and/or appeals or grievances to assess the ongoing effectiveness of the criteria.	MCO: • The Plan relies on provider and member feedback and/or appeals or grievances to assess the ongoing effectiveness of the criteria. DDD: • Outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team. • Randomized controlled trials or Cochrane are examples of strong evidence based services or items considered for coverage. Items are not excluded from coverage unless they fall outside of the purview what is allowed or required by state law, state rule, and/or contract with AHCCCS.

7. Compliance Determination

Comparability of Strategy and Evidence:

MNC adoption and development for both MH/SUD and M/S services is done to ensure that the quality and type and duration of service is appropriate to the member's needs. For both MH/SUD and M/S services, MNC is either based upon nationally-recognized criteria (such as MCG, Interqual and ASAM), or complies with AHCCCS policy that requires that where nationally-recognized criteria are not available, that the adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Based upon these findings, the strategy and evidence supporting the adoption and development of MNC for MH/SUD and DDD M/S services are comparable.

Comparability and Stringency of Processes:

Both M/S and MH/SUD MCOs utilize independently developed, evidence-based MNC when they are available; MH/SUD uses MCG® and ASAM, M/S uses MCG® and DDD uses Interqual. When nationally recognized criteria are not available, Mercy and DDD requires that any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. MH/SUD, M/S and DDD conduct a review of the MNC at least annually which includes physician review and UHC MH/SUD and M/S allows an ad hoc review if anyone identifies a potential concern. Based upon these findings, the processes supporting the adoption and development of MNC for MH/SUD and DDD M/S services are comparable and no more stringently applies to MH/SUD services.

Stringency of Strategy and Evidence:

The MCO monitors and reviews utilization data on an annual basis, per state requirement, to assess the effectiveness of the criteria. DDD also uses quality management data to monitor the effectiveness of the data. Based upon these findings, the strategy and evidence the adoption and development of MNC for MH/SUD and DDD M/S services are comparable and no more stringently applies to MH/SUD services.

Compliance Determination:

Based upon the analysis, the processes, strategies and evidentiary standards for adopting and developing MNC are comparable and no more stringently applied to MH/SUD benefits as compared to M/S benefits for Mercy and DDD.

UNITED HEALTH CARE NQTL ANALYSIS

NQTL: Medical Necessity Criteria
Benefit Packages: All benefit packages for ALTCS-DD members
Classification: Inpatient
MCO: United Health Care (UHC)

1. To which benefits type(s) is the NQTL assigned?

MCO MH/SUD	MCO M/S
MCO: • Medical necessity criteria applies to all inpatient and residential care.	MCO: • Medical necessity is applied to all inpatient and SNF. DDD: • All benefits that are subject to prior authorization, concurrent review and/or retrospective review in this classification are subject to the MNC NQTL • Acute Inpatient facility • SNF • Acute Inpatient Rehab (AIR) facility • Inpatient hospice Care • Intermediate Care Facility

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO: • To ensure that the quality and type and duration of service is appropriate to the member's needs.	MCO: • To ensure that the quality and type and duration of service is appropriate to the member's needs. DDD:

MCO MH/SUD	MCO M/S
	• Medical necessity criteria are intended to optimize decision-making by emphasizing the use of evidence from well-designed and well conducted research.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S
MCO: • The MCO utilizes MCG© Care Guidelines including Chronic Care Guidelines and American Society of Addiction Medicine (ASAM). Use of this criteria is supported by AHCCCS state regulations as found in AMPM Chapter 1000 and 1020. • Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. • BHRF MNC guidelines were developed in compliance with AMPM Chaper 1020 and utilize a review of numerous sources including the AAC R9 Article 7 and AMPM 320, CRS Residential facility policies, as well as information from other documents including Nebraska and Louisiana's Office of Behavioral Health Therapeutic Group Home Policies, ASAM criteria, Magellan Clinical Guidelines for Behavioral Residential facilities, Milliman Clinical Guidelines, and RBHA policies. The APA and AMA were also reviewed.	MCO: • The MCO uses MCG© Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines. Use of this criteria is supported by AHCCCS state regulations as found in AMPM Chapter 1000 and 1020. • The MCO plan reports using MCG and other nationally recognized clinical guidelines. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. DDD: • Utilizes Division policy and InterQual criteria as the standard for evidence-based clinical decision support for IP and OP LTSS. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include

	positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO: • Consistent with State requirements, all such clinical criteria are reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants. A UHC MD may utilize their discretion and medical expertise to reconsider denial decisions based upon the medical criteria.	MCO: • Consistent with State requirements, on an annual basis, the medical necessity criteria are assessed internally as part of the Plan's continual review of releases of new national practice guidelines from specialty organizations, and following recommendations from the Plan's Medical Technology Assessment Committee (MTAC). A UHC MD may utilize their discretion and medical expertise to reconsider denial decisions based upon the medical criteria DDD: • Consistent with State requirements, all such clinical criteria are reviewed and updated annually by the Plan's MDs. The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants. Any identified trends are further evaluated and may signal a change in current practice and/or medical policy or medical necessity in the evaluation, hospitalization, treatment, and/or discharge planning of members.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO:	MCO:

• In addition to the annual review, an adhoc review can be conducted at the request of the medical director, a provider or anyone who identifies a potential concern. Reasons for ad hoc review include: – Overutilization trend identified mid-year – Services added – New research resulting in a change – Treatment moved from experimental to FDA approved – Provider Grievances	• In addition to the annual review, an adhoc review can be conducted at the request of the medical director, a provider or anyone who identifies a potential concern. Reasons for ad hoc review include: – Overutilization trend identified mid-year – Services added – New research resulting in a change – Treatment moved from experimental to FDA approved – Provider grievances DDD: • As part of the annual review process, the Plan reports that services or items considered too rigorous or out of date, as well as unintended outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team would result in changes to the level of evidence as reviewed and updated by the CMO or designee (Medical Director) as well as other members of the Division's Health Care Services Unit.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • The MCO monitors and reviews utilization data on an annual basis, per state requirement, to assess the effectiveness of the criteria. The Plan monitors the frequency of requests and associated denial rates. Provider grievances regarding the Plan's application of the medical necessity criteria are also monitored and used to trigger a review of the criteria when necessary in between the scheduled annual reviews.	MCO: • The MCO monitors and reviews utilization data on an annual basis, per state requirement, to assess the effectiveness of the criteria. The Plan monitors the frequency of requests and associated denial rates. Provider grievances regarding the Plan's application of the medical necessity criteria are also monitored and used to trigger a review of the criteria when necessary in between the scheduled annual reviews.

MCO MH/SUD	MCO M/S
	DDD: • Outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team. • Randomized controlled trials or Cochrane are examples of strong evidence based services or items considered for coverage. Items are not excluded from coverage unless they fall outside of the purview what is allowed or required by state law, state rule, and/or contract with AHCCCS.

7. Compliance Determination

Comparability of Strategy and Evidence:

MNC adoption and development for both MH/SUD and M/S services is done to ensure that the quality and type and duration of service is appropriate to the member's needs. For both MH/SUD and M/S services, MNC is either based upon nationally-recognized criteria (such as MCG, InterQual and ASAM), or complies with AHCCCS policy that requires that where nationally-recognized criteria are not available, that the adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Based upon these findings, the strategy and evidence supporting the adoption and development of MNC for MH/SUD and DDD M/S services are comparable.

Comparability and Stringency of Processes:

Both M/S and MH/SUD MCOs utilize independently developed, evidence-based MNC when they are available; MH/SUD uses MCG® and ASAM, M/S uses MCG® and DDD uses InterQual. When nationally recognized criteria are not available, UHC and DDD requires that any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. MH/SUD, M/S and DDD conduct a review of the MNC at least annually which includes physician review and UHC MH/SUD and M/S allows an ad hoc review if anyone identifies a potential concern. Based upon these findings, the processes supporting the adoption and development of MNC for MH/SUD and DDD M/S services are comparable and no more stringently applies to MH/SUD services.

Stringency of Strategy and Evidence:

The MCO monitors and reviews utilization data on an annual basis, per state requirement, to assess the effectiveness of the criteria. DDD also uses quality management data to monitor the effectiveness of the data. Based upon these findings, the strategy and evidence the adoption and development of MNC for MH/SUD and DDD M/S services are comparable and no more stringently applies to MH/SUD services.

Compliance Determination:

Based upon the analysis, the processes, strategies and evidentiary standards for adopting and developing MNC are comparable and no more stringently applied to MH/SUD benefits as compared to M/S benefits for UHC and DDD.

NQTL: Medical Necessity Criteria
Benefit Package: All benefit packages for ALTCS-DD members
Classification: Outpatient
MCO: United Health Care (UHC)

1. To which benefits type(s) is the NQTL assigned?

MCO MH/SUD	MCO M/S
MCO: **Very few outpatient BH services require medical necessity review:** • Electro-convulsive treatment (provided in outpatient setting) • Home Care Training Client (H0018) • Non-Emergency Outpatient Services Outside the Geographic Service Area • Non-Emergency Outpatient Services Outside the Contracted Network • Neurobehavioral Status Exam • Psychological and Neuropsychological Testing • OON/OOS • TMS	MCO: • Allergy Immunotherapy • Bariatric Surgery • Bone Growth Stimulator BRACA Genetic Testing • Breast Reconstruction (non-mastectomy) • Cancer Supportive Care • Cardiology* • Carpal Tunnel Surgery* • Cataract Surgery*Chemotherapy • Chiropractic Care • Circumcisions • Cochlear and other Auditory Implants • Colonoscopy* • Cosmetic and Reconstructive Procedures* • Dental Services • Diabetic Supplies* • Durable Medical Equipment • Ear, Nose, and Throat Procedures* • Enteral/Parenteral/Oral Services

MCO MH/SUD	MCO M/S
	• Experimental and Investigative • Eye Care/Optometry • Femoroacetabular Impingement Syndrome • Functional Endoscopic Sinus Surgery • Genetic Testing • Gynecologic Procedures* • Hearing Aids and Services • Hernia repair* • Home Health Care • Hospice • Injectable Medications* • Joint Replacement • Liver Biopsy* • Non-emergent Air Ambulance Transport • Orthognathic Surgery • Orthotics and Prosthetics* • Outpatient Therapy (Physical, Speech, Occupational) • Pregnancy Termination • Private Duty Nursing • Proton Beam Therapy • Radiology* • Sleep Apnea Procedures and Surgeries • Specialty/Enclosed Beds • Spinal Surgery • Sterilization*

MCO MH/SUD	MCO M/S
	• Stimulators (Bone growth/Neurostimulators) • Tonsillectomy and Adenoidectomy* • Transplant Services • Upper Gastrointestinal Endoscopy* • Urologic Procedures* • Vagus Nerve Stimulation • Vein Procedures • Ventricular Assist Devises • Wound Vac* • Note: Prior authorization requirements marked with (*) Site of Service Requirement – Prior Authorization is required if performed in an OP hospital setting DDD • All benefits OP benefits are subject to prior authorization, concurrent review and/or retrospective review in this classification are subject to the NQTL.

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO: • To ensure that the quality and type and duration of service is appropriate to the member's needs.	MCO: • To ensure that the quality and type and duration of service is appropriate to the member's needs. DDD: • Medical necessity criteria are intended to optimize decision-making by emphasizing the use of evidence from well-designed and well conducted research.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S
MCO: • The MCO utilizes MCG™ Care Guidelines including Chronic Care Guidelines and American Society of Addiction Medicine (ASAM). Use of this criteria is supported by AHCCCS state regulations as found in AMPM Chapter 1000 and 1020. • Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.	MCO: • The MCO utilizes MCG™ Care Guidelines including Chronic Care Guidelines and American Society of Addiction Medicine (ASAM). Use of this criteria is supported by AHCCCS state regulations as found in AMPM Chapter 1000 and 1020. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale. DDD: • Utilizes Division clinical policy and InterQual criteria for both IP and OP LTSS. The Division also follows AMPM chapter 300. AMPM 430 is used for EPSDT services which includes vision and dental up to age 21, Dental EPSDT AMPM 431, ALTCS dental age 21+ or older including AIHP AMPM 310D2. Where nationally-recognized criteria are not available, the State requires any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO: • Consistent with State requirements, all such clinical criteria are reviewed and updated annually by the MH/SUD Plan's medical directors (MDs). The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants. A UHC MD may utilize their discretion and medical expertise to reconsider denial decisions based upon the medical criteria.	MCO: • Consistent with State requirements, all such clinical criteria are reviewed and updated annually by the MH/SUD Plan's MDs. The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants. A UHC MD may utilize their discretion and medical expertise to reconsider denial decisions based upon the medical criteria. DDD: • Consistent with State requirements, all such clinical criteria are reviewed and updated annually by the Plan's MDs. The review, comment and suggestions for changes with the medical necessity criteria is completed by the Plan's MDs and review and approval comes from the Medical Management/Utilization Management Committee which has provider MD level participants. • Any identified trends are further evaluated and may signal a change in current practice and/or medical policy or medical necessity in the evaluation, hospitalization, treatment, and/or discharge planning of members.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO: • In addition to the annual review, an adhoc review can be conducted at the request of the medical director, a provider or	MCO: • In addition to the annual review, an adhoc review can be conducted at the request of the medical director, a provider or

MCO MH/SUD	MCO M/S
anyone who identifies a potential concern. Reasons for ad hoc review include: – Overutilization trend identified mid-year – Services added – New research resulting in a change – Treatment moved from experimental to FDA approved – Provider Grievances	anyone who identifies a potential concern. Reasons for ad hoc review include: – Overutilization trend identified mid-year – Services added – New research resulting in a change – Treatment moved from experimental to FDA approved – Provider Grievances DDD: • As part of the annual review process, the Plan reports that services or items considered too rigorous or out of date, as well as unintended outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team would result in changes to the level of evidence as reviewed and updated by the CMO or designee (Medical Director) as well as other members of the Division's Health Care Services Unit.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • The MCO monitors and reviews utilization data on an annual basis, per state requirement, to assess the effectiveness of the criteria. The Plan monitors the frequency of requests and associated denial rates. Provider grievances regarding the Plan's application of the medical necessity criteria are also monitored and used to trigger a review of the criteria when necessary in between the scheduled annual reviews.	MCO: • The MCO monitors and reviews utilization data on an annual basis, per state requirement, to assess the effectiveness of the criteria. The Plan monitors the frequency of requests and associated denial rates. Provider grievances regarding the Plan's application of the medical necessity criteria are also monitored and used to trigger a review of the criteria when necessary in between the scheduled annual reviews. DDD:

MCO MH/SUD	MCO M/S
	• Outcomes from adverse incidents, hospital admissions, side effects for medications, ineffective treatment as noted by the Plan's quality management team. • Randomized controlled trials or Cochrane are examples of strong evidence based services or items considered for coverage. Items are not excluded from coverage unless they fall outside of the purview what is allowed or required by state law, state rule, and/or contract with AHCCCS.

7. Compliance Determination

Comparability of Strategy and Evidence:

MNC adoption and development for both MH/SUD and M/S services is done to ensure that the quality and type and duration of service is appropriate to the member's needs. For both MH/SUD and M/S services, MNC is either based upon nationally-recognized criteria (such as MCG and ASAM), or complies with AHCCCS policy that requires that where nationally-recognized criteria are not available, that the adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. Peer reviewed medical literature must include well-designed investigations that have been reproduced by non-affiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale. Based upon these findings, the strategy and evidence supporting the adoption and development of MNC for MH/SUD and DDD M/S services are comparable.

Comparability and Stringency of Processes:

Both M/S and MH/SUD MCOs utilize independently developed, evidence-based MNC when they are available; MH/SUD uses MCG® and ASAM, M/S uses MCG® and DDD uses InterQual. When nationally recognized criteria are not available, UHC and DDD requires that any adaptation or development of criteria must be based upon evaluated peer reviewed medical literature published in the United States. MH/SUD, M/S and DDD conduct a review of the MNC at least annually which includes physician review and UHC MH/SUD and M/S allows an ad hoc review if anyone identifies a potential concern. Based upon these findings, the processes supporting the adoption and development of MNC for MH/SUD and DDD M/S services are comparable and no more stringently applies to MH/SUD services.

Stringency of Strategy and Evidence:

The MCO monitors and reviews utilization data on an annual basis, per state requirement, to assess the effectiveness of the criteria. DDD also uses quality management data to monitor the effectiveness of the data. Based upon these findings, the strategy and evidence the adoption and development of MNC for MH/SUD and DDD M/S services are comparable and no more stringently applies to MH/SUD services.

Compliance Determination:

Based upon the analysis, the processes, strategies and evidentiary standards for adopting and developing MNC are comparable and no more stringently applied to MH/SUD benefits as compared to M/S benefits for UHC and DDD.

MERCY CARE PLAN NQTL ANALYSIS

NQTL: Utilization Management (UM)
Benefit Packages: All benefit packages for ALTCS-DD members
Classification: Inpatient (IP)
MCO: Mercy Care Plan (MCP)

1. To which benefits type(s) is the NQTL assigned?

MCO Mental Health/Substance Use Disorder (MH/SUD)	MCO Medical/Surgical (M/S)
MCO: • All non-emergent inpatient MH/SUD services, including: – Arizona State Hospital (AzSH) – IP Psychiatric Acute Hospital – Institution for Mental Diseases (IMD) – Sub-Acute Facility – Behavioral Health Inpatient Facility (BHIF) – Behavioral Health Residential Facility (BHRF) – Non-Emergency IP Services Outside the Geographic Service Area – Non-Emergency IP Services Outside the Contracted Network DDD conducts a second level review (SLR) for the following benefits: • AzSH • Behavioral Health Residential Facility (BHRF) • Out-of-State placements	MCO: • All non-emergent inpatient services, including: – IP M/S services – Hospital – Skilled Nursing Facilities (SNF) – Long-Term Care Facilities (that provide rehabilitative, restorative and/or ongoing skilled nursing care) – Non-Emergency IP Services Outside the Geographic Service Area – Non-Emergency IP Services Outside the Contracted Network DDD: • Acute Inpatient facility • Acute Inpatient Rehab (AIR) facility • IP hospice care DDD conducts a SLR for the following benefits: • Enclosed or partially enclosed beds • Hysterectomy

	• Out-of-State placements • Transplant of heart, heart/lung or liver.

2.

Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO: • Services have the potential for overutilization. • Services require UM because they are high cost and UM provides the opportunity to reduce unnecessary costs through medical necessity and facilitating discharge planning. DDD SLR: • To ensure that behavioral health services which are considered high-risk and/or high-cost are medically necessary and cost-effective. • To have oversight for behavioral health services considered to be high-risk and/or high-cost for its vulnerable population. • Out-of-state placements for behavioral health (BH) services are considered when the medically necessary service is not available in state, and only available in another state.	**MCO:** • Services have the potential for overutilization. • Services require UM because they are high cost and UM provides the opportunity to reduce unnecessary costs through medical necessity and facilitating discharge planning. DDD: • The need for the prior authorization (PA) and concurrent review is due to high costs and UM provides the opportunity to reduce unnecessary costs through medical necessity review. DDD SLR: • To ensure that physical health services which are considered high-risk and/or high-cost are medically necessary and cost-effective. • To have oversight for physical health services considered to be high-risk and/or high-cost for its vulnerable population. • Requests for partially/fully enclosed beds must be in compliance with Arizona Administrative Code (AAC) Article 9: R-6-6-901 to R6-6-909.

MCO MH/SUD	MCO M/S
	• Out-of-state placements for PH services are considered when the medically necessary service is not available in state, and only available in another state. • To ensures compliance with Arizona Health Care Cost Containment System (AHCCCS) medical polices for hysterectomy, and transplant of heart, heart/lung or liver.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S
MCO: • The MCO reports using utilization data and cost data. DDD SLR: • Annual Cost reports for high-cost services using an industry standard (e.g. out of state behavioral health inpatient facilities). • Audit of appropriate consent processes and/or proof of guardianship for MH/SUD services e.g. members on court ordered treatment or inpatient hospitalization. • Verification of AHCCCS network provider's credentials and contract accepting the network rate. • Utilization reports and degree of variation across providers and services.	MCO: • The MCO reports using utilization data and cost data. DDD: • Reviews are based on claims data for cost, state requirements (AMPM chapter 300), and clinical review from current providers and AHCCCS medical policies. DDD SLR: • Annual Cost reports for high-cost services using an industry standard (e.g. liver transplants). • Audit of appropriate consent processes and/or proof of guardianship for termination of pregnancy, sterilization, and hysterectomy procedures. • Verification of AHCCCS network provider's credentials and contract accepting the network rate. • Utilization reports and degree of variation across providers and services.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO: • Providers must submit notification of admission via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile. • The requesting provider must submit notification with supporting clinical documentation required per MCG guidelines. • For planned IP admissions, requests are reviewed within required federal timeframes – 14 days for standard requests, three days for an expedited request. • For inpatient admission requests that are lacking sufficient clinical information, providers are given an opportunity to submit necessary information within 24 hours after the second notification. After the second notification the absence of the necessary clinical information enables licensed health care professionals to issue administrative denial. • The MCO utilizes licensed health care professionals to render authorization decisions while a physician is required to deny an admission. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). • The Medical Director will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. • Exceptions to PA include emergency services, which can be reviewed retrospectively. Providers are to provide notification within 24 hours of an admission.	MCO: • Providers must submit notification of admission via facsimile or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile. • The requesting provider must submit notification with supporting clinical documentation required per MCG guidelines. • For planned IP admissions, requests are reviewed within required federal timeframes – 14 days for standard requests, three days for an expedited request. • For inpatient admission requests that are lacking sufficient clinical information, providers are given an opportunity to submit necessary information within 24 hours after the second notification. After the second notification the absence of the necessary clinical information enables licensed health care professionals to issue administrative denial. • The MCO utilizes licensed health care professionals to render authorization decisions while a physician is required to deny an admission. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). • The Medical Director will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided. • Exceptions to PA include emergency services, which can be reviewed retrospectively. Providers are to provide notification within 24 hours of an admission.

MCO MH/SUD	MCO M/S
• Only the Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. • In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • The UM appeal process would only apply if the services had not been rendered. Once the service is rendered the provider can request a retro review or file the claim and submit a claims dispute. DDD SLR: • SLR are conducted by DDD for all the listed services subject to SLR, whether approved or denied by the health plans with the exception of Behavioral Health Residential facilities which only requires a SLR if the service was denied by a health plan. • Per AAC R9-34-206, the SLR timeframe follows the Notice of Action time-frame for Service Authorization Requests, which is 14 calendar days from receipt of the request from the member/guardian; the steps are as follows: – Day 1: The health plan (HP) receives the member/guardian request – Determination is made by the HP Medical Director – HP sends all medical info and requests SLR from DDD Medical Director – DDD Medical Director reviews request and sends determination to HP. A Peer-to Peer review occurs if the DDD	• Only the Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. • In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • The UM appeal process would only apply if the services had not been rendered. Once the service is rendered the provider can request a retro review or file the claim and submit a claims dispute. DDD: • Providers must obtain PA prior to admission (there is no timeframe) by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. • Providers must notify DDD within 24 hours of an emergency admission. • The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the Chief Medical Officer or Medical Director reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. • Requests are reviewed within required federal timeframes – 14 days for standard requests, three days for expedited requests.

MCO MH/SUD	MCO M/S
Medical Director's determination does not match the HP Medical Director's determination. – Day 14: Final HP decision in writing is mailed to the member/guardian as a Notice of Action indicating authorization approval, or a Notice of Adverse Benefit Determination, indicating authorization denial. • A Letter of Extension (LOE) may be filed by the health plan if the initial information received is insufficient. At that time, an additional 14 days is allowed for the SLR process from the date the LOE is filed. Written notice is given to the member/guardian of the reason for the decision to extend the time-frame and the right to file a grievance of the member/guardian disagrees with the decision. • For an Expedited Authorization request in which the provider indicates or the contractor determines the 14-day time-frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO will submit all information to DDD within 48 hours and DDD shall make an expedited authorization decision within 24 hours. The Notice of Action will be mailed as expeditiously as the member's health requires, but no later than 72 hours after receipt of the request for service. • All denied SLR MH/SUD services are subject to appeal by the member or provider • No exceptions to the process.	• The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). • Exceptions to PA include emergency services, which can be reviewed retrospectively. DDD must be notified within 24 hours of an emergency service. • Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • Members/providers on behalf of the member can appeal a decision. This would result in a SLR to determine medical necessity. An appeal can be done via phone, facsimile, or written in the form of mail or email. DDD SLR: • SLR are conducted by DDD for all the listed services subject to SLR, whether approved or denied by the health plans. • Per AAC R9-34-206, the SLR timeframe follows the Notice of Action time-frame for Service Authorization Requests, which is 14 calendar days from receipt of the request from the member/guardian; the steps are as follows:

MCO MH/SUD	MCO M/S
	– Day 1: The health plan (HP) receives the member/guardian request – Determination is made by the HP Medical Director – HP sends all medical info and requests SLR from DDD Medical Director – DDD Medical Director reviews request and sends determination to HP. A Peer-to Peer review occurs if the DDD Medical Director's determination does not match the HP Medical Director's determination. – Day 14: Final health plan decision in writing is mailed to the member/guardian as a Notice of Action indicating authorization approval, or a Notice of Adverse Benefit Determination, indicating authorization denial. • A Letter of Extension (LOE) may be filed by the health plan if the initial information received is insufficient. At that time, an additional 14 days is allowed for the SLR process from the date the LOE is filed. Written notice is given to the member/guardian of the reason for the decision to extend the time-frame and the right to file a grievance if the member/guardian disagrees with the decision. • For an Expedited Authorization request in which the provider indicates or the contractor determines the 14-day time-frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO will submit all information to DDD within 48 hours and DDD shall make an expedited authorization decision within 24 hours. The Notice of Action will be mailed as expeditiously as the member's health requires, but no later than 72 hours after receipt of the request for service.

MCO MH/SUD	MCO M/S
	• All denied SLR M/S services are subject to appeal by the member or provider. • No exceptions to the process.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO: • 100% of MH/SUD IP services are subject to PA. • MH/SUD IP services are typically authorized for three days. • MH/SUD IP services are paid per diem. • Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into consideration before changes are made. • AHCCCS guidelines, policy updates, MCG annual updates, Aetna clinical policy guidelines and monthly updates are also considered and may prompt a review more frequent than annually. DDD SLR timeframes: • Per R9-34-206	**MCO:** • 100% of M/S IP services are subject to PA. • M/S IP services are typically authorized for three days. • M/S IP services are paid DRG. • Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into consideration before changes are made. • AHCCCS guidelines, policy updates, MCG annual updates, Aetna clinical policy guidelines and monthly updates are also considered and may prompt a review more frequent than annually. DDD: • 100% of all elective admissions require PA. For members not enrolled in AIHP the PA is delegated to the health plans. DDD does not require PA for emergency or admissions to IHS facilities for AIHP members. DDD utilizes Chapter 300 of the AMPM, if there is not adequate guidance in the AMPM the medical director will review and determine necessity of services. • PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of procedure that may need to be enhanced or removed.

MCO MH/SUD	MCO M/S
	• For an inpatient hospitalization authorization is provided for 30 days at a time. For an elective procedure, authorization is provided with a 14 day window. DDD second level review timeframes: • Per R9-34-206

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • The MCO relies on claims data, provider utilization data, readmission rates, and predictive analytics. • Clinical PA and Concurrent Review staff: Monthly quality audits are conducted 90 days after an employee is hired. A minimum of twenty-four (24) cases annually are reviewed for all clinical staff with the expectation of having a passing score 90% or above. The number of audits may be increased as a result of corrective action plan or Performance Improvement Plan. • IRR testing is required annually for all existing clinical staff with the expectation of having a passing score of 90% or above. DDD SLR: • DDD monitors and reviews approvals, denials and appeals of these services.	MCO: • The MCO relies on claims data, provider utilization data, readmission rates, and predictive analytics. • Clinical PA and Concurrent Review staff: Monthly quality audits are conducted 90 days after an employee is hired. A minimum of twenty-four (24) cases annually are reviewed for all clinical staff with the expectation of having a passing score 90% or above. The number of audits may be increased as a result of corrective action plan or Performance Improvement Plan. • IRR testing is required annually for all existing clinical staff with the expectation of having a passing score of 90% or above. DDD: • Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the Medical Management Committee. The audits assess timeliness and appropriateness of authorization. • The Plan conducts annual IRR testing for UR staff and requires a standard of 90%.

MCO MH/SUD	MCO M/S
	DDD SLR: • DDD monitors and reviews approvals, denials and appeals of these services.

7. Compliance Determination

IP Benefits:

All non-emergent MH/SUD and M/S IP admissions require PA (notification). In addition, the following services managed by DDD require UM: Acute Inpatient, SNF, Acute Inpatient Rehab Facility, and IP hospice care. All services requiring PA require subsequent concurrent review. If a member is admitted to a MH/SUD or M/S IP facility for an emergency service, the MCO and DDD require notification within 24 hours. UM is required by DDD for each of the identified services managed by DDD. DDD also conducts a SLR of specific MH/SUD and M/S services which include admissions to AzSH, BHRF and Out of State placements for MH/SUD and enclosed or partially enclosed beds, hysterectomy, out of state placements and transplant of heart, heart/lung or liver on the M/S side.

Comparability of Strategy and Evidence:

DDD's strategy for applying UM to the IP services is because the services are high cost and medical necessity review offers an opportunity to reduce unnecessary costs. The evidentiary standard for this strategy is a review of claims data to identify high cost services. Also, state requirements including AMPM Chapter 300 requires UM. DDD's strategy for the services requiring SLR is also because the services are high risk and high cost, and because the population being served is vulnerable. In addition, use of partially or fully enclosed beds must be in compliance with AAC Article 9. R-6-6-901 to R6-6-909. The evidentiary standards for the DDD SLR includes cost and utilization reports, audits of consent processes/proof of guardianship and verification of network provider credentials and rate negotiations for OOS placements.

The MCO applies UM to the identified MH/SUD and M/S IP services because these services have the potential for overutilization and because the services are high cost and UM provides an opportunity to reduce unnecessary costs through medical necessity review and facilitate transition planning. The MCO reviews MH/SUD and M/S cost and utilization data to identify services subject to UM strategies. The strategies and evidentiary support are comparable.

Comparability and Stringency of Processes:

MH/SUD and M/S providers must submit notification with supporting clinical documentation of IP admission. Both the MH/SUD and M/S providers submit notification via two options (facsimile and phone). The MCO utilizes licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) and, if indicated, refer potential service denial decisions to a physician for review. MCP indicated that for planned MH/SUD and M/S IP admissions, requests are reviewed within 14 days for standard requests and three days for an

expedited request. Per State policy AAC R9-34-206, expedited requests must be reviewed within 72 hours. Mercer recommends the State confirm with MCP that expedited IP MH/SUD and M/S requests are reviewed within 72 hours. For MH/SUD and M/S IP requests lacking sufficient clinical information, providers are given the opportunity to submit necessary information within 24 hours of the second notification. After the second notification, licensed clinical health care professionals can issue an administrative denial. Both MH/SUD and M/S offer the provider the opportunity for a peer to peer reconsideration. Failure to meet the requirement of the UM strategy results in a denial of payment. The MCO permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. The UM appeal process only applies if the service had not been rendered. The only exception in the application of PA/concurrent review for both MH/SUD and M/S is at the discretion of the Medical Director. Dependent upon the recommended changes as noted regarding MCP's review of expedited requests within 72 hours, the NQTL processes for MH/SUD are comparable and no more stringently applied than for M/S benefits.

DDD requires providers to obtain PA prior to the admission via facsimile, electronic mail or telephone and does not prescribe a timeframe. Licensed health care professionals apply nationally-recognized medical necessity guidelines (InterQual) and, if indicated, refer potential service denial decisions to a physician for review. When PA is not met, the Chief Medical Officer or Medical Director reviews documentation and may request additional information or will have a peer-to-peer consultation. Requests are reviewed within the required federal timeframes – 14 days for standard requests and three days for expedited requests. DDD permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Members/providers on behalf of the member may request an appeal via phone, facsimile, mail or email. The only exception in the application of PA/concurrent review for M/S is at the discretion of the Medical Director or Assistant Medical Director.

DDD applies the SLR for all the listed services regardless of approval or denial by the health plans with the exception of BHRF which only requires a SLR if the service was denied by a health plan. Both MH/SUD and M/S services follow the same timeframes per AAC R9-34-206. The processes are the same for letters of extension and expedited requests. All denied SLR are subject to appeal by the member or provider on the member's behalf, and there are no exceptions to the process.

Stringency of Strategy and Evidence:

All MH/SUD and M/S IP services are subject to PA. MH/SUD IP services are paid per diem and M/S IP services are paid by DRG. The MCO reported the average length of authorization for MH/SUD IP and M/S IP is 3 days. The reported range of MH/SUD IP authorization is no more stringent for MH/SUD than M/S. Measures of the stringency and consistency with which UM is conducted include IRR standards. The MCO utilizes an IRR testing and requires a 90% pass rate.

DDD reported that 100% of all elective admissions require PA. For members not enrolled in AIHP, the PA is delegated to the MCOs. IP hospitalization authorization is provided for 30 days at a time based on continued review and medical necessity. For an elective procedure, authorization is provided with a 14-day window. Measures of the stringency and consistency with which UM is conducted include IRR standards. The MCO utilizes an annual IRR testing and requires a 90% pass rate.

The DDD SLR is supported by AAC R9-34-206 for both MH/SUD and M/S services.

Based upon these findings, the strategy and evidence are applied to MH/SUD benefits no more stringently than to M/S benefits.

Compliance Determination:

Dependent upon the recommended change as noted regarding MCP's review of expedited requests within 72 hours, and as a result of the analysis, the processes, strategies and evidentiary standards used in applying UM to MH/SUD inpatient services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying utilization management to M/S inpatient services, in writing or in operation.

NQTL: Utilization Management
Benefit Package: All benefit packages for ALTCS-DD members
Classification: Outpatient (OP)
MCO: Mercy Care Plan

1. To which benefits type(s) is the NQTL assigned?

MCO MH/SUD	MCO M/S
• MCO: Non-Emergency OP Services Outside the Geographic Service Area • Non-Emergency OP Services Outside the Contracted Network Therapeutic Group Home DDD second level (SLR) review: • None	MCO: • Radiology • Lab (other than Sonora Quest Laboratories) • OP Surgery DDD: • Abdominal Paracentesis • Bariatric Surgery • Bone Growth Stimulator • BRACA Genetic Testing • Cardiology • Cardiovascular • Carpal Tunnel Surgery • Cataract Surgery • Chemotherapy • Chiropractic Care • Circumcisions • Cochlear & other Auditory Implants • Colonoscopy • Cosmetic & Reconstructive Procedures

	• Dental Services • Diabetic Supplies • Durable Medical Equipment >$500.00 • Ear, Nose, & Throat Procedures • Enteral/Parenteral/Oral Services • Experimental & Investigative • Eye Care • Femoracetabular Impingement Syndrome • Functional Endoscopic Sinus Surgery (FESS) • Genetic Testing • Gynecologic Procedures • Hearing Services • Tonsillectomy & Adenoidectomy • Transplant Services • Upper Gastrointestinal Endoscopy • Urologic Procedures • Vagus Nerve Stimulation Implant • Vein Procedures • Ventricular Assist Devices • Wound Vac **Note: PA is not needed if members receive services from an IHS facility. DDD conducts a SLR for these benefits: • Sterilization • Termination of pregnancy

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO: • The MCO applies the UM strategy (PA and concurrent review) due to potential for over utilization. • Services are high cost and UM provides the opportunity to reduce unnecessary costs through medical necessity.	MCO: • The MCO applies the UM strategy (PA and concurrent review) due potential for over utilization. • Services are high cost and UM provides the opportunity to reduce unnecessary costs through medical necessity. DDD: • The need for the PA and concurrent review due to high costs and to ensure that services provided are appropriate and timely for the member's needs. The Plan reviews retrospective services in the event that the initial request for the clinical review occurs after the member is discharged and a retrospective review is requested. DDD SLR: • To ensure that physical health services which are considered high-risk and/or high-cost are medically necessary and cost-effective. • To have oversight for physical health services considered to be high-risk and/or high-cost for its vulnerable population. • To ensure compliance with AHCCCS medical polices for sterilization, termination of pregnancy.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S
MCO: • Cost and utilization data including trends are reviewed monthly	MCO: • Cost and utilization data including trends are reviewed monthly. DDD:

MCO MH/SUD	MCO M/S
	• DDD uses claims data for cost, state requirements (AMPM Chapter 300), and clinical review from current providers and AHCCCS medical policies.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO**:** • Provider must obtain PA prior to the delivery of the service by requests initiated via facsimile or telephone. Requests for continued authorization of that particular service are treated as a request for PA. • The requesting provider must submit the PA with supporting clinical documentation required per MCG guidelines. • For OP requests lacking sufficient clinical information, providers are given the opportunity to submit the necessary information. The MCO allows for three attempts for providers to submit additional information. • Requests are reviewed within required federal timeframes – 14 days for standard requests, 72 hours for an expedited request. • The MCO utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). • The Medical Director will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided.	MCO: • Provider must obtain PA prior to the delivery of the service by requests initiated via facsimile or telephone. Requests for continued authorization of that particular service are treated as a request for PA. • The requesting provider must submit the PA with supporting clinical documentation required per MCG guidelines. • For OP requests lacking sufficient clinical information, providers are given the opportunity to submit the necessary information. The MCO allows for three attempts for providers to submit additional information. • Requests are reviewed within required federal timeframes – 14 days for standard requests, 72 hours for an expedited request. • The MCO utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (MCG). • The Medical Director will offer a peer to peer discussion, if the intention is to deny the services for any additional information that can be provided.

MCO MH/SUD	MCO M/S
• Exceptions to PA include emergency services. Providers must notify MCO within 24 hours. • Only the Medical Director may use discretion in applying the UM strategies. Retrospective review for cases in which fraud, waste, abuse (FWA) is suspected. • In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • The UM appeal process would only apply if the services had not been rendered. Once the service is rendered the provider can request a retro review or file the claim and submit a claims dispute.	• Exceptions to PA include emergency services. Providers must notify MCO within 24 hours. • Only the Medical Director may use discretion in applying the UM strategies. Retrospective review for cases in which FWA is suspected. • In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • The UM appeal process would only apply if the services had not been rendered. Once the service is rendered the provider can request a retro review or file the claim and submit a claims dispute. DDD: • Providers must obtain PA 14 days prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. • The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the Chief Medical Officer or Medical Director reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. • Requests are reviewed within required federal timeframes – 14 days for standard requests, three days for an expedited request. • The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request.

MCO MH/SUD	MCO M/S
	• UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). • Exceptions to PA include emergency services, which can be reviewed retrospectively. DDD must be notified within 24 hours of the emergency service. • Only the Medical Director or Assistant Medical Director may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. • In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • Members/providers on behalf of the member can appeal the decision. This would result in a SLR to determine medical necessity. An appeal can be done via phone, facsimile, or written in the form of mail or email. DDD SLR: • SLR are conducted by DDD for all the listed services, whether approved or denied by the health plans. • Per AAC R9-34-206, the SLR timeframe follows the Notice of Action time-frame for Service Authorization Requests, which is 14 calendar days from receipt of the request from the member/guardian; the steps are as follows: – Day 1: The health plan (HP) receives the member/guardian request – Determination is made by the HP Medical Director

MCO MH/SUD	MCO M/S
	– HP sends all medical info and requests SLR from DDD Medical Director – DDD Medical Director reviews request and sends determination to HP. A Peer-to Peer review occurs if the DDD Medical Director's determination does not match the HP Medical Director's determination. – Day 14: Final health plan decision in writing is mailed to the member/guardian as a Notice of Action indicating authorization approval, or a Notice of Adverse Benefit Determination, indicating authorization denial. • A Letter of Extension (LOE) may be filed by the health plan if the initial information received is insufficient. At that time, an additional 14 days is allowed for the SLR process from the date the LOE is filed. Written notice is given to the member/guardian of the reason for the decision to extend the time-frame and the right to file a grievance if the member/guardian disagrees with the decision. • For an Expedited Authorization request in which the provider indicates or the contractor determines the 14-day time-frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the contractor shall make an expedited authorization decision and mail the Notice of Action as expeditiously as the member's health requires, but no later than 72 hours after receipt of the request for service. • All denied SLR M/S services are subject to appeal by the member or provider • No exceptions process.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO: • 6% of MH/SUD OP services subject to PA. The MCO calculated the percentages of MH/SUD services subject to PA by utilizing the AHCCCS BH code list along with the Mercy Care's codes specific PA Grid. Using the AHCCCCS BH code list, MCO identified all the MH/SUD codes including those codes that can be used for both MH/SUD and M/S. For example, CT of the brain can be used for both MH/SUD and M/S. Using our code specific PA grid we separated out all 17,190 codes into two categories. M/S codes included all codes accept those that were specific to MH/SUD only, the total count of those codes was 17,070 of which 2,728 required authorization giving us 16% of M/S OP Services requiring authorization. MH/SUD code list included all codes that could be MH/SUD and M/S which totaled 466 of which 28 codes require authorization giving us 6% of MH/SUB OP services requiring authorization. • OP MH/SUD services are typically authorized for 60 days, unless a provider requests a different amount of days than 60. • Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into consideration before changes are made. • Arizona Health Care Cost Containment System guidelines, policy updates, MCG annual updates, Aetna clinical policy guidelines and monthly updates are also considered and may prompt a review more frequent than annually.	MCO: • 16% of M/S OP services that are subject to PA. The MCO calculated the percentages of M/S services subject to PA by utilizing the AHCCCS BH code list along with the Mercy Care's codes specific PA Grid. Using the AHCCCCS BH code list, MCO identified all the MH/SUD codes including those codes that can be used for both MH/SUD and M/S. For example, CT of the brain can be used for both MH/SUD and M/S. Using our code specific PA grid we separated out all 17,190 codes into two categories. M/S codes included all codes accept those that were specific to MH/SUD only, the total count of those codes was 17,070 of which 2,728 required authorization giving us 16% of M/S OP Services requiring authorization. • OP M/S services are typically authorized for 60 days, unless a provider requests a different amount of days than 60. • Annually, a review is conducted on authorization requirements. Utilization and denial rates are taken into consideration before changes are made. • Arizona Health Care Cost Containment System guidelines, policy updates, MCG annual updates, Aetna clinical policy guidelines and monthly updates are also consideration and may prompt a review more frequent than annually. DDD: • All non-emergent physical health services require PA with the exception of members who are under the age of 21. OP behavioral health services do not require PA (Psychiatric services, psychological assessment, ABA, OP counseling, skills training, peer support services). 85% of services require PA, calculated

MCO MH/SUD	MCO M/S
	through using this list and determining the BH services not needing PA. • PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of procedure that may need to be enhanced or removed. • Services may be authorized for 14 days to 6 months dependent on type of service. DDD SLR timeframes: • Per AAC R9-34-206

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • The MCO monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, and grievances to assess the stringency of the NQTL. • IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter. Passing score of 90% or above is required.	MCO: • The MCO monitors utilization patterns, service denial rates, appeals, percent of overturned appeals, and grievances to assess the stringency of the NQTL. • IRR testing is also used for this purpose and is required annually for all UR staff who make determinations and is completed after 90 days of employment as well as annually thereafter. Passing score of 90% or above is required. DDD: • Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the Medical Management Committee. The audits assess timeliness

MCO MH/SUD	MCO M/S
	and appropriateness of authorization. The Plan conducts annual IRR testing for UR staff and requires a 90% pass rate. DDD SLR: • DDD monitors and reviews approvals, denials and appeals of these services.

7. Compliance Determination

OP Benefits: The MCO applies UM to select non-emergent MH/SUD and M/S OP services. In addition, select OP services managed by DDD require UM, as outlined in Section One. DDD also conducts a second level review (SLR) of specific M/S services, specifically termination of pregnancy and sterilization. There are no MH/SUD OP services subject to the DDD SLR.

Comparability of Strategy and Evidence:

DDD's strategy for applying UM to the identified OP services is because the services are high cost and medical necessity review offers an opportunity to reduce unnecessary costs. The evidentiary standard for this strategy is a review claims data to identify high cost services. Also, state requirements including AMPM Chapter 300 requires UM. DDD's strategy for the services requiring SLR is also because the services are high risk and high cost, and because the population being served is vulnerable The evidentiary standards for the DDD SLR includes cost and utilization reports, and audits of consent processes/proof of guardianship and verification of network provider credentials.

The MCO applies UM to the identified MH/SUD and M/S OP services because these services have the potential for overutilization and because the services are high cost and UM provides an opportunity to reduce unnecessary costs through medical necessity review. The MCO reviews MH/SUD and M/S cost and utilization data monthly to identify services subject to UM strategies. The strategies and evidentiary support are comparable.

Comparability and Stringency of Processes:

MH/SUD and M/S providers must request PA prior to the delivery of the service. The MCO permits MH/SUD PA and concurrent review requests to be initiated via two methods including facsimile and telephone. The MCO reports using retrospective review for MH/SUD and M/S for purposes of detecting FWA. The MCO utilizes licensed health care professionals to apply nationally-recognized medical necessity guidelines (MCG) and, if indicated, refer potential service denial decisions to a physician for review. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. The MCO offers the MH/SUD and M/S provider the opportunity for a peer to peer discussion if the intention is to deny the services. Failure to meet the requirement of the UM strategy results in a denial of payment. For OP requests lacking sufficient clinical information, providers are given the opportunity to submit the necessary information up to three attempts. The

UM appeal process only applies if the services had not been rendered. Once the service has been provided, the provider can request a retrospective review. The only exception in the application of PA/concurrent review for both MH/SUD and M/S is at the discretion of the Medical Director. The NQTL processes for MH/SUD are comparable and no more stringently applied than for M/S benefits**.**

DDD requires providers to obtain PA prior to the service via facsimile, electronic mail or telephone. Licensed health care professionals apply nationally-recognized medical necessity guidelines (InterQual) and, if indicated, refer potential service denial decisions to a physician for review. When PA is not met, the Chief Medical Officer or Medical Director reviews documentation and may request additional information or will have a peer-to-peer consultation. Requests are reviewed within the required federal timeframes – 14 days for standard requests and 72 hours for expedited requests. DDD permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Members/providers on behalf of the member may request an appeal via phone, facsimile, mail or email. The only exception in the application of PA/concurrent review for M/S is at the discretion of the Medical Director or Assistant Medical Director. DDD applies the SLR for all the listed services regardless of approval or denial by the health plans. M/S services follow the timeframes per AAC R9-34-206. All denied SLR are subject to appeal by the member or provider and there are no exceptions to the process.

Stringency of Strategy and Evidence:

6% of MH/SUD and 16% of M/S OP services are subject to PA. The MCO reported the average length of authorization for MH/SUD and M/S OP is 60 days. The reported range of MH/SUD OP authorization is no more stringent for MH/SUD than M/S. Measures of the stringency and consistency with which UM is conducted include IRR standards. The MCO utilizes an IRR testing and requires a 90% pass rate.

DDD reported that 85% of services require PA. All non-emergent physical health services require PA with the exception of members who are under the age of 21. Services may be authorized for 14 days to 6 months dependent on type of service. Measures of the stringency and consistency with which UM is conducted include IRR standards. The MCO utilizes an annual IRR testing and requires a 90% pass rate. The DDD SLR is supported by AAC R9-34-206 for both MH/SUD and M/S services.

Based upon these findings, the strategy and evidence are applied no more stringently to MH/SUD benefits than to M/S benefits.

Compliance Determination: As a result of the analysis, the processes, strategies and evidentiary standards used in applying UM to MH/SUD OP services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S OP services, in writing or in operation.

UNITED HEALTH CARE NQTL ANALYSIS

NQTL: Utilization Management (UM)
Benefit Packages: All benefit packages for ALTCS-DD members
Classification: Inpatient
MCO: United Health Care (UHC)

1. To which benefits type(s) is the NQTL assigned?

MCO MH/SUD	MCO M/S
MCO: • All Inpatient (IP) services • Residential care DDD conducts a second level review (SLR) for the following benefits: • Admission to the Arizona State Hospital • Behavioral Health Residential Facility (BHRF) • Out-of-State placements	MCO: • All IP services • Skilled Nursing Facilities (SNF) DDD: • Acute IP facility • SNF • Acute Inpatient Rehab (AIR) facility • IP hospice care DDD conducts a second level review (SLR) for the following benefits: • Enclosed or partially enclosed beds • Hysterectomy • Out-of-State placements • Transplant of heart, heart/lung or liver.

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO: • To manage the potential for overutilization. • Services require UM because they are high cost and UM provides the opportunity to reduce unnecessary costs through medical	MCO: • To manage the potential for overutilization. • Services require UM because they are high cost and UM provides the opportunity to reduce unnecessary costs through medical

MCO MH/SUD	MCO M/S
necessity review and facilitate transition planning. DDD SLR: • To ensure that behavioral health services which are considered high-risk and/or high-cost are medically necessary and cost-effective. • To have oversight for behavioral health services considered to be high-risk and/or high-cost for its vulnerable population. • Out-of-state placements for BH services are considered when the medically necessary service is not available in state, and only available in another state.	necessity review and facilitate transition planning. DDD: • The need for the prior authorization (PA) and concurrent review is due to high costs and UM provides the opportunity to reduce unnecessary costs through medical necessity review. DDD SLR: • To ensure that physical health services which are considered high-risk and/or high-cost are medically necessary and cost-effective. • To have oversight for physical health services considered to be high-risk and/or high-cost for its vulnerable population. • Requests for partially/fully enclosed beds must be in compliance with Arizona Administrative Code (AAC) Article 9: R-6-6-901 to R6-6-909. • Out-of-state placements for PH services are considered when the medically necessary service is not available in state, and only available in another state. • To ensure compliance with AHCCCS medical polices for hysterectomy, and transplant of heart, heart/lung or liver.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S
MCO: • Claims data for cost and utilization reviewed at least annually. • Reviews are based on state requirements (e.g., AMPM, ACOM, Clinical Guidelines), evidence-based scientific evidence (e.g., ASAM, MCG, Peer Reviewed Scientific Literature), and specialty society guidance.	MCO: • Claims data for cost and utilization is reviewed at least annually. • Reviews are based on state requirements (e.g., AMPM, ACOM, Clinical Guidelines), evidence-based scientific evidence (e.g., MCG, Peer Reviewed Scientific Literature), and specialty society guidance. DDD:

MCO MH/SUD	MCO M/S
DDD SLR: • Annual Cost reports for high-cost services using an industry standard (e.g., out of state BHIFs). • Audit of appropriate consent processes and/or proof of guardianship for mental health/SUD services (e.g., members on court ordered treatment or IP hospitalization). • Verification of AHCCCS network provider's credentials and contract accepting the network rate. • Utilization reports and degree of variation across providers and services.	• Reviews are based on claims data for cost, state requirements (AMPM chapter 300), and clinical review from current providers and AHCCCS medical policies. DDD SLR: • Annual Cost reports for high-cost services using an industry standard (e.g., liver transplants). • Audit of appropriate consent processes and/or proof of guardianship for termination of pregnancy, sterilization, and hysterectomy procedures. • Verification of AHCCCS network provider's credentials and contract accepting the network rate. • Utilization reports and degree of variation across providers and services.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO: • For Emergent IP admissions, MCO requires notification and clinical documentation, within 24 hours, to determine medical necessity. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal or via phone. • Requests are reviewed within 24 hours of notification. • For planned admissions, the provider must obtain PA prior to admission by requests initiated via online or telephone; standard request within 14 days of elective IP service request. • Requests are reviewed within required federal timeframes – 14 days for standard requests, 72 hours for an expedited request.	MCO: • For Emergent IP admissions, MCO requires notification and clinical documentation, within 24 hours, to determine medical necessity. Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal or via phone. • Requests are reviewed within 24 hours of notification. • For planned admissions, the provider must obtain PA prior to admission by requests initiated via Online or telephone; Standard request within 14 days of elective IP service request. • Requests are reviewed within required federal timeframes – 14 days for standard requests, 72 hours for an expedited request.

MCO MH/SUD	MCO M/S
• Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal, or by phone. The requesting provider must provide clinical information which meets medical necessity. • Requests lacking sufficient clinical information will be pended and requests are initiated by the MCO for providers to submit the necessary information. Providers have up to 28 days (in total) to submit additional information. For expedited requests, providers have 72 hours plus an additional 14 days. If the needed information is not received, it will be referred to a Medical Director (MD) for peer review. • The MCO utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (e.g., MCG, ASAM). • Exceptions to PA include emergency services, which can be reviewed retrospectively. If a member is admitted to a facility for an emergency service, provider is to notify MCO within 24 hours. • The UHC MD may use their discretion and experience to overturn and or re-decision denial decisions to meet member's medical needs on a case by case basis. • Retrospective review is permitted with mitigating circumstances, such as the provider's inability to verify eligibility or coverage. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • Members, or providers on a member's behalf, may request an appeal in writing for reconsideration within 60 days of a decision to	• Concurrent review must be conducted prior to the expiration of the authorization and is completed via a provider portal, or by phone. The requesting provider must provide clinical information which meets medical necessity. • Requests lacking sufficient clinical information will be pended and requests are initiated by the MCO for providers to submit the necessary information. Providers have up to 28 days (in total) to submit additional information. For expedited requests, providers have 72 hours plus an additional 14 days. If the needed information is not received, it will be referred to a MD for peer review. • The MCO utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (e.g., MCG). • Exceptions to PA include emergency services, which can be reviewed retrospectively. If a member is admitted to a facility for an emergency service, provider is to notify MCO within 24 hours. • The UHC MD may use their discretion and experience to overturn and or re-decision denial decisions to meet member's medical needs on a case by case basis. • Retrospective review is permitted with mitigating circumstances, such as the provider's inability to verify eligibility or coverage. In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • Members, or providers on a member's behalf, may request an appeal in writing for reconsideration within 60 days of a decision to deny or reduce services. Members are given their appeal rights

MCO MH/SUD	MCO M/S
deny or reduce services. Members are given their appeal rights within the Notice of Benefit Determination letter.	within the Notice of Benefit Determination letter. DDD: • Providers must obtain PA prior to admission (there is no timeframe) by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. • Providers must notify DDD within 24 hours of an emergency admission. • The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the Chief Medical Officer or MD reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. • Requests are reviewed within required federal timeframes – 14 days for standard requests, three days for expedited requests. • The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). • Exceptions to PA include emergency services, which can be reviewed retrospectively. DDD must be notified within 24 hours of an emergency service. • Only the MD or Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. In the event that PA, concurrent review or retrospective review determines that the

MCO MH/SUD	MCO M/S
	service does not meet medical necessity, the outcome would be a denial of payment. • Members/providers on behalf of the member can appeal a decision. This would result in a SLR to determine medical necessity. An appeal can be done via phone, facsimile, or written in the form of mail or email.
DDD SLR: • Conducted by DDD for all the listed services subject to SLR, whether approved or denied by the health plans with the exception of Behavioral Health Residential facilities which only requires a SLR if the service was denied by a health plan. • Per AAC R9-34-206, the SLR timeframe follows the Notice of Action timeframe for Service Authorization Requests, which is 14 calendar days from receipt of the request from the member/guardian; the steps are as follows: – Day 1: The health plan (HP) receives the member/guardian request. – Determination is made by the HP MD. – HP sends all medical info and requests SLR from DDD MD. – DDD MDR reviews request and sends determination to HP. A Peer-to Peer review occurs if the DDD MD's determination does not match the HP MD's determination. – Day 14: Final health plan decision in writing is mailed to the member/guardian as a Notice of Action indicating authorization approval, or a Notice of Adverse Benefit Determination, indicating authorization denial. • A Letter of Extension (LOE) may be filed by the health plan if the initial information received is insufficient. At that time, an additional 14 days is allowed for the SLR process from the date the LOE is	DDD SLR: • Conducted by DDD for all the listed services subject to SLR, whether approved or denied by the health plans. • Per AAC R9-34-206, the SLR timeframe follows the Notice of Action timeframe for Service Authorization Requests, which is 14 calendar days from receipt of the request from the member/guardian; the steps are as follows: – Day 1: The health plan (HP) receives the member/guardian request. – Determination is made by the HP MDR. – HP sends all medical info and requests SLR from DDD MD. – DDD MDR reviews request and sends determination to HP. A Peer-to Peer review occurs if the DDD MD's determination does not match the HP MD's determination. – Day 14: Final health plan decision in writing is mailed to the member/guardian as a Notice of Action indicating authorization approval, or a Notice of Adverse Benefit Determination, indicating authorization denial. • A Letter of Extension (LOE) may be filed by the health plan if the initial information received is insufficient. At that time, an additional 14 days is allowed for the SLR process from the date the LOE is filed. Written notice is given to the member/guardian of the reason

MCO MH/SUD	MCO M/S
filed. Written notice is given to the member/guardian of the reason for the decision to extend the timeframe and the right to file a grievance of the member/guardian disagrees with the decision. • For an Expedited Authorization request in which the provider indicates or the contractor determines the 14-day timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO will submit all information to DDD within 48 hours and DDD shall make an expedited authorization decision within 24 hours. The Notice of Action will be mailed as expeditiously as the member's health requires, but no later than 72 hours after receipt of the request for service. • All denied SLR MH/SUD services are subject to appeal by the member or provider. • No exceptions process.	for the decision to extend the timeframe and the right to file a grievance if the member/guardian disagrees with the decision. • For an Expedited Authorization request in which the provider indicates or the contractor determines the 14-day timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO will submit all information to DDD within 48 hours and DDD shall make an expedited authorization decision within 24 hours. The Notice of Action will be mailed as expeditiously as the member's health requires, but no later than 72 hours after receipt of the request for service. • All denied SLR M/S services are subject to appeal by the member or provider. • No exceptions process.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO: • All MH/SUD IP services are subject to PA. • MH/SUD IP services are paid per diem. • Average authorization for IP MH/SUD is three days. • Length of continued stay is determined by MCG and ASAM guidelines as appropriate to the member's medical necessity needs.	MCO: • All M/S IP services are subject to PA. • M/S IP services are paid for by diagnostic –related group (DRG). • Average authorization for IP M/S is three days. IP M/S may not be reviewed quite as often with the DRG. • Length of continued stay is determined by MCG guidelines as appropriate to the member's medical necessity needs. DDD: • 100% of all elective admissions require PA. For members not enrolled in AIHP, the PA is delegated to the health plans. DDD

MCO MH/SUD	MCO M/S
DDD SLR timeframes: • Per R9-34-206.	does not require PA for emergency or admissions to IHS facilities for AIHP members. DDD utilizes Chapter 300 of the AMPM, if there is not adequate guidance in the AMPM the MD will review and determine necessity of services. • PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of procedure that may need to be enhanced or removed. • For an IP hospitalization authorization is provided for 30 days at a time per InterQual level of care criteria. For an elective procedure, authorization is provided with a 14-day window. DDD SLR timeframes: • Per R9-34-206.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. • The plan utilizes an inter-rater reliability (IRR) testing of MCG and ASAM at a 90% passing score and various quality metrics to assess the effectiveness of the NQTL.	MCO: • The MD and other clinical staff review hospitalizations to detect and better manage over and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. • The plan utilizes an inter-rater reliability (IRR) testing of MCG at a 90% passing score and various quality metrics to assess the effectiveness of the NQTL. DDD: • Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the

MCO MH/SUD	MCO M/S
DDD SLR: • DDD monitors and reviews approvals, denials and appeals of these services.	Medical Management Committee. The audits assess timeliness and appropriateness of authorization. • The Plan conducts annual IRR testing for utilization review staff and requires a standard of 90%. DDD SLR: • DDD monitors and reviews approvals, denials and appeals of these services.

7. Compliance Determination

IP Benefits: MH/SUD requires PA for all IP services including Residential Care. M/S requires PA for all IP services including SNFs. In addition, the following services managed by DDD require UM: Acute IP, SNF, Acute IP Rehab Facility, and IP hospice care. All services requiring PA require subsequent CR. If a member is admitted to an MH/SUD or M/S IP facility for an emergency service, the MCO and DDD require notification within 24 hours. UM is required by DDD for each of the identified services managed by DDD. DDD also conducts a SLR of specific MH/SUD and M/S services which include admissions to Arizona State Hospital, BHRF and out of state placements for MH/SUD and enclosed or partially enclosed beds, hysterectomy, out of state placements and transplant of heart, heart/lung or liver on the M/S side.

Comparability of Strategy and Evidence: DDD's strategy for applying UM to the IP services is because the services are high cost and medical necessity review offers an opportunity to reduce unnecessary costs. The evidentiary standard for this strategy is a review of claims data to identify high cost services. Also, state requirements including AMPM Chapter 300 requires UM. DDD's strategy for the services requiring SLR is also because the services are high risk and high cost, and because the population served is vulnerable. In addition, use of partially or fully enclosed beds must be in compliance with AAC Article 9. R-6-6-901 to R6-6-909. The evidentiary standards for the DDD SLR includes cost and utilization reports, audits of consent processes/proof of guardianship and verification of network provider credentials and rate negotiations for out of state placements.

The MCO applies UM to the identified MH/SUD and M/S IP services because these services have the potential for overutilization and because the services are high cost and UM provides an opportunity to reduce unnecessary costs through medical necessity review and facilitate transition planning. The MCO reviews MH/SUD and M/S cost and utilization data at least annually to identify services subject to UM strategies. The strategies and evidentiary support are comparable.

Comparability and Stringency of Processes: For emergent MH/SUD and M/S IP admissions, the MCO requires notification and clinical

documents within 24 hours. For planned MH/SUD and M/S IP admissions, the MCO requires the provider to obtain PA prior to admission via online or telephone. The MCO utilizes licensed health care professionals to apply nationally-recognized medical necessity guidelines (ASAM, MCG) and, if indicated, refer potential service denial decisions to a physician for review. Timelines for authorization decision are the same for MH/SUD and M/S and required in their respective contracts. Requests lacking sufficient clinical information are pended and the MH/SUD and M/S providers have up to 28 days in total to submit additional information. Failure to meet the requirement of the UM strategy results in a denial of payment. The MCO permits a provider to request a retrospective review to obtain coverage for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Members, or providers on the member's behalf, may request an appeal in writing for reconsideration within 60 days of a decision to deny or reduce an MH/SUD or M/S service. The only exception in the application of PA/CR for both MH/SUD and M/S is at the discretion of the MD.

DDD requires providers to obtain PA prior to the admission via facsimile, electronic mail or telephone and does not prescribe a timeframe. Licensed health care professionals apply nationally-recognized medical necessity guidelines (InterQual) and, if indicated, refer potential service denial decisions to a physician for review. When PA is not met, the CMO or MD reviews documentation and may request additional information or will have a peer-to-peer consultation. Requests are reviewed within the required federal timeframes – 14 days for standard requests and 72 hours for expedited requests. DDD permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Members/providers on behalf of the member may request an appeal via phone, facsimile, mail or email. The only exception in the application of PA/CR for M/S is at the discretion of the MD or Assistant MD.

DDD applies the SLR for all the listed services regardless of approval or denial by the health plans with the exception BHRF which only requires a SLR if the service was denied by a health plan. Both MH/SUD and M/S services follow the same timeframes per AAC R9-34-206. The processes are the same for LOEs and expedited requests. All denied SLR are subject to appeal by the member or provider on the member's behalf, and there are no exceptions to the process.

The NQTL processes for MH/SUD are comparable and no more stringently applied that the NQTL processes for M/S benefits.

Stringency of Strategy and Evidence: All MH/SUD and M/S IP services are subject to PA. MH/SUD IP services are paid per diem and M/S IP services are paid by DRG. The MCO reported the average length of authorization for MH/SUD IP and M/S IP is three days and the length of continued stay is determined by MCG and/or ASAM guidelines as appropriate to the member's medical necessity needs. The reported range of MH/SUD IP authorization is not more stringent for MH/SUD than M/S. Measures of the stringency and consistency with which UM is conducted include IRR standards. The MCO utilizes an IRR testing and requires a 90% pass rate.

DDD reported that 100% of all elective admissions require PA. For members not enrolled in AIHP, the PA is delegated to the MCOs. IP

hospitalization authorization is provided for 30 days at a time, based InterQual level of care criteria. For an elective procedure, authorization is provided with a 14-day window. Measures of the stringency and consistency with which UM is conducted include IRR standards. The MCO utilizes an annual IRR testing and requires a 90% pass rate.

The DDD SLR is supported by AAC R9-34-206 for both MH/SUD and M/S services.

Based upon these findings, the strategy and evidence are applied to MH/SUD benefits no more stringently than to M/S benefits.

Compliance Determination: As a result of the analysis, the processes, strategies and evidentiary standards used in applying UM to MH/SUD IP services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards used in applying UM to M/S IP services, in writing or in operation.

NQTL: Utilization Management (UM)
Benefit Package: All benefit packages for ALTCS-DD members
Classification: Outpatient
MCO: United Health Care (UHC)

1. To which benefits type(s) is the NQTL assigned?

MCO MH/SUD	MCO M/S
MCO: • Electro-convulsive treatment (provided in outpatient setting) • Home Care Training Client (H0018) • Neurobehavioral Status Exam • Psychological and Neuropsychological Testing • Out of Network/Out of State • TMS DDD second level review (SLR): None.	MCO: • Allergy Immunotherapy • Bariatric Surgery • Bone Growth Stimulator BRACA Genetic Testing • Breast Reconstruction (non-mastectomy) • Cancer Supportive Care • Cardiology* • Carpal Tunnel Surgery* • Cataract Surgery*Chemotherapy • Chiropractic Care • Circumcisions • Cochlear and other Auditory Implants • Colonoscopy* • Cosmetic and Reconstructive Procedures* • Dental Services • Diabetic Supplies* • Durable Medical Equipment • Ear, Nose, and Throat Procedures* • Enteral/Parenteral/Oral Services

MCO MH/SUD	MCO M/S
	• Experimental and Investigative • Eye Care/Optometry • Femoroacetabular Impingement Syndrome • Functional Endoscopic Sinus Surgery • Genetic Testing • Gynecologic Procedures* • Hearing Aids and Services • Hernia repair* • Home Health Care • Hospice • Injectable Medications* • Joint Replacement • Liver Biopsy* • Non-emergent Air Ambulance Transport • Orthognathic Surgery • Orthotics and Prosthetics* • Outpatient Therapy (Physical, Speech, Occupational) • Pregnancy Termination • Private Duty Nursing • Proton Beam Therapy • Radiology* • Sleep Apnea Procedures and Surgeries • Specialty/Enclosed Beds • Spinal Surgery • Sterilization*

MCO MH/SUD	MCO M/S
	• Stimulators (Bone growth/Neurostimulators) • Tonsillectomy and Adenoidectomy* • Transplant Services • Upper Gastrointestinal Endoscopy* • Urologic Procedures* • Vagus Nerve Stimulation • Vein Procedures • Ventricular Assist Devises • Wound Vac* Note: Prior authorization requirements marked with (*) Site of Service Requirement – Prior Authorization is required if performed in an OP hospital setting DDD: • Abdominal Paracentesis • Bariatric Surgery • Bone Growth Stimulator • BRACA Genetic Testing • Cardiology • Cardiovascular • Carpal Tunnel Surgery • Cataract Surgery • Chemotherapy • Chiropractic Care • Circumcisions • Cochlear & other Auditory Implants

MCO MH/SUD	MCO M/S
	• Colonoscopy • Cosmetic & Reconstructive Procedures • Dental Services • Diabetic Supplies • Durable Medical Equipment >$500.00 • Ear, Nose, & Throat Procedures • Enteral/Parenteral/Oral Services • Experimental & Investigative • Eye Care • Femoracetabular Impingement Syndrome • Functional Endoscopic Sinus Surgery (FESS) • Genetic Testing • Gynecologic Procedures • Hearing Services • Tonsillectomy & Adenoidectomy • Transplant Services • Upper Gastrointestinal Endoscopy • Urologic Procedures • Vagus Nerve Stimulation Implant • Vein Procedures • Ventricular Assist Devices • Wound Vac **Note: Prior Authorization is not needed if members receive services from an IHS facility. DDD conducts a second level review (SLR) -- for these benefits:

MCO MH/SUD	MCO M/S
	• Sterilization • Termination of pregnancy

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO: • Services require UM because they have the potential for overutilization. • UM provides the opportunity to reduce unnecessary costs. • Criteria are applied to ensure quality and medical appropriateness of care to monitor cost and quality of services being delivered.	MCO: • Services require UM because they have the potential for overutilization. • UM provides the opportunity to reduce unnecessary costs. • Criteria are applied to ensure quality and medical appropriateness of care to monitor cost and quality of services being delivered. DDD: • The need for the prior authorization (PA) and concurrent review due to high costs and to ensure that services provided are appropriate and timely for the member's needs. The Plan reviews retrospective services in the event that the initial request for the clinical review occurs after the member is discharged and a retrospective review is requested. DDD SLR: • To ensure that physical health services which are considered high-risk and/or high-cost are medically necessary and cost-effective. • To have oversight for physical health services considered to be high-risk and/or high-cost for its vulnerable population. • To ensure compliance with AHCCCS medical polices for sterilization and termination of pregnancy.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S

MCO MH/SUD	MCO M/S
MCO: • Claims data for cost and utilization is reviewed at least annually. • Reviews are based on state requirements (e.g., AMPM, ACOM, Clinical Guidelines), evidence-based scientific evidence (e.g., MCG, Peer Reviewed Scientific Literature), and specialty society guidance.	MCO: • Claims data for cost and utilization is reviewed at least annually. • Reviews are based on state requirements (e.g., AMPM, ACOM, Clinical Guidelines), evidence-based scientific evidence (e.g., MCG, Peer Reviewed Scientific Literature), specialty society guidance. DDD: • DDD uses claims data for cost, state requirements (AMPM Chapter 300), and clinical review from current providers.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO: • Provider must obtain PA 14 days prior to providing the service by requests initiated via telephone or provider portal. If provider does not request 14 days prior to service and service has been rendered, MCO will begin the authorization the day the MCO receives notice and can perform a retrospective review. Requests for continued authorization of that particular service are treated as a request for PA. • Retrospective review is conducted in the event that the PA process occurred on a weekend or holiday. • The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information within standard and expedited timeframes, unless and extension is granted for an additional 14 days.	MCO: • Provider must obtain PA 14 days prior to providing the service by requests initiated via telephone or provider portal. If provider does not request 14 days prior to service and service has been rendered, MCO will begin the authorization the day the MCO receives notice and can perform a retrospective review. Requests for continued authorization of that particular service are treated as a request for PA. • Retrospective review is conducted in the event that the PA process occurred on a weekend or holiday. • The requesting provider must submit the PA with supporting clinical documentation. Requests lacking sufficient clinical information will be pended and requests are initiated by the Plan for providers to submit the necessary information within standard and expedited timeframes, unless and extension is granted for an additional 14 days.

MCO MH/SUD	MCO M/S
• Requests are reviewed within required federal timeframes – 14 days for standard requests, 72 hours for an expedited request. • Retrospective Review is used when PA could not be conducted. • The MCO utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (e.g., MCG, ASAM). • Only the Medical Director (MD) may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • Members, or providers on a member's behalf, may request an appeal in writing for reconsideration within 60 days of a decision to deny or reduce services. Members are given their appeal rights within the Notice of Benefit Determination letter.	• Requests are reviewed within required federal timeframes – 14 days for standard requests, 72 hours for an expedited request. • Retrospective Review is used when mitigating circumstances are present and PA could not be conducted. • The MCO utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (e.g., MCG). • Only the MD may use discretion in applying the UM strategies. In the event that PA or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • Members, or providers on a member's behalf, may request an appeal in writing for reconsideration within 60 days of a decision to deny or reduce services. Members are given their appeal rights within the Notice of Benefit Determination letter. DDD: • Providers must obtain PA 14 days prior to admission by requests initiated via facsimile, electronic mail or telephone. Concurrent review must be conducted prior to the expiration of the authorization and is completed via facsimile or electronic mail. • The requesting provider must submit the PA with supporting clinical documentation required per InterQual guidelines. When the PA is not met, the CMO or MD reviews all the documentation and may request additional information when necessary or will have a peer-to-peer consultation regarding the service. • Requests are reviewed within required federal timeframes – 14

MCO MH/SUD	MCO M/S
	days for standard requests, three days for an expedited request. • The Plan utilizes licensed health care professionals to render authorization decisions while a physician is required to deny a PA request. • UM authorization decisions are consistent with nationally-recognized medical necessity guidelines (InterQual). • Exceptions to PA include emergency services, which can be reviewed retrospectively. DDD must be notified within 24 hours of the emergency service. • Only the MD or Assistant MD may use discretion in applying the UM strategies. Retrospective review is permitted for circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. • In the event that PA, concurrent review or retrospective review determines that the service does not meet medical necessity, the outcome would be a denial of payment. • Members/providers on behalf of the member can appeal the decision. This would result in a SLR to determine medical necessity. An appeal can be done via phone, facsimile, or written in the form of mail or email. DDD SLR: • SLR are conducted by DDD for all the listed services, whether approved or denied by the health plans. • Per AAC R9-34-206, the SLR timeframe follows the Notice of Action timeframe for Service Authorization Requests, which is 14 calendar days from receipt of the request from the member/guardian; the steps are as follows:

MCO MH/SUD	MCO M/S
	• Day 1: The health plan (HP) receives the member/guardian request. • Determination is made by the HP MDR. • HP sends all medical info and requests SLR from DDD MDR. • DDD MDR reviews request and sends determination to HP. A Peer-to Peer review occurs if the DDD MDR's determination does not match the HP MDR's determination. • Day 14: Final health plan decision in writing is mailed to the member/guardian as a Notice of Action indicating authorization approval, or a Notice of Adverse Benefit Determination, indicating authorization denial. • A Letter of Extension (LOE) may be filed by the health plan if the initial information received is insufficient. At that time, an additional 14 days is allowed for the SLR process from the date the LOE is filed. Written notice is given to the member/guardian of the reason for the decision to extend the timeframe and the right to file a grievance if the member/guardian disagrees with the decision. • For an Expedited Authorization request in which the provider indicates or the contractor determines the 14-day timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the contractor shall make an expedited authorization decision and mail the Notice of Action as expeditiously as the member's health requires, but no later than 72 hours after receipt of the request for service. • All denied SLR M/S services are subject to appeal by the member or provider. • No exceptions process.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO: • BH Services = 436; 10 codes (ECT, H0018, Neurobeh status exam, neuropsych testing codes, psych testing codes, and TMS) require PA. 10/436 = 2% of BH services require PA. • Psychological testing is authorized for 180 days to ensure families have time to complete services. • TMS is authorized for 180 days to ensure families have time to complete services. • The MCO reviews and evaluates the services subjected to the UM strategies and compares to the latest evidence-based scientific evidence, state requirements, specialty society guidance and claims data to guide coverage decisions. The reviews are conducted on a quarterly basis and ad hoc per regulator updates. UHC does not utilize a percentage of services to determine PA requirements. UHC does not utilize a benefit limit for days for services for Methadone Maintenance or Intensive Outpatient Treatment. Prior Authorization is not required for these services.	MCO: • M/S services =13,897; 2187 codes require PA. 2187/13897 = 16% of M/S services require PA. • M/S OP services are typically authorized for 90 days to allow the services to implemented but the authorization depends on what the provider requested (e.g., 6 PT visits). • The MCO reviews and evaluates the services subjected to the UM strategies and compares to the latest evidence-based scientific evidence, state requirements, specialty society guidance and claims data to guide coverage decisions. The reviews are conducted on a quarterly basis and ad hoc per regulator updates. UHC does not utilize a percentage of services to determine PA requirements. UHC does not utilize a benefit limit for days for services. Prior Authorization decisions are based upon a member's medical necessity for on-going treatment and the applicable lowest level of service to sufficiently fulfill that member's treatment needs. DDD: • All non-emergent physical health services require PA with the exception of members who are under the age of 21. Outpatient behavioral health services do not require PA (Psychiatric services, psychological assessment, ABA, outpatient counseling, skills training, peer support services). 85% of services require PA, calculated through using this list and determining the BH services not needing PA. • PA requirement and processes may be reviewed at any time, however are contractually required to be reviewed annually at minimum. Frequent requests for PA without adequate information or confusion over the service may result in the creation or review of

MCO MH/SUD	MCO M/S
	procedure that may need to be enhanced or removed. • Services may be authorized for 14 days to six months dependent on type of service. DDD SLR timeframes: • Per AAC R9-34-206

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • The MCO utilizes an MCG and ASAM inter-rater reliability (IRR) testing and various quality metrics on an annual basis to assess the effectiveness of the NQTL. Medical/behavioral staff must meet a 90% IRR score to meet review requirements.	MCO: • The MCO utilizes an MCG IRR testing and various quality metrics on an annual basis to assess the effectiveness of the NQTL. Medical staff must meet a 90% IRR score to meet review requirements. DDD: • Denial rates and approvals are reviewed quarterly and there is a monthly unit audit of five cases which are reported quarterly to the Medical Management Committee. The audits assess timeliness and appropriateness of authorization. The Plan conducts annual IRR testing for utilization review staff and requires a 90% pass rate. DDD SLR: • DDD monitors and reviews approvals, denials and appeals of these services.

7. Compliance Determination

OP Benefits: The MCO applies UM to select non-emergent MH/SUD and M/S OP services. In addition, select OP services managed by DDD require UM, as outlined in Section One. DDD also conducts an SLR of specific M/S services, specifically termination of pregnancy and sterilization. There are no MH/SUD OP services subject to the DDD SLR.

Comparability of Strategy and Evidence: DDD's strategy for applying UM to the identified OP services is because the services are high cost

and medical necessity review offers an opportunity to reduce unnecessary costs. The evidentiary standard for this strategy is to review claims data to identify high cost services. Also, state requirements including AMPM Chapter 300 requires UM. DDD's strategy for the services requiring SLR is also because the services are high risk and high cost, and because the population served is vulnerable. The evidentiary standards for the DDD SLR includes cost and utilization reports, and audits of consent processes/proof of guardianship and verification of network provider credentials.

The MCO applies UM to the identified MH/SUD and M/S OP services because these services have the potential for overutilization and because the services are high cost and UM provides an opportunity to reduce unnecessary costs through medical necessity review. The MCO reviews MH/SUD and M/S cost and utilization data at least annually to identify services subject to UM strategies. The strategies and evidentiary support are comparable.

Comparability and Stringency of Processes: MCO requires PA 14 days prior to providing the MH/SUD or M/S service via telephone or the provider portal. If the provider does not request PA 14 days prior to the service and the service has been rendered, the MCO begins authorization the day the MCO receives notice and can perform retrospective review. The MCO utilizes licensed health care professionals to apply nationally-recognized medical necessity guidelines (e.g., ASAM, MCG) and, if indicated, refer potential service denial decisions to a physician for review. Requests are reviewed within required federal timeframes – 14 days for standard requests, 72 hours for an expedited MH/SUD request and three days for an M/S expedited request. Requests lacking sufficient clinical information are pended and the MH/SUD and M/S providers can submit additional information within the standard and expedited timeframes unless an extension is granted. Failure to meet the requirement of the UM strategy results in a denial of payment. Retrospective review is used when mitigating circumstances are present and PA could not be conducted. Members, or providers on the member's behalf, may request an appeal in writing for reconsideration within 60 days of a decision to deny or reduce an MH/SUD or M/S service. The only exception in the application of PA/CR for both MH/SUD and M/S is at the discretion of the MD.

DDD requires providers to obtain PA prior to the service via facsimile, electronic mail or telephone. Licensed health care professionals apply nationally-recognized medical necessity guidelines (InterQual) and, if indicated, refer potential service denial decisions to a physician for review. When PA is not met, the CMO or MD reviews documentation and may request additional information or will have a peer-to-peer consultation. Requests are reviewed within the required federal timeframes – 14 days for standard requests and 72 hours for expedited requests. DDD permits a provider to request a retrospective review to obtain coverage when the circumstances in which the provider was unable to obtain PA due to inability to determine coverage for the member. Members/providers on behalf of the member may request an appeal via phone, facsimile, mail or email. The only exception in the application of PA/CR for M/S is at the discretion of the MD or Assistant MD. DDD applies the SLR for all the listed services regardless of approval or denial by the health plans. M/S services follow the timeframes per AAC R9-34-206. All denied SLR are subject to appeal by the member or provider and there are no exceptions to the process.

The NQTL processes for MH/SUD are comparable and no more stringently applied that the NQTL processes for M/S benefits.

Stringency of Strategy and Evidence: 2% of MH/SUD and 16% of M/S OP services are subject to PA. The MCO reported the average length of authorization for MH/SUD OP is six months (Psychological Testing, TMS). M/S OP services are typically authorized for 90 days. Measures of the stringency and consistency with which UM is conducted include IRR standards. The MCO utilizes an IRR testing and requires a 90% pass rate.

DDD reported that 85% of services require PA. All non-emergent physical health services require PA with the exception of members who are under the age of 21. Services may be authorized for 14 days to six months dependent on type of service. Measures of the stringency and consistency with which UM is conducted include IRR standards. The MCO utilizes an annual IRR testing and requires a 90% pass rate. The DDD SLR is supported by AAC R9-34-206 for both MH/SUD and M/S services.

Based upon these findings, the strategy and evidence are applied no more stringently to MH/SUD benefits than to M/S benefits.

Compliance Determination: As a result, the processes, strategies and evidentiary standards used in applying UM to MH/SUD OP services are comparable to, and applied no more stringently than, the processes, strategies and evidentiary standards in writing or in operation.

MERCY CARE PLAN NQTL ANALYSIS

NQTL: Prior Authorization for Prescription Drugs
Benefit Packages: All benefit packages for ALTCS-DD members
Classification: Prescription Drugs
MCO: Mercy Care Plan (MCP)

1. To which benefits type(s) is the NQTL assigned?

MH/SUD	M/S
• Selected medications	• Selected medications

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MH/SUD	M/S
• The MCO uses the Arizona Health Care Cost Containment System (AHCCCS) Drug List and follows AHCCCS policy. • To provide member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines. • The AHCCCS Drug List was developed to encourage the use of safe, effective, clinically appropriate and the most cost-effective medications. • AHCCCS policy for prior authorization of smoking cessation aids to members under age 18 and for Bupropion 24 hour/Wellbutrin.	• The MCO uses the AHCCCS Drug List and follows AHCCCS policy. • To provide member access to appropriate drug therapies that meet nationally recognized therapeutic guidelines. • The AHCCCS Drug List was developed to encourage the use of safe, effective, clinically appropriate and the most cost-effective medications. • AHCCCS policy for prior authorization of long-acting opioid medications and direct acting antiviral treatment for hepatitis C.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
• Per AHCCCS 310-V Policy: – Food and Drug Administration (FDA)-approved indications and limits. – Published practice guidelines and treatment protocols.	• Per AHCCCS 310-V Policy: – Food and Drug Administration (FDA)-approved indications and limits. – Published practice guidelines and treatment protocols.

MH/SUD	M/S
– Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes. – Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies. – Drug reference resources (e.g., Micromedex, Drug Facts and Comparisons, Up-to-Date). • AHCCCS 310-V Policy (for smoking cessation aids)	– Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes. – Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies. – Drug reference resources (e.g., Micromedex, Drug Facts and Comparisons, Up-to-Date). • AHCCCS 310-V Policy (for certain opioids and treatment of Hep C)

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO: • The provider completes and submits a prior authorization (PA) request form along with relevant clinical documentation to support medical necessity. • The PA request is received and a clinical review for medical necessity is conducted. • The MCO responds to PA requests within 24 hours of request. • If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. • Once the review is complete a notice of action is sent to both the member and provider. If the notice of action is a denial, then the member and provider are advised of their options and appeals rights.	MCO: • The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. • The PA request is received and a clinical review for medical necessity is conducted. • The MCO responds to PA requests within 24 hours of request. • If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. • Once the review is complete a notice of action is sent to both the member and provider. If the notice of action is a denial, then the member and provider are advised of their options and appeals rights.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• The MCO uses the AHCCCS-mandated Preferred Drug List (PDL). The AHCCCS Pharmacy & Therapeutics (P&T) Committee (Committee) is advisory to the AHCCCS Administration and is responsible for evaluating scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs. • The Committee regularly meets to assess the PDL and consider recommendations to AHCCCS administration. • The Committee makes recommendations to the AHCCCS Administration on the development and maintenance of a statewide drug list and prior authorization criteria as appropriate. The Committee may also evaluate individual drugs and therapeutic classes of drugs.	• The MCO uses the AHCCCS-mandated PDL. The AHCCCS P&T Committee (Committee) is advisory to the AHCCCS Administration and is responsible for evaluating scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs. • The Committee regularly meets to assess the PDL and consider recommendations to AHCCCS administration. • The Committee makes recommendations to the AHCCCS Administration on the development and maintenance of a statewide drug list and prior authorization criteria as appropriate. The Committee may also evaluate individual drugs and therapeutic classes of drugs.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MH/SUD	M/S
• The MCO's P&T committee reviews changes to the PA criteria. • The MCO implements prior authorization required by AHCCCS policy. • The MCO monitors PA approval and denial rates, PA appeals and overturns, and utilization and cost data on a quarterly basis.	• The MCO's P&T committee reviews changes to the PA criteria. • The MCO implements prior authorization required by AHCCCS policy. • The MCO monitors PA approval and denial rates, PA appeals and overturns, and utilization and cost data on a quarterly basis.

7. Compliance Determination

Comparability of Strategy and Evidence: The MCO uses the AHCCCS-mandated PDL which applies (PA) criteria to certain MH/SUD and M/S drugs to promote the appropriate and cost-effective use of prescription drugs. Evidence used to determine which MH/SUD and M/S drugs are subject to PA includes FDA prescribing guidelines, published practice guidelines and treatment protocols, comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential

member outcomes, peer reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and drug reference resources (e.g., Micromedex, Drug Facts and Comparisons, Up-to-Date) The strategy and evidence for applying prior authorization to prescription drugs are comparable for MH/SUD and M/S drugs.

Comparability and Stringency of Processes: To obtain PA, for both MH/SUD and M/S drugs, the provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. A clinical review for medical necessity is conducted, with a response within 24 hours of request. If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. Once the review is complete, a notice of action is sent to both the member and provider. If the notice of action is a denial, then the member and provider are advised of their options and appeals rights. The PA processes for MH/SUD and M/S drugs are comparable and applied no more stringently to MH/SUD drugs.

Stringency of Strategy and Evidence: The MCO uses the AHCCCS-mandated PDL. PDL development and maintenance recommendations are provided regularly by the P&T Committee to the AHCCCS administration. For medications not listed on the AHCCCS PDL, a prior authorization may be submitted for a non-preferred federally and state reimbursable medication. The prior authorization is evaluated for coverage based on medical necessity. The MCO monitors approval, denial, and appeal rates. The PA stringency of strategy and evidence for MH/SUD and M/S drugs are comparable and applied no more stringently to MH/SUD drugs.

Compliance Determination: As a result, the processes, strategies, and evidentiary standards for prior authorization of MH/SUD prescription drugs are comparable and no more stringently applied, in writing and in operation, to M/S drugs.

UNITED HEALTH CARE NQTL ANALYSIS

NQTL: Prior Authorization for Prescription Drugs
Benefit Packages: All benefit packages for ALTCS-DD members
Classification: Prescription Drugs
MCO: United Health Care (UHC)

1. To which benefits type(s) is the NQTL assigned?

MH/SUD	M/S
• Selected medications	• Selected medications

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MH/SUD	M/S
• The MCO uses the AHCCCS Drug List and follows AHCCCS policy. • The AHCCCS Drug List was developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications. • AHCCCS policy for prior authorization of smoking cessation aids to members under age 18 and for Bupropion 24 hour/Wellbutrin. • Per the AHCCCS drug list requirements, prior authorization (PA) is required on all antipsychotics when prescribed by a non-behavioral health specialist.	• The MCO uses the AHCCCS Drug List and follows AHCCCS policy. • The AHCCCS Drug List was developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications. • AHCCCS policy for prior authorization of long-acting opioid medications and direct acting antiviral treatment for hepatitis C. • Some non-behavioral health drug classes have similar provider specialty type PA requirements (e.g. Hep C, growth hormone).

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MH/SUD	M/S
• Per AHCCCS 310-V Policy: – Food and Drug Administration (FDA)-approved indications and limits. – Published practice guidelines and treatment protocols.	• Per AHCCCS 310-V Policy: – Food and Drug Administration (FDA)-approved indications and limits. – Published practice guidelines and treatment protocols.

MH/SUD	M/S
– Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes. – Peer reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies. – Drug reference resources (e.g., Micromedex, Drug Facts and Comparisons, Up-to-Date). • AHCCCS 310-V Policy (for smoking cessation aids)	– Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes. – Peer reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies. – Drug reference resources (e.g., Micromedex, Drug Facts and Comparisons, Up-to-Date). • AHCCCS 310-V Policy (for certain opioids and treatment of Hep C)

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MH/SUD	M/S
MCO: • The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. • The PA request is received and a clinical review for medical necessity is conducted. The request is reviewed against the applicable clinical policy. • The MCO responds to PA requests within 24 hours of request. • If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language. • If the request is denied, the MCO sends a notice of action that includes appeal rights.	MCO: • The provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. • The PA request is received and a clinical review for medical necessity is conducted. The request is reviewed against the applicable clinical policy. • The MCO responds to PA requests within 24 hours of request. • If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. If there are formulary medications that could be appropriate alternatives to the drug requested they will be suggested in the denial language. • If the request is denied, the MCO sends a notice of action that includes appeal rights.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MH/SUD	M/S
• The MCO uses the AHCCCS-mandated Preferred Drug List (PDL). The AHCCCS Pharmacy & Therapeutics (P&T) Committee (Committee) is advisory to the AHCCCS Administration and is responsible for evaluating scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs. • The Committee regularly meets to assess the PDL and consider recommendations to AHCCCS administration. • The Committee makes recommendations to the AHCCCS Administration on the development and maintenance of a statewide drug list and prior authorization criteria as appropriate. The Committee may also evaluate individual drugs and therapeutic classes of drugs.	• The MCO uses the AHCCCS-mandated PDL. The AHCCCS P&T Committee (Committee) is advisory to the AHCCCS Administration and is responsible for evaluating scientific evidence of the relative safety, efficacy, effectiveness and clinical appropriateness of prescription drugs. • The Committee regularly meets to assess the PDL and consider recommendations to AHCCCS administration. • The Committee makes recommendations to the AHCCCS Administration on the development and maintenance of a statewide drug list and prior authorization criteria as appropriate. The Committee may also evaluate individual drugs and therapeutic classes of drugs.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MH/SUD	M/S
MCO: • The MCO's P&T committee reviews changes to the PA criteria. • The MCO implements prior authorization required by AHCCCS policy. • The MCO monitors PA approval and denial rates, PA appeals and overturns, and utilization and cost data on a quarterly basis.	MCO: • The MCO's P&T committee reviews changes to the PA criteria. • The MCO implements prior authorization required by AHCCCS policy. • The MCO monitors PA approval and denial rates, PA appeals and overturns, and utilization and cost data on a quarterly basis.

7. Compliance Determination

Comparability of Strategy and Evidence: The MCO uses the AHCCCS-mandated PDL which applies prior authorization (PA) criteria to certain MH/SUD and M/S drugs to promote the appropriate and cost-effective use of prescription drugs. Evidence used to determine which MH/SUD and M/S drugs are subject to PA includes FDA prescribing guidelines, published practice guidelines and treatment protocols, comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well

as the risks, benefits and potential member outcomes, peer reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies, and drug reference resources (e.g., Micromedex, Drug Facts and Comparisons, Up-to-Date) The strategy and evidence for applying prior authorization to prescription drugs are comparable for MH/SUD and M/S drugs.

Comparability and Stringency of Processes: To obtain PA, for both MH/SUD and M/S drugs, the provider completes and submits a PA request form along with relevant clinical documentation to support medical necessity. A clinical review for medical necessity is conducted, with a response within 24 hours of request. If the clinical information submitted with the PA request does not establish medical necessity, the request is denied. Once the review is complete, a notice of action is sent to both the member and provider. If the notice of action is a denial, then the member and provider are advised of their options and appeals rights. The PA processes for MH/SUD and M/S drugs are comparable and applied no more stringently to MH/SUD drugs.

Stringency of Strategy and Evidence: The MCO uses the AHCCCS-mandated PDL. PDL development and maintenance recommendations are provided regularly by the P&T Committee to the AHCCCS administration. For medications not listed on the AHCCCS PDL, a prior authorization may be submitted for a non-preferred federally and state reimbursable medication. The prior authorization is evaluated for coverage based on medical necessity. The MCO monitors approval, denial, and appeal rates. The PA stringency of strategy and evidence for MH/SUD and M/S drugs are comparable and applied no more stringently to MH/SUD drugs.

Compliance Determination: As a result, the processes, strategies, and evidentiary standards for prior authorization of MH/SUD prescription drugs are comparable and no more stringently applied, in writing and in operation, to M/S drugs.

MERCY CARE PLAN NQTL ANALYSIS

NQTL: Out-of-Network (OON)/Out-of-State (OOS) Requirements
Benefit Package: All benefit packages for ALTCS-DD members
Classification: Inpatient and Outpatient
MCO: Mercy Care Plan (MCP)

1. To which provider type(s) is the NQTL assigned?

MCO MH/SUD	MCO M/S
MCO: • All OON/OOS (non-emergent) providers	MCO: • All OON/OOS (non-emergent) providers DDD: • All OON/OOS (non-emergent) providers

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO: • To confirm OON/OOS benefits comply with federal or State regulation and contract requirements. • The MCO limits coverage to in network and offers coverage under this strategy when in-network care is not available or not available within geo access or clinical specialty not available in network. • Ensures network adequacy by making services available to members (e.g., specialized care) through approval for out of network providers.	MCO: • To confirm OON/OOS benefits comply with federal or State regulation and contract requirements. • The MCO limits coverage to in network and offers coverage under this strategy when in-network care is not available or not available within geo access or clinical specialty not available in network. • Ensures network adequacy by making services available to members (e.g., specialized care) through approval for out of network providers. DDD: • DDD reports that the strategies are in place to ensure that the claims may be encountered and that timely services are provided by qualified OON/OOS providers who meet network standards.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S
MCO: • ACOM Policy 415, ACOM Policy 436, 42 CFR 457.1218 and 42 CFR 438.68 [42 CFR 438.206(c)(1), 42 CFR 438.207(a), 42 CFR 438.207(c) • Exceptions: 42 CFR 457.1218, 42 CFR 438.68 • State contract and policy requires the MCO to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). • State policy establishes timeliness and distance standards for all MCOs. For example, see the selected standards below: – Behavioral Health Residential Facility › For Maricopa and Pima counties: 90% membership do not need to travel more than 15 minutes/10 miles from residence. › ACOM Policy 415 – Crisis Stabilization Crisis Stabilization Facility › For Maricopa and Pima counties: 90% of membership does not need to travel more than 15 minutes/10 miles from their residence. › For all other counties: 90% of membership does not need to travel more than 45 miles from their residence.	MCO: • ACOM Policy 415, ACOM Policy 436, 42 CFR 457.1218 and 42 CFR 438.68 [42 CFR 438.206(c)(1), 42 CFR 438.207(a), 42 CFR 438.207(c) • Exceptions: 42 CFR 457.1218, 42 CFR 438.68 • State contract and policy requires the MCO to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). • State policy establishes timeliness and distance standards for all MCOs. For example, see the selected standards below: – Hospital, Nursing Facility › For Maricopa and Pima counties 90% membership do not need to travel more than 45 minutes/30 miles from residence. › For all other counties 90% membership do not need to travel more than 95 minutes/85 miles from residence. – PCP Adult and Pediatric › For Maricopa and Pima counties: 90% of membership does not need to travel more than 15 minutes/10 miles from their residence.

MCO MH/SUD	MCO M/S
– Behavioral Health Outpatient and Integrated Clinic Adult and Pediatric › For Maricopa and Pima counties: 90% membership do not need to travel more than 15 minutes/10 miles from residence. • All Other Counties: 90% of membership does not need to travel more than 60 miles from their residence. OON providers are required if MCO's network is unable to provide adequate and timely services until a network provider is available. • The MCO must maintain a defined number of hospitals in the geographic region they serve. • Data showing specialty services not available within time and distance standards in the State in accordance with 42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2).	› For all other counties: 90% of membership does not need to travel more than 40 minutes/30 miles from their residence. – OBGYN Adult and Pediatric › For Maricopa and Pima counties: 90% of membership does not need to travel more than 45 minutes/30 miles from their residence. › For all other counties: 90% of membership does not need to travel more than 90 minutes/75 miles from their residence. • OON providers are required if MCO's network is unable to provide adequate and timely services until a network provider is available. • The MCO must maintain a defined number of hospitals in the geographic region they serve. • Data showing specialty services not available within time and distance standards in the State in accordance with 42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2). DDD: • ACOM Policy 436, 42 CFR 457.1218 and 42 CFR 438.68 [42 CFR 438.206(c)(1), 42 CFR 438.207(a), 42 CFR 438.207(c) • Exceptions: 42 CFR 457.1218, 42 CFR 438.68 • State contract and policy requires DDD to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered

MCO MH/SUD	MCO M/S
	services and satisfy all service delivery requirements (including access standards). • OON/OOS providers are required if network is unable to provide adequate and timely services until a network provider is available. • State policy establishes timeliness and distance standards for all Plans. For example, some contractors must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO: • A request for OON coverage or a planned OOS placement requires prior authorization. • To initiate a request for OON coverage or OOS placement, a provider submits a prior authorization request. The request must include medical records that support medical necessity of the service. A member could also initiate a request via the MCO's Customer Service Department or through the member's clinical team. • The MCO confirms that a participating provider is not available to provide the requested service. • The MCO will complete the review within three days for expedited requests and 14 days for standard requests.	MCO: • A request for OON coverage or a planned OOS placement requires prior authorization. • To initiate a request for OON coverage or OOS placement, a provider submits a prior authorization request. The request must include medical records that support medical necessity of the service. A member could also initiate a request via the MCO's Customer Service Department or through the member's clinical team. • The MCO confirms that a participating provider is not available to provide the requested service. • The MCO will complete the review within three days for expedited requests and 14 days for standard requests.

MCO MH/SUD	MCO M/S
• Once the request is approved, the MCO requests the provider's Medicaid identification number, W-9 form and tax identification number. The MCO will check if the provider is actively enrolled as a Medicaid provider. This information is submitted to contracting when the negotiate the Single Case Agreement (SCA). • If the MCO verifies the OON/OOS provider meets their network admission requirements, the MCO will establish a SCA with the provider. • The MCO defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a SCA. • Members have grievance/appeal rights if an OON/OOS request is denied. • Providers may submit grievance/appeal on behalf of the member only when an OON/OSS request is denied. • The MCO allows delayed or retrospective requests for OON/OOS coverage that follow standard UM retrospective review (RR) processes and conditions. Standard limits (by contract) apply similarly to physical and behavioral health service retrospective reviews. • MCO staff may exercise discretion based on: – Approving OON providers in process of credentialing. – When appointment timeliness standards cannot be met. – Based on member clinical risk/need. – In service areas where providers are known to be scarce.	• Once the request is approved, the MCO requests the provider's Medicaid identification number, W-9 form and tax identification number. The MCO will check if the provider is actively enrolled as a Medicaid provider. • If the MCO verifies the OON/OOS provider meets their network admission requirements, the MCO will establish a SCA with the provider. • The MCO defaults the service reimbursement to the AHCCCS rate but will negotiate an alternative rate and execute a SCA. • Members have grievance/appeal rights if an OON/OOS request is denied. • Providers may submit grievance/appeal on behalf of the member only when an OON/OSS request is denied. • The MCO allows delayed or retrospective requests for OON/OOS coverage that follow standard UM RR processes and conditions. Standard limits (by contract) apply similarly to physical and behavioral health service retrospective reviews. • MCO staff may exercise discretion based on: – Approving OON providers in process of credentialing. – When appointment timeliness standards cannot be met. – Based on member clinical risk/need. – In service areas where providers are known to be scarce.

MCO MH/SUD	MCO M/S
	DDD: • The plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network. • A request for OON coverage or a planned OOS placement requires prior authorization. • A request for OON coverage or OOS placement can be initiated by a member, DES/DDD field staff or a provider. • DDD confirms that a participating provider is not available to provide the requested service. • The member's team determines if the LTSS meet medical necessity criteria to determine if the service will be authorized. • DDD completes the service plan review within three days for expedited requests and 14 days for standard requests. • DDD identifies an OON provider. • DDD verifies if the OON provider is actively registered as a Medicaid provider. • Once the request is approved, the Plan requests the provider’s Medicaid identification number, NPI (if required) and tax identification number. • DDD determines the rate it will pay and generates a letter of authorization. • Members have grievance/appeal rights if an OON/OOS request is denied.

MCO MH/SUD	MCO M/S
	• Providers may submit grievance/appeal on behalf of the member only when an OON/OOS request is denied. • DDD staff may exercise discretion based on: – Approving OON providers in process of credentialing. – When appointment timeliness standards cannot be met. – Based on member clinical risk/need. – In service areas where providers are known to be scarce. (DDD would use OON/OOS providers when it is deemed there is no appropriate and available provider within the geographical location.)

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO: • The MCO allow OON/OOS exceptions for the following reason(s): – Geographic access standards cannot be met. – Appointment access standards cannot be met. – Unique clinical needs of a member. – Out-of-area (OOA) emergencies and OOA placements (e.g., CISC, college students, foster care, residential treatment). There is no set limit for MH/SUD OOA emergencies/placements. • No limitations exist when considering OON/OOS exception requests.	MCO: • The MCO allow OON/OOS exceptions for the following reason(s): – Geographic access standards cannot be met. – Appointment access standards cannot be met. – Unique clinical needs of a member. – OOA emergencies and OOA placements (e.g., CISC, college students, foster care, residential treatment). There is no set limit for MH/SUD OOA emergencies/placements. • No limitations exist when considering OON/OOS exception requests. DDD:

MCO MH/SUD	MCO M/S
	• DDD allow OON/OOS exceptions for the following reason(s): – Geographic access standards cannot be met. – Appointment access standards cannot be met. – Unique clinical needs of a member. – Out-of-area emergencies and out-of-area placements (e.g., CISC, college students, foster care, residential treatment). There is no set limit for MH/SUD OOA emergencies/placements. • No limitations exist when considering OON/OOS exception requests.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • On an annual and ad hoc basis, OON Policies and Procedures (P&Ps) are reviewed and updated to address changes in internal operations, or new State or federal requirements. • The MCO regularly reviews trended claims data, grievances, complaints and the volume and type of OON requests. The information is reviewed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. • The MCO reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the	MCO: • On an annual and ad hoc basis, OON P&Ps are reviewed and updated to address changes in internal operations, or new State or federal requirements. • The MCO regularly reviews trended claims data, grievances, complaints and the volume and type of OON requests. The information is reviewed weekly via the Contracts Committee and bi-weekly through the Network Sufficiency Committee. • The MCO reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the

MCO MH/SUD	MCO M/S
only medically viable alternative for the member when the service is not available within the contracted network. • If established network standards cannot be met, the MCO must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. OON coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified.	only medically viable alternative for the member when the service is not available within the contracted network. • If established network standards cannot be met, the MCO must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements. Out of network coverage protocols are reviewed annually or more frequently if opportunities for improvement are identified. DDD: • DDD reviews policies annually, but would only review the OON procedure if changes were deemed necessary, the procedure lacked clarity or it was determined that process steps needed to be reconfigured. • DDD reviews grievance and complaint data, authorization data and tracks the volume and type of OON requests to assess the stringency of the strategy. • DDD monitors grievances, appeals, denials, and incident reports on an ongoing basis to monitor the need for procedure review. • DDD reviews the DDD network at least annually or if an immediate need is recognized by executive leadership within the division.

7. Compliance Determination

Comparability of Strategy and Evidence: The MCO and DDD restrict member access to OON/OOS (non-emergent) providers of MH/SUD and M/S services in order to comply with federal or State regulation and contract requirements, when in-network care is not available, and to ensure network adequacy for specialty care. DDD, through its OON/OOS requirements, additionally aims to

ensure that claims can be processed. The MCO and DDD make exceptions for OON limits for reasons that include: lack of INN provider or appointment availability or accessibility, unique member need and OOA emergencies and OOA placements.

For both non-emergency MH/SUD and M/S OON benefits, the MCO and DDD use State contract and policy requirements regarding maintaining a sufficient contracted and credentialed network, State policy regarding time and distance standards, and data regarding specialty services unavailable within time and distance standards. Time and distance standards allow easier access to providers for MH/SUD as compared to M/S services. As a result, the MCO's strategy and evidence for OON coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

Comparability and Stringency of Processes: The MCO and DDD require a standard UM review and prior authorization for requests for non-emergency OON MH/SUD and M/S benefits. Members, providers and DES/DDD field staff can request OON coverage or placement. After the MCO confirms that INN providers are unavailable to meet time and distance standards, are medically necessary and the request is approved, the provider's Medicaid identification number, W-9 and tax identification number are requested and Medicaid eligibility is verified. The MCO will check that the provider is actively enrolled as a Medicaid provider. The review takes 14 days for standard requests and up to three days for expedited requests. The MCO and DDD require both MH/SUD and M/S OON providers to sign a SCA.

Delayed or retrospective requests for both MH/SUD and M/S OON coverage are allowed by the MCO and follow standard UM RR processes and conditions. It is unclear if DDD allows retrospective requests to occur. Members and providers may appeal the denial of OON authorization requests.

Discretion in applying OON limits to both MH/SUD and M/S is allowed based on factors including OON providers in process of credentialing, when INN access and appointment timeliness standards cannot be met, member clinical risk/need, and scarcity of providers.

Based on these factors, the MCO's processes applied to limit MH/SUD non-emergency OON benefits are comparable and applied no more stringently than to M/S non-emergency OON benefits.

Stringency of Strategy and Evidence: The MCO and DDD review OON P&Ps for both providers of MH/SUD and M/S services at least annually, and update the P&Ps when needed. Additionally, the MCO and DDD review metrics to ensure OON restrictions and discretion are relevant for both MH/SUD and M/S.

The MCO reviews trended claims data, grievances, complaints and the volume and type of out of network requests on a weekly and bi-weekly basis (depending upon the committee); out of network coverage protocols are reviewed at least annually; and gaps are identified and addressed in the Annual Network Development and Management Plan. DDD reviews similar data to assess overall stringency.

Based upon these factors, neither the MCO nor DDD applies OON strategies nor evidence standards more stringently to MH/SUD benefits than to M/S benefits.

Compliance Determination: As a result of the review, the processes, strategies, and evidentiary standards for the application of OON limits to providers of non-emergency MH/SUD benefits are comparable and no more stringently applied, in writing and in operation, than to providers of non-emergency M/S benefits.

UNITED HEALTH CARE NQTL ANALYSIS

NQTL: Out-of-Network (OON)/Out-of-State (OOS) Requirements
Benefit Package: All benefit packages for ALTCS-DD members
Classification: Inpatient and Outpatient
MCO: United Health Care (UHC)

1. To which provider type(s) is the NQTL assigned?

MCO MH/SUD	MCO M/S
MCO: • All OON/OOS (non-emergent) providers	MCO: • All OON/OOS (non-emergent) providers DDD: • All OON/OOS (non-emergent) providers

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO: • To confirm OON/OOS benefits comply with federal or State regulation and contract requirements. • The MCO covers in network (INN) and offers coverage for out of network when geo access or clinical specialty is not available in network, thus meeting access to care needs. All OON/OOS do require prior authorization. • Ensures network adequacy by making services available to members (e.g., specialized care) through approval for out of network providers.	MCO: • To confirm OON/OOS benefits comply with federal or State regulation and contract requirements. • The MCO covers in network and offers coverage for out of network when geo access or clinical specialty is not available in network, thus meeting access to care needs. All OON/OOS do require prior authorization. • Ensures network adequacy by making services available to members (e.g., specialized care) through approval for out of network providers. DDD: • DDD reports that the strategies are in place to ensure that the claims may be encountered and that timely services are

MCO MH/SUD	MCO M/S
	provided by qualified OON/OOS providers who meet network standards.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S
MCO: • ACOM Policy 415, ACOM Policy 436, 42 CFR 457.1218 and 42 CFR 438.68 [42 CFR 438.206(c)(1), 42 CFR 438.207(a), 42 CFR 438.207(c) • Exceptions: 42 CFR 457.1218, 42 CFR 438.68 • State contract and policy requires the MCO to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). • State policy establishes timeliness and distance standards for all MCOs. For example, see the selected standards below: – Behavioral Health Residential Facility › For Maricopa and Pima counties: 90% membership do not need to travel more than 15 minutes/10 miles from residence. › ACOM Policy 415 – Crisis Stabilization Crisis Stabilization Facility › For Maricopa and Pima counties: 90% of membership does not need to travel more than 15 minutes/10 miles from their residence.	MCO: • ACOM Policy 415, ACOM Policy 436, 42 CFR 457.1218 and 42 CFR 438.68 [42 CFR 438.206(c)(1), 42 CFR 438.207(a), 42 CFR 438.207(c) • Exceptions: 42 CFR 457.1218, 42 CFR 438.68 • State contract and policy requires the MCO to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). • State policy establishes timeliness and distance standards for all MCOs. For example, see the selected standards below: – Hospital, Nursing Facility › For Maricopa and Pima counties 90% membership do not need to travel more than 45 minutes/30 miles from residence. › For all other counties 90% membership do not need to travel more than 95 minutes/85 miles from residence. – PCP Adult and Pediatric

MCO MH/SUD	MCO M/S
› For all other counties: 90% of membership does not need to travel more than 45 miles from their residence. – Behavioral Health Outpatient and Integrated Clinic Adult and Pediatric › For Maricopa and Pima counties: 90% membership do not need to travel more than 15 minutes/10 miles from residence. • All Other Counties: 90% of membership does not need to travel more than 60 miles from their residence. OON providers are required if MCO's network is unable to provide adequate and timely services until a network provider is available. • The MCO must maintain a defined number of hospitals in the geographic region they serve. • Data showing specialty services not available within time and distance standards in the State in accordance with 42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2).	› For Maricopa and Pima counties: 90% of membership does not need to travel more than 15 minutes/10 miles from their residence. › For all other counties: 90% of membership does not need to travel more than 40 minutes/30 miles from their residence. – OBGYN Adult and Pediatric › For Maricopa and Pima counties: 90% of membership does not need to travel more than 45 minutes/30 miles from their residence. › For all other counties: 90% of membership does not need to travel more than 90 minutes/75 miles from their residence. • OON providers are required if MCO's network is unable to provide adequate and timely services until a network provider is available. • The MCO must maintain a defined number of hospitals in the geographic region they serve. • Data showing specialty services not available within time and distance standards in the State in accordance with 42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2). DDD: • ACOM Policy 436, 42 CFR 457.1218 and 42 CFR 438.68 [42 CFR 438.206(c)(1), 42 CFR 438.207(a), 42 CFR 438.207(c) • Exceptions: 42 CFR 457.1218, 42 CFR 438.68

MCO MH/SUD	MCO M/S
	• State contract and policy requires DDD to maintain a contracted and credentialed network that is sufficient in size, scope and types to deliver all medically necessary covered services and satisfy all service delivery requirements (including access standards). • OON/OOS providers are required if network is unable to provide adequate and timely services until a network provider is available. • State policy establishes timeliness and distance standards for all Plans. For example, some contractors must have a network that provides access so that 90% of their membership does not need to travel more than 15 minutes or 10 miles from their original residence to obtain outpatient clinic services.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO: • A request for OON coverage or a planned out-of-state placement requires prior authorization. • To initiate a request for out of network coverage or out-of-state placement, a provider contacts the MCO's Utilization Management Department. • The MCO confirms that a participating provider is not available to provide the requested service and requests the medical record and medical necessity criteria to determine if	MCO: • A request for OON coverage or a planned out-of-state placement requires prior authorization. • To initiate a request for out of network coverage or out-of-state placement, a provider contacts the MCO's Utilization Management Department. • The MCO confirms that a participating provider is not available to provide the requested service and requests the medical record and medical necessity criteria to determine if

MCO MH/SUD	MCO M/S
the service will be authorized. Additional criteria we may use include: – Approving OON providers in process of credentialing. – When appointment timeliness standards cannot be met. – Based on member clinical risk/need. – In service areas where providers are known to be scarce. • The MCO will complete the review within 72 hours for expedited requests and 14 days for standard requests. • Once the request is approved, the MCO requests the provider's Medicaid identification number, W-9 form and tax identification number. The MCO will check if the provider is actively enrolled as a Medicaid provider. • If the MCO verifies the OON/OOS provider meets their network admission requirements, the authorization is completed for the provider. • The MCO defaults the service reimbursement to the AHCCCS rate but may negotiate an alternative rate and execute a single case agreement. • Members have grievance/appeal rights if an OON/OOS request is denied. • Providers may submit grievance/appeal on behalf of the member only when an OON/OOS request is denied. • The MCO allows delayed or retrospective review (RR) for OON/OOS coverage that follows standard UM RR processes and conditions. Standard limits (by contract)	the service will be authorized. Additional criteria we may use include: – Approving OON providers in process of credentialing. – When appointment timeliness standards cannot be met. – Based on member clinical risk/need. – In service areas where providers are known to be scarce • The MCO will complete the review within 72 hours for expedited requests and 14 days for standard requests. • Once the request is approved, the MCO requests the provider's Medicaid identification number, W-9 form and tax identification number. The MCO will check if the provider is actively enrolled as a Medicaid provider. • If the MCO verifies the OON/OOS provider meets their network admission requirements, the authorization is completed for the provider. • The MCO defaults the service reimbursement to the AHCCCS rate but may negotiate an alternative rate and execute a single case agreement. • Members have grievance/appeal rights if an OON/OOS request is denied. • Providers may submit grievance/appeal on behalf of the member only when an OON/OOS request is denied. • The MCO allows delayed or retrospective review (RR) for OON/OOS coverage that follows standard UM RR processes and conditions. Standard limits (by contract) apply similarly to physical and behavioral health service retrospective reviews.

MCO MH/SUD	MCO M/S
apply similarly to physical and behavioral health service retrospective reviews. • MCO staff may exercise discretion based on: – Continuity of care – Provider gap – Access along the border of state	• MCO staff may exercise discretion based on: – Continuity of care – Provider gap – Access along the border of state DDD: • The plan reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network. • A request for OON coverage or a planned out-of-state placement requires prior authorization. • A request for OON coverage or OOS placement can be initiated by a member, DES/DDD field staff or a provider. • DDD confirms that a participating provider is not available to provide the requested service. • The member's team determines if the LTSS meet medical necessity criteria to determine if the service will be authorized. • DDD completes the service plan review within three days for expedited requests and 14 days for standard requests. • DDD identifies an OON provider. • DDD verifies if the out of network provider is actively registered as a Medicaid provider.

MCO MH/SUD	MCO M/S
	• Once the request is approved, the Plan requests the provider's Medicaid identification number, NPI (if required) and tax identification number. • DDD determines the rate it will pay and generates a letter of authorization. • Members have grievance/appeal rights if an OON/OOS request is denied. • Providers may submit grievance/appeal on behalf of the member only when an OON/OOS request is denied. • DDD staff may exercise discretion based on: – Approving OON providers in process of credentialing. – When appointment timeliness standards cannot be met. – Based on member clinical risk/need. – In service areas where providers are known to be scarce (DDD would use OON/OOS providers when it is deemed there is no appropriate and available provider within the geographical location.)

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO: • There is no set frequency; it is dependent upon member access to care. • The MCO allows OON/OOS exceptions for the following reason(s): – Geographic access standards cannot be met.	MCO: • There is no set frequency; it is dependent upon member access to care. • The MCO allows OON/OOS exceptions for the following reason(s): – Geographic access standards cannot be met.

MCO MH/SUD	MCO M/S
– Appointment access standards cannot be met. – Unique clinical needs of a member. – Out-of-area emergencies and out-of-area (OOA) placements (e.g., CISC, college students, foster care, residential treatment). There is no set limit for MH/SUD OOA emergencies/placements.	– Appointment access standards cannot be met. – Unique clinical needs of a member. – Out-of-area emergencies and OOA placements (e.g., CISC, college students, foster care, residential treatment). There is no set limit for M/S OOA emergencies/placements. DDD: • DDD allows OON/OOS exceptions for the following reason(s): – Geographic access standards cannot be met. – Appointment access standards cannot be met. – Unique clinical needs of a member. – OOA emergencies and OOA placements (e.g., CISC, college students, foster care, residential treatment). There is no set limit for MH/SUD OOA emergencies/placements. • No limitations exist when considering OON/OOS exception requests.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • On an annual and ad hoc basis, OON Policies and Procedures (P&Ps) are reviewed and updated to address changes in internal operations, or new State or federal requirements.	MCO: • On an annual and ad hoc basis, OON P&Ps are reviewed and updated to address changes in internal operations, or new State or federal requirements. • The MCO regularly reviews trended claims data, grievances, complaints, appeals and the volume and type of out of

MCO MH/SUD	MCO M/S
• The MCO regularly reviews trended claims data, grievances, complaints, appeals and the volume and type of out of network requests. The information is provided to the Network contracting teams for potential action. • The MCO reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only viable alternative for the member when the service is not available within the contracted network. • If established network standards cannot be met, the MCO must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan. Per quarterly ACOM 436 reporting requirements we additionally identify gaps and address necessary interventions.	network requests. The information is provided to the Network contracting teams for potential action. • The MCO reviews their network to determine if there is an established need to refer to a non-contracted provider (e.g., specialty not available in network) and that the service is the only medically viable alternative for the member when the service is not available within the contracted network. • If established network standards cannot be met, the MCO must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan. Per quarterly ACOM 436 reporting requirements we additionally identify gaps and address necessary interventions. DDD: • DDD reviews policies annually, but would only review the OON procedure if changes were deemed necessary, the procedure lacked clarity or it was determined that process steps needed to be reconfigured. • DDD reviews grievance and complaint data, authorization data and tracks the volume and type of OON requests to assess the stringency of the strategy. • DDD monitors grievances, appeals, denials, and incident reports on an ongoing basis to monitor the need for procedure review. • DDD reviews the DDD network at least annually or if an immediate need is recognized by executive leadership within the division.

7. Compliance Determination

Comparability of Strategy and Evidence: The MCO and DDD restrict member access to OON/OOS (non-emergent) providers of MH/SUD and M/S services in order to comply with federal or State regulation and contract requirements, when in-network care is not available, and to ensure network adequacy for specialty care. DDD, through its OON/OOS requirements, additionally aims to ensure that claims can be processed. The MCO and DDD make exceptions for OON limits for reasons that include: lack of INN provider or appointment availability or accessibility, unique member need and OOA emergencies and OOA placements.

For both non-emergency MH/SUD and M/S OON benefits, the MCO and DDD use State contract and policy requirements regarding maintaining a sufficient contracted and credentialed network, State policy regarding time and distance standards, and data regarding specialty services unavailable within time and distance standards. Time and distance standards allow easier access to providers for MH/SUD as compared to M/S services. As a result, the MCO's strategy and evidence for OON coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

Comparability and Stringency of Processes: The MCO and DDD require a standard UM review and prior authorization for requests for non-emergency OON MH/SUD and M/S benefits. Members, providers and DES/DDD field staff can request OON coverage or placement. After the MCO confirms that INN providers are unavailable to meet time and distance standards, are medically necessary and the request is approved, the provider's Medicaid identification number, W-9 and tax identification number are requested if the provider is actively enrolled as a Medicaid provider. The review takes 14 days for standard requests and up to three days for expedited requests. The MCO and DDD require both MH/SUD and M/S OON providers to sign a SCA.

Delayed or retrospective requests for both MH/SUD and M/S OON coverage are allowed by the MCO and follow standard UM RR processes and conditions. It is unclear if DDD allows retrospective requests to occur. Members and providers may appeal the denial of OON authorization requests.

Discretion in applying OON limits to both MH/SUD and M/S is allowed by the MCO and DDD based on factors including ensuring continuity of care, and alleviating the scarcity of providers, ensuring access to care along state borders, consideration for OON providers in process of credentialing, when INN access and appointment timeliness standards cannot be met and member clinical risk/need.

Based on these factors, the MCO's processes applied to limit MH/SUD non-emergency OON benefits are comparable and applied no more stringently than to M/S non-emergency OON benefits.

Stringency of Strategy and Evidence: The MCO and DDD review OON P&Ps for both providers of MH/SUD and M/S services at least annually, and update the P&Ps when needed.

The MCO reviews trended claims data, grievances, complaints and the volume and types of out of network requests regularly. Gaps are identified and addressed in the Annual Network Development and Management Plan. DDD reviews similar data to assess overall stringency.

Based upon these factors, neither the MCO nor DDD applies OON strategies nor evidence standards more stringently to MH/SUD benefits than to M/S benefits.

Compliance Determination: As a result of the review, the processes, strategies, and evidentiary standards for the application of OON limits to providers of non-emergency MH/SUD benefits are comparable and no more stringently applied, in writing and in operation, than to providers of non-emergency M/S benefits.

MERCY CARE PLAN NQTL ANALYSIS

NQTL: Documentation Requirements
Benefit Package: All benefit packages for ALTCS-DD members
Classification: Inpatient and Outpatient
MCO: Mercy Care Plan (MCP)

1. To which services is the NQTL assigned?

MCO MH/SUD	MCO M/S
MCO: • All inpatient and outpatient services	MCO: • NQTL is not applicable to M/S Services managed by the MCO. DDD: • All inpatient and outpatient M/S services

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

MCO MH/SUD	MCO M/S
MCO: • The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. • This process includes a determination of medical necessity for identified services. AHCCCS:	MCO: • NQTL is not applicable to M/S Services managed by the MCO. DDD: • The requirements of developing an assessment and service plan by a multi-disciplinary team, including the member and family members, are largely to ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services. • In addition, this process includes a determination of medical necessity for identified services. AHCCCS:

MCO MH/SUD	MCO M/S
• The NQTL is applied to this population because these members have chronic, complex behavioral health conditions and needs, with multiple systems involved in the delivery of care. For the population with these conditions, there is a compelling need to have a highly coordinated, well-represented (for other systems like education, probation or others that have an impact on the member's overall health and functioning) team collaborating to identify and addressing the member's behavioral health treatment needs. The requirements are supported by State policy and protocols and are recognized as clinical best practices for managing chronic, complex behavioral health conditions for members with multi-systemic involvement.	• The NQTL is supported by state rule, contract and policy to support person-centered service planning, a best practice approach for engaging individuals with I/DD to determine the individual's strengths, preferences, and capacities for acquiring new skills and abilities, and the services and supports necessary to support the individual's goals. The process includes the engagement of other people who also know the person well, support the individual in expressing their preferences and those who are involved in supporting the individual in achieving their goals.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

MCO MH/SUD	MCO M/S
MCO: • State law (Arizona Administrative Code, Title 9, Chapter 21, Article 3), contract and policy requires the Plan to implement assessment and service planning requirements for both classifications. • For children and adults, documentation requirements are required as set forth in AMPM Policy 320-O.	MCO: • NQTL is not applicable to M/S Services managed by the MCO. DDD: • State law (Arizona Administrative Code, Title 6, Chapter 6, Article 6), contract and policy requires the Plan to implement assessment and service planning requirements for both classifications.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the MCO, member, and provider perspectives).

MCO MH/SUD	MCO M/S
MCO:	MCO: • NQTL is not applicable to M/S Services managed by the MCO. DDD:

MCO MH/SUD	MCO M/S
• The initial and annual assessment must be completed by a behavioral health professional (BHP), or by a behavioral health technician (BHT) with BHP oversight. • The initial assessment and preliminary Service Plan are developed as expeditiously as the member need requires but no later than seven days of the intake appointment that identifies interventions and services. • If an assessment is conducted and documented by a BHT, a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature. • Service planning is developed by service planning teams. For children, the MCO developed a service planning team called Child and Family Team (CFT), for adults the MCO developed a service planning team called the Adult Recovery Team (ART). Both teams are composed of multi-disciplinary members and the member and/or guardian, as appropriate to capacity or age. The length of time involved varies and is dependent upon the complexity of the situation and the engagement of the member/guardian in the process. • A complete service plan must be completed no later than 90 days after the initial appointment. • The provider fills out all pages requiring only the signature of the member.	• Service planning begins within 10 days of eligibility. • During service planning appropriate services are placed in the Individualized Service Plan (ISP). • Referrals for services are made following the ISP process and are required to be in place with a service provider (vendor) within 30 days for a new service and 14 days for an existing service. • Individuals responsible for coordinating this are support coordinators hired by DDD. • All services are accessed through this process. • Member and guardians/family must attend the planning process and, with the assistance of a support coordinator, determine their needs and the services that will be needed to assist them. • Member must then work with the support coordinator to determine which qualified vendor they want to work with for each service. • The planning and referral process always occurs unless the family or member is unwilling to participate in the process which could lead to loss of benefits due to non-participation. • In-person participation is necessary for the planning process. • The support Coordinator fills out all pages requiring only the signature of the member.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

MCO MH/SUD	MCO M/S
MCO: • Members may be able to begin to access services without a written assessment and service plan, but those services will	MCO: • NQTL is not applicable to M/S Services managed by the MCO.

MCO MH/SUD	MCO M/S
not be able to continue without the appropriate documentation. • At a minimum, the assessment and an individual service plan are updated on an annual basis. • Providers are at risk (for recoupment) through audits, inclusive of Centers for Medicare & Medicaid Services (CMS), should services be rendered without documentation of an assessment and treatment plan.	DDD: • Members need an ISP to initiate services including appropriate referrals. This does not include emergency services. • Service planning is updated every 90 days following the development of the initial service plan.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

MCO MH/SUD	MCO M/S
MCO: • As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. • The MCO monitors the Documentation NQTL by reviewing access to care/timeliness of service data, the provider monitoring for compliance with assessment and service planning requirements, and grievance and appeal data.	MCO: • NQTL is not applicable to M/S Services managed by the MCO. DDD: • As these requirements are State mandates, changes to the NQTL would be made when changes to the State mandates are made. • Documentation requirements are evaluated through access to care data addressing timeliness of service, provider monitoring and grievance and appeal data.

7. Compliance Determination

Comparability of Strategy and Evidence:

MCP (MH/SUD services) and DDD (M/S services) apply documentation requirements (assessment and service planning, which includes a determination of medical necessity) by a multi-disciplinary team, including the member and family members, to: 1) ensure that members (families) are afforded the opportunity to provide voice and choice in the identification and selection of services, and 2) to comply with State rule, contract and policy. The NQTL for both MH/SUD and M/S services is supported by

Arizona Administrative Code (Title 9, Chapter 21, Article 3 and Title 6, Chapter 6, Article 6), MCO and DDD contracts and policy. For MH/SUD services for children and adults, documentation requirements are set forth in AMPM Policy 320-O. State requirements for assessment and service planning for MH/SUD and DDD M/S services are recognized best practices for the population to support voice and choice (self determination) and care coordination for individuals whose conditions necessitate multi-system involvement and collateral supports. Based upon these findings, the strategy and evidence supporting the documentation requirements for MH/SUD and DDD M/S services are comparable.

Comparability and Stringency of Processes:

For MH/SUD services, MCP completes an initial and annual assessment by a BHP, or by a behavioral health technician with BHP oversight. The initial assessment and preliminary service plan are developed as expeditiously as the member need requires, but no later than seven days of the intake appointment that identifies interventions and services. In the event an assessment is conducted and documented by a BHT, a BHP must review and sign the assessment information that was documented by the BHT within 30 days of the BHT signature.

For DDD M/S services, DDD service planning begins within 10 days of eligibility in which appropriate services are identified and documented in a member's ISP. Referrals for services are made following the ISP process and are required to be in place with a service provider within 30 days for a new service and 14 days for an existing service.

For both MH/SUD and M/S services, service plans are developed by service planning teams. For MH/SUD services for children, the service planning process is conducted by a service planning team called Child and Family Team (CFT), for adults the service planning team is called the Adult Recovery Team (ART). Both teams are composed of multi-disciplinary members and the member and/or guardian, as appropriate to capacity or age. The MCO is required to complete a service plan no later than 90 days after the initial appointment with the member which is signed by the member. The length of time to develop the ISP varies due based on urgency of needs, availability and member/guardian involvement. DDD also requires members and guardians/family to attend the planning process and, with the assistance of a support coordinator, determine their needs and the services that will be needed to assist them. Members work with their support coordinators to identify providers for approved ISP services as all DDD M/S services are accessed this way and monitored through the ISP. In limited circumstances, such as when the member/guardian is unwilling to participate in the process, the ISP is developed with limited input from the member.

Based upon these findings, service planning process for MH/SUD services are comparable and applied no more stringently than to the service planning process for DDD M/S services.

Stringency of Strategy and Evidence:

Members may access MH/SUD services without a written assessment and service plan, but coverage for services may be denied without appropriate documentation. Additionally, providers are subject to audits to ensure assessments and ISPs are complete and updated regularly, and are at risk for recoupment in the event services are delivered without appropriate service planning documentation. The MCO updated member ISPs on an annual basis or more frequently as necessary.

DDD applies service planning more stringently for DDD M/S services, requiring DDD members to have ISPs in order to initiate and access services, including services with referrals. ISPs are updated every 90 days following the initial development.

For both MH/SUD and M/S services, the MCO and DDD evaluates the stringency of the NQTL by reviewing access to care data addressing timeliness of service, provider monitoring and grievance and appeal data. As a result, the strategies and evidentiary standards for documentation requirements are no more stringently applied to MH/SUD services than to DDD M/S services.

Compliance Determination:

Based upon the analysis, the processes, strategies and evidentiary standards for assessments and ISP development, in writing and in operation, are comparable and no more stringently applied to providers of MH/SUD services than to providers of M/S services.