Public Employees Insurance Agency

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December 13, 2022

Aaron Allred
Legislative Manager
Legislative Services Division
1900 Kanawha Boulevard, East
Building 1, Room E-132
Charleston, West Virginia 25305

Re: PEIA 2022 Annual Report to the West Virginia Legislature Joint Committee on Government and Finance Pursuant to W. Va. Code §5-16-3(f) – Mental Health Parity

Dear Mr. Allred:

I am writing on behalf of West Virginia Public Insurance Agency (PEIA) CFO and Acting Executive Director, Jason Haught, to submit the enclosed copy of PEIA's 2022 Annual Mental Health Parity Report, being provided pursuant to W. Va. Code §5-16-3(f). Please let me know if you have any questions or concerns.

Respectfully,

Kasi L. Bell
PEIA Legal
ASA I

Enclosure(s): 2022 Annual Report Pursuant to W. Va. Code §5-16-3(f)
NQTL Analysis – Mental Health Parity and Addiction Equity Act

cc: Jason Haught, CFO/Interim Executive Director
William B. Hicks, General Counsel
Felice B. Joseph, Pharmacy Director

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West Virginia Public Employees Insurance Agency (PEIA) – Annual Report
Joint Committee on Government and Finance Pursuant to W.Va. Code §5-16-3(f)

PEIA reports the following programs and initiatives:

1. Following a Request for Proposal (RFP) Express Scripts (ESI) was awarded the Pharmacy Benefit Manager (PBM) contract with a July 1, 2022, effective date. There were no benefit changes with the new contract.
2. PEIA contracts with TruData Rx for a pilot program to only cover fluoxetine (generic Prozac) capsules and exclude the tablet dosage form. This is estimated to save PEIA $211,700.00 at the end of twelve months.
3. Increasing generic fill rates. PEIA is constantly looking at programs to increase the use of effective low-cost generic medications. PEIA has step therapy on several classes of medications. Step Therapy requires a trial of a generic medication in the same therapeutic class before a brand name medication is covered. The PEIA generic fill rate is slightly under 90%.
4. PEIA manages specialty pharmacy costs. Prior authorization of injectable specialty medications administered in a provider's office or facility are handled by UMR. Prior authorization of oral and self-administered injectable specialty medications was handled by CVS/Caremark until June 30, 2022. Beginning July 1, 2022, Express Scripts will be handling the prior authorization of oral and self-administered injectable specialty medications.
5. PEIA has always covered continuous glucose monitors (CGM) as a medical benefit. Effective July 1, 2022, PEIA also covers CGMs as a pharmacy benefit which will sometimes result in less out of pocket cost to the member. All CGMs require prior authorization.
6. Effective October 1, 2022, PEIA has partnered with SaveOnSP, a specialty medication program which helps members and PEIA save costs by utilizing existing manufacturer copay assistance programs. SaveOnSP is estimated to save PEIA approximately $13 million in FY 2023.
7. Effective October 1, 2022, ESI offered the Specialty Precision Network (SPN) to West Virginia retail pharmacies that want to fill specialty medications for PEIA members. Previously, PEIA had an exclusive specialty network with Accredo Specialty Pharmacy, the ESI specialty pharmacy.
8. PEIA continues to offer the Safe and Effective Management of Pain Program (SEMPP) in collaboration with the West Virginia University School of Pharmacy. Designed to ensure that patients experiencing pain are treated according to the federal guidelines, SEMPP pharmacists are working with the physician community conducting case reviews, reviewing prescribing patterns, and providing member and provider education. SEMPP is aligned with the Centers for Disease Control (CDC) prescribing guidelines. PEIA has seen a substantial decrease in members receiving doses of opioid medications that exceed the CDC's guidelines since the inception of

this program. PEIA has taken this one step further by offering members with backpain two chiropractic visits at no cost to the member. This encourages our members to seek alternative therapy to avoid the use of opioids.

9. The agency continues to reduce the number of PEIA PPB Plan members who experience avoidable readmissions to a hospital for the same diagnosis-related illness within thirty days of being discharged, consistent with the payment policies, operations guidelines, and implementation timetable established by the Federal Centers for Medicare and Medicaid Services (CMS). PEIA has been involved in the state's various community paramedicine projects to prevent readmission. Adopting measures identified by CMS to reduce costs and enhance quality. PEIA follows Medicare payment guidelines and is a rapid follower in adopting new Medicare cost-containment and utilization management programs. UMR provides community nurses, case management and maternity management. These Community Resource Consultants/Nurses are an effective model/role for UMR and WV PEIA. The nurses are strategically positioned throughout the State and live and work in the communities they serve. They work as an extension of the UMR Case Management and Disease Management teams for PEIA to connect and educate providers and members about the resources available to help them make well informed choices about their health care. The goal is to provide members with the best quality care within the State of WV, connect them with the providers and keep the overall cost to members and WV PEIA as low as possible.
10. Implementing and evaluating medical home models and health care delivery, such as the Comprehensive Care Partnership Program (CCP). PEIA has been pursuing alternative payment models using a global-fee-based medical home model for several years. PEIA members who participate choose a "comprehensive care" provider who coordinates the member's care providing primary care and other services. We continue to explore new models within the industry and refine existing arrangements while exploring other parts of the state to increase our CCP population. On January 1, 2022, we added Pleasant Valley Hospital, Williamson Health and Wellness Center, Minnie Hamilton Hospital and Fayette Physician Network to our CCP program. This will bring our total CCP membership to almost 37,000 members using 13 provider groups, and 300 separate locations encompassing 32 counties in West Virginia within our CCP program.
11. PEIA has been in discussions with Kanawha County Emergency Ambulance Authority on implementation of ET3. ET3 (Emergency, Triage, Treat & Transport) is a CMS program that encourages avoiding use of the Emergency Department for non-emergent cases. The Pilot Program is an alternative used to safely triage the member, then direct the member to telehealth, or reroute the patient to an Urgent Care center or their existing Physician's office, when appropriate.
12. PEIA provides the Weight Management Program. Weight Management is a face-to-face weight loss program that requires members to see Registered Dieticians, Exercise Physiologists and Personal Trainers in a prescribed sequence of visits over 2 years.
13. PEIA also has a Face-to-Face Diabetes program. This is a two-year diabetes education program in which participants can receive waived copays on generic and formulary-brand medications for diabetes and some supplies.

14. The number of policyholders, spouses, and dependents over 18 returning to these community-based disease management programs continue to go up following the pandemic lockdowns. We hope to add more facilities in 2023. We continue to improve the online enrollment processes for these programs. By doing so, we strive to continue to broaden our reach in enrollment for Face-to-Face Diabetes and our Weight Management programs. PEIA partnered with a new vendor, Let's Get Checked, in a pilot program to provide at-home fingerstick HbA1C kits to our members in the Face-to-Face Diabetes program and in our new diabetes prevention program offered through Cecelia Health. We expect this to help improve the health of PEIA members by preventing or managing their diabetes more efficiently. PEIA covers registered dietician services four times a year for any chronic medical condition for both adults and pediatric members.
15. PEIA strives to provide opportunities for our members to address and impact Diabetes. As of July 1, 2022, we offer two new programs, Day Two and Cecilia. PEIA has offered two enrollment periods for each of these on-line pilot programs.
16. Through collaboration with UMR, PEIA continues to identify members who have multiple chronic illnesses and steer them to coordination of care programs like Face-to-Face Diabetes, Weight Management Program, Comprehensive Care Partnership (CCP), and other pilot initiatives. PEIA offers telemedicine through a contract with iSelectMD, allowing PEIA members to connect with a physician via phone or video from their home for non-emergent medical conditions that need treatment. Members are connected to a state-licensed, board-certified physician to resolve issues 24 hours a day for a $10 copay.

UMR offers additional programs and resources to help members manage their health conditions and navigate the healthcare system, including:

a. Complex Condition CARE: A program from UMR to identify catastrophic and complex illnesses, transplants, and trauma cases, and work with members to maximize their benefits.
b. Ongoing Condition CARE: A program from UMR to identify individuals who have certain chronic diseases and would benefit from working with specially trained nurses to manage those chronic diseases and maintain quality of life.
c. HealtheNotes: UMR provides targeted mailings to members and providers. HealtheNotes provide useful, personalized information to help members manage their health.
d. Medical Complex Condition CARE: A program from UMR to identify members experiencing a serious or long-term illness or injury. UMR helps these members learn about available resources, provides early support for the family, and find ways to contain medical costs, including members' out-of-pocket expenses.
e. Transition of Care (TOC) Program (New Participants Only): A program from UMR to identify new PEIA PPB Plan members who have been receiving medical treatment from an out-of-state provider, and transition that care to in-state or in-network providers. Members who qualify for TOC can continue to receive medical treatment from a non-network provider during a transition period specified by UMR and be covered at the in-network benefit level.

17. PEIA has completed quarterly cohorts, involving more than 1500 participants, with the year-long online Weight Loss Program known as Wondr, since 2018. PEIA opened up Wondr to

policyholders and spouses with quarterly on-going enrollment periods throughout the year. Wondr, PEIA's online weight loss program, is available to all policyholders and dependents who meet BMI qualifications for obesity. Since we began using Wondr, it has helped our members lose approximately 29,000 pounds.

18. PEIA's bariatric surgery policy allows members to access these services at the four West Virginia Weight Loss Centers of Excellence. Through this collaborative relationship, PEIA members can access current best practices in the treatment of obesity. These four Centers of Excellence are: Cabell Huntington Hospital, Charleston Area Medical Center, Preston Memorial Hospital and West Virginia University Hospital. PEIA covers weight loss medications through the Medical Weight Management services at these four centers as well. PEIA is monitoring both clinical and claims data and will follow these trends annually.
19. PEIA's communications department continues to provide wellness and healthy lifestyle resources on our website and social media. PEIA has added a Provider briefing section to our webpage that includes an RSS feed that will notify providers when we add content. This is an easy way for our Providers to keep track of changes PEIA is making, articles of interest or when we change fee schedules and policies. The direct link for the News page is: https://peia.wv.gov/news_center/provider-briefing/
20. We continue to recommend cutting-edge benefit designs to the Finance Board to drive member behavior and control costs for the plan. PEIA evaluates the benefit design of the plan continuously. PEIA has been a leader in wellness programs and value-based cost-sharing for many years. New ideas are presented to the finance board and the public annually.
21. The agency continues to adjust payments for the treatment of hospital acquired infections and related events consistent with the payment policies, operational guidelines and implementation timetable established by the Federal Centers of Medicare and Medicaid Services (CMS). The agency will attempt to protect employees and retired employees from any provider upward adjustment in payment for such hospital acquired infections.
22. UMR works closely with providers on PEIA's behalf to educate them regarding free programs for members with chronic and acute conditions that UMR and WV PEIA offer to improve the quality of life for members and their overall outcomes. UMR has been effective in connecting members with community resources to assist with free transportation, DME supplies and lodging. PEIA collaborates with UMR in an effort to keep the cost of care more affordable for our members.
23. PEIA continues to offer physicians telemedicine, and to bill for services that are typically done in the office during the COVID-19 pandemic and moving forward.
24. PEIA has successfully implemented a SWORD short-term pilot in 2021 to explore options which PEIA may choose to make more widely available to WV Physical Therapy Providers in the future.
25. As mandated in WV Code HB 5-16-7f, PEIA providers may achieve Gold Card status. In the event a health care practitioner has performed an average of 30 procedures per year and, in a 6-month time period, has received a 100 percent prior approval rating, PEIA shall not require the health care practitioner to submit a prior authorization for that procedure for the next 6 months. At the end of the 6-month timeframe, the exception shall be reviewed for renewal. This exemption is subject to internal auditing, at any time, by UMR and may be rescinded if UMR

determines the health care practitioner is not performing the procedure in conformity with PEIA's benefit plan based upon the results of UMR's internal audit.

26. As of July 1, 2022, PEIA has removed the precertification requirement for MRI of the spine.
27. As of July 1, 2022, National Drug Code (NDC) numbers must be on all medical benefit prescription claims, or the claim will be denied. This includes professional and outpatient facility drug claims that are reported for reimbursement. The NDC requirement does not apply to child and adult immunization drug codes. This will help with capturing our rebate opportunities.
28. Since 2020, PEIA has been diligent in keeping our COVID policy up to date with any changes and new immunizations funding over 30 million in COVID related claims.
29. As of July 1, 2022, PEIA changed its Life Insurance vendor to MetLife, and FBMC changed the Mountaineer Flexible Benefits vision benefit vendor to Eye Med.
30. PEIA has continued and expanded the substance use disorder (SUD) program with hospital and community behavioral health centers to provide in-state services to PEIA members needing detox and addiction treatment services while restricting coverage for out-of-state, out-of-network care. PEIA has six centers providing treatment services: Thomas Hospital's inpatient unit, Westbrook's Treatment Amity Center, WVU Medicine Center for Hope and Healing, Mountaineer Recovery Center, Clean and Clear Advantage and Lotus Recovery Center in Comfort, WV. Effective July 1, 2022, PEIA now covers in-state residential substance abuse treatment for 28 days per plan year for members who meet criteria, as long as, the treatment center accepts the PEIA fee schedule.
31. PEIA's Applied Behavioral Analysis (ABA) benefits have changed. The $30,000 ABA annual benefit cap has been removed. PEIA will now follow United Healthcare's ABA care policy. This action also removes the requirement that the patient be diagnosed prior to age 8 to qualify for ABA coverage and eliminates the age 18 limit on therapy.
32. PEIA has removed the additional $500 copay for injuries resulting from high-risk behavior.
33. After further analysis, PEIA has removed the time frame limitations for treatment of dental accidents.
34. PEIA has removed the limit of 6 non-emergent ER visits per plan year.

Respectfully submitted:

Jason Haught, Acting Director, CFO

12/13/22
Date

December 2022
Privileged and Confidential
Attorney Work Product

West Virginia PEIA

Mental Health Parity and Addiction Equity Act - NQTL Analysis

General Requirement: Health insurance coverage may not impose a non-quantitative treatment limit ("NQTL") with respect to mental health or substance use disorder ("MH/SUD") benefits in any classification unless, under the terms of the health insurance coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are *comparable to*, and are *applied no more stringently than*, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical ("M/S") benefits in the classification.

- By being *comparable*, the processes, strategies, evidentiary standards and other factors cannot be specifically designed to restrict access to MH/SUD benefits.
- It is unlikely that a reasonable application of the NQTL requirement would result in all MH/SUD benefits being subject to an NQTL in the same classification in which none of the M/S benefits are subject to the NQTL.

Steps for applying the General Requirement:

- **Step One:** First, identify the NQTL. *Nonquantitative treatment limitations* include—
  - ❖ Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review)
    - o Medical Necessity Review
    - o Prescription Drug Preauthorization
  - ❖ Prescription Drug Formulary Design
  - ❖ Network Tier Design
  - ❖ Standards for determining provider admission in a network, including reimbursement rates
  - ❖ Determinations of usual and customary and reasonable charges
  - ❖ Refusal to pay for higher cost therapies until lower cost therapies are used (fail-first policies or step therapy protocols)
    - o Treatment Attempt Requirements
  - ❖ Restrictions based on geographic location, facility type, or provider specialty
    - o Residential Treatment Limitations
    - o Licensure Requirements
  - ❖ Written treatment plans

  Other plan design features that limit the scope or duration of coverage for MH/SUD benefits may include plan standards such as:

  - ❖ Network adequacy
  - ❖ Plan exclusions affecting the scope of services provided under the plan.

  The plan should complete the checklist in this section for each NQTL identified in the plan.

- **Step Two**: The plan should ensure that any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
1								
1a	What standards does PEIA look to define conditions as M/S versus MH/SUD?	UMR defines medical/surgical benefits for the treatment of medical surgical condition in the current edition of the of the International Classification of Diseases.	UMR defines medical/surgical benefits for the treatment of medical surgical condition in the current edition of the of the International Classification of Diseases.	Emergency services treat any serious medical condition, with acute symptoms that requires immediate care and treatment in order to avoid jeopardy to the life and health of the person.	UMR defines behavioral health and substance use disorder as benefits for the treatment of behavioral health and substance use disorder consistent with the current Diagnostic and Statistical Manual of Mental Disorders (DSM).	UMR defines behavioral health and substance use disorder as benefits for the treatment of behavioral health and substance use disorder consistent with the current Diagnostic and Statistical Manual of Mental Disorders (DSM).	Emergency services treat any serious medical condition, with acute symptoms that requires immediate care and treatment in order to avoid jeopardy to the life and health of the person.	The standards that used to define M/S conditions as M/S versus MH/SUD are no more stringent and are comparable to MH/SUD to M/S
2	Classifying Services as Outpatient, Inpatient, or Emergency Services							
2a	What standards does PEIA look to classify MH/SUD and M/S services as outpatient, inpatient, or emergency?	**Inpatient** Non-emergent medical services that are provided in a hospital or other facility that require at least one overnight stay with a physician's written order for admission. Inpatient services include room and board, nursing services, diagnostic or therapeutic services, and medical and surgical services. This includes:	**Outpatient** Non-emergent ambulatory services not requiring an overnight stay in a hospital setting or delivered in other facility appointed to the outpatient category of benefits. This includes: • Office visits • Urgent care • Outpatient facility • Outpatient surgery	Emergency care services needed to evaluate or stabilize an emergency medical condition. An emergency medical condition exists when acute symptoms can result in: • Acute peril to the condition of the individual or in the case of a pregnant	**Inpatient** Non-emergent behavioral health and substance use disorder services that are provided in a hospital or other facility that require at least one overnight stay with a physician's written order for admission. Other facilities include other behavioral health residential facilities. Inpatient services include room and board, nursing services, diagnostic or	**Outpatient** Non-emergent ambulatory services not requiring an overnight stay in a hospital setting or delivered in other facility appointed to the outpatient category of benefits for BH/SUD. This includes: • Psychotherapy services (Individual,	Emergency care services needed to evaluate or stabilize an emergency behavioral health or substance use disorder condition. Emergency care services needed to evaluate or stabilize an emergency medical	

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Services provided in an acute care hospital and facilities licensed in accordance as such by a nationally recognized accreditation agency or state agency, delivering treatment to those incapacitated by injury or illness. This includes oversight by physicians and 24-hour nursing care.	• Outpatient professional services • Outpatient hospice • Radiology diagnostics • Advanced radiology diagnostics • Speech therapy • Physical therapy • Occupational therapy • Chiropractic services • Home health care • Neuropsychological testing • Durable Medical Equipment including breast feeding equipment and supplies	individual, the unborn child. • Acute detriment to physical and/or biological functions • Acute malfunction of organ, appendage, or part	therapeutic services, and behavioral health services. This includes: Services provided in an acute care institution licensed in accordance as such by a nationally recognized accreditation agency or state agency, delivering treatment to those incapacitated by a BH/SUD condition. This includes oversight by physicians and 24-hour nursing care. Services provided in a subacute care facility licensed in accordance as such by a nationally recognized accreditation agency or state agency, delivering treatment to those incapacitated by a BH/SUD condition. This includes oversight by physicians and 24-hour nursing care.	family, couple, group) • Counseling services • Medication management • Applied behavioral analysis (ABA) • Intensive outpatient services (IOP) • Psychological testing • Electroconvulsive therapy Outpatient partial hospitalization programs for mental health, chemical dependency and substance abuse are covered when medical necessary.	condition. An emergency medical condition exists when acute symptoms can result in: • Acute peril to the condition of the individual or in the case of a pregnant individual, the unborn child. • Acute detriment to physical and/or biological functions • Acute malfunction of organ, appendage, or part	

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
2b	How do you classify intermediate services?	UMR classifies intermediate services as medical services provided in a skilled nursing facility and/or long-term acute facilities for medical/surgical benefits. This includes coverage for room and board; nursing care; rehabilitation or therapeutic services.	N/A	N/A	UMR classifies intermediate services as behavioral health/ substance use disorder provided in a non-hospital inpatient setting as non-hospital residential services. This includes clinical care; rehabilitation and/or therapeutic services.	N/A	N/A	Classification of intermediate services of M/S to MH/SUD are comparable and not applied more stringently to MH/SUD than to M/S
3								
3a	What services, conditions, treatment, etc., require pre-authorization?	**Inpatient Services** • Out of state services if are in PEIA PPB plan A or B and live in West Virginia or a bordering county surrounding state, all services outside of the state beyond the bordering counties must have prior approval. • Plan D does not have benefits outside of the state of West Virginia • For Plan C, Care provided by non-network providers must have prior approval.	**Outpatient Services** • Out of state services if are in PEIA PPB plan A or B and live in West Virginia or a bordering county surrounding state, all services outside of the state beyond the bordering counties must have prior approval. • Plan D does not have benefits outside of the state of West Virginia • For Plan C, Care provided by non-network providers must have prior approval. The PEIA Plans require that certain services and/or types of	Not applicable	**Inpatient Services** • Out of state services if are in PEIA PPB plan A or B and live in West Virginia or a bordering county surrounding state, all services outside of the state beyond the bordering counties must have prior approval. • Plan D does not have benefits outside of the state of West Virginia • For Plan C, Care provided by non-network providers must have prior	**Outpatient Services** • Out of state services if are in PEIA PPB plan A or B and live in West Virginia or a bordering county surrounding state, all services outside of the state beyond the bordering counties must have prior approval. • For Plan C, Care provided by non-network providers must have prior approval. Services of non-network providers will be	Not applicable	

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		The PEIA Plans require that certain services and/or types of services be reviewed to determine whether they are medically necessary and to evaluate the necessity for Complex Condition CARE. Some services require "precertification," and other services require "notification." Precertification is performed to determine if the admission is medically necessary and appropriate based on the patient's documented medical condition. Precertification is required for the following for all plans: • All admissions to out-of-state hospitals/facilities • All admissions to rehabilitation or skilled nursing facilities • Surgeries a) artificial disc surgery b) bariatric surgery c) cochlear implants or implantable interosseous devices (including bone-anchored) d) discectomy with spinal fusion surgery e) potentially cosmetic surgeries including but not limited to abdominoplasty,	services be reviewed to determine whether they are medically necessary and to evaluate the necessity for Complex Condition CARE. Some services require "precertification," and other services require "notification." Precertification is performed to determine if the service is medically necessary and appropriate based on the patient's documented medical condition. Precertification is required for the following for all plans: • Ambulance Service for Non-Emergency transport, including air ambulance • Surgeries a) artificial disc surgery b) bariatric surgery c) cochlear implants or implantable interosseous devices (including bone-anchored) d) discectomy with spinal fusion surgery e) potentially cosmetic surgeries including but not limited to abdominoplasty, blepharoplasty, breast reduction, breast reconstruction, panniculectomy, penile implants/vascular procedures, otoplasty, rhinoplasty, scar		approval. Services of non-network providers will be paid at 80% of PEIA's maximum allowance and must be approved by UMR in advance. Precertification requirements apply for inpatient stays and certain outpatient procedures • Inpatient admissions (to behavioral health facilities) for mental health and substance abuse benefits **<u>Intermediate Services</u>** • Non-hospital residential services Inpatient programs for mental health, chemical dependency and substance abuse are covered when medical necessary. Precertification is required. Cases requiring more than 30 days will be assigned to	paid at 80% of PEIA's maximum allowance and must be approved by UMR in advance. Precertification requirements apply for inpatient stays and certain outpatient procedures • Plan D does not have benefits outside of the state of West Virginia • Outpatient services for mental health and substance abuse, including: Detoxification • Electroconvulsive therapy (ECT) • Applied behavior analysis (ABA) • Neuropsychological testing • Partial hospitalization day treatment • Intensive outpatient treatment • Psychiatric home care		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		blepharoplasty, breast reduction, breast reconstruction, panniculectomy, penile implants/vascular procedures, otoplasty, rhinoplasty, scar revision, testicular prosthesis, and surgery for varicose veins f) endoscopic treatment of GERD 62 g) hysterectomy h) implantable devices including, but not limited to: implantable pumps, spinal cord stimulators, neuromuscular stimulators, and bone growth stimulators i) knee arthroscopy j) laminectomy, including laminectomy with spinal fusion surgery k) spinal fusion surgery l) total joint replacement m) transplants n) uvulopalatopharyngoplasty o) vertebroplasty, kyphoplasty, and sacroplasty Transplants (including organ, stem cell, bone marrow, and kidney)	revision, testicular prosthesis, and surgery for varicose veins • Any potentially experimental/investigational procedure, medical device, or treatment • Chelation Therapy • Chemotherapy Drugs • Continuous glucose monitors • Durable medical equipment purchases and/or rentals of $500 per month rental or $1500 per purchase or more • Elective (non-emergent) facility to facility air ambulance transportation 12. Genetic testing with the exception of Cologuard • Heart Perfusion Imaging 14. Home health care and/or IV therapy in the home after the twelfth visit. • Hyperbaric Oxygen Therapy (HBOT) • Insulin Pumps (except Omnipod DASH insulin delivery systems which are covered under the Prescription Drug Program and do require prior		a nurse case manager. If approved, these services are covered when applicable coinsurance after the $100 copayment and the deductive are met. Unapproved out of network treatment is non covered. PEIA will cover substance use withdrawal and treatment services for an initial period of no more than seven days for withdrawal service no more than a 30-day period for treatment services. Exceptional cases will be considered on a case-by-case basis as authorized by UMR. PEIA preferred provider plan participants will pay 20% coinsurance after meeting their deductible. The plan will allow one allowable residential treatment program it is allowed for 28 days, on time per lifetime for the following facilities only: St. Francis; WVU Hope and Healing; Mountaineer	• Specialty drugs covered under the medical plan • Electroconvulsive shock therapy (ECT) and Trans magnetic stimulation (TMS) Precertification is required. Cases requiring more than 60 days will be assigned to a nurse case manager. If approved, these services are covered when applicable coinsurance after the $100 copayment and the deductive are met. Unapproved out of network treatment is non covered. PEIA will cover substance use withdrawal and treatment services an initial period of no more than seven days for withdrawal service no more than a 60-day period for treatment services. Exceptional cases will be considered on a case-by-case basis as authorized by UMR.		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Intermediate Services • Skilled Nursing Facility • Long Term Acute Care Facility	authorization with standard quantity limits) • Outpatient CTA (CT angiography) • Outpatient Dialysis Services • Outpatient IMRT (intensity modulated radiation therapy) • Outpatient MRI scan of the breast or spine (includes cervical, thoracic, and lumbar) • Sleep studies, services and equipment. See section on "sleep management services" • Specialty drugs provided in a physician's office by a pharmacy or mail order. • SPECT (single photon emission computed tomography) of brain or lung • Stereotactic Radiation Surgery and Stereotactic Radiation Therapy		Recovery; Amity Westbrook; Thomas Hospital: and United Summit Center. Non CCP Plans out of area: No approval needed for care Out of State (beyond bordering counties) with UHC providers. This will be Tier 2.	Outpatient mental health therapy, chemical dependency and substance abuse services are covered when medically necessary for short-term individual and/or group outpatient mental health therapy and chemical dependency services. This benefit includes evaluation and referral, diagnostic, therapeutic, and crisis intervention services performed on an outpatient basis. Cases requiring more than 20 visits will be assigned to a nurse case manager and must be approved by UMR. This benefit is covered at 80% after the deductible is met		
3b	What processes, strategies, evidentiary standards, or other factors	A cost benefit analysis is completed to determine which services are subject to prior authorization. If the benefit of prior authorization outweighs the cost correlated to the process of prior authorization	A cost benefit analysis is completed to determine which services are subject to prior authorization. If the benefit of prior authorization outweighs the cost correlated to the process of prior authorization (PA) then a	Not Applicable	A cost benefit analysis is completed to determine which services are subject to prior authorization. If the benefit of prior authorization outweighs the cost correlated to the	A cost benefit analysis is completed to determine which services are subject to prior authorization. If the benefit of prior authorization outweighs	Not applicable	

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	

	were used to develop this list?	(PA) then a PA process will be administered based upon client direction in accordance to the SPD.
		
		The data reviewed includes the following:
		• Average cost of treatment of procedure based upon network analysis
		• Treatment or procedure categorization of increasing or high cost driver
		• Claim quantity over set period of time (e.g., 12 month or 12 months to 36 months to show increasing trajectory of utilization)
		  o Paid versus denied claims
		• Propensity for fraud in treatment category
		• Employee cost for support of prior authorization process
		• Anticipated savings
			PA process will be administered based upon client direction in accordance to the SPD.
			
			The data reviewed includes the following:
			• Average cost of treatment of procedure based upon network analysis
			• Treatment or procedure categorization of increasing or high cost driver
			• Claim quantity over set period of time (e.g., 12 month or 12 months to 36 months to show increasing trajectory of utilization)
			  o Paid versus denied claims
			• Propensity for fraud in treatment category
			• Employee cost for support of prior authorization process
			• Anticipated savings
					process of prior authorization (PA) then a PA process will be administered based upon client direction in accordance to the SPD.
					
					The data reviewed includes the following:
					• Average cost of treatment of procedure based upon network analysis
					• Treatment or procedure categorization of increasing or high cost driver
					• Claim quantity over set period of time (e.g., 12 month or 12 months to 36 months to show increasing trajectory of utilization)
					  o Paid versus denied claims
					• Propensity for fraud in treatment category
					• Employee cost for support of prior authorization process
						the cost correlated to the process of prior authorization (PA) then a PA process will be administered based upon client direction in accordance to the SPD.
						
						The data reviewed includes the following:
						• Average cost of treatment of procedure based upon network analysis
						• Treatment or procedure categorization of increasing or high cost driver
						• Claim quantity over set period of time (e.g., 12 month or 12 months to 36 months to show increasing trajectory of utilization)
						  o Paid versus denied claims
						• Propensity for fraud in treatment category		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
					• Anticipated savings	• Employee cost for support of prior authorization process • Anticipated savings		
3c	Is the process for obtaining pre-authorization the same for MH/SUD services and M/S services? Similar forms, similar medical records, etc.?	Inpatient Services applicable to both In-network and Out of network providers, requiring Prior Authorization. The Plan uses Prior Authorization to accomplish the following goals: Monitor and prevent potential overutilization and underutilization; Manage high-cost and prolonged-duration services; Ensure enrollee safety; Determine the appropriate level of care; and Determine whether the service or item is medically necessary.	Outpatient Services Requiring Prior Authorization applicable to In-network and Out of network providers. The Plan uses Prior Authorization to accomplish the following goals: Monitor and prevent potential overutilization and underutilization; Manage high-cost and prolonged-duration services; Ensure enrollee safety; Determine the appropriate level of care; and Determine whether the service or item is medically necessary.	Not applicable	Inpatient Services requiring Prior Authorization applicable to In-network and Out of network providers. The Plan uses Prior Authorization to accomplish the following goals: Monitor and prevent potential overutilization and underutilization; Manage high-cost and prolonged-duration services; Ensure enrollee safety; Determine the appropriate level of care; and	Outpatient Services Requiring Prior Authorization applicable to In-network and Out of network providers. The Plan uses Prior Authorization to accomplish the following goals: Monitor and prevent potential overutilization and underutilization; Manage high-cost and prolonged-duration services; Ensure enrollee safety; Determine the appropriate level of care; and	Not applicable	For both M/S and MH/SUD, the goal of Prior Authorization is to ensure cost-effective and clinically effective treatment. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and criteria utilized for prior authorization are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both utilize evidence-

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Process for Obtaining Prior Authorization. For any inpatient service on the Prior Authorization List, the facility must confirm that the coverage approval is on file. The purpose of this protocol is to enable the facility and the Customer to have an informed pre-service conversation; in cases where it is determined that the service will not be covered the Customer can then decide whether to receive and pay for the service. When the provider or member requests Prior Authorization, appropriately qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then render a coverage determination. Both the providers and member are notified of the adverse	**Process for Obtaining Prior Authorization.** There may be some outpatient benefits for which the member is responsible for obtaining Prior Authorization which are identified in the Plan document's Schedule of Benefits. The requirement does not vary based on place of service, such as a provider's office or via approved virtual technology (i.e. telehealth). When a Prior Authorization is requested, appropriately qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then render a coverage determination. Both the providers and member are notified of the adverse determination consistent with state/federal requirements and applicable appeal rights are provided.		Determine whether the service or item is medically necessary. **Process for Obtaining Prior Authorization.** For any inpatient service on the Prior Authorization List, the facility must confirm the coverage approval is on file. The purpose of this protocol is to enable the facility and the Customer to have an informed pre-service conversation; in cases where it is determined that the service will not be covered the Customer can then decide whether to receive and pay for the service. When the provider or member requests Prior Authorization, appropriately qualified clinical staff reviews the	Determine whether the service or item is medically necessary. **Process for Obtaining Prior Authorization.** For any outpatient services on the Prior Authorization list, the provider is responsible for obtaining the Prior Authorization. There may be some outpatient benefits for which the member is responsible for obtaining Prior Authorization which are identified in the Plan document's Schedule of Benefits. The requirement does not vary based on place of service, such as a provider's office or via approved virtual technology (i.e. telehealth). When a Prior Authorization is requested, appropriately		based nationally recognized clinical guidelines in determining whether to add or maintain a prior authorization requirement. M/S and MH/SUD requests for authorization are evaluated by appropriately licensed and qualified medical or behavioral clinical staff depending on the nature of the treatment/services sought. For both MH/SUD and M/S, the treating provider is required to provide clinical information. This information is reviewed by a medical professional with appropriate

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		determination consistent with state, federal and accreditation requirements and applicable appeal rights are provided. Prior Authorization can be submitted electronically or by phone. **Guidelines/Criteria Utilized.** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Fail First/Step Therapy** Fail first requirements could apply for certain inpatient surgeries, such as hip arthroplasty. **Timeframe to respond.**	Prior Authorization can be submitted electronically or by phone. **Guidelines/Criteria Utilized.** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Fail First/Step Therapy** M/S may apply Fail First/Step Therapy to certain codes covered under Outpatient Benefits, such as medical injectables for cancer drugs. **Timeframe to respond.** M/S will follow all applicable state and federal or accreditation timeframe requirements.		request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then render a coverage determination. Both the providers and member are notified of the adverse determination consistent with state, federal and accreditation requirements and applicable appeal rights are provided. Prior Authorization can be submitted electronically or by phone. **Guidelines/Criteria Utilized:** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized	qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then render a coverage determination. Both the providers and member are notified of the adverse determination consistent with state/federal requirements and applicable appeal rights are provided. Prior Authorization can be submitted electronically or by phone. **Guidelines/Criteria Utilized:** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally		credentials necessary to confirm coverage and that the suggested treatment/service is clinically appropriate based on nationally recognized, evidence-based clinical guidelines and medical policies, standardized coverage determination guidelines (CDGs), and generally accepted, peer-reviewed medical literature. Based on the foregoing, the processes and evidentiary standards are comparable and no more stringently applied for MH/SUD.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		M/S will follow all applicable state and federal or accreditation timeframe requirements.			clinical guidelines and criteria, such as InterQual. **Fail First/Step Therapy** MH/SUD does not apply Fail First/Step Therapy to Inpatient Benefits. **Timeframe to respond.** MH/SUD will follow all applicable state and federal or accreditation timeframe requirements.	recognized clinical guidelines and criteria, such as InterQual. **Fail First/Step Therapy** MH/SUD may apply Fail First/Step Therapy to certain codes covered under Outpatient Benefits, such as Transcranial Magnetic Stimulation (TMS). **Timeframe to respond.** MH/SUD will follow all applicable state and federal or accreditation timeframe requirements.		
3d	If preauthorization is not obtained, what happens?	Services reviewed through Retrospective Review Services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge.	Retrospective Review for in-network outpatient benefits begins when the Plan receives notification post-service that the outpatient service occurred. **Post-Claim Retrospective Review.** If prior auth is required and no prior auth is on file, the claim is		Services reviewed through Retrospective Review Services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge	Retrospective Review for in-network outpatient benefits begins when the Plan receives notification post-service that the outpatient service occurred. **Post-Claim Retrospective Review.**		For both M/S and MH/SUD, the goal of Retrospective Review is to ensure that the treatment or services provided were appropriate for the member's need, and consistent with

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Post-Claim Retrospective Review. If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, if the in-network facility/physician has the med-nec addendum, the provider can request a medical necessity review post claim. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements by online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail.	denied administratively for no-prior auth on file. However, if the in-network facility/physician has the med-nec addendum, the provider can request a medical necessity review post claim. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements by online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Why does the Plan conduct Retrospective Reviews?** Retrospective Review is a component of UnitedHealthcare's utilization management program. The Medical Director and other		**Post-Claim Retrospective Review.** If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, if the in-network facility/physician has the med-nec addendum, the provider can request a medical necessity review post claim. If the provider is out of network, the customer can request a retrospective review process. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements by online or telephone for	If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, if the in-network facility/physician has the med-nec addendum, the provider can request a medical necessity review post claim. If the provider is out of network, the customer can request a retrospective review process. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements by online or telephone for Pre-		the plan guidelines regarding coverage and medical appropriateness. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and criteria utilized for Retrospective Review are the same, and therefore, comparable for MH/SUD and M/S. Accordingly, the process for performing Retrospective Review for M/S and MH/SUD benefits for the applicable benefit classifications is comparable.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Why does the Plan conduct Retrospective Reviews? Retrospective Review is a component of UnitedHealthcare's utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons: to detect and better manage over- and under-utilization; to determine whether the services reviewed are— consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. **Process for Retrospective Review**.	clinical staff review services for the following reasons: to detect and better manage over- and under-utilization; to determine whether the services reviewed are— consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. **Process for Retrospective Review.** Pre-Claim Retrospective Review Post-service When the Plan is contacted by an in-network provider who was unable to obtain prior authorization due to a qualifying mitigating circumstance, a medical necessity review will be conducted only for radiology and cardiology outpatient services.		Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Why does the Plan conduct Retrospective Reviews?** Retrospective Review is a component of Optum's utilization management program. A Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons: to detect and better manage over- and under-utilization; to determine whether the services reviewed are—	Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Why does the Plan conduct Retrospective Reviews?** Retrospective Review is a component of Optum's utilization management program. The Medical Director and other clinical staff review services for the following reasons: to detect and better manage over- and under-utilization; to determine whether the services reviewed are—		From a stringency perspective, both M/S and MH/SUD reviews are initiated similarly in that Retrospective Review of outpatient, in-network benefits are initiated when the Plan receives a claim or request for authorization (when prior authorization is required) post-service that the outpatient in-network service occurred. Further, the Retrospective Reviews applied to MH/SUD benefits are less stringent than for M/S benefits because behavioral health conducts a medical

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Pre-Claim Retrospective Review (Plan receives notification post discharge) – the Plan performs a pre-claim retrospective review, for certain inpatient in-network cases, starting with the first day of the admission if the in-network facility did not notify the Plan or seek prior authorization for an admission and provides extenuating circumstances for a late notification of inpatient admissions. This review is conducted unless post-discharge review is prohibited by hospital contract. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. **Post-Claim Retrospective Review.** If prior auth is required and no prior auth is on file, the claim is	For all other services, the in-network provider can provide this additional information upon appeal. When the Medical Director determines that the service was not medically necessary, the member and providers will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. **Post-Claim Retrospective Review** – If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, if the in-network provider has the med-nec addendum, the provider can request a medical necessity review. If the provider is out of network, the customer can request a retrospective review process. If the service is reviewed and determined to be not medically		consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. **Process for Retrospective Review.** Pre-Claim Retrospective Review(Plan receives notification post discharge) – the Plan performs a pre-claim retrospective review, for certain inpatient in-network cases, starting with the first day of the admission if the in-network facility did not notify the Plan or seek prior authorization for an admission and provides extenuating circumstances for a late notification of inpatient admissions. This review is conducted unless post-discharge review is prohibited by	consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. **Process for Retrospective Review.** Pre-Claim Retrospective Review - If the in-network provider is not able to obtain prior authorization due to an urgent situation or the provider who obtained authorization but during the course of that service needed to perform an additional/different medically necessary service for which he/she did not obtain prior authorization, the Plan will perform a post service, pre-claim review to determine if the		necessity review if mitigating circumstances exits. Thus, in each classification, as written and in operation, Retrospective Review for M/SUD benefits is applied no more stringently (and in some instances less stringently) than that M/S benefits.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		denied administratively for no-prior auth on file. However, if the in-network facility/physician has the med-nec addendum, the provider can request a medical necessity review post claim. If the provider is out of network, the customer can request a retrospective review process. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements by online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Staff Qualifications.** M/S is staffed by UnitedHealthcare clinical, non-	necessary, then the claim will deny in full and provide appeal rights. If there are extenuating circumstances for not obtaining a prior auth, the provider If the reviewer (a mid-level provider, such as a nurse for M/S benefits believes that the service is not medically necessary, the provider will be asked for more information. When the Medical Director determines whether the service is medically necessary, the provider will be notified of the determination. If denied, then the notice will include appeal rights and follow all applicable state, federal or accreditation requirements. Notification Requirements by telephone or online for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail.		hospital contract. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. **Post-Claim Retrospective Review.** If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. The Plan will review the case on appeal for medical necessity for all contracted providers Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided.	service is medically necessary. **Post-Claim Retrospective Review –** If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, the provider can request a medical necessity review post claim. If Optum determines that the service was medically necessary, the claim will be paid. Otherwise, the claim will administratively deny for no-prior auth on file. If the review is performed and the service is determined not to be medically necessary, then the claim will deny in full and provide appeal rights. If there are		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized.** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Timeframe to respond.** M/S will follow all applicable state, federal or accreditation timeframe requirements.	**Staff Qualifications.** M/S is staffed by UnitedHealthcare clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized.** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Timeframe to respond.** M/S will follow all applicable state, federal or accreditation timeframe requirements.		Notification Requirements by online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Staff Qualifications**. MH/SUD personnel are clinical, non-clinical and administrative. All clinical reviews are made by clinical staff (i.e. licensed behavioral health clinicians, nurses, PhDs, physicians, etc.) and all adverse determinations are made by PhDs, physicians/Medical Directors. **Guidelines/Criteria Utilized.**	extenuating circumstances for not obtaining a prior auth, the provider If the reviewer (a mid-level provider, such as a licensed masters level clinician such as a RN or LPC for MH/SUD benefits) believes that the service is not medically necessary, the request will be sent to a Medical Director for review. When a Medical Director determines whether the service is medically necessary, the provider will be notified of the determination. If denied, then the notice will include appeal rights and follow all applicable state, federal or accreditation requirements. Notification Requirements by		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
					MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as InterQual. **Timeframe to respond.** MH/SUD will follow all applicable state, federal or accreditation timeframe requirements.	telephone or online for Pre-Claim Retrospective Review. Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Staff Qualifications.** MH/SUD personnel are clinical, non-clinical and administrative. All clinical reviews are made by clinical staff (i.e. licensed behavioral health clinicians, nurses, PhDs, physicians, etc.) and all adverse determinations are made by PhDs, physicians/Medical Directors. **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
						utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as InterQual. **Timeframe to respond.** MH/SUD will follow all applicable state, federal or accreditation timeframe requirements.		
3e	Is a review of medical necessity conducted during the pre-authorization process?	The Plan includes a requirement that services and treatments, including supplies or pharmaceutical products, must be medically necessary to be a Covered Health Care Service, as defined by the Summary Plan Document (SPD). Determination of whether a service is medically necessary begins with the definition of "Medically Necessary" under the plan	The Plan includes a requirement that services and treatments, including supplies or pharmaceutical products, must be medically necessary to be a Covered Health Care Service, as defined by the Summary Plan Document (SPD). Determination of whether a service is medically necessary begins with the definition of "Medically Necessary" under the plan terms and then application of applicable	Emergency room is not reviewed through the pre-authorization process.	The Plan includes a requirement that services and treatments, including supplies or pharmaceutical products, must be medically necessary to be a Covered Health Care Service, as defined by the SPD. Determination of whether a service is medically necessary begins with the definition of "Medically Necessary"	The Plan includes a requirement that services and treatments, including supplies or pharmaceutical products, must be medically necessary to be a Covered Health Care Service, as defined by the SPD. Determination of whether a service is medically necessary begins with the	Emergency room is not reviewed through the pre-authorization process.	Medical necessity review is to ensure that the treatment or services provided are appropriate for the member's need and consistent with the plan guidelines regarding coverage and medical appropriateness. As detailed in other

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		terms and then application of applicable clinical policy and criteria to the specific service to evaluate whether the service is considered medically necessary. This definition applies equally to Medical/Surgical (Med/Surg) and Mental Health/Substance Use Disorder (MH/SUD) benefits. There is no other, separately applicable definition of "Medically Necessary". The Plan excludes services that are experimental or investigational, as well as unproven, to be effective for the treatment of the medical condition at issue. Determination of whether a service is experimental or investigational or unproven begins with the definition of "Experimental or Investigational Service(s)" as well as the definition of "Unproven Service(s)" under the Plan terms. And then, application of applicable clinical policy and criteria to the specific service to evaluate	clinical policy and criteria to the specific service to evaluate whether the service is considered medically necessary. This definition applies equally to Medical/Surgical (Med/Surg) and Mental Health/Substance Use Disorder (MH/SUD) benefits. There is no other, separately applicable definition of "Medically Necessary". The Plan excludes services that are experimental or investigational, as well as unproven, to be effective for the treatment of the medical condition at issue. Determination of whether a service is experimental or investigational or unproven begins with the definition of "Experimental or Investigational Service(s)" as well as the definition of "Unproven Service(s)" under the Plan terms. And then, application of applicable clinical policy and criteria to the specific service to evaluate whether the service is considered Experimental or Investigational or Unproven. The Plan SPD defines "Experimental		under the plan terms and then application of applicable clinical policy and criteria to the specific service to evaluate whether the service is considered medically necessary. This definition applies equally to Med/Surg and MH/SUD benefits. There is no other, separately applicable definition of "Medically Necessary". The Plan excludes services that are experimental or investigational, as well as unproven, to be effective for the treatment of the medical condition at issue. Determination of whether a service is experimental or investigational or unproven begins with the definition of "Experimental or Investigational Service(s)" as well as the definition of "Unproven Service(s)" under the Plan terms. And then, application of applicable clinical policy and criteria to the specific	definition of "Medically Necessary" under the plan terms and then application of applicable clinical policy and criteria to the specific service to evaluate whether the service is considered medically necessary. This definition applies equally to Med/Surg and MH/SUD benefits. There is no other, separately applicable definition of "Medically Necessary". The Plan excludes services that are experimental or investigational, as well as unproven, to be effective for the treatment of the medical condition at issue. Determination of whether a service is experimental or investigational or unproven begins with the		columns, the processes, timeframes, staff qualifications, and criteria utilized are comparable.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		whether the service is considered Experimental or Investigational or Unproven. The Plan SPD defines "Experimental or Investigational Service(s)" and "Unproven Service(s)". The definitions apply equally to both Med/Surg and MH/SUD benefits.	or Investigational Service(s)" and "Unproven Service(s)". The definitions apply equally to both Med/Surg and MH/SUD benefits.		service to evaluate whether the service is considered Experimental or Investigational or Unproven. The Plan SPD defines "Experimental or Investigational Service(s)" and "Unproven Service(s)". The definitions apply equally to both Med/Surg and MH/SUD benefits.	definition of "Experimental or Investigational Service(s)" as well as the definition of "Unproven Service(s)" under the Plan terms. And then, application of applicable clinical policy and criteria to the specific service to evaluate whether the service is considered Experimental or Investigational or Unproven. The Plan SPD defines "Experimental or Investigational Service(s)" and "Unproven Service(s)". The definitions apply equally to both Med/Surg and MH/SUD benefits.		
4								
4a	What services, conditions,	**Services Requiring Concurrent Review.**	**Services Requiring Concurrent Review.**		**Services Requiring Concurrent Review.**	**Services Requiring Concurrent Review.**		For both M/S and MH/SUD, the goal of Concurrent

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
	treatment, etc., are included in the concurrent review process?	• Non-emergent Medical/Surgical inpatient services reimbursed on a per diem payment schedule require a concurrent medical necessity review. **Intermediate Services** • Skilled Nursing Facility • Long Term Acute Care Facility Concurrent Review applies to services provided at an inpatient level of care or when an inpatient stay exceeds the expected number of days. Concurrent Review does not apply, however, when a facility has agreed to accept a flat rate per stay. **Why does the Plan Conduct Concurrent Review?** Concurrent Review is a component of UnitedHealthcare's utilization management program. The Medical Director and other	• Home health care • Outpatient dialysis • Rehabilitation services (physical therapy, occupational therapy, speech therapy) • Certain prosthetic devices and durable medical equipment if the rental period is extended or the DME is subjected to a rental to purchase timeframe • Ventricular assist devices (VADs) and total artificial hearts • Specialty drugs covered under the medical plan Concurrent Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. **Why does the Plan Conduct Concurrent Review?** Outpatient Concurrent Review is a component of UnitedHealthcare's utilization management program.		**Inpatient Services** • Inpatient admissions (to behavioral health facilities) for mental health and substance abuse benefits **Intermediate Services** • Non-hospital residential services Concurrent Review applies to services provided at an inpatient level of care or when an inpatient stay exceeds the expected number of days. Concurrent Review does not apply, however, when a facility has agreed to accept a flat rate per stay. **Why does the Plan Conduct Concurrent Review?** Concurrent Review is a component of the utilization management program. A Medical	**Outpatient Services** • Outpatient services for mental health and substance abuse, including: Detoxification • Electroconvulsive therapy (ECT) • Applied behavior analysis (ABA) • Neuropsychological testing • Partial hospitalization day treatment • Intensive outpatient treatment • Psychiatric home care • Specialty drugs covered under the medical plan Concurrent Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that		Review is to ensure cost-effective and clinically effective treatment is delivered. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and criteria utilized for Concurrent Review are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both M/S and MH/SUD utilize evidence-based nationally recognized clinical guidelines in determining

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		clinical staff review hospitalizations, other inpatient admissions for the following reasons: to detect and better manage over- and under-utilization; to determine whether the admission and continued stay are— consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines; to contribute to decisions about discharge planning and case management; and to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable.	The Medical Director and other clinical staff review services for the following reasons: to detect and better manage over- and under-utilization; to determine whether the service is— consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines; to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable. The criteria used to determine whether Concurrent Review applies to a given benefit are as follows: For Outpatient, services are concurrently reviewed to		Director and other clinical staff review hospitalizations, other inpatient admissions for the following reasons: to detect and better manage over- and under-utilization; to determine whether the admission and continued stay are— consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines; to contribute to decisions about discharge planning and case management; and to identify opportunities for quality improvement and cases that are appropriate for referral to a	was previously approved and is ending. **Why does the Plan Conduct Concurrent Review?** Outpatient Concurrent Review is a component of the utilization management program. A Medical Director and other clinical staff review services for the following reasons: to detect and better manage over- and under-utilization; to determine whether the service is— consistent with the member's coverage, medically appropriate, and		whether to add or maintain a Concurrent Review requirement. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally recognized clinical guidelines. M/S and MH/SUD requests for concurrent review are evaluated by appropriately licensed and qualified medical or behavioral clinical staff depending on the nature of the treatment/services

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Process for Concurrent Review. Concurrent review usually begins on the first business day following notification. A concurrent review may be conducted by telephone, on-site, and when available, facilities can provide clinical information via access to Electronic Medical Records ("EMR"). If the reviewer (a mid- level provider, such as a nurse for M/S benefits) believes that an admission or continued stay may not be covered, the facility will be asked for more information concerning the member's clinical condition, treatment and case management plan. The reviewer's assessment of whether an admission or continued stay is covered is based on whether the member's	determine if the continued course of outpatient treatment will be covered where outpatient services are approved for a defined period and continued, or ongoing outpatient services are requested beyond the previously approved services. **Process for Concurrent Review.** Concurrent Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan.		disease management program, if applicable. **Process for Concurrent Review.** Concurrent Review usually begins on the first business day following notification. A concurrent review may be conducted by telephone, on-site, and when available, facilities can provide clinical information via access to Electronic Medical Records ("EMR"). If the reviewer (a mid-level provider, such as a clinical social worker for MH/SUD benefits) believes that an admission or continued stay may not be covered, the facility will be asked for more information concerning the member's clinical condition,	consistent with evidence-based guidelines; to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable. The criteria used to determine whether Concurrent Review applies to a given benefit are as follows: For Outpatient, services are concurrently reviewed to determine if the continued course of outpatient treatment will be covered where outpatient services are approved for a defined period and continued, or ongoing outpatient services are requested beyond the previously approved services.		sought. For both MH/SUD and M/S, the treating provider is required to provide clinical information. This information is reviewed by a medical professional with appropriate credentials necessary to confirm coverage and that the suggested treatment/service is clinically appropriate based on nationally recognized, evidence-based clinical guidelines and medical policies, standardized coverage determination

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines. When the Medical Director determines that an admission or continued stay at the facility is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. **Admission Notification Requirements.** Notification can be submitted via online or the telephone number on the back of the members ID card. Notification should occur as soon as reasonably possible. **Staff Qualifications.**	When the Medical Director determines whether the continuing course of treatment is medically necessary, the member and provider will be notified of the determination consistent with state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements: Authorization can be obtained via online or by telephone. **Staff Qualifications.** M/S is staffed by UnitedHealthcare clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determination by utilizing evidence-based medical		treatment and case management plan. The reviewer's assessment of whether an admission or continued stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines. When a Medical Director determines that an admission or continued stay at the facility is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.	**Process for Concurrent Review.** Concurrent Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan. When a PhD/Medical Director determines whether the continuing		guidelines (CDGs), and generally accepted, peer-reviewed medical literature. Based on the foregoing, the processes and evidentiary standards are comparable and no more stringently applied for MH/SUD. As written and in operation, Concurrent Review for MH/SUD benefits is comparable and applied no more stringently than that for M/S benefits.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		M/S is staffed by UnitedHealthcare clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized.** M/S staff make determinations by utilizing evidence-based medical policy and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. **Fail First/Step Therapy**	policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Fail First/Step Therapy** M/S does not apply Fail First/Step Therapy to concurrent review for outpatient benefits. **Timeframe to respond.** M/S will follow all applicable state and federal or accreditation timeframe requirements.		**Admission Notification Requirements.** Notification can be submitted via online or the telephone number on the back of the members ID card. Notification should occur as soon as reasonably possible. **Staff Qualifications.** MH/SUD personnel are clinical, non-clinical and administrative. All clinical reviews are made by clinical staff (i.e. licensed behavioral health clinicians, nurses, PhDs, physicians, etc.) and all adverse determinations are made by PhDs, physicians/Medical Directors. **Guidelines/Criteria Utilized.**	course of treatment is medically necessary, the member and provider will be notified of the determination consistent with state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements: Authorization can be obtained via online or by telephone. **Staff Qualifications.** MH/SUD personnel are clinical, non-clinical and administrative. All clinical reviews are made by clinical staff (i.e. licensed behavioral health clinicians, nurses, PhDs, physicians, etc.) and all adverse determinations are made		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		M/S does not apply Fail First/Step Therapy to Inpatient Benefits. **Timeframe to respond.** M/S will follow all applicable state and federal or accreditation timeframe requirements.			MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as InterQual. Fail First/Step Therapy MH/SUD does not apply Fail First/Step Therapy to Inpatient Benefits. **Timeframe to respond.** MH/SUD will follow all applicable state and federal or accreditation timeframe requirements.	by PhDs, physicians/Medical Directors. **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as InterQual. **Fail First/Step Therapy** MH/SUD does not apply Fail First/Step Therapy to concurrent review for outpatient benefits **Timeframe to respond.**		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
						MH/SUD will follow all applicable state and federal or accreditation timeframe requirements.		
4b	What processes, strategies, evidentiary standards, or other factors were used to develop this list?	M/S & MH/SUD both rely on evidence-based nationally recognized clinical guidelines to evaluate whether Concurrent Review is appropriate, as well as if Medical Necessity exist. For both M/S and MH/SUD, the goal of Concurrent Review is to ensure cost-effective and clinically effective treatment is delivered. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and criteria utilized for Concurrent Review are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. A cost benefit analysis is completed to determine which services are subject to concurrent review. If the	M/S & MH/SUD both rely on evidence-based nationally recognized clinical guidelines to evaluate whether Concurrent Review is appropriate, as well as if Medical Necessity exist. For both M/S and MH/SUD, the goal of Concurrent Review is to ensure cost-effective and clinically effective treatment is delivered. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and criteria utilized for Concurrent Review are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. A cost benefit analysis is completed to determine which services are subject to concurrent review. If the benefit of		M/S & MH/SUD both rely on evidence-based nationally recognized clinical guidelines to evaluate whether Concurrent Review is appropriate, as well as if Medical Necessity exist. For both M/S and MH/SUD, the goal of Concurrent Review is to ensure cost-effective and clinically effective treatment is delivered. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and criteria utilized for Concurrent Review are comparable and applied no more stringently than, those designed and applied	M/S & MH/SUD both rely on evidence-based nationally recognized clinical guidelines to evaluate whether Concurrent Review is appropriate, as well as if Medical Necessity exist. For both M/S and MH/SUD, the goal of Concurrent Review is to ensure cost-effective and clinically effective treatment is delivered. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and criteria utilized for Concurrent Review are comparable and applied no more stringently than,		Parity compliance exists because both M/S and MH/SUD utilize evidence-based nationally recognized clinical guidelines in determining whether to add or maintain a Concurrent Review requirement. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	

		benefit of concurrent review outweighs the cost correlated to the process of concurrent review (CR) then a CR process will be administered based upon client direction in accordance to the SPD.
		
		The data reviewed includes the following:
		• Average cost of treatment of procedure based upon network analysis
		• Treatment or procedure categorization of increasing or high cost driver
		• Claim quantity over set period of time (e.g., 12 month or 12 months to 36 months to show increasing trajectory of utilization)
		  o Paid versus denied claims
		• Propensity for fraud in treatment category
		• Employee cost for support of prior authorization process
		• Anticipated savings
			concurrent review outweighs the cost correlated to the process of concurrent review (CR) then a CR process will be administered based upon client direction in accordance to the SPD.
			
			The data reviewed includes the following:
			• Average cost of treatment of procedure based upon network analysis
			• Treatment or procedure categorization of increasing or high cost driver
			• Claim quantity over set period of time (e.g., 12 month or 12 months to 36 months to show increasing trajectory of utilization)
			  o Paid versus denied claims
			• Propensity for fraud in treatment category
			• Employee cost for support of prior authorization process
			• Anticipated savings
					to M/S treatment or services.
					
					A cost benefit analysis is completed to determine which services are subject to concurrent review. If the benefit of concurrent review outweighs the cost correlated to the process of concurrent review (CR) then a CR process will be administered based upon client direction in accordance to the SPD.
					
					The data reviewed includes the following:
					• Average cost of treatment of procedure based upon network analysis
					• Treatment or procedure categorization of increasing or high cost driver
					• Claim quantity over set period of time (e.g., 12 month or 12 months to 36 months to show increasing
						those designed and applied to M/S treatment or services.
						
						A cost benefit analysis is completed to determine which services are subject to concurrent review. If the benefit of concurrent review outweighs the cost correlated to the process of concurrent review (CR) then a CR process will be administered based upon client direction in accordance to the SPD.
						
						The data reviewed includes the following:
						• Average cost of treatment of procedure based upon network analysis
						• Treatment or procedure categorization of increasing or high cost driver
						• Claim quantity over set period of time
								recognized clinical guidelines.
								
								Because M/S and MH/SUD use comparable criteria and processes, Concurrent Review for MH/SUD benefits is comparable to, and applied no more stringently than, for M/S benefits.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
					trajectory of utilization) o Paid versus denied claims • Propensity for fraud in treatment category • Employee cost for support of prior authorization process • Anticipated savings	(e.g., 12 month or 12 months to 36 months to show increasing trajectory of utilization) o Paid versus denied claims • Propensity for fraud in treatment category • Employee cost for support of prior authorization process • Anticipated savings		
4c	Is the process for concurrent review the same for MH/SUD services and M/S services? Similar forms, similar medical records, etc.?	**Confirmed.** **Process for Concurrent Review.** Concurrent review usually begins on the first business day following notification. A concurrent review may be conducted by telephone, on-site, and when available, facilities can provide clinical information via access to Electronic Medical Records	**Confirmed.** **Process for Concurrent Review.** Concurrent Review for out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. If the reviewer believes that a continuing course of outpatient treatment may not be covered, the		**Confirmed.** **Process for Concurrent Review.** Concurrent review usually begins on the first business day following notification. A concurrent review may be conducted by telephone, on-site, and when available, facilities can provide clinical information via access to	**Confirmed.** **Process for Concurrent Review.** Concurrent Review for out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved		For both M/S and MH/SUD, the goal of Concurrent Review is to ensure cost-effective and clinically effective treatment is delivered. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		("EMR"). If the reviewer (a mid- level provider, such as a nurse for M/S benefits) believes that an admission or continued stay may not be covered, the facility will be asked for more information concerning the member's clinical condition, treatment and case management plan. The reviewer's assessment of whether an admission or continued stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines. When the Medical Director determines that an admission or continued stay at the facility is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and	provider will be asked for more information concerning the treatment. The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan. When the Medical Director determines whether the continuing course of treatment is medically necessary, the member and provider will be notified of the determination consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable charges. **Notification Requirements.**		Electronic Medical Records ("EMR"). If the reviewer (a mid- level provider, such as a behavioral health clinician for MH/SUD benefits) believes that an admission or continued stay may not be covered, the facility will be asked for more information concerning the member's clinical condition, treatment and case management plan. The reviewer's assessment of whether an admission or continued stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines. When a Medical Director determines that an admission or continued	and is ending. If the reviewer believes that a continuing course of outpatient treatment may not be covered, the provider will be asked for more information concerning the treatment. The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan. When a PhD/Medical Director determines whether the continuing course of treatment is medically necessary, the member and provider will be notified of the		criteria utilized for Concurrent Review are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both M/S and MH/SUD utilize evidence-based nationally recognized clinical guidelines in determining whether to add or maintain a Concurrent Review requirement. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable charges. Admission Notification Requirements. Notification can be submitted via the telephone number on the back of the members ID card. Notification should occur as soon as reasonably possible. **Staff Qualifications.** M/S is staffed by UnitedHealthcare clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized.** M/S staff make determinations by utilizing evidence-based	The plan would typically receive the service request before the current course of treatment ends. Authorization can be obtained by calling the telephone number on the members ID card. **Staff Qualifications.** M/S is staffed by UnitedHealthcare clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized.** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. Fail First/Step Therapy		stay at the facility is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable charges. Admission Notification Requirements. Notification can be submitted via the telephone number on the back of the members ID card. Notification of treatment should occur as soon as reasonably possible. **Staff Qualifications.** MH/SUD personnel are clinical, non-clinical and administrative. All clinical	determination consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable charges. **Notification Requirements.** The plan would typically receive the service request before the current course of treatment ends. Authorization can be obtained by calling the telephone number on the members ID card. **Staff Qualifications.** MH/SUD personnel are clinical, non-clinical and administrative. All clinical reviews are made by clinical staff (i.e.		pursuant to applicable nationally recognized clinical guidelines.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		medical policy and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay.	M/S does not apply Fail First/Step Therapy to concurrent review for outpatient benefits. **Timeframe to respond.** M/S will follow all applicable state and federal or accreditation timeframe requirements.		reviews are made by clinical staff (i.e. licensed behavioral health clinicians, nurses, PhDs, physicians, etc.) and all adverse determinations are made by PhDs, physicians/Medical Directors. **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as InterQual. Fail First/Step Therapy MH/SUD does not apply Fail First/Step Therapy to Inpatient Benefits.	licensed behavioral health clinicians, nurses, PhDs, physicians, etc.) and all adverse determinations are made by PhDs, physicians/Medical Directors. **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as InterQual. Fail First/Step Therapy MH/SUD does not apply Fail First/Step Therapy to concurrent review for outpatient benefits.		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
					Timeframe to respond. MH/SUD will follow all applicable state and federal or accreditation timeframe requirements.	**Timeframe to respond.** MH/SUD will follow all applicable state and federal or accreditation timeframe requirements.		
4d	How frequently are concurrent reviews conducted?	Concurrent Review for both in network and out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. If the reviewer believes that a continuing course of inpatient treatment may not be covered, the provider will be asked for more information concerning the treatment. The criteria used to determine which services require concurrent review is based on the need for continued treatment beyond the initial authorization. Concurrent review is performed for	Concurrent Review for both in network and out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. If the reviewer believes that a continuing course of outpatient treatment may not be covered, the provider will be asked for more information concerning the treatment. The criteria used to determine which services require concurrent review is based on the need for continued treatment beyond the initial authorization. Concurrent review is performed for inpatient admissions when there is an extended length of stay.		Concurrent Review for both in network and out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. If the reviewer believes that a continuing course of inpatient treatment may not be covered, the provider will be asked for more information concerning the treatment. The criteria used to determine which services require concurrent review	Concurrent Review for both in network and out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. If the reviewer believes that a continuing course of outpatient treatment may not be covered, the provider will be asked for more information concerning the treatment. The criteria used to determine which services require concurrent		Parity compliance exists because both M/S and MH/SUD utilize evidence-based nationally recognized clinical guidelines in determining whether to add or maintain a Concurrent Review requirement. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		inpatient admissions when there is an extended length of stay. The Medical Director and other clinical staff review hospitalizations to determine whether the admission and continued stay are consistent with the member's coverage, are medically appropriate and consistent with evidence-based guidelines. The frequency of inpatient concurrent review is determined by nationally recognized criteria such as: InterQual, UHC medical policies, Medical Director review and NCCN guidelines.	The Medical Director and other clinical staff review hospitalizations to determine whether the admission and continued stay are consistent with the member's coverage, are medically appropriate and consistent with evidence-based guidelines. The frequency of inpatient concurrent review is determined by nationally recognized criteria such as: InterQual, UHC medical policies, Medical Director review and NCCN guidelines.		is based on the need for continued treatment beyond the initial authorization. Concurrent review is performed for inpatient admissions when there is an extended length of stay. The Medical Director and other clinical staff review hospitalizations to determine whether the admission and continued stay are consistent with the member's coverage, are medically appropriate and consistent with evidence-based guidelines. The frequency of inpatient concurrent review is determined by nationally recognized criteria such as: InterQual, UHC medical policies, and Medical Director review.	review is based on the need for continued treatment beyond the initial authorization. Concurrent review is performed for inpatient admissions when there is an extended length of stay. The Medical Director and other clinical staff review hospitalizations to determine whether the admission and continued stay are consistent with the member's coverage, are medically appropriate and consistent with evidence-based guidelines. The frequency of inpatient concurrent review is determined by nationally recognized criteria such as: InterQual, UHC medical policies, and Medical Director review.		pursuant to applicable nationally recognized clinical guidelines.
4e	Is a review of medical	Confirmed. Parity compliance exists because both M/S and	Confirmed. Parity compliance exists because both M/S and		Confirmed. Parity compliance exists because	Confirmed. Parity compliance exists		For both M/S and MH/SUD, the goal of Concurrent

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
	necessity conducted during the concurrent review process?	MH/SUD utilize evidence-based nationally recognized clinical guidelines in determining whether to add or maintain a Concurrent Review requirement. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally recognized clinical guidelines. We require the following details for concurrent review: •Customer name and Customer health care ID number •Facility name and TIN or NPI •Admitting/attending physician name and TIN or NPI •Description for admitting diagnosis or •ICD-9-CM (or its successor) diagnosis code •Actual admission date. •Clinical information/documentation	MH/SUD utilize evidence-based nationally recognized clinical guidelines in determining whether to add or maintain a Concurrent Review requirement. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally recognized clinical guidelines. We require the following details for concurrent review: •Customer name and Customer health care ID number •Facility name and TIN or NPI •Admitting/attending physician name and TIN or NPI •Description for admitting diagnosis •ICD-9-CM (or its successor) diagnosis code •Actual admission date. •Clinical information/documentation The above information is used to determine if a continued stay is medically necessary by applying medical necessity criteria using		both M/S and MH/SUD utilize evidence-based nationally recognized clinical guidelines in determining whether to add or maintain a Concurrent Review requirement. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally recognized clinical guidelines. We require the following details for concurrent review: •Customer name and Customer health care ID number •Facility name and TIN or NPI •Admitting/attending physician name and TIN or NPI •Description for admitting diagnosis	because both M/S and MH/SUD utilize evidence-based nationally recognized clinical guidelines in determining whether to add or maintain a Concurrent Review requirement. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally recognized clinical guidelines. We require the following details for concurrent review: •Customer name and Customer health care ID number •Facility name and TIN or NPI •Admitting/attending physician name and TIN or NPI		Review is to ensure cost-effective and clinically effective treatment is delivered at the right time and in the right clinical setting to achieve a positive clinical outcome. The processes and criteria utilized for Concurrent Review of MH/SUD treatments or services are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both M/S and MH/SUD utilize evidence-based nationally recognized clinical guidelines when applying

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		The above information is used to determine if a continued stay is medically necessary by applying medical necessity criteria using InterQual, NCCN, FDA or UHC guidelines. The outcome of the review would then allow the claim to process appropriately.	InterQual, NCCN, FDA or UHC guidelines. The outcome of the review would then allow the claim to process appropriately.		•ICD-9-CM (or its successor) diagnosis code •Actual admission date. •Clinical information/documentation The above information is used to determine if a continued stay is medically necessary by applying medical necessity criteria using InterQual, or UHC guidelines. The outcome of the review would then allow the claim to process appropriately.	•Description for admitting diagnosis •ICD-9-CM (or its successor) diagnosis code •Actual admission date. •Clinical information/documentation The above information is used to determine if a continued stay is medically necessary by applying medical necessity criteria using InterQual, or UHC guidelines. The outcome of the review would then allow the claim to process appropriately.		Concurrent Review requirements. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally recognized clinical guidelines. The processes andevidentiary standards designed and applied by MH/SUD for Concurrent Review are comparable to those designed and applied by M/S, as both follow all applicable state and federal guidelines for the service. The suggested timeframes are comparable, and

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								no more stringent for MH/SUD, as M/S and MH/SUD should notify as soon as reasonably possible. After completing the parity compliance steps and reviewing all responses both written and in operation, we have established that the MHPAEA's comparability requirements are satisfied. The plan conducted a comparison analysis of the narrative descriptions of its concurrent care review processes and strategies (referenced within step 1), as well as

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								its narrative description of its methodology for determining which M/S services and which MH/SUD services within each classification of benefits are subject to concurrent care review requirements (referenced within step 3) in order to assess whether they complied with MHPAEA **"as written."** The findings revealed the processes and strategies for applying concurrent review to MH/SUD services within each classification of benefits "as written" were in fact comparable to, and applied no more stringently than, the

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								processes and strategies used to apply concurrent care review requirements to M/S within each classification of benefits. Therefore, as noted above, the concurrent review process for MH/SUD is comparable to, and no more stringently applied, than for M/S.
5								
5a	What services, conditions, treatment, etc., are included in the retrospective review process?	Services reviewed through Retrospective Review Services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge.	Services reviewed through Retrospective Review Services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge.	Prior Authorization, Concurrent Review and Retrospective Review are not performed on Emergency Services.	Services reviewed through Retrospective Review Services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge	Services reviewed through Retrospective Review Services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge	Prior Authorization, Concurrent Review and Retrospective Review are not performed on Emergency Services.	For both M/S and MH/SUD, the goal of Retrospective Review is to ensure that the treatment or services provided were appropriate for the member's need, and consistent with

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		A list standard requiring prior authorization for medical includes: Inpatient Hospitalization Inpatient Maternity stays over 48 hours for normal delivery and 96 hours for C-section Transplant and Transplant related services Skilled Nursing Facility (extended care facilities) Home Health Care Durable Medical Equipment (excludes braces, orthotics and supplies) $500 for rental $1500 for purchase $1000 for prosthetics Clinical Trials (services related to the clinical trial)	A list standard requiring prior authorization for medical includes: Inpatient Hospitalization Inpatient Maternity stays over 48 hours for normal delivery and 96 hours for C-section Transplant and Transplant related services Skilled Nursing Facility (extended care facilities) Home Health Care Durable Medical Equipment (excludes braces, orthotics and supplies) $500 for rental $1500 for purchase $1000 for prosthetics Clinical Trials (services related to the clinical trial)		A list of standard requiring prior authorization for BH/SUD includes: Inpatient Hospitalization Inpatient Behavioral Health (acute care) Residential Treatment Partial Hospitalization Program Clinical Trials (services related to the clinical trial) Specialty injectables covered under the medical plan Specialty Injectable | UMR (umrwebapps.com) **Why does the Plan conduct Retrospective Reviews?** Retrospective Review is a component of Optum's utilization management program. A Medical Director and other clinical	A list of standard requiring prior authorization for BH/SUD includes: Inpatient Hospitalization Inpatient Behavioral Health (acute care) Residential Treatment Partial Hospitalization Program Clinical Trials (services related to the clinical trial) Specialty injectables covered under the medical plan Specialty Injectable | UMR (umrwebapps.com) **Why does the Plan conduct Retrospective Reviews?** Retrospective Review is a component of Optum's		the plan guidelines regarding coverage and medical appropriateness. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and criteria utilized for Retrospective Review are the same, and therefore, comparable for MH/SUD and M/S because. Retrospective Review is used to detect and better manage over- and under-utilization and to determine whether the service or item, reviewed retrospectively is: 1) consistent with the member's

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Bariatric Surgery (if a covered benefit) Chemotherapy (cancer diagnosis) Dialysis Specialty injectables covered under the medical plan Specialty Injectable | UMR (umrwebapps.com) **Why does the Plan conduct Retrospective Reviews?** Retrospective Review is a component of UnitedHealthcare's utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons: to detect and better manage over- and under-utilization;	Bariatric Surgery (if a covered benefit) Chemotherapy (cancer diagnosis) Dialysis Specialty injectables covered under the medical plan Specialty Injectable | UMR (umrwebapps.com) **Why does the Plan conduct Retrospective Reviews?** Retrospective Review is a component of UnitedHealthcare's utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons: to detect and better manage over- and under-utilization; to determine whether the services reviewed are—		staff review hospitalizations and other inpatient admissions, for the following reasons: to detect and better manage over- and under-utilization; to determine whether the services reviewed are— consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. **Process for Retrospective Review.** Pre-Claim Retrospective Review(Plan receives notification post discharge) – the Plan performs a pre-claim retrospective review, for certain inpatient in-network cases, starting with the first day of the admission if the in-network	utilization management program. A Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons: to detect and better manage over- and under-utilization; to determine whether the services reviewed are— consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. **Process for Retrospective Review.** Pre-Claim Retrospective Review (Plan receives		coverage, 2) medically appropriate, and 3) consistent with evidence-based guidelines. Accordingly, the process for performing Retrospective Review for M/S and MH/SUD inpatient benefits for the applicable benefit classifications is comparable. From a stringency perspective, both M/S and MH/SUD reviews are initiated similarly in that Retrospective Review of inpatient in-network benefits are initiated when

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		to determine whether the services reviewed are— consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. **Process for Retrospective Review.** Pre-Claim Retrospective Review (Plan receives notification post discharge) – the Plan performs a pre-claim retrospective review, for certain inpatient in-network cases, starting with the first day of the admission if the in-network facility did not notify the Plan or seek prior authorization for an admission and provides extenuating circumstances for a late notification of inpatient admissions. This review is conducted unless post-discharge review is prohibited by hospital contract. Notification of all	consistent with the member's coverage, medically appropriate, and consistent with evidence-based guidelines. **Process for Retrospective Review.** Pre-Claim Retrospective Review (Plan receives notification post discharge) – the Plan performs a pre-claim retrospective review, for certain inpatient in-network cases, starting with the first day of the admission if the in-network facility did not notify the Plan or seek prior authorization for an admission and provides extenuating circumstances for a late notification of inpatient admissions. This review is conducted unless post-discharge review is prohibited by hospital contract. Notification of all review outcomes is communicated in accordance with applicable state, federal or		facility did not notify the Plan or seek prior authorization for an admission and provides extenuating circumstances for a late notification of inpatient admissions. This review is conducted unless post-discharge review is prohibited by hospital contract. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. **Post-Claim Retrospective Review.** If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. The Plan will review the case on appeal for medical	notification post discharge) – the Plan performs a pre-claim retrospective review, for certain inpatient in-network cases, starting with the first day of the admission if the in-network facility did not notify the Plan or seek prior authorization for an admission and provides extenuating circumstances for a late notification of inpatient admissions. This review is conducted unless post-discharge review is prohibited by hospital contract. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided.		the Plan is notified of the inpatient stay after discharge and Retrospective Review of inpatient benefits is initiated when the Plan receives a claim or request for authorization (when prior authorization is required) post-service. Further, the Retrospective Reviews applied to MH/SUD benefits are less stringent than for M/S benefits because behavioral health conducts a medical necessity review if mitigating circumstances exits. Thus, in each classification, as written and in operation,

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. **Post-Claim Retrospective Review.** If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, if the in-network facility/physician has the med-nec addendum, the provider can request a medical necessity review post claim. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements by online or telephone for Pre-Claim Retrospective Review. For	accreditation requirements and applicable appeal rights are provided. **Post-Claim Retrospective Review.** If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, if the in-network facility/physician has the med-nec addendum, the provider can request a medical necessity review post claim. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements by online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can		necessity for all contracted providers Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements by online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Staff Qualifications.** MH/SUD personnel are clinical, non-clinical and administrative. All clinical reviews are made by clinical staff (i.e. licensed behavioral health	**Post-Claim Retrospective Review.** If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. The Plan will review the case on appeal for medical necessity for all contracted providers Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided. Notification Requirements by online or telephone for Pre-Claim Retrospective Review.		Retrospective Review for MH/SUD benefits is applied no more stringently (and in some instances less stringently) than that M/S benefits.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Staff Qualifications.** M/S is staffed by UnitedHealthcare clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized.** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Timeframe to respond.**	notify the plan via phone, on-line or mail. **Staff Qualifications.** M/S is staffed by UnitedHealthcare clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized.** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Timeframe to respond.** M/S will follow all applicable state, federal or accreditation timeframe requirements.		clinicians, nurses, PhDs, physicians, etc.) and all adverse determinations are made by PhDs, physicians/Medical Directors. **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as InterQual. **Timeframe to respond.** MH/SUD will follow all applicable state, federal or accreditation timeframe requirements.	For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Staff Qualifications.** MH/SUD personnel are clinical, non-clinical and administrative. All clinical reviews are made by clinical staff (i.e. licensed behavioral health clinicians, nurses, PhDs, physicians, etc.) and all adverse determinations are made by PhDs, physicians/Medical Directors. **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy,		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		M/S will follow all applicable state, federal or accreditation timeframe requirements.				standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as InterQual. **Timeframe to respond.** MH/SUD will follow all applicable state, federal or accreditation timeframe requirements.		
5b	What processes, strategies, evidentiary standards, or other factors were used to develop this list?	Determining the med/surg inpatient benefits that concurrent review is applied, UMR and UHC conducts a cost-benefit analysis based upon the specific factors: Projected savings Cost of the staff to support concurrent review for the treatment type	Determining the med/surg outpatient benefits that concurrent review is applied, UMR and UHC conducts a cost-benefit analysis based upon the specific factors: Projected savings Cost of the staff to support concurrent review for the treatment type Treatment types that have higher incidents of fraud, waste or abuse		Determining the BH/SUD inpatient benefits that concurrent review is applied, UMR and UHC conducts a cost-benefit analysis based upon the specific factors: Projected savings Cost of the staff to support concurrent review for the treatment type	Determining the BH/SUD outpatient benefits that concurrent review is applied, UMR and UHC conducts a cost-benefit analysis based upon the specific factors: Projected savings Cost of the staff to support concurrent		determine whether the service or item, reviewed retrospectively is: 1) consistent with the member's coverage, 2) medically appropriate, and 3) consistent with evidence-based guidelines. Accordingly, the

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Treatment types that have higher incidents of fraud, waste or abuse Claim volume for treatment type including pain/denied claim status Inconsistency in cost and utilization in accordance with diagnosis, treatment, geographic area, and provider specialty Determination if treatment is a category of cost progression Total rate of procedure and/or treatment	Claim volume for treatment type including pain/denied claim status Inconsistency in cost and utilization in accordance with diagnosis, treatment, geographic area, and provider specialty Determination if treatment is a category of cost progression Total rate of procedure and/or treatment		Treatment types that have higher incidents of fraud, waste or abuse Claim volume for treatment type including pain/denied claim status Inconsistency in cost and utilization in accordance with diagnosis, treatment, geographic area, and provider specialty Determination if treatment is a category of cost progression Total rate of procedure and/or treatment	review for the treatment type Treatment types that have higher incidents of fraud, waste or abuse Claim volume for treatment type including pain/denied claim status Inconsistency in cost and utilization in accordance with diagnosis, treatment, geographic area, and provider specialty Determination if treatment is a category of cost progression Total rate of procedure and/or treatment		process for performing Retrospective Review for M/S and MH/SUD inpatient benefits for the applicable benefit classifications is comparable. For both M/S and MH/SUD, the goal of Retrospective Review is to ensure that the treatment or services provided were appropriate for the member's need, and consistent with the plan guidelines regarding coverage and medical appropriateness. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								criteria utilized for Retrospective Review are the same, and therefore, comparable for MH/SUD and M/S because. Retrospective Review is used to detect and better manage over- and under-utilization and toFrom a stringency perspective, both M/S and MH/SUD reviews are initiated similarly in that Retrospective Review of inpatient in-network benefits are initiated when the Plan is notified of the inpatient stay after discharge and Retrospective Review of inpatient benefits is initiated when the Plan receives a

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								claim or request for authorization (when prior authorization is required) post-service. Further, the Retrospective Reviews applied to MH/SUD benefits are less stringent than for M/S benefits because behavioral health conducts a medical necessity review if mitigating circumstances exits. Thus, in each classification, as written and in operation, Retrospective Review for MH/SUD benefits are applied no more stringently (and in some instances less stringently) than that M/S benefits.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
5c	Is the process for retrospective review the same for MH/SUD services and M/S services? Similar forms, similar medical records, etc.?	Confirmed. The process is similar for BH/SUD and Medical retrospective reviews.	Confirmed. The process is similar for BH/SUD and Medical retrospective reviews.		Confirmed. The process is similar for BH/SUD and Medical retrospective reviews.	Confirmed. The process is similar for BH/SUD and Medical retrospective reviews.		Both M/S and MH/SUD utilize similar sources for evidentiary standards; Professionally recognized treatment guidelines and state specific evidentiary standards as required. Therefore, the MHPAEA's comparability requirements are satisfied.
6	**Medical Necessity**							
6a	What sources/ guidelines are used to determine medical necessity?	The medical plan uses MCG Care Guidelines or other guidelines, which are nationally recognized, to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. The medical plan clinical criteria	The medical plan uses MCG Care Guidelines or other guidelines, which are nationally recognized, to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. The medical plan clinical criteria can be		UMR uses guidelines based on nationally recognized clinical guidelines, to assist clinicians in making informed decisions. This includes acute and sub-acute behavioral treatment. UMR's clinical criteria can be requested from the case reviewer. Other criteria may be used in situations	UMR uses guidelines based on nationally recognized clinical guidelines, to assist clinicians in making informed decisions. This includes acute and sub-acute behavioral treatment. UMR's clinical criteria can be requested from the case reviewer. Other criteria		Since both M/S and MH/SUD Guidelines/Criteria Utilized are both utilizing evidence-based medical policies, guidelines and criteria the MHPAEA's comparability requirements are satisfied.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		can be requested from the case reviewer. Criteria other than MCG Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay.	requested from the case reviewer. Criteria other than MCG Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay.		when published peer-reviewed literature or guidelines are available form nationally specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay.	may be used in situations when published peer-reviewed literature or guidelines are available form nationally specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay.		Since both M/S and MH/SUD both perform an annual review by committee to leverage and update policies and Membership contains both M/S and MH/SUD staff, this is comparable. In addition, there is additional detailed information in the Medical Necessity document that outlines the process in greater detail.
7								
7a	Describe the process and criteria used to admit professional providers into your network.	All providers in the state of West Virginia and contiguous counties are considered in network accepting the West Virginia PEIA fee schedule. For the UHC network outside of the state of West Virginia and the contiguous counties, the Plan uses the credentialing and recredentialing process to ensure its network of contracted providers, who require credentialing, and providers seeking to join the Plan's network, have the appropriate level of education/licensure/certification and satisfy additional qualifications in order to provide care to Plan members. To do this, the Plan applies the following factors to determine whether to credential a provider or facility, or, in other words, to determine whether			All providers in the state of West Virginia and contiguous counties are considered in network accepting the West Virginia PEIA fee schedule. For the UHC network outside of the state of West Virginia and the contiguous counties, the Plan uses the credentialing and recredentialing process to ensure its network of contracted providers, who require credentialing, and providers seeking to join the Plan's network, have the appropriate level of education/licensure/certification and satisfy additional qualifications in order to provide care to Plan members. To do this, the Plan applies the following factors to determine whether to credential a provider		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		they meet the standards to join, or maintain their status in, the Plan's network of participating providers: • The provider or facility completes and attests to the accuracy of the content of the application. • The Plan verifies certain information in the application; and • The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan. Credentialing generally is not required for health care professionals who are permitted to furnish services only under the direct supervision of another provider or for hospital-based or facility-based health care professionals who provide services to members incidental to hospital or facility services.			or facility, or, in other words, to determine whether they meet the standards to join, or maintain their status in, the Plan's network of participating providers: • The provider or facility completes and attests to the accuracy of the content of the application. • The Plan verifies certain information in the application; and • The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan. Credentialing generally is not required for health care professionals who are permitted to furnish services only under the direct supervision of another provider or for hospital-based or facility-based health care professionals who provide services to members incidental to hospital or facility services.		
7b	Describe the process and criteria used to admit institutional providers into your network.	All facilities in the state of West Virginia and contiguous counties are considered in network accepting the West Virginia PEIA fee schedule. For the UHC network outside of the state of West Virginia and the contiguous counties, the Plan uses the credentialing and recredentialing process to ensure its network of contracted providers, who require credentialing, and providers seeking to join the Plan's network, have the appropriate level of education/licensure/certification and satisfy additional qualifications in order to provide care to Plan members. To do this, the Plan applies the following factors to determine whether to credential a provider or facility, or, in other words, to determine whether they meet the standards to join, or maintain their status in, the Plan's network of participating providers: • The provider or facility completes and attests to the accuracy of the content of the application.			PEIA has an open network in West Virginia and contiguous counties are considered in network accepting the West Virginia PEIA schedule. For the UHC network outside of the state of West Virginia and the contiguous counties, the Plan uses the credentialing and recredentialing process to ensure its network of contracted providers, who require credentialing, and providers seeking to join the Plan's network, have the appropriate level of education/licensure/certification and satisfy additional qualifications in order to provide care to Plan members. To do this, the Plan applies the following factors to determine whether to credential a provider or facility, or, in other words, to determine whether they meet the standards to join, or maintain their status in, the Plan's network of participating providers: • The provider or facility completes and attests to the accuracy of the content of the application. • The Plan verifies certain information in the application; and		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		• The Plan verifies certain information in the application; and • The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan. Credentialing generally is not required for health care professionals who are permitted to furnish services only under the direct supervision of another provider or for hospital-based or facility-based health care professionals who provide services to members incidental to hospital or facility services.			• The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan. Credentialing generally is not required for health care professionals who are permitted to furnish services only under the direct supervision of another provider or for hospital-based or facility-based health care professionals who provide services to members incidental to hospital or facility services.			
7c	What is the credentialing criteria for Skilled Nursing Facilities and Residential Treatment Centers?	All facilities in the state of West Virginia and contiguous counties are considered in network accepting the West Virginia PEIA fee schedule. For the UHC network outside of the state of West Virginia and the contiguous counties, the Plan uses the credentialing and recredentialing process to ensure its network of contracted providers, who require credentialing, and providers seeking to join the Plan's network, have the appropriate level of education/licensure/certification and satisfy additional qualifications in order to provide care to Plan members. To do this, the Plan applies the following factors to determine whether to credential a provider or facility, or, in other words, to determine whether they meet the standards to join, or maintain their status in, the Plan's network of participating providers: The provider or facility completes and attests to the accuracy of the content of the application. The Plan verifies certain information in the application; and The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan. Credentialing generally is not required for health care professionals who are permitted to furnish services only under the direct supervision of another provider or for hospital-based or facility-based health care professionals who provide services to members' incidental to hospital or facility services. The Plan does not credential unlicensed providers. The Plan uses			Inpatient programs and outpatient partial hospitalization day programs for mental health, chemical dependency and substance abuse are covered when medically necessary. Facilities willing to accept the PEIA fee schedule in the State of WV, credentialed to provide requested service, and are unrestricted to provide services are considered In Network. For the UHC network outside of the state of West Virginia and the contiguous counties, the Plan uses the credentialing and recredentialing process to ensure its network of contracted providers, who require credentialing, and providers seeking to join the Plan's network, have the appropriate level of education/licensure/certification and satisfy additional qualifications in order to provide care to Plan members. To do this, the Plan applies the following factors to determine whether to credential a provider or facility, or, in other words, to determine whether they meet the standards to join, or maintain their status in, the Plan's network of participating providers: The provider or facility completes and attests to the accuracy of the content of the application.			For the UHC plan outside of West Virginia and the contiguous counties, the Plan uses the credentialing and recredentialing process to ensure its network of contracted physicians, and physicians seeking to join the Plan's network, have the appropriate level of education/licensure /certification and satisfy additional qualifications in

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		credentialing processes and plans based on NCQA standards and applicable state or Federal regulatory requirements when determining whether to credential a provider for both M/S and MH/SUD providers and facilities. To successfully complete the credentialing process, both M/S and MH/SUD providers must meet the baseline criteria as applicable to the State and practicing specialty, which can be found in the UnitedHealthcare Credentialing-Plan-State and Federal Regulatory-Addendum Individual (and certain facility-based) providers must complete the CAQH application and applicable attestation. The Plan verifies the following credentialing requirements within NCQA timeframes. Required medical or professional degrees or training, including any additional post-graduate education or training within the scope of practice (e.g., a fellowship, etc.); Current unrestricted licensure and/or certification; Valid DEA certificate, Controlled Substance Certificate (CSC) or acceptable substitute; Absence of Medicare/Medicaid sanctions; Five-year work history with an explanation of gaps greater than 6-months; Proof of insurance or state-approved alternative; Malpractice history for the past five years; Absence of sanctions or limitations on licensure; Status of hospital privileges, if applicable; No prior denials or terminations within the past 24 months; On recredentialing, data from any quality improvement activities;			The Plan verifies certain information in the application; and The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan. Credentialing generally is not required for health care professionals who are permitted to furnish services only under the direct supervision of another provider or for hospital-based or facility-based health care professionals who provide services to members' incidental to hospital or facility services. The Plan does not credential unlicensed providers. The Plan uses credentialing processes and plans based on NCQA standards and applicable state or Federal regulatory requirements when determining whether to credential a provider for both M/S and MH/SUD providers and facilities. To successfully complete the credentialing process, both M/S and MH/SUD providers must meet the baseline criteria as applicable to the State and practicing specialty, which can be found in [United Behavioral Health Clinician and Facility Credentialing Plan Individual (and certain facility-based) providers must complete the CAQH application and applicable attestation. The Plan verifies the following credentialing requirements within NCQA timeframe. Required medical or professional degrees or training, including any additional post-graduate education or training within the scope of practice (e.g., a fellowship, etc.); Current unrestricted licensure and/or certification;			order to provide care to Plan members. As detailed in the accompanying columns, the Plan uses credentialing processes and plans based on National Committee for Quality Assurance (NCQA) accreditation standards and applicable state or Federal regulatory requirements when determining whether to credential a provider for both M/S and MH/SUD providers and facilities.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Affirmative responses to disclosure questions on the application.			Valid DEA certificate, Controlled Substance Certificate (CSC) or acceptable substitute; Absence of Medicare/Medicaid sanctions; Five-year work history with an explanation of gaps greater than 6-months; Proof of insurance or state-approved alternative; Malpractice history for the past five years; Absence of sanctions or limitations on licensure; Status of hospital privileges, if applicable; No prior denials or terminations within the past 24 months; On recredentialing, data from any quality improvement activities; Affirmative responses to disclosure questions on the application.			The Plan also has similar governance structures and follows similar processes for credentialing new and recredentialing existing physicians, delegated credentialing, and the ongoing monitoring of existing providers. As such, comparable processes are used to credential physicians interested in joining the Plan's networks for MH/SUD and M/S. Therefore, the test of comparability is met.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								Credentialing criteria are not applied more stringently to MH/SUD benefits under the Plan as written and in operation because both MH/SUD and M/S require physicians verify the same information before credentialing a physician.
8								
8a	Does your organization impose any limitations on network participation ?	West Virginia PEIA has an open network. Outside of West Virginia and the contiguous counties, our standard is to ensure that our access standards are met. In some instances where access is met, there may be a determination that the network would be closed, and we would allow access as needed.			For individual BH/SUD providers, PEIA has an open network. Outside of West Virginia and the contiguous counties, Optum Behavioral Health has an open network			M/S and MH/SUD share a network contracting aim of ensuring access to appropriate care. Specifically, with regard to open and closed networks, M/S and MH/SUD have an open network, although

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								M/S may close parts of the network, if needed. Therefore, the test of comparability is met. And because MH/SUD, unlike M/S, maintains an open network without such exception, the MH/SUD plan is designed and applied in a no more stringent manner than the M/S plan. Therefore, parity compliant exists with regard to open and closed networks.
8b	How does your organization determine network adequacy?	UnitedHealthcare Network Management will maintain and monitor the existing Employer and Individual (E&I) network to continually evaluate critical network variations and identify strategies to fix such variations on a monthly basis.			Availability of providers is assessed via the national network audit program. Critical data elements audited include: Participating status with Tax ID, Name, License type/Specialty, Gender, Practice Addresses, Appointment Phone Numbers, and Accepting New Patients Status.			
9								

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
9a	**In-Network Reimbursement:** Describe your reimbursement methodology, specifically the type of payment (e.g., fee-for-service, case rate, DRG, etc.).	With the 2006 OPPS update, PEIA established a goal that all hospitals reimbursed through OPPS would have their rates set at 111% of Medicare's rates. There was a transition of this reimbursement change over a 3-year period, beginning with calendar year 2006. In February 2008, the third year of the transition, hospital rates were set at 111% of Medicare's rates completing the transition. Annual updates to the conversion faction will continue. In addition to the annual update of the conversion factor, there are also quarterly updates to the OPPS grouper used to assign APCs. Updates include changes initiated by CMS such as adjustments to the status codes assigned to each APC. OPPS rates have been updated. Below is a summary of the changes that were effective January 2019: 1. For CY2019, the fixed dollar threshold is $4825. The multiple thresholds does not change, therefore, the new outlier threshold is the maximum of 1.75 * APC_Pay and APC_Pay + $4825. 2. The statewide conversion factor (CF) has been set at $88.23. 3. The quarterly update will be loaded by mid-January 2019. Hospitals reimbursed through OPPS continue to have their rates set at 111% of Medicare's rates. Under West Virginia Public Payers' prospective payment system (PPS), payments are made prospectively on a per-DRG basis. We follow Medicare's definition of inpatient services as the basis for the standardized payment amount for operating costs. The following is a list of inpatient services as defined by Medicare: • bed and board • Nursing services and other related services, medical social services that are ordinarily furnished by the hospital for the care and treatment of inpatients; • drugs, biological, supplies, appliances, and equipment, for use in the hospital for the care and treatment of inpatients; • diagnostic or therapeutic items or services, furnished by the hospital; • physical therapy, occupational and speech therapy. Operating costs of inpatient hospital services, which includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services, are included in the standardized operating payment amount under the prospective payment system. The standardized payment amount also includes malpractice costs, costs of prosthetic devices, costs of independent laboratory services and other services related to the admission. In addition, costs from the following ancillary departments are also included in the standardized operating amount: operating rooms, radiology, medical supplies, laboratory, pharmacy, anesthesia, oxygen therapy, physical and occupational therapies, speech pathology, electrocardiology, electroencephalography, and renal dialysis.			With the 2006 OPPS update, PEIA established a goal that all hospitals reimbursed through OPPS would have their rates set at 111% of Medicare's rates. There was a transition of this reimbursement change over a 3-year period, beginning with calendar year 2006. In February 2008, the third year of the transition, hospital rates were set at 111% of Medicare's rates completing the transition. Annual updates to the conversion faction will continue. In addition to the annual update of the conversion factor, there are also quarterly updates to the OPPS grouper used to assign APCs. Updates include changes initiated by CMS such as adjustments to the status codes assigned to each APC. Updates include changes initiated by CMS such as adjustments to the status codes assigned to each APC. OPPS rates have been updated. Below is a summary of the changes that were effective January 2019: 1. For CY2019, the fixed dollar threshold is $4825. The multiple thresholds does not change, therefore, the new outlier threshold is the maximum of 1.75 * APC_Pay and APC_Pay + $4825. 2. The statewide conversion factor (CF) has been set at $88.23. 3. The quarterly update will be loaded by mid-January 2019. Hospitals reimbursed through OPPS continue to have their rates set at 111% of Medicare's rates. Under West Virginia Public Payers' prospective payment system (PPS), payments are made prospectively on a per-DRG basis. We follow Medicare's definition of inpatient services as the basis for the standardized payment amount for operating costs. The following is a list of inpatient services as defined by Medicare: • bed and board • Nursing services and other related services, medical social services that are ordinarily furnished by the hospital for the care and treatment of inpatients; • drugs, biological, supplies, appliances, and equipment, for use in the hospital for the care and treatment of inpatients; • diagnostic or therapeutic items or services, furnished by the hospital; • physical therapy, occupational and speech therapy. Operating costs of inpatient hospital services, which includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services, are included		Both M/S and MH/SUD services and treatments use the same methodology for determining in-network provider reimbursements, the MHPAEA comparability requirements are satisfied.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Reimbursement for UHC in-network individual providers and facilities are determined through a negotiated process. During contract negotiations, the Plan applies the following factors to determine reimbursement for in-network providers: • Applicable CMS or other rate-setting methodology and benchmark reimbursement data for the provider type; • Member access by geography and specialty; • Impact on total medical cost relative to market and affordability; • Market dynamics, including provider leverage, competitor networks, scarcity of provider type in the market, and the need for provider type in network; • Quality and efficiency; and/or • Provider type (rates may be adjusted for specialists, higher acuity facility types or non-physician provider types like physician assistants or social workers). While some variation may exist for all services, in-network provider reimbursement is generally based on external rate sources for services provided by the same provider type in the same geography and the additional negotiation factors and data points discussed more fully below. In setting in-network provider reimbursement, the Plan utilizes/analyzes the Centers for Medicare & Medicaid Services (CMS) reimbursement rates and benchmark data by provider/facility type. 1. Individual or Group Professional Care Providers. Individual or group professional care providers, who provide services in an inpatient, outpatient, or office setting, the Plan uses CMS's resource-based relative value scale ("RVRBS") methodology as a base to negotiate fee schedules with physicians. The Plan creates template fee schedule documents based on this payment methodology. Ultimately, rates are negotiated based on the factors identified. When CMS rates are not available for a given code, other sources are used by the Plan to assess the relativities and ensure consistent alignment. The other data and information sources can include third-party resources, like the FairHealth database and rates/relativities obtained through studies from third-party vendors, discussion with internal subject-matter experts on the services and other market information. Default fee schedules are developed by geography typically at a state level. These schedules are routinely updated to ensure the CMS relativities by code are current and relevant to each			in the standardized operating payment amount under the prospective payment system. The standardized payment amount also includes malpractice costs, costs of prosthetic devices, costs of independent laboratory services and other services related to the admission. In addition, costs from the following ancillary departments are also included in the standardized operating amount: operating rooms, radiology, medical supplies, laboratory, pharmacy, anesthesia, oxygen therapy, physical and occupational therapies, speech pathology, electrocardiology, electroencephalography, and renal dialysis. Reimbursement for UHC in-network individual providers and facilities are determined through a negotiated process. During contract negotiations, the Plan applies the following factors to determine reimbursement for in-network providers: • Applicable CMS or other rate-setting methodology and benchmark reimbursement data for the provider type; • Member access by geography and specialty; 3) Impact on total medical cost relative to market and affordability; • Market dynamics, including provider leverage, competitor networks, scarcity of provider type in the market, and the need for provider type in network; • Quality and efficiency; and/or • Provider type (rates may be adjusted for specialists, higher acuity facility types or non-physician provider types like physician assistants or social workers). While some variation may exist for all services, in-network provider reimbursement is generally based on external rate sources for services provided by the same provider type in the same geography and the additional negotiation factors and data points discussed more fully below. In setting in-network provider reimbursement, the Plan utilizes/analyzes the		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		specialty. The default fee schedules are set at a competitive rate level that other similar medical professionals have accepted in the past and are reasonably expected to accept to participate in the Plan's network in the future. As a result, default fee schedules generally are set below the mean or median rates because those rates are influenced by provider leverage/negotiation. Only new providers get the benefit of an updated base fee schedule. While, existing contracted providers will stay on the same fee schedule or payment appendix originally negotiated unless or until they decide to renegotiate. 2. Facilities. For Med/Surg facilities—or in-network, inpatient or outpatient facility services—the Plan uses a combination of CMS methodologies (MS-DRG inpatient, APC for outpatient, Fee Schedules, Per Diems, Percentage Payment Rate (PPR), per visit/per unit, etc.) and proprietary methods to develop targeted rates based on geography and facility type and to negotiate fee schedules/structures with facilities. The factors considered in negotiating rates are discussed in greater detail below. The most common measures in setting reimbursement level are based on percentage of CMS and discount level. For Med/Surg, market dynamics influence the target reimbursement range for the facility. The Plan looks at cost-to-charge ratio concepts within CMS filings, and considers what the facility needs to make a reasonable margin. The Plan also looks at external filing documents, including financials, and considers whether the facility's cost relativity to other facilities is not an outlier. In other words, the target reimbursement rates are based on allowing the facility to make a fair margin and to ensure the Plan is not disadvantaged by the rate looking at cost-to-charge. Agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics. Rates based on a percentage of CMS or other payment methodology may also fluctuate from year-to-year. Most provider agreements are evergreen, meaning the agreement renews automatically each year unless one, or both, parties provide notice of their intention not to renew the agreement at the end of the term. If an agreement does not have an inflator or is not based on a percent			Centers for Medicare & Medicaid Services (CMS) reimbursement rates and benchmark data by provider/facility type. For BH/SUD, Optum reimburses providers based on a standard network fee schedule. The standard approach is to reimburse at 100% of the fee schedule. Optum's standard fee schedule is developed using CMS national Relative Value Units (RVUs) as a guide to develop the reimbursement rate to the providers. The RVUs are obtained from the CMS Physician Fee Schedule Final Rule, Addendum B, which is posted on the CMS.gov website. The RVU for a specific code represent the relative resources required to perform that service compared to other services. Optum utilizes a set of internally developed base rates as a starting point. RVUs are used to check the relativities among the codes to ensure they are properly aligned. Rates are then adjusted based on a variety of factors including, supply/demand, geography, license level, and market conditions. Optum evaluates fee schedules on an annual basis and any necessary adjustments are made to remain competitive in the marketplace. In addition, when an RVU is not available for a given code other sources are used by Optum to assess the relativities and ensure consistent alignment. The other data and information sources can include the FairHealth database and rates/relativities obtained through studies from third-party vendors, consultation with subject matter experts on the services, and other market information. Just like med/surg, Optum's physician rates are negotiable and Optum considers the factors identified below when negotiating rates with providers.		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		of applicable payment methodology, like CMS, either the provider or the Plan may provide notice of termination to initiate contract negotiations and renegotiate rates.						
9b	**In-Network Reimbursement:** Describe your reimbursement methodology, specifically your methodology for setting the rate.	With the 2006 OPPS update, PEIA established a goal that all hospitals reimbursed through OPPS would have their rates set at 111% of Medicare's rates. There was a transition of this reimbursement change over a 3-year period, beginning with calendar year 2006. In February 2008, the third year of the transition, hospital rates were set at 111% of Medicare's rates completing the transition. Annual updates to the conversion faction will continue. In addition to the annual update of the conversion factor, there are also quarterly updates to the OPPS grouper used to assign APCs. Updates include changes initiated by CMS such as adjustments to the status codes assigned to each APC. OPPS rates have been updated. Below is a summary of the changes that were effective January 2019: 1. For CY2019, the fixed dollar threshold is $4825. The multiple thresholds do not change; therefore, the new outlier threshold is the maximum of 1.75 * APC_Pay and APC_Pay + $4825. 2. The statewide conversion factor (CF) has been set at $88.23. 3. The quarterly update will be loaded by mid-January 2019. Hospitals reimbursed through OPPS continue to have their rates set at 111% of Medicare's rates. Under West Virginia Public Payers' prospective payment system (PPS), payments are made prospectively on a per-DRG basis. We follow Medicare's definition of inpatient services as the basis for the standardized payment amount for operating costs. The following is a list of inpatient services as defined by Medicare: • bed and board • Nursing services and other related services, medical social services that are ordinarily furnished by the hospital for the care and treatment of inpatients; • drugs, biological, supplies, appliances, and equipment, for use in the hospital for the care and treatment of inpatients; • diagnostic or therapeutic items or			With the 2006 OPPS update, PEIA established a goal that all hospitals reimbursed through OPPS would have their rates set at 111% of Medicare's rates. There was a transition of this reimbursement change over a 3-year period, beginning with calendar year 2006. In February 2008, the third year of the transition, hospital rates were set at 111% of Medicare's rates completing the transition. Annual updates to the conversion faction will continue. In addition to the annual update of the conversion factor, there are also quarterly updates to the OPPS grouper used to assign APCs. Updates include changes initiated by CMS such as adjustments to the status codes assigned to each APC. Updates include changes initiated by CMS such as adjustments to the status codes assigned to each APC. OPPS rates have been updated. Below is a summary of the changes that were effective January 2019: 1. For CY2019, the fixed dollar threshold is $4825. The multiple thresholds do not change; therefore, the new outlier threshold is the maximum of 1.75 * APC_Pay and APC_Pay + $4825. 2. The statewide conversion factor (CF) has been set at $88.23. 3. The quarterly update will be loaded by mid-January 2019. Hospitals reimbursed through OPPS continue to have their rates set at 111% of Medicare's rates. Under West Virginia Public Payers' prospective payment system (PPS), payments are made prospectively on a per-DRG basis. We follow Medicare's definition of inpatient services as the basis for the standardized		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		services, furnished by the hospital; • physical therapy, occupational and speech therapy. Operating costs of inpatient hospital services, which includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services, are included in the standardized operating payment amount under the prospective payment system. The standardized payment amount also includes malpractice costs, costs of prosthetic devices, costs of independent laboratory services and other services related to the admission. In addition, costs from the following ancillary departments are also included in the standardized operating amount: operating rooms, radiology, medical supplies, laboratory, pharmacy, anesthesia, oxygen therapy, physical and occupational therapies, speech pathology, electrocardiology, electroencephalography, and renal dialysis. For UHC outside of West Virginia and the contiguous counties, reimbursement for in-network individual providers and facilities are determined through a negotiated process. During contract negotiations, the Plan applies the following factors to determine reimbursement for in-network providers: • Applicable CMS or other rate-setting methodology and benchmark reimbursement data for the provider type; • Member access by geography and specialty; • Impact on total medical cost relative to market and affordability; • Market dynamics, including provider leverage, competitor networks, scarcity of provider type in the market, and the need for provider type in network; • Quality and efficiency; and/or • Provider type (rates may be adjusted for specialists, higher acuity facility types or non-physician provider types like physician assistants or social workers). While some variation may exist for all services, in-network provider reimbursement is generally based on external rate sources for services provided by the same provider type in the same geography and the additional negotiation factors and data points discussed more fully below. In setting in-network provider reimbursement, the Plan utilizes/analyzes the Centers for Medicare & Medicaid Services (CMS) reimbursement rates and benchmark data by provider/facility type. 1. Individual or Group Professional Care Providers.			payment amount for operating costs. The following is a list of inpatient services as defined by Medicare: • bed and board • Nursing services and other related services, medical social services that are ordinarily furnished by the hospital for the care and treatment of inpatients; • drugs, biological, supplies, appliances, and equipment, for use in the hospital for the care and treatment of inpatients; • diagnostic or therapeutic items or services, furnished by the hospital; • physical therapy, occupational and speech therapy. Operating costs of inpatient hospital services, which includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services, are included in the standardized operating payment amount under the prospective payment system. The standardized payment amount also includes malpractice costs, costs of prosthetic devices, costs of independent laboratory services and other services related to the admission. In addition, costs from the following ancillary departments are also included in the standardized operating amount: operating rooms, radiology, medical supplies, laboratory, pharmacy, anesthesia, oxygen therapy, physical and occupational therapies, speech pathology, electrocardiology, electroencephalography, and renal dialysis. For the UHC network outside of West Virginia and the contiguous counties, reimbursement for in-network individual providers and facilities are determined through a negotiated process. During contract negotiations, the Plan applies the following factors to determine reimbursement for in-network providers: • Applicable CMS or other rate-setting methodology and benchmark reimbursement data for the provider type; • Member access by geography and specialty; 3) Impact on total medical cost relative to market and affordability; • Market dynamics, including provider leverage, competitor networks, scarcity of provider type in the market, and the need for provider type in network;	

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Individual or group professional care providers, who provide services in an inpatient, outpatient, or office setting, the Plan uses CMS's resource-based relative value scale ("RVRBS") methodology as a base to negotiate fee schedules with physicians. The Plan creates template fee schedule documents based on this payment methodology. Ultimately, rates are negotiated based on the factors identified. When CMS rates are not available for a given code, other sources are used by the Plan to assess the relativities and ensure consistent alignment. The other data and information sources can include third-party resources, like the FairHealth database and rates/relativities obtained through studies from third-party vendors, discussion with internal subject-matter experts on the services and other market information. Default fee schedules are developed by geography typically at a state level. These schedules are routinely updated to ensure the CMS relativities by code are current and relevant to each specialty. The default fee schedules are set at a competitive rate level that other similar medical professionals have accepted in the past and are reasonably expected to accept to participate in the Plan's network in the future. As a result, default fee schedules generally are set below the mean or median rates because those rates are influenced by provider leverage/negotiation. Only new providers get the benefit of an updated base fee schedule. While, existing contracted providers will stay on the same fee schedule or payment appendix originally negotiated unless or until they decide to renegotiate. 2. Facilities. For Med/Surg facilities—or in-network, inpatient or outpatient facility services—the Plan uses a combination of CMS methodologies (MS-DRG inpatient, APC for outpatient, Fee Schedules, Per Diems, Percentage Payment Rate (PPR), per visit/per unit, etc.) and proprietary methods to develop targeted rates based on geography and facility type and to negotiate fee schedules/structures with facilities. The factors considered in negotiating rates are discussed in greater detail below. The most common measures in setting reimbursement level are based on percentage of CMS and discount level. For Med/Surg, market dynamics influence the target reimbursement range for the facility. The Plan looks at cost-to-charge ratio concepts within CMS filings, and considers what the facility needs to make a reasonable margin. The Plan also looks at external filing documents, including financials, and considers whether the facility's cost relativity to other facilities is not an outlier. In other words, the			• Quality and efficiency; and/or • Provider type (rates may be adjusted for specialists, higher acuity facility types or non-physician provider types like physician assistants or social workers). While some variation may exist for all services, in-network provider reimbursement is generally based on external rate sources for services provided by the same provider type in the same geography and the additional negotiation factors and data points discussed more fully below. In setting in-network provider reimbursement, the Plan utilizes/analyzes the Centers for Medicare & Medicaid Services (CMS) reimbursement rates and benchmark data by provider/facility type. For BH/SUD, Optum reimburses providers based on a standard network fee schedule. The standard approach is to reimburse at 100% of the fee schedule. Optum's standard fee schedule is developed using CMS national Relative Value Units (RVUs) as a guide to develop the reimbursement rate to the providers. The RVUs are obtained from the CMS Physician Fee Schedule Final Rule, Addendum B, which is posted on the CMS.gov website. The RVU for a specific code represent the relative resources required to perform that service compared to other services. Optum utilizes a set of internally developed base rates as a starting point. RVUs are used to check the relativities among the codes to ensure they are properly aligned. Rates are then adjusted based on a variety of factors including, supply/demand, geography, license level, and market conditions. Optum evaluates fee schedules on an annual basis and any necessary adjustments are made to remain competitive in the marketplace. In addition, when an RVU is not available for a given code other sources are used by Optum to assess the relativities and ensure consistent alignment. The other data and information sources can include the FairHealth database and rates/relativities obtained through studies from third-party vendors, consultation with subject matter experts on the		

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		target reimbursement rates are based on allowing the facility to make a fair margin and to ensure the Plan is not disadvantaged by the rate looking at cost-to-charge. Agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics. Rates based on a percentage of CMS or other payment methodology may also fluctuate from year-to-year. Most provider agreements are evergreen, meaning the agreement renews automatically each year unless one, or both, parties provide notice of their intention not to renew the agreement at the end of the term. If an agreement does not have an inflator or is not based on a percent of applicable payment methodology, like CMS, either the provider or the Plan may provide notice of termination to initiate contract negotiations and renegotiate rates.			services, and other market information. Just like med/surg, Optum's physician rates are negotiable and Optum considers the factors identified below when negotiating rates with providers.			
9c	**Have you compared the reimbursements for specific M/S providers and MH/SUD providers?**	Individual or group professional care providers, who provide services in an inpatient, outpatient, or office setting, the Plan uses CMS's resource-based relative value scale ("RVRBS") methodology as a base to negotiate fee schedules with physicians. The Plan creates template fee schedule documents based on this payment methodology. Ultimately, rates are negotiated based on the factors identified. When CMS rates are not available for a given code, other sources are used by the Plan to assess the relativities and ensure consistent alignment. The other data and information sources can include third-party resources, like the FairHealth database and rates/relativities obtained through studies from third-party vendors, discussion with internal subject-matter experts on the services and other market information. Default fee schedules are developed by geography typically at a state level. These schedules are routinely updated to ensure the CMS relativities by code are current and relevant to each specialty. The default fee schedules are set at a competitive rate level that other similar medical professionals have accepted in the past and are reasonably expected to accept to participate in the Plan's network in the future. As a result, default fee schedules generally are set below the mean or median rates because those rates are influenced by provider leverage/negotiation.			While some variation may exist for all services, in-network provider reimbursement is generally based on external rate sources for services provided by the same provider type in the same geography and the additional negotiation factors and data points discussed more fully below. In setting in-network provider reimbursement, the Plan utilizes/analyzes the Centers for Medicare & Medicaid Services (CMS) reimbursement rates and benchmark data by provider/facility type. For BH/SUD, Optum reimburses providers based on a standard network fee schedule. The standard approach is to reimburse at 100% of the fee schedule. Optum's standard fee schedule is developed using CMS national Relative Value Units (RVUs) as a guide to develop the reimbursement rate to the providers. The RVUs are obtained from the CMS Physician Fee Schedule Final Rule, Addendum B, which is posted on the CMS.gov website. The RVU for a specific code represent the relative resources required to perform that service compared to other services.			Both M/S and MH/SUD services and treatments use the same methodology for determining out-of-network provider reimbursements, the MHPAEA comparability requirements are satisfied.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		Only new providers get the benefit of an updated base fee schedule. While, existing contracted providers will stay on the same fee schedule or payment appendix originally negotiated unless or until they decide to renegotiate.			Optum utilizes a set of internally developed base rates as a starting point. RVUs are used to check the relativities among the codes to ensure they are properly aligned. Rates are then adjusted based on a variety of factors including, supply/demand, geography, license level, and market conditions. Optum evaluates fee schedules on an annual basis and any necessary adjustments are made to remain competitive in the marketplace. In addition, when an RVU is not available for a given code other sources are used by Optum to assess the relativities and ensure consistent alignment. The other data and information sources can include the FairHealth database and rates/relativities obtained through studies from third-party vendors, consultation with subject matter experts on the services, and other market information. Just like med/surg, Optum's physician rates are negotiable and Optum considers the factors identified below when negotiating rates with providers.		
9d	**Out-of-Network Reimbursement:** Describe your out of network reimbursement methodology.	The Plan applies one of the following reimbursement methodologies to pay OON claims: (1) a "reasonable and customary" ("UCR") standard; (2) a Maximum Non-Network Reimbursement Program ("MNRP") methodology; or (3) Extended Non-Network Reimbursement Program ("ENRP") methodology. Alternatively, the Plan may have an agreement with Shared Savings/Multiplan to negotiate discounts with out-of-network providers for the Plan. Each benefit plan specifies which of the methodologies applies to all OON claims, both M/S and MH/SUD. For example, if a benefit plan uses UCR for OON inpatient and outpatient reimbursement, the UCR methodology applies to both M/S and MH/SUD benefits. We apply the same factors for each methodology for reimbursement of both M/S services and MH/SUD services.			The Plan applies one of the following reimbursement methodologies to pay OON claims: (1) a "reasonable and customary" ("UCR") standard; (2) a Maximum Non-Network Reimbursement Program ("MNRP") methodology; or (3) Extended Non-Network Reimbursement Program ("ENRP") methodology. Alternatively, the Plan may have an agreement with Shared Savings/Multiplan to negotiate discounts with out-of-network providers for the Plan. Each benefit plan specifies which of the methodologies applies to all OON claims, both M/S and MH/SUD. For example, if a benefit plan uses UCR for OON inpatient and outpatient reimbursement, the UCR methodology applies to both M/S and MH/SUD benefits.			Both M/S and MH/SUD services and treatments use the same methodology for determining out-of-network provider reimbursements, the MHPAEA comparability requirements are satisfied.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
					We apply the same factors for each methodology for reimbursement of both M/S services and MH/SUD services.			
10								
10a	Are there any services, conditions, treatment, etc. that require step therapy/fail first?	**Fail First/Step Therapy** M/S may apply Fail First/Step Therapy to certain codes covered under Outpatient Benefits, such as medical injectables for cancer drugs. Fail first requirement could apply for certain inpatient surgeries such as hip arthroplasty but not to an inpatient benefit.			**Fail First/Step Therapy** MH/SUD may apply Fail First/Step Therapy to certain codes covered under Outpatient Benefits, such as Transcranial Magnetic Stimulation (TMS). MH/SUD does not apply Fail First/Step therapy to inpatient benefits.			For both M/S and MH/SUD, the goal of Prior Authorization and concurrent review is to ensure cost-effective and clinically effective treatment. As detailed in the accompanying columns, the processes, timeframes, staff qualifications and criteria utilized for prior authorization are comparable and applied no more stringently than,

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								those designed and applied to M/S treatment or services. Parity compliance exists because both utilize evidence-based nationally recognized clinical guidelines in determining whether to add or maintain a prior authorization requirement. M/S and MH/SUD requests for authorization are evaluated by appropriately licensed and qualified medical or behavioral clinical staff depending on the nature of the treatment/services

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								sought. For both MH/SUD and M/S, the treating provider is required to provide clinical information. This information is reviewed by a medical professional with appropriate credentials necessary to confirm coverage and that the suggested treatment/service is clinically appropriate based on nationally recognized, evidence-based clinical guidelines and medical policies, standardized coverage determination

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								guidelines (CDGs), and generally accepted, peer-reviewed medical literature. Based on the foregoing, the processes and evidentiary standards are comparable and no more stringently applied for MH/SUD.
10b	What processes, strategies, evidentiary standards, or other factors were used to develop this list?	Application of a "fail first" or "step therapy" requirement is based on use of nationally recognized clinical standards, which may be incorporated into the plan's review guidelines. Based on, and consistent with, these nationally recognized clinical standards, some of the plan's medical/surgical review guidelines have what may be considered to be "fail first" or "step therapy" protocols. The full list of the guidelines (Medical & Drug Policies and Coverage Determination Guidelines) is available at www.unitedhealthcareonline.com. Go to Quick Links > Policies, Protocols and Administrative Guides.			Application of "fail first" or "step therapy" requirements is based on use of nationally recognized clinical standards which may be incorporated into the plan's guidelines. Based on, and consistent with, these nationally recognized clinical standards, some of the plan's MH/SUD review guidelines have what may be considered to be "fail first" or "step therapy" protocols. Further, application of "fail first" or "step therapy" protocols must be distinguished from the following: 1. Re-direction to an alternative level of care, when appropriate, based on the specific clinical needs of the particular patient. 2. Prior treatment failure criteria that support the need for a higher level of care when such failure is not a prerequisite for the higher level of care.			For both M/S and MH/SUD, the goal of Prior Authorization and concurrent review is to ensure cost-effective and clinically effective treatment. As detailed in the accompanying columns, the processes, timeframes, staff

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								qualifications and criteria utilized for prior authorization are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both utilize evidence-based nationally recognized clinical guidelines in determining whether to add or maintain a prior authorization requirement. M/S and MH/SUD requests for authorization are evaluated by appropriately licensed and

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								qualified medical or behavioral clinical staff depending on the nature of the treatment/services sought. For both MH/SUD and M/S, the treating provider is required to provide clinical information. This information is reviewed by a medical professional with appropriate credentials necessary to confirm coverage and that the suggested treatment/service is clinically appropriate based on nationally recognized, evidence-based

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								clinical guidelines and medical policies, standardized coverage determination guidelines (CDGs), and generally accepted, peer-reviewed medical literature. Based on the foregoing, the processes and evidentiary standards are comparable and no more stringently applied for MH/SUD.
11								
11a	Are there any services, conditions, treatment, etc. that require written	Clinical factors used when reviewing Medical Necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of specialty drugs, and any applicable prior authorization requirements. The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in			Clinical factors used when reviewing Medical Necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of specialty drugs, and any applicable prior authorization requirements. The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or			The definition of treatment plans used for all benefits is comparable, and applied no more

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
	treatment plans?	itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary. Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion. UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.			facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary. Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion. UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.			stringently, to MH/SUD than to M/S.
11b	What processes,	Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, Injury, mental illness, substance use disorder, condition, disease or its			Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, Injury, mental illness, substance use disorder, condition, disease or its symptoms, which are all of the following			The definition of evidentiary standards used for

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
	strategies, evidentiary standards, or other factors were used to develop this list?	symptoms, which are all of the following as determined by UnitedHealthcare or our designee, within our sole discretion. • In accordance with *Generally Accepted Standards of Medical Practice* • Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's sickness, injury, mental illness, substance use disorder, disease or its symptoms • Not mainly for the member's convenience or that of the member's doctor or other health care provider • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's sickness, injury, disease or symptoms. The plan does not cover services, supplies, treatment, facilities or equipment which the plan determines are not medically necessary. *Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinions in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society		as determined by UnitedHealthcare or our designee, within our sole discretion. • In accordance with *Generally Accepted Standards of Medical Practice* • Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's sickness, injury, mental illness, substance use disorder, disease or its symptoms • Not mainly for the member's convenience or that of the member's doctor or other health care provider • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's sickness, injury, disease or symptoms. The plan does not cover services, supplies, treatment, facilities or equipment which the plan determines are not medically necessary. *Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult			all benefits is comparable, and applied no more stringently, to MH/SUD than to M/S.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion. UnitedHealthcare develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on UnitedHealthcare's member website or by calling the telephone number on the Covered Person's ID card. They are available to Physicians and other health care professionals on www.umr.com or by calling the telephone number on the Covered Person's ID card.			expert opinions in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion. UnitedHealthcare develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on UnitedHealthcare's member website or by calling the telephone number on the Covered Person's ID card. They are available to Physicians and other health care professionals on www.umr.com or by calling the telephone number on the Covered Person's ID card.		
12								
12a	How is the P&T Committee used? Does the P&T Committee include individuals with	The P&T Committee is comprised of a diversity of clinical disciplines including behavioral health.			The P&T Committee is comprised of a diversity of clinical disciplines including behavioral health.			The disciplines involved in the development of the PDL/formulary requirements for both M/S and MH/SUD prescription drugs all make up one national Pharmacy

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
	MH/SUD training?							& Therapeutics Committee.
15								
15a	Which drugs have step therapy applied to them?	Prescription drugs are subject to prior authorization, step therapy and supply/quantity limits. Prescription drugs are not subject to an NQTL based on their tier. Medical/surgical prescription drugs and mental health/substances use disorder prescription drugs are subject to the same NQTLs as based on the Clinical Programs Policy.			Prescription drugs are subject to prior authorization, step therapy and supply/quantity limits. Prescription drugs are not subject to an NQTL based on their tier. Medical/surgical prescription drugs and mental health/substances use disorder prescription drugs are subject to the same NQTLs as based on the Clinical Programs Policy.			The plan uses prior authorization, step therapy and supply/quantity limits as NQTLS. Prior authorization requires a prescriber to provide information about why a member is taking a medication to determine how it may be covered by the plan. Step therapy requires prior authorization and may require a member to try one or more other prescription drugs before the prescription drug

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								they are requesting may be covered. Supply/quantity limits specifies the largest quantity of a prescription drug covered per copayment or in a defined period of time and are based on FDA approved labeling and clinical evidence. The requirements for NQTLs, including prior authorization and step therapy or "fail first", for both M/S and MH/SUD prescription drugs help to ensure the clinically appropriate prescription drug is provided to the member. As

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								detailed in the accompanying columns, the criteria utilized to administer the prior authorization and step therapy requirement is the same for MH/SUD and M/S. Parity compliant comparability is satisfied by use of the same factors and evidentiary standards to determine whether the requirement will apply for a particular prescription drug. Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources and trend analysis in order to create and maintain

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								a prior authorization or step therapy requirement. In this way, the MH/SUD prior authorization and step therapy requirements, in design and application, are the same and no more stringent than those utilized for M/S. For prescription drugs covered under the medical and pharmacy benefit for both M/S and MH/SUD drugs, UHC uses the same policies and procedures to create clinical criteria and to develop clinical policies. Furthermore, all documents are

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								reviewed by one Pharmacy & Therapeutics Committee. There is no distinction between MH/SUD and M/S prescription drugs, and the processes are administered in the same fashion and not applied more stringently to MH/SUD prescription drugs. MHPAEA provides the "processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification." However, it does not require the outcomes and non-quantitative treatment limitations (NQTL) to be the same for every prescription drug. Attached is the current Clinical Programs Policy used to determine if a prescription drug should be

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								subject to Prior Authorization.
15b	What processes, strategies, evidentiary standards, or other factors were used to develop the list of drugs subject to step therapy?	The process applied by the plan for prescription drug formulary design is the same process used for MH/SUD and M/S prescription drugs using the same committee, work groups and factors. MH/SUD or M/S prescription drugs are assessed under the same process without regard to their primary indication. The clinical criteria (NQTLs) for MH/SUD and M/S prescriptions drugs are all based on the Clinical Programs Policy (see attached dated 5/28/20). The Policy lays out when prescription drugs will be subject to a NQTL such as prior authorization or step therapy and makes no distinction between MH/SUD and M/S prescription drugs. The Policy is administered in the same fashion and is not applied more stringently to M/S prescription drugs.			The process applied by the plan for prescription drug formulary design is the same process used for MH/SUD and M/S prescription drugs using the same committee, work groups and factors. MH/SUD or M/S prescription drugs are assessed under the same process without regard to their primary indication. The clinical criteria (NQTLs) for MH/SUD and M/S prescriptions drugs are all based on the Clinical Programs Policy (see attached dated 5/28/20). The Policy lays out when prescription drugs will be subject to a NQTL such as prior authorization or step therapy and makes no distinction between MH/SUD and M/S prescription drugs. The Policy is administered in the same fashion and is not applied more stringently to M/S prescription drugs.			The pharmacy management processes, including cost-control measures, therapeutic substitution, and step therapy for both M/S and MH/SUD prescription drugs help to ensure that the clinically appropriate prescription drug is provided to the member. As detailed in the accompanying columns, the processes and criteria utilized to administer the pharmacy management policies are the

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								same between MH/SUD and M/S. Parity compliant comparability is satisfied by use of the same factors and evidentiary standards to determine whether the requirement will apply for a particular prescription drug. Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources and trend analysis in order to create and maintain a pharmacy management process. In this way, the MH/SUD pharmacy

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								management process requirements, in design and application, are the same and no more stringent than those utilized for M/S.
16								
16a	Which drugs have quantity limits applied to them?	On the medical plan, the provider administered drugs are reviewed for dosing per administration per medical necessity guidelines.			On the medical plan, the provider administered drugs are reviewed for dosing per administration per medical necessity guidelines.			
16b	What are the processes, evidentiary standards, strategies, and other factors used to determine whether to apply quantity limits?	The process applied by the plan for prescription drug formulary design is the same process used for MH/SUD and M/S prescription drugs using the same committee, work groups and factors. MH/SUD or M/S prescription drugs are assessed under the same process without regard to their primary indication. The clinical criteria (NQTLs) for MH/SUD and M/S prescriptions drugs are all based on the Clinical Programs Policy (see attached dated 5/28/20). The Policy lays out when prescription			The process applied by the plan for prescription drug formulary design is the same process used for MH/SUD and M/S prescription drugs using the same committee, work groups and factors. MH/SUD or M/S prescription drugs are assessed under the same process without regard to their primary indication. The clinical criteria (NQTLs) for MH/SUD and M/S prescriptions drugs are all based on the Clinical Programs Policy (see attached dated 5/28/20). The Policy lays out when prescription drugs will be subject to a NQTL such as prior authorization or step therapy and makes			The pharmacy management processes, including cost-control measures, therapeutic substitution, and step therapy for both M/S and MH/SUD prescription drugs help to ensure that the clinically

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
		drugs will be subject to a NQTL such as prior authorization or step therapy and makes no distinction between MH/SUD and M/S prescription drugs. The Policy is administered in the same fashion and is not applied more stringently to M/S prescription drugs.			no distinction between MH/SUD and M/S prescription drugs. The Policy is administered in the same fashion and is not applied more stringently to M/S prescription drugs.			appropriate prescription drug is provided to the member. As detailed in the accompanying columns, the processes and criteria utilized to administer the pharmacy management policies are the same between MH/SUD and M/S. Parity compliant comparability is satisfied by use of the same factors and evidentiary standards to determine whether the requirement will apply for a particular prescription drug.

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources and trend analysis in order to create and maintain a pharmacy management process. In this way, the MH/SUD pharmacy management process requirements, in design and application, are the same and no more stringent than those utilized for M/S.
17								
17a	What prescription drugs require prior authorization?	Specialty drugs administered by a provider listed at this link: Specialty Injectable | UMR (umrwebapps.com)			Specialty drugs administered by a provider listed at this link: Specialty Injectable | UMR (umrwebapps.com)			

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
17b	What processes, strategies, evidentiary standards, or other factors were used to develop this list?	The process applied by the plan for prescription drug formulary design is the same process used for MH/SUD and M/S prescription drugs using the same committee, work groups and factors. MH/SUD or M/S prescription drugs are assessed under the same process without regard to their primary indication. The clinical criteria (NQTLs) for MH/SUD and M/S prescriptions drugs are all based on the Clinical Programs Policy. The Policy lays out when prescription drugs will be subject to a NQTL such as prior authorization or step therapy and makes no distinction between MH/SUD and M/S prescription drugs. The Policy is administered in the same fashion and is not applied more stringently to M/S prescription drugs. The national Pharmacy & Therapeutic (P&T) Committee reviews and evaluates all NQTLs including clinical and therapeutic factors. The following are considered in the development of NQTLs for all prescription drugs: FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. The P&T Committee assesses the prescription drug's place in therapy, and its relative safety and efficacy. The Committee reviews decisions consistent with published evidence relative to these factors development by a pharmacoeconomic work group which extensively reviews medical and outcomes literature and financial models which assess the impact of cost versus potential offsets from the use of a prescription drug such as decreases in hospital stays, reduction in lab tests, or medical utilization due to side effects.		The process applied by the plan for prescription drug formulary design is the same process used for MH/SUD and M/S prescription drugs using the same committee, work groups and factors. MH/SUD or M/S prescription drugs are assessed under the same process without regard to their primary indication. The clinical criteria (NQTLs) for MH/SUD and M/S prescriptions drugs are all based on the Clinical Programs Policy (see attached dated 5/28/20). The Policy lays out when prescription drugs will be subject to a NQTL such as prior authorization or step therapy and makes no distinction between MH/SUD and M/S prescription drugs. The Policy is administered in the same fashion and is not applied more stringently to M/S prescription drugs. The national Pharmacy & Therapeutic (P&T) Committee reviews and evaluates all NQTLs including clinical and therapeutic factors. The following are considered in the development of NQTLs for all prescription drugs: FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. The P&T Committee assesses the prescription drug's place in therapy, and its relative safety and efficacy. The Committee reviews decisions consistent with published evidence relative to these factors development by a pharmacoeconomic work group which extensively reviews medical and		The pharmacy management processes, including cost-control measures, therapeutic substitution, and step therapy for both M/S and MH/SUD prescription drugs help to ensure that the clinically appropriate prescription drug is provided to the member. As detailed in the accompanying columns, the processes and criteria utilized to administer the pharmacy management policies are the same between MH/SUD and

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
					outcomes literature and financial models which assess the impact of cost versus potential offsets from the use of a prescription drug such as decreases in hospital stays, reduction in lab tests, or medical utilization due to side effects.			M/S. Parity compliant comparability is satisfied by use of the same factors and evidentiary standards to determine whether the requirement will apply for a particular prescription drug. Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources and trend analysis in order to create and maintain a pharmacy management process. In this way, the MH/SUD pharmacy management process requirements, in

Medical/Surgical					Mental Health/Substance Use Disorder			Comparability and Rationale for Any Difference
Question		Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	Inpatient (In-Network and Out-of-Network)	Outpatient (In-Network and Out-of-Network)	ER	
								design and application, are the same and no more stringent than those utilized for M/S.
17c	Is the process for obtaining pre-authorization the same for MH/SUD drugs and M/S drugs? Similar forms, similar medical records, etc.?	Confirmed. The process is similar for BH/SUD and Medical specialty injectable reviews.			Confirmed. The process is similar for BH/SUD and Medical specialty injectable reviews.			
18								
18a	Are there any other limitations on the scope of services?	Not applicable			Not applicable			