UTAH DEPARTMENT OF
HEALTH

DIVISION OF MEDICAID AND HEALTH FINANCING
BUREAU OF MANAGED HEALTH CARE

UTAH MEDICAID COMPLIANCE WITH MENTAL HEALTH PARITY

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INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) issued the Mental Health Parity and Addiction Equity Act (MHPAEA) on March 30, 2016. In summary, the rule requires Medicaid managed care plans, Children's Health Insurance Programs and Alternative Benefit Plans to ensure that they are not placing limits on access to mental health or substance use disorder (MH/SUD) services that are not similarly applied to medical/surgical services (M/S).

The act requires states to conduct a parity analysis and to document their findings. States must analyze financial requirements, dollar limits, and treatment limitations on its MH/SUD services in order to ensure that those limitations are no more restrictive than those for its M/S benefits. States must also ensure that certain availability of information requirements are met.

The purpose of this report is to meet the analysis and reporting requirements of MHPAEA as it relates to managed care plans.

OVERVIEW OF UTAH'S MEDICAID PROGRAM

The Division of Medicaid and Health Financing (DMHF), in the Utah Department of Health, administers the Medicaid program and CHIP. CHIP is a separate program from the Medicaid expansion program. Therefore, Utah is required to use CMS' SPA template for states with separate CHIP programs to indicate how Utah's CHIP complies with parity. Utah does not have any Alternative Benefit Plans.

For purposes of this parity analysis, DMHF contracts with the following types of managed care plans:

- Managed Care Organizations (MCOs) also called Accountable Care Organizations (ACOs)* that cover M/S benefits and some pharmacy;
- MCOs that cover M/S, MH/SUD services, and some pharmacy (these are called Utah Medicaid Integrated Care or UMIC MCOs;
- An MCO, the Healthy Outcomes Medical Excellence (HOME) program, that covers M/S and MH/SUD services; and
- Prepaid Inpatient Health Plans (PIHPs) that cover MH, and/or SUD services; these are also called Prepaid Mental Health Plans (PMHPs).

*For purposes of clarity, ACO is used throughout this document.

ACCOUNTABLE CARE ORGANIZATIONS

The Choice of Health Care Delivery Program is a waiver program authorized under Section 1915(b) of the Social Security Act. Under this waiver program, beneficiaries in 13 of Utah's 29 counties must enroll in an ACO. Enrolling in an ACO is voluntary in the remaining 16 counties; Medicaid members may choose an ACO or FFS in these counties. The ACOs cover most physical health services covered by Utah Medicaid. The ACOs also cover most pharmacy services except specific classes of drugs related to mental health and substance use disorder treatment drugs, transplant immunosuppressive drugs and hemophilia drugs.

UTAH MEDICAID INTEGRATED CARE MCOs

The UMIC MCOs operate under an amendment to Utah's section 1115 demonstration project, Primary Care Network. The amendment allows Utah to operate an integrated managed care model called Utah Medicaid Integrated Care (UMIC) that combines the delivery of M/S and MH/SUD services in five Utah counties; enrollment is mandatory for Utah's Adult Expansion Population.

HEALTHY OUTCOMES MEDICAL EXCELLENCE (HOME) PROGRAM

The HOME program is permitted under Section 1915(a) of the Social Security Act and provides a vehicle for voluntary enrollment into capitated managed care otherwise unavailable. It is a voluntary program that provides M/S and MH/SUD services to Medicaid enrollees with a developmental disability and mental illness or behavioral problems. It is available statewide to qualified Medicaid beneficiaries. For purposes of this analysis, the HOME program is included with the ACOs, unless otherwise noted.

PREPAID MENTAL HEALTH PLAN (PMHP)

The PMHP is a waiver program authorized under Section 1915(b) of the Social Security Act. The PMHP is comprised of 11 PIHPs. Clients living in 28 of Utah's 29 counties are automatically enrolled in the PMHP. The PMHP is a coordinated, managed care delivery system that is responsible for inpatient psychiatric M/H care and outpatient MH/SUD services.

DEFINING CLASSIFICATIONS AND MAPPING BENEFITS TO CLASSIFICATIONS

The MHPAEA requires states to categorize benefits as either M/S or MH/SUD. In addition, services must be classified as one of the following benefit types: Inpatient, Outpatient, Prescription Drugs, or Emergency Care.

Utah Medicaid uses the following definitions for each of these classifications of benefits (the definitions follow the source of the definition):

UTAH ADMINISTRATIVE CODE R414-2A-2:

Inpatient hospital services are services that a hospital provides for the care and treatment of inpatients with disorders other than mental illness, under the direction of a physician or other practitioner of the healing arts.

DEFINITION FOR PURPOSES OF THIS MENTAL HEALTH PARITY ANALYSIS:

Outpatient services means any service covered by a managed health care plan other than inpatient hospital stays or outpatient hospital services.

42 CFR §440.120:

Prescribed drugs means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are— (1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; (2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and (3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

ACO, HOME, PMHP & UMIC CONTRACTS:

Emergency Services means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition.

ACO, HOME, PMHP & UMIC CONTRACTS:

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Utah Medicaid's M/S and MH/SUD benefits are classified as follows:

Benefit Type	Benefit Classification	Benefit Classification	Benefit Classification	Benefit Classificaion
	Inpatient	**Outpatient**	**Prescription Drugs**	**Emergency Care**
MH/SUD	• Psychiatric hospital stays • Psychiatrists in hospital • Inpatient medical detoxification*	• Psychiatric exam • Mental health assessment • Psychological testing • Individual/group/ family psychotherapy • Individual/group therapeutic behavioral services • Pharmacologic management • Individual skills training • Psychosocial rehabilitative services • Peer support svcs • Targeted case management svcs • Electroconvulsive therapy • General medical consultation, etc., for diagnosing MH/SUD	• ADHD stimulant drugs • Anti-psychotic drugs • Anti-depressant drugs • Anti-anxiety drugs • Anti-convulsant drugs • SUD treatment drugs (& generics)	• Services in the ER • Crisis services
M/S	• Hospital stays • Surgery • Physicians in hospital	• Preventive • Physician • Home health • Lab & radiology • Podiatry • Vision • Hospice • PT & OT • Medical supplies and equipment • Speech & hearing	• Generic Drugs • Brand name drugs	• Ambulance • Services in the ER

*The only inpatient SUD benefit is medical detoxification.

The chart below summarizes the entities that cover MH/SUD services and M/S services:

Benefit Classification	Benefit Type	Benefit Type
Service	**MH/SUD**	**M/S**
Inpatient	PMHPs cover MH for their enrollees; ACOs cover SUD (medical detoxification) for their enrollees;* HOME covers MH/SUD for its enrollees; UMIC plans cover MH/SUD for their enrollees; and FFS covers MH/SUD for members not enrolled in a managed care plan.	ACOs cover M/S for their enrollees; HOME covers M/S for its enrollees; UMIC plans cover M/S for their enrollees; and FFS covers M/S for members not enrolled in a managed care plan.
Outpatient	PMHPs cover MH/SUD for their enrollees; HOME covers MH/SUD for its enrollees; UMIC plans cover MH/SUD for their enrollees; and FFS covers MH/SUD for members not enrolled in a managed care plan.	ACOs cover M/S for their enrollees; HOME covers M/S for its enrollees; UMIC plan cover M/S for their enrollees; and FFS covers M/S for members not enrolled in a managed care plan.
Emergency	PMHPs cover MH/SUD for their enrollees; HOME covers MH/SUD for its enrollees; UMIC plans cover MH/SUD for their enrollees; and FFS covers MH/SUD for members not enrolled in a managed care plan.	ACOs cover M/S for their enrollees; HOME covers M/S for its enrollees; UMIC plans covers M/S for their enrollees; and FFS covers M/S for members not enrolled in a managed care plan.
Pharmacy	FFS covers drugs used to treat MH/SUD.	ACOs and UMIC plans cover all M/S pharmacy except hemophilia and immunosuppressant drugs for their enrollees.

*The only inpatient SUD benefit is medical detoxification.

Regulations that apply MHPAEA requirements to Medicaid require that states perform an analysis of limits on MH/SUD benefits that involve the following:

- financial requirements;
- aggregate lifetime or annual dollar limits;

- quantitative treatment limitations;
- non-quantitative treatment limitations; and
- availability of information requirements.

FINANCIAL REQUIREMENTS

Financial requirements are payments by enrollees for services received that are in addition to payments made by the State, ACO, HOME, PMHP, or UMIC plans for those services. Payments that some Medicaid beneficiaries must pay are cost sharing amounts and include copayments and coinsurance. All Utah Medicaid beneficiaries whether enrolled in a managed care plan or are covered under fee-for-service have the same cost sharing requirements.

The following beneficiaries do not have cost sharing requirements: Alaska Natives, American Indians, pregnant women, members eligible for EPSDT, those receiving hospice care, those in the Medicaid Cancer Program, and Targeted Adults Medicaid (TAM) members. All other beneficiaries have cost sharing requirements for non-emergency use of the emergency room, inpatient hospital stays, physician visits, urgent care, podiatrist visits, and pharmacy. Outpatient services have cost sharing requirements except for the following: dental services, family planning, immunizations, lab, radiology, nursing home stays, preventive services, tobacco cessation services, and outpatient MH/SUD services.

Since outpatient MH/SUD services do not require a co-payment, M/S financial requirements are more stringent than those for MH/SUD. Therefore, there are no financial requirements that apply to MH/SUD services that are more stringent than those applied to M/S benefits. Utah meets the mental health parity financial requirements.

AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS

Aggregate lifetime or annual dollar limits are dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.

INPATIENT, OUTPATIENT, & EMERGENCY CARE SERVICES

ACOs, HOME, PMHPs, and UMIC plans do not have any aggregate lifetime or annual dollar limits on any inpatient hospital, outpatient services or emergency care services. Therefore, Utah is in compliance with parity regarding aggregate lifetime and annual dollar limits.

PHARMACY SERVICES

ACOs and UMIC plans are the only managed care plans that cover pharmacy services. Prescription drugs that treat MH/SUD issues are carved out of the ACO and UMIC contracts. Medicaid fee-for-services pays pharmacies directly for all behavioral health (MH/SUD) pharmacy services. ACOs and UMIC plans cover M/S pharmacy services and are required to

follow the State's policies and procedures for pharmacy services. The State has a preferred drug list (PDL) and non-preferred drug list for all MH/SUD and M/S drugs. The prescriber must obtain prior authorization (PA) from the State or managed care entity, if applicable, to dispense drugs designated as "non-preferred" in each class of drugs. The PA process is the same for all pharmacy services in that the approval determination is based on the drug's safety, clinical efficacy, and cost.

However, there is an exception for MH/SUD prescriptions. If a prescriber writes "dispense as written" (DAW) on the prescription for a non-preferred MH/SUD drug, and the pharmacy submits a DAW code in the claim, the claim will bypass the PA requirement.

Based on this exception, the State has determined that PA requirements for MH/SUD are applied less stringently than to M/S drugs. Therefore, pharmacy services provided by ACOs and UMIC plans meet the MQTL PA mental health parity requirements.

QUANTITATIVE TREATMENT LIMITATIONS

Quantitative treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment that are expressed numerically (such as 50 visits per year).

INPATIENT

There are limits in the scope of services for M/S inpatient hospital services. For example, Non-Traditional enrollees are limited to specific organ transplants, i.e., they are limited to bone marrow, cornea, heart, kidney, liver, lung, and stem cell organ transplants.

There are no limits in the scope of services for inpatient MH/SUD services. Therefore, there are no concerns regarding parity compliance related to inpatient hospital QTLs.

OUTPATIENT

Non-Traditional Medicaid enrollees are limited to a maximum of 10 visits per calendar year in any combination of physical and occupational therapy services. There are no set limits on MH/SUD services.

The following services are not covered for Non-Traditional Medicaid (NTM) enrollees: speech-language pathology and audiology services, and private duty nursing. In addition, there are some differences in coverage for medical supplies and equipment under NTM.

There are no set limits on MH/SUD outpatient services. Nor are there limits on the scope or duration of services related to MH/SUD outpatient services. Therefore, there are no concerns regarding parity compliance related to outpatient QTLs.

EMERGENCY

No QTLs were identified for emergency services.

PHARMACY

ACOs and UMIC plans cover drugs for M/S problems. Fee-for-service Medicaid covers drugs for MH/SUD issues. Since drugs for treating MH/SUD mental health issues are carved out of the ACO, HOME, PMHP, and UMIC plan contracts, there is no risk of non-parity between M/S and MH/SUD pharmacy benefits.

NON-QUANTITATIVE TREATMENT LIMITATIONS

A non-quantitative treatment limitation (NQTL) is a limit on the scope or duration of benefits such as utilization review or network admission standards. This NQTL analysis does not focus on whether the final result is the same, instead compliance is based upon parity in application of the underlying strategies, processes, and evidentiary standards, both in writing and operation.

The State identified and analyzed the following NQTLs for the MH/SUD and M/S managed care plans: utilization management (i.e., prior authorization, concurrent review, and retrospective review), network provider admission, reimbursement rates, fail first policies (step therapy), and failure to complete a course of treatment.

The HOME program's NQTLs were the same in HOME's application of strategies, processes, and evidentiary standards strategies for its MH/SUD and M/S benefits; therefore, there is no risk of non-parity in the HOME program.

No NQTLs were identified for emergency services and there is no risk of non-parity between MH/SUD and M/S pharmacy benefits because the drugs for treating MH/SUD are carved out of the ACO, HOME, PMHP, and UMIC contracts. Therefore, this NQTL analysis addresses only inpatient and outpatient benefits.

UTILIZATION MANAGEMENT – PMHPS & ACOS

INPATIENT

Prior Authorization – Inpatient Hospital Stays

STRATEGY	
What are the overall reasons for requiring PA for inpatient hospital stays?	
MH/SUD - PMHPs	**M/S - ACOs**
To determine appropriate level of care; manage high-cost stays; monitor overutilization; assist with transition of care efforts; and coordinate services.	To determine appropriate level of care; manage high-cost stays; monitor overutilization; to review stays that may be prone to fraud/abuse; to assist with transition of care efforts; and to coordinate services.
Are the PA reasons the same for both in-network and out-of-network providers?	
Yes.	Yes.
PROCESS	
What entity performs the PA processes?	
MH/SUD - PMHPs	**M/S - ACOs**
PAs are performed by the PMHPs.	PAs are performed by the ACOs.
Are there exceptions to the application of the criteria used to determine whether a PA will be granted? List the situations when exceptions are granted.	
Yes. One PMHP makes exceptions if there is no history with the patient; one PMHP makes exceptions if it meets exception policy guidelines & the medical director feels it is beneficial from quality, member experience or cost-effective perspective; and two PMHPs make exceptions based on peer-to-peer review.	Yes. One ACO makes exceptions based on complex medical situations that require a more comprehensive evaluation, and one ACO based on peer-to-peer review.
Are there any time restrictions? For example, what is the maximum amount of time allowed to issue a determination on a prior authorization request?	
MH/SUD - PMHPs	**M/S - ACOs**
Yes, PMHPs must make a decision within 14 calendar days after the PMHP receives the request with a possible 14 additional calendar days if certain criteria are met; and within 72 hours if an expedited decision is necessary based on client's health.	Yes, ACOs must make a decision within 14 calendar days after the PMHP receives the request with a possible 14 additional calendar days if certain criteria are met; and within 72 hours if an expedited decision is necessary based on client's health.
If there are any change to PA policies or procedures, does the plan update providers about the change? If so, how does the plan update providers?	
MH/SUD - PMHPs	**M/S - ACOs**
For those PMHPs that require PA, PMHPs update providers about changes to policies/ procedures regarding PAs. PMHPs update providers prior to the implementation of the change via email, letters, fax.	Yes, all ACOs update providers about changes to policies/procedures regarding PAs. ACOs update providers prior to the implementation of the change via email, letters, fax.

EVIDENTIARY STANDARDS	
What evidence/criteria does the plan use to determine whether PA will be granted for an inpatient hospital stay?	
MH/SUD - PMHPs	**M/S - ACOs**
Medical necessity criteria; plan of care, and clinical guidelines.	Medically necessity criteria; plan of care; and clinical guidelines.
MH/SUD - PMHPs	**M/S - ACOs**
If the processes used to apply PA are different for MH/SUD than for M/S benefits, what evidence was relied upon to determine that these differences are appropriate?	
No differences.	No differences.

Concurrent Review (CR) – Inpatient Hospital Stays

STRATEGY	
What are the overall reasons for requiring CR for inpatient hospital stays?	
MH/SUD - PMHPs	**M/S - ACOs**
To determine the appropriate level of care; to manage high-cost stays; to monitor overutilization; and to coordinate care.	To monitor overutilization; to determine appropriate level of care; to manage high-cost stays; to conduct peer-to-peer review; and to monitor stays prone to fraud/abuse.
Are the PA reasons the same for both in-network and out-of-network providers?	
Yes.	Yes.
PROCESS	
What entity conducts CR processes?	
MH/SUD - PMHPs	**M/S - ACOs**
CRs are performed by the PMHPs.	CRs are conducted the ACOs.
Are there exceptions to the application of the criteria used for requiring CR? List the situations when exceptions are granted.	
Yes, based on peer-to-peer review; if the exception meets exception policy guidelines and the medical director feels it is beneficial from a quality, member experience and/or cost-effective perspective, and if medical necessity is no longer met for an inpatient stay and there is an appropriate step-down option available, then the member may stay at an inpatient level of care until the step-down option is available.	Yes, based on peer-to-peer review.
If there are any changes to CR policies or procedures, does the plan update providers about the change? If so, how does the plan update providers?	
MH/SUD - PMHPs	**M/S - ACOs**
Yes, for those PMHPs that require CR, PMHPs update providers about changes to CR policies/ procedures. Depending on the significance of the change, PMHPs update providers prior to the implementation of the change.	Yes, all ACOs update providers about changes to PA policies/procedures regarding PAs. Depending on the significance of the change, ACOs update providers prior to the implementation of the change.

EVIDENTIARY STANDARDS	
What evidence/criteria was relied upon to make determinations about which benefits meet the strategy criteria to apply CR?	
MH/SUD - PMHPs	**M/S - ACOs**
Medical necessity criteria, plan of care, and clinical guidelines.	Medically necessity criteria, plan of care, and clinical guidelines.
MH/SUD - PMHPs	**M/S - ACOs**
If the processes used to apply CR are different for MH/SUD than for M/S benefits, what evidence was relied upon to determine that these differences are appropriate?	
No differences.	No differences.

Retrospective Review (RR) – Inpatient Hospital Stays

STRATEGY	
What are the overall reasons for requiring RR for inpatient hospital stays?	
MH/SUD - PMHPs	**M/S - ACOs**
To review high-cost stays; to ensure the appropriate level of care was provided; and to monitor overutilization.	If there is a quality of care concern; to make sure InterQual criteria was met for the stay; to monitor overutilization; to determine if appropriate level of care was provided, review high-cost stays; and to review stays that may be prone to fraud/abuse.
Are the reasons for conducting RR the same the same for both in-network and out-of-network providers?	
Yes.	Yes.
PROCESS	
What entity conducts RR processes?	
MH/SUD - PMHPs	**M/S - ACOs**
RRs are conducted by the PMHPs.	RRs are conducted the ACOs.
Are there exceptions to the application of the criteria used for requiring RR? List the situations when exceptions are granted.	
Yes, PMHPs may make exceptions in cases where a client's clinical history indicates there is no need for RR; and to ensure that the level of care provided remained consistent and relevant to the client's issues.	Yes, ACOs may make exceptions based on peer-to-peer review.
If there are any changes to RR policies or procedures, does the plan update providers about the change? If so, how does the plan update providers?	
MH/SUD - PMHPs	**M/S - ACOs**
For those PMHPs that require RR, they all update providers about changes to policies/ procedures regarding RR. PMHPs update providers prior to implementing the change through emails, phone calls and letters.	Yes, all ACOs update providers about changes to policies/procedures regarding RR. Yes, ACOs update providers prior to the implementing the change through emails, phone calls, and letters.

EVIDENTIARY STANDARDS	
What evidence/criteria was relied upon to make determinations about which benefits meet the strategy criteria to apply RR?	
MH/SUD - PMHPs	**M/S - ACOs**
Medical necessity criteria; plan of care; and clinical guidelines.	Medically necessity criteria; plan of care; clinical guidelines; and short-term readmissions under the same DRG.
MH/SUD - PMHPs	**M/S - ACOs**
If the processes used to apply CR are different for MH/SUD than for M/S benefits, what evidence was relied upon to determine that these differences are appropriate?	
No differences.	No differences.

The State reviewed the ACOs' and PMHPs' survey results regarding inpatient hospital utilization review (UR) requirements (i.e. PA, CC, and RR) including the reasons for requiring UR, the criteria applied and exceptions to the criteria used. Although the results varied among ACOs and among PMHPs, and also across ACOs and PMHPs, the reasons, criteria, and exceptions to the criteria, all were comparable in intent. Utah's EQRO has found that all ACOs and PMHPs that require PA have mechanisms to ensure consistent application of their review criteria. All ACOs and PMHPs inform their providers of significant changes to their UR policies and procedures prior to implementing the changes. All ACOs and PMHPs follow the federal regulations regarding PA determinations.

UTILIZATION MANAGEMENT – UMIC PLANS

INPATIENT

Prior Authorization – Inpatient Hospital Stays

STRATEGY	
What are the overall reasons for requiring PA for inpatient hospital stays?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: No PA required. Healthy U: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and based on stays prone to fraud/abuse. Molina: To monitor overutilization; to manage high-cost stays; and determine appropriate level of care. SelectHealth: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and based on stays prone to fraud/abuse.	Health Choice: PA required. Healthy U: To monitor overutilization; manage high-cost stays; to determine appropriate level of care; and based on stays prone to fraud/abuse. Molina: To monitor overutilization manage high-cost stays; determine appropriate level of care; and based on stays prone to fraud/abuse. SelectHealth: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and based on stays prone to fraud/abuse.

Are the PA reasons the same for both in-network and out-of-network providers?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: Yes Molina: Yes SelectHealth: Yes	Health Choice: Yes Healthy U: Yes Molina: Yes SelectHealth: Yes
PROCESS	
What entity performs the PA processes?	
MH/SUD - UMIC	**M/S - UMIC**
For those UMIC plans that require PA, PAs are performed by the UMIC plan.	PAs are performed by the UMIC plan.
Are there exceptions to the application of the criteria used to determine whether a PA will be granted? List the situations when exceptions are granted.	
MH/SUD	M/S
Health Choice: N/A Healthy U: No Molina: No SelectHealth: Yes, exceptions to PA criteria may be made based on peer-to-peer reviews or through the appeals process.	Health Choice: Yes, when a clinical situation needs to be evaluated comprehensively (clinical guidelines cannot always adequately address complex medical situations). Healthy U: No Molina: No SelectHealth: Yes, exceptions to PA criteria may be made based on peer-to-peer reviews or through the appeals process.
Are there any time restrictions? For example, what is the maximum amount of time allowed to issue a determination on a prior authorization request?	
MH/SUD - UMIC	**M/H - UMIC**
Yes, UMIC plans must make a decision within 14 calendar days after the PMHP receives the request with a possible 14 additional calendar days if certain criteria are met; and within 72 hours if an expedited decision is necessary based on client's health.	Yes, UMIC plans must make a decision within 14 calendar days after the PMHP receives the request with a possible 14 additional calendar days if certain criteria are met; and within 72 hours if an expedited decision is necessary based on client's health.
If there are any change to PA policies or procedures, does the plan update providers about the change? If so, how are providers updated?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: Yes, via provider newsletters and website. As needed, changes may be communicated to individual providers orally and/or in writing.	HealthChoice: Yes, via website; fax; letter; provider manual; and/or through provider representatives. Healthy U: Yes, via newsletter, website, letter.

Molina: Yes, at least 30 days mailed notification before implementation, when possible, through emails, letters, and fax. SelectHealth: Yes, when PA criteria changes for MH/SUD stays, the guidelines are updated in the policies on SelectHealth's provider portal and providers are notified of the update through letter, email or phone by Provider Relations teams.	Molina: Yes, at least 30 days mailed notification before implementation, when possible, through emails, letters, and fax. SelectHealth: Yes, when PA criteria changes for M/S stays, the guidelines are updated in the policies on SelectHealth's provider portal and providers are notified of the update through letter, email or phone by Provider Relations teams.
EVIDENTIARY STANDARDS	
What evidence/criteria is relied upon to make determinations about which benefits meet the strategy criteria to apply PA?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: MN criteria; plan of care; clinical guidelines; and InterQual criteria. Healthy U: MN criteria; plan of care; and clinical guidelines. Molina: MN criteria and clinical guidelines. SelectHealth: MN criteria; clinical guidelines; and InterQual	Health Choice: MN criteria; plan of care; clinical guidelines; and InterQual criteria. Healthy U: MN criteria; plan of care; and clinical guidelines. Molina: MN criteria; plan of care; and clinical guidelines. SelectHealth: MN criteria; clinical guidelines; and InterQual
If the processes used to apply PA are different for MH/SUD than for M/S benefits, what evidence was relied upon to determine that these differences are appropriate?	
MH/SUD - UMIC	**M/S - UMIC**
See M/S column.	Molina has as additional criterion for determining whether PA will be granted for a M/S stay; i.e. plan of care. Molina explained that for an MH/SUD stay, it is always an emergent situation which would not be included in a plan of care. In fact, the admission would be going against the plan of care.

Concurrent Review (CR) – Inpatient Hospital Stays

STRATEGY	
What are the overall reasons for conducting CR for inpatient hospital stays?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: To monitor overutilization; to manage high-cost stays; and to determine appropriate level of care. Healthy U: To monitor overutilization; to manage high-cost stays, to determine appropriate level of care; and based on stays prone to fraud/abuse.	Health Choice: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and to manage transition of care. Healthy U: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and based on stays prone to fraud/abuse.

Molina: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and to monitor for discharge disposition and needs. SelectHealth: To monitor overutilization; to manage high-cost stays; and to determine appropriate level of care.	Molina: To monitor overutilization, to manage high-cost stays, to determine appropriate level of care; and based on stays prone to fraud/abuse. SelectHealth: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and to check against InterQual criteria for extended stays.
Are the reason for requiring CR the same for both in-network and out-of-network providers?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: Yes Healthy U: Yes Molina: Yes SelectHealth: Yes	Health Choice: Yes Healthy U: Yes Molina: Yes SelectHealth: Yes
PROCESS	
What entity conducts CR?	
MH/SUD - UMIC	**M/S - UMIC**
CR is conducted by the UMIC plans.	CR is conducted by the UMIC plans.
Are there exceptions to the application of the criteria used for requiring CR? List the situations when exceptions are granted.	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: Yes, Health Choice uses InterQual (IQ) criteria to evaluate all [MH/SUD and M/S] inpatient stays. If the IQ criteria subset does not recommend approval but the medical reviewer feels the inpatient stay is medically necessary, they can review it with the Clinical Services Director and/or the Medical Director to make an exception to IQ criteria. The IQ criteria set for behavioral health (BH) is much more appropriate to address BH issues than it is for M/S issues. Healthy U: No. Molina: No SelectHealth: Yes, exceptions to PA criteria may be made based on peer-to-peer reviews or through the appeals process.	Health Choice: Yes, if the clinical situation needs to be evaluated comprehensively. Algorithmic medical necessity criteria, (InterQual, MCG) and clinical guidelines provide a necessary foundation, but are not always able to adequately address more complex medical situations. Concurrent review of the clinical details of inpatient stays with the Medical Director reveals occasional situations in which inpatient status is appropriate. Healthy U: No. Molina: No. SelectHealth: Yes, exceptions to PA criteria may be made based on peer-to-peer reviews or through the appeals process.
If there are any changes to policies or procedures regarding CR, does the plan update providers about the change? If so, how are providers updated?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: Yes, the Network Services representative for the provider contacts providers through fax, email, or phone.	Health Choice: Yes, updates are communicated via the website, fax, letter, provider manual, and/or through the provider representatives.

Healthy U: Yes, via provider newsletter, and website. As needed, changes may also be made to individual providers orally and/or in writing. Molina: Yes, phone calls, contracts, emails, and fax. SelectHealth: Yes, when CR criteria changes for MH/SUD stays, the guidelines are updated in the policies on SelectHealth's provider portal and providers are notified of the update through letter, email, or phone by the Provider Relations teams.	Healthy U: Yes, via provider newsletter, and website. As needed, changes may also be made to individual providers orally and/or in writing. Molina: Yes, phone calls, contracts emails, and fax. SelectHealth: Yes, when CR criteria changes for MH/SUD stays, the guidelines are updated in the policies on SelectHealth's provider portal and providers are notified of the update through letter, email, or phone by the Provider Relations teams.
EVIDENTIARY STANDARDS	
What evidence/criteria was relied upon to make determinations about which benefits meet the strategy criteria to apply CR?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: MN criteria; plan of care; and clinical guidelines Healthy U: MN criteria; plan of care; and clinical guidelines. Molina: MN criteria and clinical guidelines. SelectHealth: MN criteria; clinical guidelines; and InterQual.	Health Choice: MN criteria; plan of care; and clinical guidelines. Healthy U: MN criteria; plan of care; and clinical guidelines. Molina: MN criteria; plan of care; and clinical guidelines. SelectHealth: MN criteria; clinical guidelines; and InterQual.
If the processes used to apply CR are different for MH/SUD than for medical/surgical benefits, what evidence was relied upon to determine that these differences are appropriate?	
MH/SUD - UMIC	**M/S - UMIC**
Molina has a different overall reason for conducting CR for MH/SUD stays, i.e., to monitor for discharge disposition and needs. These are different reasons that do not indicate more stringent reasons for conducting MH/SUD reviews. Health Choice's explanation as to the differences in the exceptions made to the criteria for requiring CR is that InterQual criteria (which is used to evaluate all inpatient stays) "is much more appropriate to address [MH/SUD] issues. If the [InterQual] criteria subset does not recommend approval but the medical reviewer feels the inpatient stay is medically necessary they can review it with the Clinical Services Director and/or the Medical Director.	Molina has a different overall reason for conducting CR for M/S, i.e., based on stays prone to fraud/abuse.

Retrospective Review (RR) – Inpatient Hospital Stays

STRATEGY	
What are the overall reasons for conducting RR for inpatient hospital stays?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: No RR Healthy U: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and based on stays prone to fraud/abuse. Molina: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and if provider not aware of the member insurance carrier upon admission. SelectHealth: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and based on stays prone to fraud/abuse.	Health Choice: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; based on stays prone to fraud/abuse; and if there is a quality of care concern. Healthy U: To monitor overutilization, to manage high-cost stays, to determine appropriate level of care; and based on stays prone to fraud/abuse. Molina: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and based on stays prone to fraud/abuse. SelectHealth: To monitor overutilization; to manage high-cost stays, to determine appropriate level of care, based on stays prone to fraud/abuse, and to make sure InterQual criteria was met for the stay.
Are the reason for conducting RR the same for both in-network and out-of-network providers?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: Yes Molina: Yes SelectHealth: Yes	Health Choice: Yes Healthy U: Yes Molina: Yes SelectHealth: Yes
PROCESS	
What entity conducts RR?	
MH/SUD - UMIC	**M/S - UMIC**
RR is conducted by the UMIC plans.	RR is conducted by the UMIC plans.
Are there exceptions to the application of the criteria used for requiring RR? List the situations when exceptions are granted.	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: No exceptions. Molina: No exceptions. SelectHealth: Yes, exceptions to PA criteria may be made based on peer-to-peer reviews or through the appeals process.	Health Choice: No Healthy U: No Molina: No SelectHealth: Yes, exceptions to PA criteria may be made based on peer-to-peer reviews or through the appeals process.

If there is any change to policies or procedures regarding RR, does the plan update its providers about the change? If so, how does the plan update its providers?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: Yes. Molina: Yes, 30 days notification through phone calls, emails, and fax. SelectHealth: Yes, when RR criteria changes for MH/SUD stays, the guidelines are updated in the policies on SelectHealth's provider portal and providers are notified of the update through letter, email, or phone by the Provider Relations teams.	Health Choice: Yes, Healthy U: Yes. Molina: Yes, 30 days mailed notification before implementation through phone call, emails, and fax. SelectHealth: Yes, when RR criteria changes for MH/SUD stays, the guidelines are updated in the policies on SelectHealth's provider portal and providers are notified of the update through letter, email, or phone by the Provider Relations teams.
What evidence/criteria is relied upon to make determinations about which benefits meet the strategy criteria to apply RR?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: MN criteria; plan of care; and clinical guidelines. Molina: MN criteria and clinical guidelines. SelectHealth: MN criteria; clinical guidelines; and InterQual.	Health Choice: MN criteria, clinical guidelines, short-term readmission under the same DRG. Healthy U: MN criteria, plan of care, and clinical guidelines. Molina: MN criteria; plan of care; and clinical guidelines. SelectHealth: MN criteria; clinical guidelines; and InterQual.
If the processes used to apply RR are different for MH/SUD than for M/S benefits, what evidence was relied upon to determine that these differences are appropriate?	
MH/SUD - UMIC	**M/S - UMIC**
No differences.	No differences.

SUMMARY OF UMIC INPATIENT UTILIZATION CRITERIA

Inpatient Prior Authorization (PA)

Regarding UMIC plans, one plan, Health Choice, does not require PA for MH/SUD but does for M/S inpatient stays. The other three plans' overall reasons for requiring PA for inpatient stays are either the same (Healthy U and SelectHealth) for both MH/SUD and M/S benefits or more stringently applied to M/S benefits; Molina has one additional reason (based on stays prone to fraud/abuse) for requiring PA to its M/S benefits than to its MH/SUD benefits.

The specific criteria that the plans use to determine if an inpatient stay is approved are the same for each plan's MH/SUD and M/S inpatient stays that require PA except one plan (Molina) has an additional criterion for M/S stays, i.e., plan of care.

As noted on page 14 above, Molina explained that plan of care is not a reason for determining if a MH/SUD stay is approved because these stays are "always an emergent situation which would not be included in a plan of care. In fact, the admission would be going against the plan of care."

Two of the three plans, Healthy U and Molina, that require PA do not make exceptions to their criteria for MH/SUD or M/S stays. The third plan, SelectHealth, makes exceptions to its PA criteria for MH/SUD and M/S stays for the same reasons.

The three plans that require PA, inform their providers of changes to PA polices or procedures in the same way, i.e., the plans do not differentiate by benefit type (MH/SUD or M/S) the way in which they update providers of changes to PA policies or procedures.

All UMIC plans follow the federal regulations regarding PA determinations.

Inpatient Concurrent Review (CR)

One UMIC plan (Healthy U) conducts inpatient CRs for the same overall reasons for both their MH/SUD and M/S benefits. One plan, Molina, monitors MH/SUD stays and M/S stays for the same reasons, but has an additional reason for monitoring MH/SUD stays, i.e., "to monitor discharge disposition and needs" and an additional reason for monitoring M/S stays, i.e., "based on stays prone to fraud and abuse." Two plans (Health Choice and SelectHealth) conduct CR for inpatient stays for MH/SUD benefits and M/H benefits for the same reasons except both plans have one additional reason for conducting CR for M/H benefits: Health Choice to "manage transition of care" and SelectHealth to "check against InterQual criteria for extended stays".

As noted on page 16 above, none of these reasons is indicative of a UMIC plan applying CR more stringently to MH/SUD benefits than to M/S benefits.

The specific criteria that the plans use to determine if CR should be conducted for inpatient stays are the same for three of the plans for both MH/SUD and M/S inpatient stays. One plan (Molina) has an additional criterion for conducting CR related to M/S stays, i.e., plan of care.

This additional criterion for M/S stays is not indicative of Molina applying the CR criteria more stringently to MH/SUD benefits.

Regarding exceptions to the application of the criteria used for requiring CR, two of the plans, Healthy U and Molina, do not make exceptions for MH/SUD or for M/S inpatient benefits. SelectHealth makes the same criteria exceptions for both MH/SUD and M/S benefits. Health

Choice makes exceptions for both MH/SUD and M/S benefits but the situations for granting exceptions are different. Health Choice makes exceptions to the M/S criteria when the clinical situation needs to be evaluated comprehensively. This is because clinical guidelines do not adequately address more complex medical situations. Health Choice's explanation as to the differences in the exceptions made to the criteria for requiring CR is that InterQual criteria (which is used to evaluate all inpatient stays) "is much more appropriate to address [MH/SUD] issues. If the [InterQual] criteria subset does not recommend approval but the medical reviewer feels the inpatient stay is medically necessary they can review it with the Clinical Services Director and/or the Medical Director." (See page16 above.)

Inpatient Retrospective Review (RR)

One of the four UMIC plans (Health Choice) does not conduct RR for MH/SUD inpatient hospital stays, but does for M/S stays. Therefore, this is less restrictive because RR could result in denying a previously paid claim.

One plan, Healthy U, conducts RR for the same reasons for both MH/SUD and M/S stays. Most of Molina's and SelectHealth's reasons for conducting RR are the same for both their MH/SUD and M/H stays. However, for Molina, an additional reason that Molina conducts RR for MH/SUD stays is that the "provider not aware of the member insurance carrier upon admission." An additional reason Molina conducts RR for M/S stays is "based on stays prone to fraud/abuse." Neither of these reasons indicate that processes are applied more stringently for MH/SUD stays than for M/S stays. SelectHealth's additional reason for conducting RR for M/S stays is to "make sure InterQual criteria is met for stay." This additional reason indicates that reasons for conducting RR is more stringent for M/S stays.

Regarding the criteria used to make determinations about which benefits meet the criteria to apply RR, Healthy U and SelectHealth use the same criteria for both their MH/SUD and M/S inpatient benefits. Molina has one additional criterion for conducting RR (plan of care) for M/S inpatient benefits than for MH/SUD benefits. This additional reason is not indicative of more or less stringency placed on MH/SUD benefits. (Health Choice does not conduct RR for its MH/SUD inpatient benefits.)

Regarding exceptions to the application of the criteria used for requiring RR, Healthy U and Molina do not make exceptions for either MH/SUD or M/S inpatient benefits. SelectHealth makes exceptions for MH/SUD and M/S inpatient benefits and for the same reasons. Exceptions to RR criteria are no more stringent for MH/SUD than for M/S benefits.

The State has determined that inpatient hospital UR requirements for M/S and MH/SUD benefits are comparable and applied no more stringently to MH/SUD than to M/S benefits.

UTILIZATION MANAGEMENT – PMHPS & ACOS

OUTPATIENT

Outpatient Prior Authorization (PA)

STRATEGY	
What are the overall reasons for requiring PA for outpatient services?	
MH/SUD - PMHPs	**M/S - ACOs**
For those PMHPs that require outpatient PAs, they do so to monitor overutilization; manage high-cost services; determine appropriate level of care; and based on services that may be prone to fraud/abuse.	To monitor utilization; manage high-cost service; deter mine appropriate level of care; based on services that may be prone to fraud/abuse; to be informed about procedures or conditions that would warrant care management; to be in compliance with federal law; and to avoid unnecessary tests or treatments.
Are the PA reasons the same for both in-network and out-of-network providers?	
MH/SUD - PMHPs	**M/S - ACOs**
Yes.	Yes.
PROCESS	
What entity performs the PA process?	
MH/SUD - PMHPs	**M/S - ACOs**
PAs are performed by the PMHPs.	PAs are performed by the ACOs, with one exception. One ACO contracts with an outside entity to perform the PA processes for vision care.
Are there exceptions to the application of the criteria used to determine whether a PA will be granted? List the situations when exceptions are granted.	
MH/SUD - PMHPs	**M/S - ACOs**
Yes. Exceptions include peer-to-peer review, and consideration of unique circumstances.	Yes. In addition to objective criteria, a subjective assessment may be necessary; peer-to-peer review; and based on the outcome of an appeal.
Are there any time restrictions? For example, what is the maximum amount of time allowed to issue a determination on a prior authorization request?	
MH/SUD - PMHPs	**M/S - ACOs**
Yes, within 14 calendar days after the PMHP receives the request with a possible 14 additional calendar days if certain criteria are met. Within 72 hours if an expedited decision is necessary based on client's health.	Yes, within 14 calendar days after the PMHP receives the request with a possible 14 additional calendar days if certain criteria are met. Within 72 hours if an expedited decision is necessary based on client's health.
If there is any change to PA policies or procedures, does the plan update providers about the change? How often do these updates occur?	
MH/SUD - PMHPs	**M/S - ACOs**
For those PMHPs that require PA, they all update providers about changes to policies/ procedures regarding PAs. Depending on the significance of the change, PMHPs update providers prior to the implementation of the change.	For those PMHPs that require PA, they all update providers about changes to policies/ procedures regarding PAs. Depending on the significance of the change, PMHPs update providers prior to the implementation of the change.

EVIDENTIARY STANDARDS	
What evidence/criteria is relied upon to make determinations about which benefits meet the strategy criteria to apply PA?	
MH/SUD - PMHPs	**M/S - ACOs**
Medical necessity criteria; plan of care; clinical guidelines; and peer-to-peer review.	Medically necessity criteria; plan of care; clinical guidelines; and peer-to-peer review.
If the processes used to apply PA are different for MH/SUD than for M/S benefits, what evidence was relied upon to determine that these differences are appropriate?	
MH/SUD - PMHPs	**M/S - ACOs**
No differences.	No differences.

Outpatient Concurrent Review (CR)

STRATEGY	
What are the overall reasons for requiring CC for outpatient services?	
MH/SUD - PMHPs	**M/S - ACOs**
For those PMHPs that require outpatient PAs, they do so to monitor overutilization; manage high-cost services; determine appropriate level of care; and based on services that may be prone to fraud/abuse.	To monitor utilization; manage high-cost service; determine appropriate level of care; based on services that may be prone to fraud/abuse; to be informed about procedures or conditions that would warrant care management; to be in compliance with federal law; and to avoid unnecessary tests or treatments.
Are the PA reasons the same for both in-network and out-of-network providers?	
MH/SUD - PMHPs	**M/S - ACOs**
Yes.	Yes.
PROCESS	
What entity performs the PA process?	
MH/SUD - PMHPs	**M/S - ACOs**
PAs are performed by the PMHPs.	PAs are performed by the ACOs, with one exception. One ACO contracts with an outside entity to perform the PA processes for vision care.
Are there exceptions to the application of the criteria used to determine whether a PA will be granted? List the situations when exceptions are granted.	
MH/SUD - PMHPs	**M/H - ACOs**
Yes. Exceptions include peer-to-peer review, and consideration of unique circumstances.	Yes. In addition to objective criteria, a subjective assessment may be necessary; peer-to-peer review; and based on the outcome of an appeal.
Are there any time restrictions? For example, what is the maximum amount of time allowed to issue a determination on a prior authorization request?	
MH/SUD - PMHPs	**M/H - ACOs**
Yes, within 14 calendar days after the PMHP receives the request with a possible 14 additional calendar days if certain criteria are met. Within 72 hours if an expedited decision is necessary based on client's health.	Yes, within 14 calendar days after the PMHP receives the request with a possible 14 additional calendar days if certain criteria are met. Within 72 hours if an expedited decision is necessary based on client's health.

If there is any change to PA policies or procedures, does the plan update providers about the change? How often do these updates occur?	
MH/SUD - PMHPs	**M/H - ACOs**
For those PMHPs that require PA, they all update providers about changes to policies/ procedures regarding PAs. Depending on the significance of the change, PMHPs update providers prior to the implementation of the change.	For those PMHPs that require PA, they all update providers about changes to policies/ procedures regarding PAs. Depending on the significance of the change, PMHPs update providers prior to the implementation of the change.
EVIDENTIARY STANDARDS	
What evidence/criteria is relied upon to make determinations about which benefits meet the strategy criteria to apply PA?	
MH/SUD - PMHPs	**M/H - ACOs**
Medical necessity criteria; plan of care; clinical guidelines; and peer-to-peer review.	Medically necessity criteria; plan of care; clinical guidelines; and peer-to-peer review.
If the processes used to apply PA are different for MH/SUD than for M/S benefits, what evidence was relied upon to determine that these differences are appropriate?	
MH/SUD - PMHP	**M/H - ACOs**
No differences.	No differences.

The State reviewed the ACOs' and PMHPs' survey results of their outpatient services utilization review (UR) requirements (i.e., PA, CC, and RR) including the reasons for requiring UR, the criteria applied and exceptions to the criteria used. Although the results varied among ACOs and among PMHPs, and also across ACOs and PMHPs, the reasons, criteria, and exceptions to the criteria, all were comparable in intent. Utah's EQRO has found that all ACOs and PMHPs that require PA have mechanisms to ensure consistent application of their review criteria. All ACOs and PMHPs inform their providers of significant changes to their UR policies and procedures prior to implementing the changes. All ACOs and PMHPs follow the federal regulations regarding PA determinations.

The State has determined that UR requirements for MH/SUD outpatient service are comparable and applied no more stringently to MH/SUD benefits than to M/S benefits.

UTILIZATION MANAGEMENT - UMIC

OUTPATIENT

Outpatient Prior Authorization (PA)

STRATEGY	
What are the overall reasons for requiring PA for outpatient services?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: To manage high-cost services and to determine appropriate level of care.	Health Choice: To monitor overutilization; to manage high-cost services; to determine appropriate level of care; based on stays prone to fraud/abuse; in order to receive notification about procedures or conditions that would be amenable

	to care management; to be in compliance with federal law (i.e. sterilization procedures); and to avoid ineffective, unnecessarily risky, or harmful tests or treatments.
Healthy U: To monitor overutilization; to manage high-cost services; to determine appropriate level of care; and based on services that may be prone to fraud/abuse. Molina: To monitor overutilization; to manage high-cost services; and to determine appropriate level of care. SelectHealth: PA is not required.	Healthy U: To monitor overutilization; to manage high-cost services; to determine appropriate level of care; and based on services that may be prone to fraud/abuse. Molina: To monitor overutilization; to manage high-cost services; to determine appropriate level of care; and based on services prone to fraud/abuse. SelectHealth: To monitor overutilization; to manage high-cost services; to determine appropriate level of care; and based on services prone to fraud/abuse.
Are the PA reasons the same for both in-network and out-of-network providers?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: No, PA requests from out-of-network providers are evaluated for redirection to a network provider. Healthy U: Yes. Molina: No, all out-of-network services require PA. SelectHealth: N/A	Health Choice: No, PA requests from out-of-network providers are evaluated for redirection to a network provider. Healthy U: Yes. Molina: No, all out-of-network services require PA. SelectHealth: Yes.
PROCESS	
What entity performs the PA process?	
MH/SUD - UMIC	**M/S - UMIC**
For those UMIC plans that require PA, PA is performed by the UMIC plan.	PA is performed by the UMIC plan.
Are there exceptions to the application of the criteria used to determine whether a PA will be granted? List the situations when exceptions are granted.	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: No Healthy U: No Molina: No SelectHealth: N/A	Health Choice: No Healthy U: No. Molina: No. SelectHealth: Yes. Exceptions to PA criteria may be made based on peer-to-peer reviews or through the appeals process.

Are there any time restrictions? For example, what is the maximum amount of time allowed to issue a determination on a prior authorization request?	
MH/SUD - UMIC	**M/S - UMIC**
Yes, within 14 calendar days after the UMIC plan receives the request with a possible 14 additional calendar days if certain criteria are met. Within 72 hours if an expedited decision is necessary based on client's health.	Yes, within 14 calendar days after the UMIC plan receives the request with a possible 14 additional calendar days if certain criteria are met. Within 72 hours if an expedited decision is necessary based on client's health.
If there is any change to PA policies or procedures, does the plan update providers about the change? If so, how does the plan update its providers?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: Yes, all providers receive information on changes via fax and email blast as well as via postings to the Health Choice website. Network Services representatives may also reach out on a targeted basis if updates pertain specifically to one provider type. Healthy U: Yes, via Provider newsletters and plan website. As needed, PA changes may also be communicated to individual providers orally and/or in writing. Molina: Yes, mailed notification before implementation. SelectHealth: Yes, when PA criteria changes for MH/SUD services, the guidelines are updated in the policies on SelectHealth's provider portal and providers are notified of the update through letter, email or phone by Provider Relations teams.	Health Choice: Yes, all providers receive information on changes via fax and email blast as well as via postings to the Health Choice website. Network Services representatives may also reach out on a targeted basis if updates pertain specifically to one provider type. Healthy U: Yes, via Provider newsletters and plan website. As needed, PA changes may also be communicated to individual providers orally and/or in writing. Molina: Yes, mailed notification before implementation. SelectHealth: Yes, when PA criteria changes for MH/SUD services, the guidelines are updated in the policies on SelectHealth's provider portal and providers are notified of the update through letter, email or phone by Provider Relations teams.
EVIDENTIARY STANDARDS	
What evidence/criteria is relied upon to make determinations about which benefits meet the strategy criteria to apply PA?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: MN criteria; plan of care; and clinical guidelines; Healthy U: MN criteria; plan of care; and clinical guidelines.	Health Choice: MN criteria; plan of care; clinical guidelines; and an assessment of the whole patient, including history. Risk factors, the social situation, complicating behavioral health factors, alternative interventions that are available, and current evidence. Healthy U: MN criteria; plan of care; and clinical guidelines.

Molina: MN criteria; plan of care; and clinical guidelines. SelectHealth: N/A	Molina: MN criteria; plan of care; and clinical guidelines. SelectHealth: MN criteria; clinical guidelines; and InterQual.
If the processes used to apply PA are different for MH/SUD than for M/S benefits, what evidence was relied upon to determine that these differences are appropriate?	
MH/SUD - UMIC	**M/S - UMIC**
No differences.	No differences.

Outpatient Concurrent Review (CR)

STRATEGY	
What are the overall reasons for requiring CR for outpatient services?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: No CR. Healthy U: To monitor overutilization; to manage high-cost services; to determine appropriate level of care; and based on services prone to fraud/abuse. Molina: No CR. SelectHealth: No CR.	Health Choice: To monitor overutilization; to manage high-cost services; to determine appropriate level of care; and based on services prone to fraud/abuse. Healthy U: To monitor overutilization; to manage high-cost services; to determine appropriate level of care; and based on services prone to fraud/abuse. Molina: To monitor overutilization; to manage high-cost services; to determine appropriate level of care; and based on stays prone to fraud/abuse. SelectHealth: No CR.
Are the reason for requiring CR for outpatient services the same for both in-network and out-of-network providers?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: Yes Molina: N/A SelectHealth: N/A	Health Choice: Yes Healthy U: No Molina: Yes SelectHealth: N/A
PROCESS	
Who conducts CR?	
MH/SUD - UMIC	**M/S - UMIC**
For those UMIC plans that conduct CR, CR is performed by the UMIC plans.	For those UMIC plans that conduct CR, CR is performed by the UMIC plans.
Are there exceptions to the application of the criteria used for requiring CR? List the situations when exceptions are granted.	
Health Choice: N/A	Health Choice: Yes. A subjective assessment is often necessary in addition to the application of objective criteria.

Healthy U: No Molina: N/A SelectHealth: N/A	Healthy U: No. Molina: No. SelectHealth: N/A
If there is any change to CR policies or procedures, does the plan update providers about the change? If so, how does the plan update its providers?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: Yes, via Provider newsletters and plan website. As needed, PA changes may also be communicated to individual providers orally and/or in writing. Molina: N/A Selecthealth: N/A	Health Choice: Yes, updates are communicated in the via website, fax, letter, provider manual, and/or through the provider representatives. Healthy U: Yes, via Provider newsletters and plan website. As needed, PA changes may also be communicated to individual providers orally and/or in writing. Molina: Yes, mailed notification before implementation. SelectHealth: N/A
EVIDENTIARY STANDARDS	
What evidence/criteria is relied upon to make determinations about which benefits meet the strategy criteria to apply CR?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: medical necessity criteria, plan of care, clinical guidelines Molina: N/A SelectHealth: N/A	Health Choice: Monitor overutilization, manage high-cost services, determine appropriate level of care, based on stays prone to fraud/abuse, & to assist with transition of care efforts. Healthy U: medical necessity criteria, plan of care, clinical guidelines Molina: medical necessity, plan of care, clinical guidelines SelectHealth: N/A
If the processes used to apply CR are different for MH/SUD than for M/S benefits, what evidence was relied upon to determine that these differences are appropriate?	
MS/SUD - UMIC	**M/S - UMIC**
No differences.	No differences.

Outpatient Retrospective Review (RR)

STRATEGY	
What are the overall reasons for requiring RR for outpatient services?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: No RR.	Health Choice: To monitor overutilization; to manage high-cost stays; to determine appropriate level of care; and based on stays prone to fraud/abuse.
Healthy U: To monitor utilization; to manage high-cost services; to determine that the level of care was appropriate; and based on services that may be prone to fraud/abuse.	Healthy U: To monitor overutilization; to manage high-cost services; to determine if the level of care was appropriate; and based on stays that may be prone to fraud/abuse.
Molina: Molina only conducts retro review in the instance of continuity of care.	Molina: To monitor overutilization; to manage high-cost services; to determine that the level of care was appropriate; and based on stays prone to fraud/abuse.
SelectHealth: No RR.	SelectHealth: Monitor overutilization; manage high-cost services; to determine if the level of care was appropriate; and based on stays that may be prone to fraud/abuse.
Are the reasons for conducting RR the same for both in-network and out-of-network providers?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: Yes Molina: Yes SelectHealth: N/A	Health Choice: Yes Healthy U: Yes Molina: Yes SelectHealth: Yes
PROCESS	
What entity conducts RR?	
MH/SUD - UMIC	**M/S - UMIC**
If RR is conducted, the UMIC plan conducts the RR.	If RR is conducted, the UMIC plan conducts the RR.
Are there exceptions to the application of the criteria used for requiring RR? List the situations when exceptions are granted.	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: No Molina: No	Health Choice: Yes. A subjective assessment is often necessary in addition to the application of objective criteria. Healthy U: No Molina: No

SelectHealth: N/A	SelectHealth: Yes. Exceptions to PA criteria may be made based on peer-to-peer reviews or through the appeals process.
If there is any change to policies or procedures regarding RR, does the plan update providers about the change? If so, how does the plan update its providers?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: Yes, via Provider newsletters and plan website. As needed, PA changes may also be communicated to individual providers orally and/or in writing. Molina: Yes, mailed notification before implementation via email, letters, and fax. SelectHealth: N/A	Health Choice: Yes. Healthy U: Yes, via Provider newsletters and plan website. As needed, PA changes may also be communicated to individual providers orally and/or in writing. Molina: Yes, mailed notification before implementation vis email, letters, and fax. SelectHealth: Yes, when RR criteria changes for MH/SUD outpatient services, the guidelines are updated in the policies on SelectHealth's provider portal and providers are notified of the update through letter, email or phone by Provider Relations.
EVIDENTIARY STANDARDS	
What evidence/criteria is relied upon to make determinations about which benefits meet the strategy criteria to apply RR?	
MH/SUD - UMIC	**M/S - UMIC**
Health Choice: N/A Healthy U: MN criteria; plan of care; and clinical guidelines. Molina: MN criteria; plan of care; and clinical guidelines. SelectHealth: N/A	Health Choice: MN criteria and clinical guidelines. Healthy U: MN criteria; plan of care; and clinical guidelines. Molina: MN criteria; plan of care; and clinical guidelines. SelectHealth: MN criteria; clinical guidelines; InterQual; or internal policy.
If the processes used to apply RR are different for MH/SUD than for M/S benefits, what evidence was relied upon to determine that these differences are appropriate?	
MH/SUD - UMIC	**M/S - UMIC**
No differences.	No differences.

The State has determined that UR requirements for M/S and MH/SUD outpatient services are comparable and applied no more stringently to MH/SUD benefits than to M/S benefits.

OUTPATIENT UMIC SUMMARY

Outpatient PA
Regarding UMIC plans, Select Health does not require PA for MH/SUD benefits. the other three plans require PA for some MH/SUD and some M/S outpatient services. Healthy U's overall reasons for requiring PA are the same for MH/SUD and M/S benefits. Health Choice and Molina each has the same reasons for requiring PA for their MH/SUD and their M/S benefits, plus additional reasons for requiring PA for M/S benefits. Health Choices additional reasons are to monitor overutilization, based on services prone to fraud/abuse, to receive notification about procedures that may need care management, and to comply with federal law (e.g., sterilization procedures), and to avoid unnecessary treatments. Molina's additional reason is based on services prone to fraud/abuse. These are additional reasons. Since both plans have additional reasons for requiring PA for their M/S benefits than for their MH/SUD benefits this assures that the PA requirements are less stringent for MH/SUD benefits.

Two of the plans have the same criteria/evidentiary standards for both their MH/SUD and M/S outpatient services. One plan (Health Choice) has two of the same criteria. However, for MH/SUD services, Health Choice has an additional criterion, i.e., based on the contract with the State. For M/S services, an additional criterion is "an assessment of the whole patient, including history. Risk factors, the social situation, complicating behavioral health factors, alternative interventions that are available, and current evidence." (SelectHealth does not require PA for MH/SUD benefits.) The additional reasons do are not indicative of PA criteria being more or less stringent for MH/SUD than for M/S benefits.

None of the three UMIC plans that require PA make exceptions to the criteria used for determining if a MH/SUD service is approved nor do they make exception for M/S benefits; therefore, there is no issue with mental health parity.

One plan, Healthy U, has the same PA reasons for both in-network and out-of-network providers. The other two plans (Health choice and Molina) that require PA do not have the same PA reasons for requiring PA from their in-network and out-of-network providers. Health Choice and Molina require PA from all out-of-network providers for both their MH/SUD and M/S benefits.

Outpatient CR
Three of the UMIC plans do not conduct CR for MH/SUD outpatient services. Both Health Choice and SelectHealth conduct CR for M/S services. The plan, Healthy U, that conducts CR for outpatient services does so for the same overall reasons for both its MH/SUD and M/S outpatient services.

Healthy U's criteria for determining which benefits should apply CR are the same for both its MH/SUD and M/S outpatient services: medical necessity criteria, plan of care, and clinical guidelines.

Regarding exceptions to the application of the criteria used for requiring CR, Healthy U does not make exceptions for either its MH/SUD or its M/S outpatient benefits.

Outpatient RR

Two of the four plans, Healthy U and Molina, conduct RR for MH/SUD outpatient services. All plans conduct RR for M/S services. The plan, Health Choice, that conducts RR for M/S but not for MH/SUD conducts RR to monitor overutilization, manage high-cost services, determine appropriate level of care, and based on services prone to fraud/abuse. Healthy U, conducts RR for the same reasons as above and the same reasons apply to both MH/SUD and M/S services. Molina, conducts RR for the same MH/SUD services only for purposes of continuity of care. For M/S services, Molina conducts RR to monitor overutilization, managed high cost services, determine that the level of care was appropriate, and based on services prone to fraud/abuse. SelectHeath conducts RR for M/S benefits to determine that the level of care was appropriate to monitor overutilization, manage high-cost services, and based on services prone to fraud/abuse.

In all of instances above, there is no indication that the reasons for conducting RR for MH/SUD benefits is more stringent than for the M/S benefits.

The criteria used to conduct RR for outpatient services are the same for Healthy U and Molina: medically necessary criteria, plan of care, and clinical guidelines. SelectHealth conducts RR for M/S benefits based on MN criteria, clinical guidelines, InterQual, and internal policy.

Neither Healthy U or Molina make exceptions to the application of criteria for requiring RR for either RR for either MH/SUD or M/s benefits.

The State reviewed the UMIC plans' survey results of their outpatient services utilization review (UR) requirements (i.e., PA, CC, and RR) including the reasons for requiring UR, the criteria applied and exceptions to the criteria used. Although the results varied among UMIC plans, the reasons, criteria, and exceptions to the criteria, all were comparable in intent. All UMIC plans inform their providers of changes to their UR policies and procedures in the same way whether the changes are to MH/SUD or M/H UR policies and procedures. All UMIC plans follow the federal regulations regarding PA determinations for both their MH/SUD and M/S benefits.

The State has determined that UR requirements for MH/SUD outpatient and M/S outpatient services are comparable and applied no more stringently to MH/SUD benefits than to M/S benefits.

PROVIDER NETWORK ADMISSION – ALL MANAGED CARE PLANS

INPATIENT & OUTPATIENT PROVIDERS

ACOs, HOME UMIC plans, and PMHPs must maintain a network of providers that is sufficient to provide adequate access to all services covered under the contract with the State.

ACOs, HOME, UMIC plans, and PMHPs use the same criteria for selecting their network providers, i.e., all providers must be appropriately credentialed, in good standing with the licensing board, have primary source verification of licensure, and have written agreements with the managed care plans.

PROVIDER REIMBURSEMENT - ACO AND PMHP REIMBURSEMENT

INPATIENT & OUTPATIENT PROVIDERS

ACOs and PMHPs use a variety of methods for determining reimbursement rates for inpatient stays including rates based on the DRG, negotiated per diem rates, negotiations on a case-by-case basis, or published fee schedules.

For outpatient rates, methods for determining reimbursement rates include the Utah Medicaid fee schedule, analysis of historical cost, and through contract negotiations.

The processes used by ACOs and PMHPs for establishing reimbursement rates for inpatient hospital stays and outpatient services are comparable and applied no more stringently to PMHP network providers than to ACO network providers.

PROVIDER REIMBURSEMENT – UMIC PLANS

INPATIENT UMIC PROVIDERS

Health Choice (MH/SUD): Inpatient behavioral health providers are paid according to the Utah Department of Health Medicaid fee schedule.
Health Choice (M/S): Health Choice closely follows "prevailing Utah Medicaid payment methodologies for inpatient hospital services, which reimburse urban hospitals a NS-DRG rate and rural hospital on a percentage of eligible billed charges.

Healthy U (MH/SUD): Generally, the University of Utah Health Plans utilizes the Utah Department of Health's Fee-For-Service fee schedule as the primary benchmark for setting rates for inpatient hospital providers. Additionally, Healthy U runs an analysis comparing CMS Medicare rates, and its contracted commercial rates to help gauge what the provider community will accept. This analysis may lead to an adjustment of the benchmark rates.
Healthy U (M/S): Inpatient hospital services are negotiated on a case by case basis and can vary both on rates and methodology.

Molina (MH/SUD): Molina bases all reimbursements for its network behavioral inpatient hospitals based on the Medicaid fee schedule.
Molina (M/S): Molina reimburses its network M/S hospitals through contracted rates and DRGs.

SelectHealth (MH/SUD): SelectHealth uses the Utah State Medicaid fee schedule to determine reimbursement.
SelectHealth (M/S): SelectHealth determines reimbursement through analysis of historical cost and negotiation with providers.

The processes used by UMIC plans for establishing reimbursement rates for inpatient hospital stays are comparable and applied no more stringently to UMIC plans' MH/SUD providers than to its M/H providers.

PROVIDER REMIBURSEMTSNT – UMIC PLANS

OUTPATIENT UMIC PROVIDERS

Health Choice (MH/SUD): Health Choice reimburse its MH/SUD network providers according to the Utah Department of Health Medicaid fee schedule.
Health Choice (M/S): Health Choice reimburses outpatient providers "in close proximity to the Utah Medicaid fee schedule."

Healthy U (MH/SUD): University of Utah Health Plans utilizes the Utah Department of Health's Fee-For-Service fee schedule as the primary benchmark for setting rates. In addition, Healthy U runs an analysis comparing CMS Medicare rates, and Healthy U's contracted commercial rates to help gauge what the provider community will accept. This analysis may lead to an adjustment of the benchmark rates.
Healthy U (M/S): Outpatient services are negotiated on a case by case basis and can vary both on rates and methodology.

Molina (MH/SUD): Molina bases all reimbursements on the Medicaid Fee Schedule.
Molina (M/S): Molina reimburses based on contractual rates.

SelectHealth (MH/SUD): SelectHealth uses the Utah Medicaid Fee schedule to determine reimbursement.
SelectHealth (M/S): SelectHealth reimburses its outpatient providers through a single case agreement or through contracting.

The processes used by UMIC plans for establishing reimbursement rates for outpatient providers are comparable and applied no more stringently to UMIC plans' MH/SUD providers than to its M/H providers.

FAIL FIRST POLICIES (STEP THERAPY) – ACOS & PMHPS

INPATIENT

Two of the ACOs have fail first policies for inpatient hospital stays and two do not. None of the PMHPs have fail first policies for inpatient hospital stays.

The PMHPs do not have fail first policies, whereas two of the ACOs do have fail first policies. Therefore, Utah meets the fail first NQTL parity requirement for inpatient hospital stays.

FAIL FIRST POLICIES (STEP THERAPY) – UMIC PLANS

INPATIENT

Health Choice (MH/SUD): No fail first policies for inpatient hospital stays.
Health Choice (M/S): Yes. Under specific circumstances, InterQual inpatient admission criteria for certain diagnoses require trial and failure of lower cost outpatient management of that condition (e.g. asthmatic exacerbation, pain control).

Healthy U (MH/SUD): No
Healthy U (M/S): Yes. An example is joint replacements.

Molina (MH/SUD): No.
Molina (M/S): No.

SelectHealth (MH/SUD): No.
SelectHealth (M/S): No.

None of the UMIC plans has fail first policies for MH/SUD inpatient hospital stays, whereas, two of the UMIC plans have fail first policies for inpatient stays. Therefore, Utah meets the NQTL fail first parity requirements for UMIC plans' inpatient hospital stays.

FAIL FIRST POLICIES (STEP THERAPY) – PMHPS & ACOS

OUTPATIENT

Three of the ACOs have fail first policies for outpatient services and one does not. None of the PMHPs have fail first policies for outpatient services.

Since the PMHPs do not have fail first policies for outpatient services and all but one of the ACOs do have fail first policies, Utah meets the fail first NQTL parity requirement for outpatient services.

Fail First Policies (Step therapy) – UMIC PLANS

OUTPATIENT

Health Choice (MH/SUD): No fail first policies for outpatient services.
Health Choice (M/S): Yes. Specific criteria are required for certain advanced imaging, bariatric surgery, cardiac procedures, investigational treatments, interventional pain management, pharmaceuticals, and other services.

Healthy U (MH/SUD): No fail first policies for outpatient services.
Healthy U (M/S): Yes. Radiology: example is conservative therapy prior to MRI of the joint.

Molina (MH/SUD): Yes. For residential treatment centers, part of the clinical guidelines include providing evidence that a lower level had been failed or would not be appropriate prior to approving the higher level of outpatient behavioral health services.
Molina (M/S): Yes. Injections of the spine for pain control. Physical therapy must be attempted and failed or completed. Some surgeries per InterQual require attempts at more conservative measures showing failure of relief before surgery can be approved.

SelectHealth (MH/SUD): No
SelectHealth (M/S): No

Three of the UMIC plans do not have fail first policies for outpatient MH/SUD. Two of those plans have fail first for M/S services and one does not. One UMIC plan does not have fail first policies for either its MH/SUD or its M/S outpatient services.

Utah meets the fail first NQTL parity requirement for outpatient services provided by the UMIC plans.

FAILURE TO COMPLETE A COURSE OF OUTPATIENT TREATMENT – ACOS & PMHPS

OUTPATIENT SERVICES ONLY

Three of the ACOs have policies that may exclude services based on failure to complete a course of treatment. None of the PMHPs has such policies.

Utah meets the parity requirement for PMHPs and ACOs related to conditions that may exclude services if a member fails to complete a course of treatment.

FAILURE TO COMPLETE A COURSE OF OUTPATIENT TREATMENT – UMIC PLANS

OUTPATIENT SERVICES ONLY

None of the UMIC plans have policies that exclude MH/SUD services if a member fails to complete a course of treatment; one plan has such policies for M/S services.

Utah meets the parity requirement for UMIC plans related to conditions that may exclude services if a member fails to complete a course of treatment.

AVAILABILITY OF INFORMATION REQUIREMENTS

Availability of information requirements are requirements to make available certain types of information pertaining to MH/SUD benefits.

The Medicaid parity rule includes two requirements regarding availability of information related to MH/SUD benefits. The first requirement is that the criteria for medical necessity determinations for MH/SUD benefits must be made available to managed care enrollees, potential enrollees, and affected Medicaid providers, upon request. The second information requirement specifies that the reason for any denial of reimbursement or payment for MH/SUD benefits must be made available to the beneficiary.

CRITERIA FOR MEDICAL NECESSITY DETERMINATION

(All managed care plans)

All of Utah's managed care plans (ACOs, PMHPs, HOME, and UMIC plans) comply with the requirement outlined in 42 CFR 438.236(c) to disseminate practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees.

Therefore, Utah is in compliance with the requirement in 438.915(a) to make the criteria for medical necessity determination available to all enrollees, all potential enrollees, and all providers upon request.

REASON FOR DENIAL OF PAYMENT

(All managed care plans)

All of Utah's managed care plans (ACOs, PMHPs, HOME, and UMIC plans) send a notice of adverse benefit determination (consistent with 42 CFR 438.404, including the right of the enrollee to be given information specified in 438.404(b)(2)) to enrollees for any denial of reimbursement or payment.

Therefore, Utah is in compliance with the requirement in 438.915(b) to make the reason for denial of reimbursement or payment available to all managed care enrollees.

SUMMARY OF PARITY ANALYSIS

Utah confirms its compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) for its Medicaid program. Utah will continue to monitor its compliance with MHPAEA and address any parity issues that may arise in the future.