State of West Virginia Department of Human Services Medicaid & CHIP Mental Health Parity Compliance Documentation

Version 1.1

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Submitted On: May 8, 2026

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Table 1: Common Terms, Abbreviations and Acronyms

Term/Acronym	Definition
AAP	American Academy of Pediatrics
AAPD	American Academy of Pediatric Dentistry
ABA	Applied Behavioral Analysis
ABP	Alternative Benefit Plan
ACA	Affordable Care Act
ACT	Assertive Community Treatment
ADD	Attention Deficit Disorder
ADHD	Attention Deficit/Hyperactivity Disorder
ADL	Aggregate Dollar Limit
Aetna	Aetna Better Health® of West Virginia
AICD	Automatic Implantable Cardioverter-Defibrillator
AIM	American Imaging Management
AL	Aggregate Lifetime
ASAM®	American Society of Addiction Medicine
ASO	Administrative Service Organization
BCF	Bureau for Children and Families
BH	Behavioral Health
BMS	Bureau for Medical Services
BSS	Bureau for Social Services
CALOCUS	Child and Adolescent Level of Care/Service Intensity System
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPT®	Current Procedural Terminology
CSED	Children with Serious Emotional Disorder
CSEDW	Children with Serious Emotional Disorder Waiver
CSU	Community Psychiatric Supportive Treatment
CT	Computed Tomography
DME	Durable Medical Equipment
DoHS, Department	Department of Human Services
DSM	Diagnostic and Statistical Manual of Mental Disorders

Term/Acronym	Definition
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
E&M	Evaluation and Monitoring
ECT	Electro-Convulsive Treatment
EEG	Electroencephalogram
EHB	Essential Health Benefit
EPSDT	Early Periodic Screening, Diagnostic, and Treatment
ER	Emergency Room
FFPSA	Family First Prevention Services Act
FFS	Fee-For-Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FRs	Financial Requirements
HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
ICD	International Classification of Diseases
IOP	Intensive Outpatient Services
IRR	Interrater Reliability
LCSW	Licensed Clinical Social Worker
LOCUS	Level of Care Utilization System
M/S	Medical/Surgical
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MCG™	MCG Care Guidelines®
MD	Doctor of Medicine
MECA	Medical Eligibility Contracted Agent
MH	Mental Health
MHPAEA	Mental Health Parity and Addiction Equity Act of 2008
MHT	Mountain Health Trust
MOUD	Medications for Opioid Use Disorder
MPI	Myocardial Perfusion Imaging
MRA	Magnetic Resonance Angiogram

Term/Acronym	Definition
MRI	Magnetic Resonance Imaging
NAMI	National Alliance on Mental Illness
NCCN	National Comprehensive Cancer Network
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NP	Nurse Practitioner
NQTL	Non-Quantitative Treatment Limit
OBRA	Omnibus Budget Reconciliation Act of 1989
OP	Outpatient
OT	Occupational Therapy
OTP	Outpatient Treatment Program
OUD	Opioid Use Disorder
PA	Physician Assistant
PA	Prior Authorization
PBM	Pharmacy Benefit Manager
PCP	Primary Care Physician
PDL	Preferred Drug List
PET	Positron Emission Tomography
PHP	Partial Hospitalization Program
PRTF	Psychiatric Residential Treatment Facility
PT	Physical Therapy
QTL	Quantitative Treatment Limit
RFI	Request for Information
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SED	Serious Emotional Disorder
SFY	State Fiscal Year
SPA	State Plan Amendment
ST	Speech Therapy
State	West Virginia
SUD	Substance Use Disorder
TCM	Targeted Case Management

Term/Acronym	Definition
THP	The Health Plan
TUD	Tobacco Use Disorder
USC	United States Code
Wellpoint	Wellpoint West Virginia, Inc
WM	Withdrawal Management
WVCHIP	West Virginia Children's Health Insurance Program

1.0 Introduction

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).[1,2] MHPAEA requires health insurance issuers and group health plans that offer mental health (MH) and substance use disorder (SUD) benefits to ensure that financial requirements (FRs), such as deductibles and copayments, and treatment limitations, including quantitative and non-quantitative limits, applicable to MH/SUD benefits are no more restrictive than those applied to medical and surgical (M/S) benefits under the same plan and benefit classification.

The Affordable Care Act (ACA) expanded access to MH and SUD services by establishing MH and SUD as essential health benefits (EHBs)[3] and extending MHPAEA requirements to the individual and small group markets, thereby reinforcing and broadening the application of parity principles across coverage programs.

For Medicaid, MHPAEA parity requirements are incorporated through Section 1932(b)(8) of the Social Security Act for Medicaid managed care organizations (MCOs)[4] and Section 1937 of the Act for Medicaid Alternative Benefit Plans (ABPs).[5] On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) finalized regulations implementing MHPAEA parity requirements for Medicaid managed care, Medicaid ABPs, and the Children's Health Insurance Program (CHIP), with an effective date of May 31, 2016.[6,7]

Under the Medicaid and CHIP parity framework, states are responsible for ensuring compliance with MHPAEA across delivery systems and benefit designs, including oversight of Managed Care Organization (MCO) contracts, ABP benefit packages, and CHIP state plans. This includes ensuring that FRs, quantitative treatment limitations (QTLs), and non-quantitative treatment limitations (NQTLs) are comparable and applied no more stringently to MH and SUD benefits than to M/S benefits. States are also responsible for monitoring managed care entities and other contractors for ongoing mental health parity compliance and for addressing identified parity concerns.

In January 2017, CMS issued guidance and a toolkit[8] to assist the states in achieving compliance with the law. This report is informed by and aligns with that guidance.

As of February 2026, over 83% of West Virginia's Medicaid and West Virginia Children's Health Insurance Program (WVCHIP) members are enrolled in managed care, with a few services carved out and provided as fee-for-service (FFS).[9] Mountain Health Trust is West Virginia's managed care program for both Medicaid and WVCHIP. WVCHIP joined Mountain Health Trust on January 1, 2021, and aligned its benefit package with Medicaid on July 1, 2023.[10] Four MCOs entered contracts with the State to provide comprehensive health services, including Aetna Better Health® of West Virginia (Aetna), Highmark Health Options (Highmark), The Health Plan (THP), and Wellpoint West Virginia, Inc (Wellpoint). Figure 1 shows Mountain Health Trust membership by MCO. Figure 2 shows WVCHIP membership by MCO.

Figure 1: West Virginia Medicaid Membership by MCO

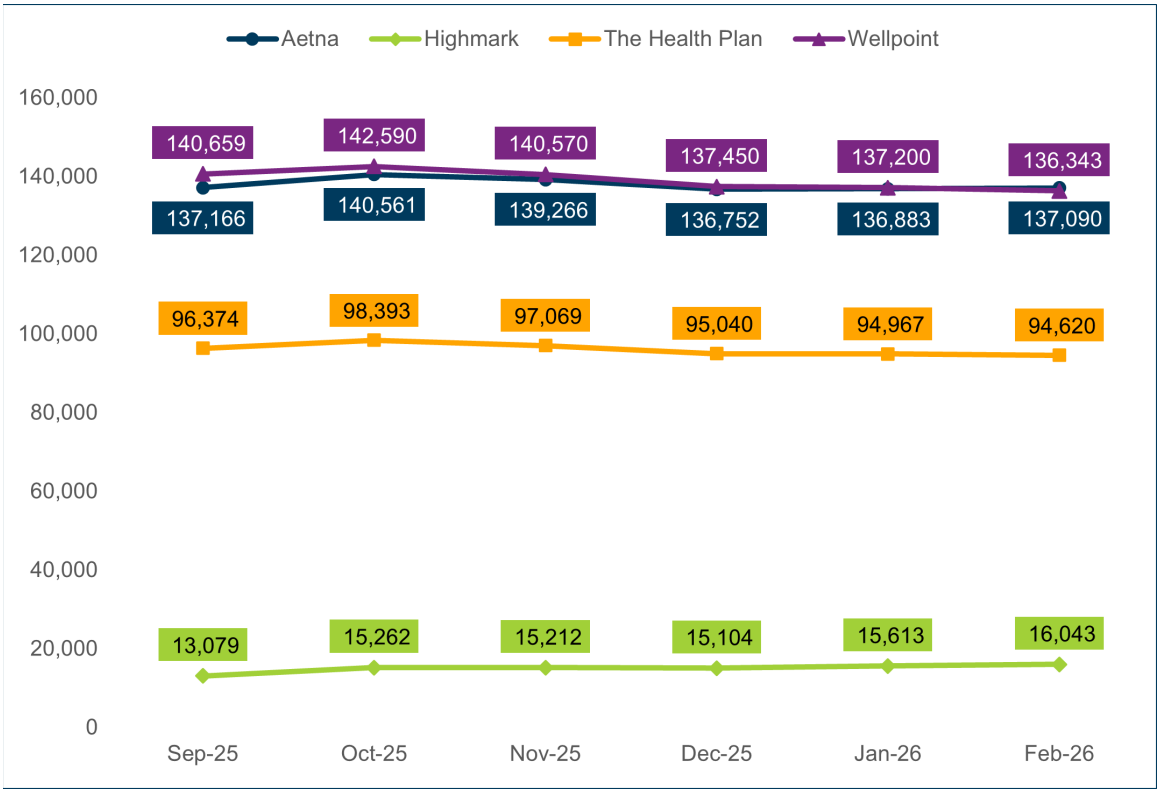
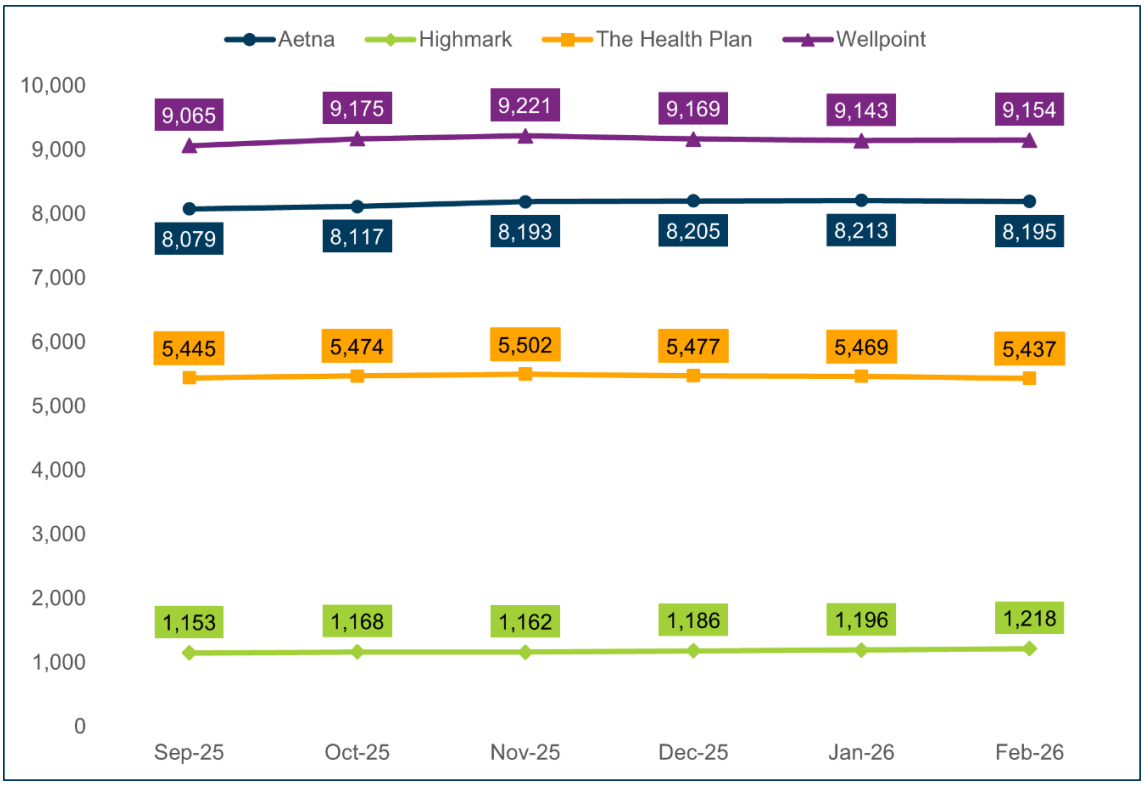


Figure 2: WVCHIP Membership by MCO



Mountain Health Promise is a specialized managed care program for Medicaid children and youth. The program supports children in foster care, kinship care, adoptive care, as well as children and youth from age 3 through age 20 who are eligible for the Children with Serious Emotional Disorder (CSED)[i] Home and Community-Based Services (HCBS) waiver program.[11] Aetna serves as the single MCO for Mountain Health Promise and provides risk-based comprehensive health services, children's residential care services, and skilled nursing services.

The goal of the CSED HCBS waiver is to reduce the number of children housed in Psychiatric Residential Treatment Facilities (PRTFs) and shorten length of stay for children who require residential care. Per the Bureau for Medical Services (BMS) manual, "this waiver prioritizes children/youth with serious emotional disorder (SED) who are:

1) In PRTFs or other residential treatment providers either in-state or out-of-state; and
2) Other Medicaid-eligible CSED who are at risk of institutionalization."[12]

As of March 2026, Mountain Health Promise enrollment included 9,651 members in foster care and 13,928 members in adoptive care, with 994 members receiving CSED services.

This document reviews Mountain Health Trust and Mountain Health Promise MCOs compliance with mental health parity requirements as established in applicable statutes and regulations. The report summarizes findings from MCO-submitted materials used to demonstrate compliance with parity standards and includes analysis of aggregated quarterly MCO data to identify trends and potential concerns related to parity compliance or barriers to accessing MH/SUD services. Mountain Health Trust and Mountain Health Promise are reviewed together, as the core benefit packages are the same; relevant programmatic differences are noted throughout the report.

[i] The BMS Provider Manual defines CSED as "children with an [serious emotional disorder] SED who are ages three through 20 and who currently have or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) (or International Classification of Disease (ICD) equivalent) that is current at the date of evaluation and results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities."

2.0 Methodology

2.1 Benefit Package Identification Process

The West Virginia Department of Human Services (DoHS, Department), BMS, is the designated single State agency responsible for the administration of the State's Medicaid and CHIP programs.[ii] BMS provides access to appropriate healthcare for Medicaid and CHIP-eligible individuals.

For the Medicaid and WVCHIP benefit package, BMS has entered contracts with four MCOs to provide risk-based comprehensive services to Mountain Health Trust's managed care enrollees: Aetna, Highmark, THP, and Wellpoint.

In 2022, Aetna was re-awarded the contract to serve as the sole vendor for the Mountain Health Promise (MHP) program. These services are similar to the Medicaid and WVCHIP benefits package, with the addition of socially necessary services (as defined by the Bureau for Children and Families [BCF]) and services specifically for CSED members (see Section 4.2). This contract was initially effective beginning July 1, 2023, through June 30, 2024 (SFY 2024), and was renewed for SFYs 2025 and 2026, with an additional renewal planned for SFY 2027.[13] The State will initiate a competitive procurement in fall 2026 to solicit a vendor to provide Mountain Health Promise services beginning in July 2027 (SFY 2028).

In accordance with CMS guidance, the State submitted a WVCHIP State Plan Amendment (SPA) as part of its approach to achieving deemed compliance with parity requirements for the population under age 21.[14] For this reason, this report includes additional details on the provision of Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which helps ensure access to all medically necessary MH/SUD services, including those that exceed typical service limits.

2.2 Benefit Package Delivery Systems

The State's Medicaid and CHIP programs deliver most benefits using managed care; a few services are carved out and provided through FFS delivery systems. Pharmacy, Birth-to-Three services, school-based health services, and a few specific medical procedures are carved out of the MCO contract and provided on an FFS basis to MCO members.

Coverage for SUD services transitioned from FFS to the MCOs in 2019, with the exception of Outpatient Treatment Programs (OTPs) for Methadone.[15,16] As part of the current West Virginia Continuum of Care for Medicaid Enrollees with Substance Use Disorders 11-W-00307/3 1115 Waiver, Medicaid beneficiaries with opioid use disorder (OUD) and SUD in West Virginia are

[ii] References to "BMS" in the Mountain Health Trust contract and "the Department" in the Mountain Health Promise contract both refer to the State agency administering managed care, currently the Department of Human Services, Bureau for Medical Services. The terminology reflects contract-specific definitions rather than a substantive difference in authority or responsibility. This Section uses "BMS" for simplicity.

eligible to receive treatment, (e.g., counseling, inpatient services) as deemed appropriate and medically necessary, including Medication Assisted Treatment (MAT).[17]

Because of the mixed delivery system (i.e., FFS and managed care), the State is responsible for conducting the mental health parity analysis.[18] To strengthen the compliance monitoring in place, the State requires Mountain Health Trust MCOs to also maintain internal mental health parity compliance plans that outline mental health parity monitoring.

2.3 FFS Coverage of Comprehensive Benefits

Most West Virginia Medicaid members, and all WVCHIP members, are enrolled in an MCO. Members move into the FFS delivery system only under specific circumstances that include:[19,20]

- BMS (or its designee) automatically assigns individuals to an MCO as soon as they become eligible for Medicaid or WVCHIP. Assignments are made, when possible, based on prior enrollment history and existing family relationships, while also ensuring members are distributed evenly across MCOs over time.
- Specific Populations: Members receiving certain specialized services, such as long-term nursing home care or specific waiver services, may remain in or move to FFS.
- Exemptions: Members with specific medical conditions that make them exempt from mandatory managed care enrollment.

2.4 WV Expansion Population

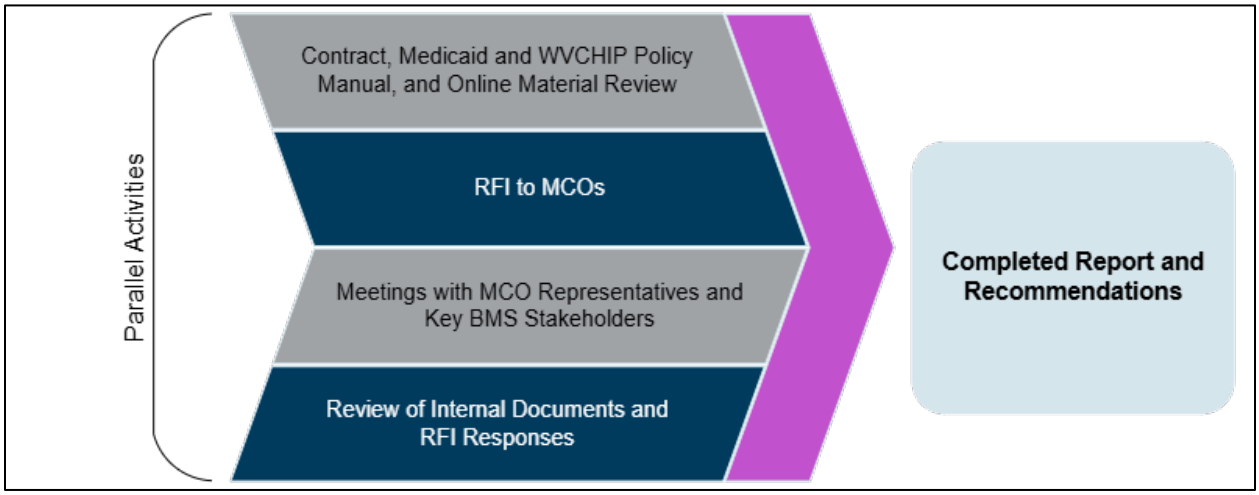
The expansion population is a core component of West Virginia's Medicaid program, specifically serving as the State's ABP for adults. This plan provides comprehensive health coverage for eligible adults aged 19 to 64 with household incomes up to 138% of the federal poverty level. As part of the Mountain Health Trust managed care program, services are administered by MCOs.[21,22] To maintain eligibility, members must typically complete an annual renewal process, and beginning in January 2027, many able-bodied adults on the expansion plan will be required to participate in at least 80 hours per month of community engagement activities, such as work, education, or volunteering.[23] Members receive Medicaid benefits, and this population is included in the compliance analysis.

2.5 Stakeholder Participation

Stakeholders from DoHS, BMS, and different State delivery systems were involved in the review process, including the BMS Director of Managed Care, the Director of BMS Pharmacy Services, and individuals from Aetna (for the State Medicaid program and Mountain Health Promise), Highmark, THP, and Wellpoint. BMS contracted with BerryDunn to facilitate the workgroups and provide mental health parity subject matter expertise, research, information gathering, and project management support.

As part of the review, BerryDunn sent request for information (RFI) documents to representatives at each of the MCOs and BMS Pharmacy Services (Appendix D).

Figure 3: MH Parity Review Process



3.0 Methodology

3.1 Benefit Groupings

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is the generally recognized independent standard utilized by the State to define and distinguish MH and SUD benefits from M/S benefits.

3.1.1 M/S Benefits

M/S benefits are benefits for items or services for medical conditions or surgical conditions as defined by the State, and in accordance with applicable federal and State law, which do not include MH or SUD benefits.

3.1.2 MH/SUD Benefits

MH/SUD services are identified using principal ICD-10-CM diagnosis codes, consistent with claims-based MHPAEA analytic standards. Specifically, MH/SUD services are defined as services billed with a principal ICD-10-CM diagnosis code in the F01 – F09 and F20 – F99 range and diagnoses in the SUD range (F10 – F19.99). This approach is also used to distinguish MH/SUD services for procedure codes that may be used in both M/S and MH/SUD contexts.

3.2 Benefit Classifications

Benefit classification definitions for State Medicaid, WVCHIP, and Mountain Health Promise are defined by the State and are as follows.[24]

3.2.1 Inpatient

Per the BMS Provider Manual, “inpatient services are services provided to an individual who has been formally admitted to a hospital or long-term care facility on the recommendation of a physician and is receiving room, board, and professional services in the institution on a continuous, 24-hour-a-day basis.”[25] Inpatient services include reasonable and medically necessary services for the diagnosis or treatment of an illness or injury, ordered by a qualified physician, consistent with accepted standards of medical practice, and provided during an inpatient admission.[26]

3.2.2 Outpatient

Per the BMS Provider Manual, “outpatient services are services provided to a patient who is evaluated or treated at a hospital emergency department, medical clinic, diagnostic center, or other appropriate medical facility who is not receiving room, board, and professional services on a 24-hour-a-day basis.”[27] Outpatient services include medically necessary treatments, equipment, diagnostic tests, procedures, and clinician-administered pharmaceuticals provided to individuals who are evaluated or treated in a clinical setting without a formal inpatient

admission, including services delivered in an emergency department that do not result in admission.[28]

3.2.3 Emergency Care

Per the BMS Provider Manual, “emergency care services are medical services provided to an eligible member after the sudden onset of a medical condition with severe symptoms, including severe pain, so that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.” [29] Emergency care services are services that are part of a treatment episode that includes Current Procedural Technology (CPT®) codes 99281 – 99285. For MH/SUD services, certain crisis services, including crisis intervention (Healthcare Common Procedure Coding System [HCPCS] H2011) and community psychiatric supportive treatment (HCPCS H0036), are included in the emergency care classification based on their clinical purpose to rapidly assess, stabilize, and determine the most appropriate disposition for individuals experiencing an acute behavioral health crisis. While these services are not emergency department services, they function as emergent interventions and, in some cases, serve as alternatives to ED care.

3.2.4 Prescription Drug

Prescription drugs are drugs and medication that, by law, require a prescription. MCOs do not provide prescription drug coverage, as pharmacy benefits are carved out and provided FFS to members. BMS provides outpatient prescription drug coverage directly to Medicaid, WVCHIP, and Mountain Health Promise enrollees.

4.0 Grouping and Classification of Benefits

4.1 Methodology

4.1.1 Benefit Grouping Process

For purposes of the parity analysis, ICD-10 diagnosis codes were used to group WVCHIP and Medicaid benefits into M/S and MH/SUD categories.

To group the pharmacy benefits into MH, SUD, and M/S, the First Databank (FDB) Hierarchical Ingredient Code 3 (HIC3) was used. In February 2026, the BMS Office of Pharmacy Services reviewed and updated the pharmacy benefit groupings.

4.1.2 Benefit Classification Process

To map non-pharmacy benefits to the inpatient, outpatient, prescription drug, and emergency care classifications as defined earlier, the MCO benefit package was reviewed against the agreed-upon definitions.

Pharmacy benefits were mapped to the prescription drug classification, except drugs administered by a provider as part of an inpatient, outpatient, or emergency care episode of care.

4.2 Non-Pharmacy Benefit Grouping and Classification

The following lists show the Medicaid and WVCHIP non-pharmacy benefits grouped as MH, SUD, and M/S and classified as inpatient, outpatient, and emergency care. The State's Medicaid program covers MH/SUD benefits in every classification in which there is an M/S benefit. Pharmacy benefits can be found in Section 4.3.

4.2.1 Mountain Health Trust WV Medicaid and WVCHIP Non-Pharmacy Benefits Classifications for M/S

- **Inpatient:**
    - Early and Periodic Screening, Diagnoses and Treatment (EPSDT)
    - Family Planning Services and Supplies
    - Gender Affirmation Surgery for Gender Dysphoria (age 21 and over)[iii]
    - Inpatient Hospital Services
    - Inpatient Rehabilitation
    - Laboratory and X-Ray Services

[iii] Gender affirmation services are currently the subject of litigation. This report reflects current policy as of the report publication date. Subsequent policy changes and/or legal decisions may affect coverage of these benefits.

- Nurse Practitioners' Services
- Speech Therapy
- Physical Therapy
- Occupational Therapy
- Physician Services
- Podiatry Services
- Tubal Ligation (FFS, MCO)
- Nursing Facility Services (FFS)
- Organ Transplant Services (FFS)

- **Outpatient:**
  - Ambulatory Surgical Center Services
  - Cardiac Rehabilitation
  - Chiropractor Services
  - Clinic Services
  - Early and Periodic Screening, Diagnoses and Treatment (EPSDT)
  - Family Planning Services and Supplies
  - Gender Affirmation Services for Gender Dysphoria
  - Handicapped Children's Services/Children and Youth With Special Health Care Needs
  - Home Health Care Services
  - Hospice
  - Outpatient Hospital Services
  - Laboratory and X-Ray Services
  - Nurse Practitioners' Services
  - Speech Therapy
  - Physical Therapy
  - Occupational Therapy
  - Physician Services
  - Podiatry Services
  - Private Duty Nursing (PDN)
  - Prosthetic Devices and Durable Medical Equipment (DME)
  - Pulmonary Rehabilitation
  - Right from the Start (RFTS) Services
  - Rural Health Clinic Services: Including Federally Qualified Health Centers (FQHCs)
  - Tobacco Cessation
  - Tubal Ligation
  - Vision Services
  - Dental Services (Adult)
  - Dental Services (Children)

- Abortion (FFS)
- Early Intervention Services for Children 3 Years and Under (FFS)
- ICF/MR-Intermediate Care Facility (FFS)
- Personal Care Services (FFS)
- Personal Care for Individuals Enrolled in the Aged/Disability Waiver (FFS)
- School-Based Services (FFS)
- Organ Transplant Services (FFS)
- Non-Emergency Transportation (FFS)
- Tubal Ligation (FFS)
- Substance Use Disorder (SUD) Waiver Services/Opioid Treatment Program (Methadone) (FFS)
- Aged and Disability Waiver
- Intellectual and Developmental Disability (IDD) Waiver

- **Emergency Care:**
  - Emergency M/S Services
  - Emergency Transportation
  - Dental Services (Adult)
  - Dental Services (Children)

4.2.2 Mountain Health Trust WV Medicaid and WVCHIP Non-Pharmacy Benefit Classifications for MH/SUD

- **Inpatient:**
  - Early and Periodic Screening, Diagnoses and Treatment (EPSDT)
  - Behavioral Health Rehabilitation for Individuals Under Age 21
  - Psychological Services
  - Hospital Services, Inpatient – Behavioral Health and Substance Use Stays
  - Inpatient Psychiatric Services for Individuals Under Age 21
  - Inpatient Psychiatric Services for Individuals Age 21 to 64 (Medicaid Only)
  - Drug Screening
  - Substance Use Disorder (SUD) Services
- **Outpatient:**
  - Behavioral Health Outpatient Services
  - Psychological Services
  - Drug Screening
  - Substance Use Disorder (SUD) Services
- **Emergency Care:**
  - Emergency Behavioral Health Services

Mountain Health Promise offers core benefits that are consistent with Mountain Health Trust Medicaid, with the exception of inpatient psychiatric services for individuals aged 21 to 64.

Additionally, children eligible under the Children with Serious Emotional Disorder Waiver (CSEDW) program, a subset of Mountain Health Promise enrollees, are provided with expanded outpatient benefits.[iv,30] With the exception of transportation and general case management services, the listed codes represent behavioral health services and would be analyzed as MH/SUD benefits for parity purposes.

Table 2: CSEDW Services and Service Codes[31]

CSEDW Service Name	Service Code	Classification
Assistive Equipment	T2035-HA	MH/SUD
Community Transition	T2038-HA	MH/SUD
Family Therapy	H0004-HO-HA	MH/SUD
Independent Living/Skills Building	H2033-HA	MH/SUD
In-Home Family Support	H0004-HA	MH/SUD
Job Development	T2021-HA	MH/SUD
Mobile Response	H2017-HA	MH/SUD
Non-Medical Transportation	A0160-HA	Admin
Peer Parent Support	H0038-HA	MH/SUD
Respite Care: In-Home	T1005-HA	MH/SUD
Respite Care: Out-of-Home	T1005-HA-HE	MH/SUD
Specialized Therapy	G0176-HA	MH/SUD
Supported Employment: Individual	T2019-HA	Admin
Wrap Facilitation	T1016-HA	Admin
Wraparound Facilitation: Moderate Intensity	T1016-HA-TF	Admin
Wraparound Facilitation: High Intensity	T1016-HA-TG	Admin

4.3 Pharmacy Benefit Grouping and Classification

Appendix G groups and classifies approved prescription drugs according to the definitions provided in Section 3.0.

[iv] As part of the current Section 1115 demonstration (January 1, 2025 – December 31, 2029), the MCO is required to implement a transition of care protocol for CSEDW members, including continuation of medically necessary services without prior authorization and without regard to network status for at least 90 days following enrollment. The provision is protective in nature and does not impose a restriction on behavioral health benefits.

4.3.1 Pharmacy Benefit Design and Administration

Pharmacy benefits for WV Medicaid, WVCHIP, and Mountain Health Promise are carved out and administered by a pharmacy benefit manager (PBM), under a single Preferred Drug List (PDL) that applies to both programs. The PDL is used to support clinically appropriate and cost-effective prescribing and is implemented consistently across medication categories used to treat MH/SUD and M/S conditions. The pharmacy benefit includes mandatory generic substitution. In general, non-preferred medications are subject to prior authorization, most commonly because non-preferred medications are higher cost than preferred alternatives. Step therapy and other utilization management requirements are applied consistently across MH, SUD, and M/S medications, with no differences in copayments by diagnosis category.

4.3.2 Pharmacy Continuity of Care and Legacy Therapy

The PDL framework includes provisions to support continuation of existing therapies when clinically justified, consistent with a continuity-of-care approach. While clinical criteria for PDL management, such as requirements for trials of preferred agents and recognition of legacy therapy status, are applied consistently across M/S and MH/SUD medications, legacy therapy protections are used more frequently for MH/SUD medications. This reflects the heightened importance of treatment stability in behavioral health pharmacotherapy and the clinical risks associated with disruption, including loss of symptom control. In addition, certain drug classes, including long-acting injectable medications and medications associated with safety concerns, abuse potential, or high cost, are subject to prior authorization based on CMS guidance, recognized drug compendia, clinical practice guidelines, and utilization patterns.

4.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-Related Provisions

A review of MCO documentation and RFI responses demonstrates that EPSDT standards are applied consistently across Medicaid and WVCHIP and align with federal requirements. EPSDT-covered services include comprehensive physical and MH screenings, developmental history, laboratory testing, vision, hearing, dental services, immunizations, behavioral health screening, and health education, as well as medically necessary treatments to correct or ameliorate defects, illnesses, and conditions diagnosed during screenings. Initial EPSDT screenings do not require prior authorization, medical director review, or exception processes, though follow-up treatment services identified through screenings may be subject to medical necessity review.[32] Quantitative limits are treated as soft caps and may be exceeded when documentation demonstrates continued benefit, with physical therapy cited as an example. For pharmacy benefits, members under age 21 may receive coverage for medically necessary medications that fall outside the PDL, or are not otherwise covered outpatient drugs, based on an EPSDT provider determination. This process applies consistently to MH, SUD, and M/S medications, with no additional prior authorization or soft limits applied solely due to EPSDT status. EPSDT coverage and screening schedules are communicated through multiple channels, including member handbooks, outreach materials, care management interactions, and provider education, with screening intervals supported through Healthcare Effectiveness Data and

Information Set (HEDIS)-based monitoring, value-based arrangements, and performance improvement initiatives.

4.5 Applied Behavior Analysis (ABA)-Related Provisions

ABA services are covered by all MCOs in West Virginia, with variation in authorization requirements, documentation expectations, and service limits at the plan level. Under Chapter 519.23 of the WV BMS Provider Manual,[33] ABA services are available to members ages 18 months through 20 with a primary diagnosis of autism spectrum disorder (ASD) that was rendered prior to the child's 8th birthday. Covered services include CPT® codes 97151, 97152, 97153, 97154, 97155, 97156, and 97158, as well as H0031 for functional or behavioral assessment. State policy establishes prior authorization as the mechanism for determining medical necessity for all ABA services, including initial authorization and ongoing clinical progress reviews, supported by objective data and functional assessments conducted at least annually. Consistent with this framework, some MCOs report not requiring prior authorization or formal treatment plans for services delivered within established soft limits, citing alignment with Chapter 519.23 and an interest in minimizing access barriers, given limited provider availability in the State. In these cases, treatment plans and medical necessity reviews, including medical director review, are generally required only when providers request services beyond soft limits. Other MCOs require prior authorization for all ABA services but do not condition coverage on submission of a treatment plan. Coverage limits also vary across plans, with some applying soft limits of up to 40 hours per week and/or eight hours per day, consistent with BMS policy parameters across ABA codes, while others report no explicit service or financial limits and instead rely on functional assessments, clinical documentation, and periodic reviews to monitor progress. Effective February 1, 2023, ABA coverage under WVCHIP mirrors Medicaid policy, and no dollar limits are applied to ABA services under WVCHIP.[34]

5.0 QTLs

5.1 Aggregate Lifetime (AL) and Annual Dollar Limits (ADLs)

For individuals under age 21, ALs and ADLs are prohibited under EPSDT. Mountain Health Trust and Mountain Health Promise behavioral health services provided through the managed care delivery system are not subject to AL, ADL, or other cumulative financial limits as prohibited in Mountain Health Trust SFY2027 MCO contract,[35] Section 10.1 MCO Behavioral Services Administration (see Appendix A, contract pages 205 – 206), and Mountain Health Promise SFY2027 contract,[36] Section 11.1 MCO Behavioral Services Administration (pages 221 – 222), which states: "The MCO may not impose any aggregate lifetime, annual dollar limits, or other cumulative financial limits on mental health or SUD services." MCO compliance with this provision was confirmed; therefore, WV has determined the MCOs to be in compliance with the parity regulations for AL/ADLs.

5.2 FRs

Mountain Health Trust and Mountain Health Promise behavioral health services provided through the managed care delivery system are not subject to premiums or deductibles as prohibited in WV Mountain Health Trust SFY2027 MCO contract definition of "Cost-Sharing" on page 7 and Mountain Health Promise Contract on page 16, which states: "Maximum cost-sharing amounts are determined by BMS based on the enrollee's family income. Some WVCHIP enrollees are responsible for monthly premiums in addition to co-payments. There are no premiums or deductibles under the West Virginia Medicaid program."

Mountain Health Trust and Mountain Health Promise behavioral health services provided through the managed care delivery system are not subject to copayments, as evidenced in Mountain Health Trust SFY2027 MCO contract, Section 3.9.1 Services and Members Exempt from Cost-Sharing Obligations of WV Medicaid's SFY2027 MCO contract (page 135), and the Mountain Health Promise Contract, 4.9.1 (page 150), which states:

The MCO and the MCO's providers may not charge copays to the following MCO enrollees or on the following services:

1. *Family planning services;*
2. *Emergency services;*
3. *Behavioral Health services;*
4. *Medicaid enrollees under age twenty-one (21) [Mountain Health Promise: Enrollees up to age twenty-six (26)];*
5. *Pregnant women (including the twelve (12) month postpartum period following the end of pregnancy)*
6. *American Indians and Alaska Natives;*

7. *Enrollees receiving hospice care;*
8. *Enrollees in nursing homes;*
9. *Any additional enrollees or services excluded under the [Mountain Health Trust: Medicaid or WVCHIP] State Plan authority;*
10. *Enrollees who have met their household maximum limit for the cost-sharing obligations per calendar quarter.*

Mountain Health Trust and Mountain Health Promise contracts prohibit the MCOs from charging copayments for behavioral health services, so there was no quantitative treatment limit (QTL) analysis performed, as it would meet the parity test for FRs.

For CSEDW services provided by Mountain Health Promise, Assistive Equipment (T2035-HA) and Specialized Therapy (G0176-HA) share a combined limit of $1,000 per plan of care service year. Specialized Therapy is one dollar ($1) per service unit and draws from the same shared funding source as Assistive Equipment. Community Transition Services (T2038-HA) are limited to $3,000 on a one-time basis. These limits are treated as soft limits, and requests to exceed established thresholds may be reviewed and approved when medical necessity is established.[37] Beneficiaries have not requested to exceed these caps since Mountain Health Promise was established in 2020.

5.2.2 Pharmacy FRs

For Medicaid, pharmacy copayments are the same for all members regardless of income level.[38] There are no copayments for generic drugs; copayments for brand drugs are based on the total allowed charge rather than income.[39] For WVCHIP, members have copayments on covered brand name drugs, with the specific copayment amount varying by plan tier (Gold, Blue, or Premium).[40] Generic prescriptions carry no copayment under any WVCHIP plan tier.[41] Importantly for mental health parity, the State reports that member copayments do not differ for MH/SUD medications versus M/S medications and do not vary by preferred versus non-preferred status. Because the copayments are determined on a reasonable factor (cost) without regard to whether a drug is generally prescribed for M/S or MH/SUD benefits, the pharmacy FRs satisfy parity requirements.[42]

5.3 QTLs

5.3.1 MCOs

MCOs apply quantitative service thresholds to certain MH/SUD benefits; however, these thresholds function as soft limits when additional services may be authorized based on medical necessity. For Mountain Health Promise, the benefit package includes CSEDW services for a medically eligible subset of members, which are subject to defined service and financial limits. Consistent with Aetna's responses, certain CSEDW service limits may be exceeded when medical necessity is established and approval is obtained from the WV BMS, though not all services have historically exceeded established caps. Service thresholds for Family Therapy, In-Home Family Support, Peer Parent Support, and Extended Professional Services, including

Specialized Therapy, may be exceeded when medically necessary. Table 4 below outlines available CSEDW services, including Service Codes and QTLs.

Table 3: CSEDW Service Names, Service Codes, and Limitations[43]

CSEDW Service Name	Service Code	Limitation
Wraparound Facilitation (Case Management)	T1016-HA	Capped at 12 units per service plan year (1 unit per month). Caseloads capped at 15 members per wraparound facilitator. Up to 50% of services per year of enrollment may be delivered via telehealth.
Independent Living/Skills Building	H2033-HA	Capped at 160 units per week (40 hours) in combination with Job Development and Supported Employment for members between ages 15 to 20. Up to 25% of services are eligible to be delivered via telehealth per enrollment year.
Job Development	T2021-HA	Capped at 160 units per week (40 hours) in combination with Independent Living/Skill Building and Supported Employment for members between ages 15 to 20.
Supported Employment: Individual	T2019-HA	Capped at 160 units per week (40 hours) in combination with Independent Living/Skill Building and Job Development for members between ages 15 to 20.
Specialized Therapy	G0176-HA	Covers up to $1,000 of Specialized Therapy in combination with Assistive Equipment per Plan of Care year.
Assistive Equipment	T2035-HA	Covers up to $1,000.00 per plan of care year in combination with Specialized Therapy.
Community Transition	T2038-HA	Covers up to $3,000 for a one-time transition period up to six months for eligible individuals between ages 18 to 20.
Family Therapy	H0004-HO-HA	Capped at 8 units per day (about 14 hours a week). Up to 50% of services per year of enrollment may be delivered via telehealth.
In-Home Family Support	H0004-HA	Capped at 8 units per day (2 hours). Up to 50% of services per year of enrollment may be delivered via telehealth.
Peer Parent Support	H0038-HA	Capped at 8 units per week (2 hours) or 32 units per month (8 hours). Up to 50% of services per year of enrollment may be delivered via telehealth.
Respite Care: In-Home	T1005-HA	Capped at 24 days per year in combination with Out-of-Home Respite. Not available to foster parents, as this is a benefit they receive as a foster parent from the Bureau for Children and Families.
Respite Care: Out-of-Home	T1005-HA-HE	Capped at 24 days per year in combination with In-Home Respite. Not available to foster parents, as this is a benefit they receive as a foster parent from the Bureau for Children and Families.
Transportation	A0160-HA	Transit for non-emergent CSEDW services only, up to 800 miles per month. Not available to foster families.

6.0 NQTL Comparative Analyses

6.1 NQTL Identification and Analysis Process

6.1.1 NQTL Identification

The State identified NQTLs by reviewing documentation applicable to both FFS and managed care delivery systems. Materials reviewed included documentation for carved out FFS benefits, managed care organization policies and procedures, the WV Medicaid and WVCHIP State Plan, Medicaid provider manuals, and MCO member and provider handbooks. This review was conducted to identify NQTLs applicable to MH, SUD, and M/S benefits.

To assess NQTL application in operation and to identify any changes implemented during the review period, the State collected supplemental information from the MCOs using standardized NQTL data collection tools. Comparable information for carved out FFS benefits was collected from program staff responsible for administering those services. Pharmacy related NQTLs are evaluated separately and are included in Appendix F.

6.1.2 NQTL Analysis Process

Upon receipt of all requested NQTL information, BerryDunn conducted a comparability and stringency analysis consistent with federal parity guidance, including the Parity Compliance Toolkit and CMS technical assistance materials. In accordance with guidance presented during the CMS August 22, 2017, webinar, BerryDunn evaluated each NQTL by classification and MCOs using a standardized analytical framework to support parity compliance determinations.

For each NQTL, the analysis addressed the following elements:

1. The benefits to which the NQTL applies
2. The strategies or factors used to determine the application of the NQTL
3. The evidentiary standards supporting those strategies or factors
4. The processes used to apply the NQTL, including procedural steps, timelines, and requirements applicable to the MCO, providers, and beneficiaries
5. The frequency and level of rigor with which the NQTL is applied in operation
6. The evidentiary standards supporting the frequency and level of rigor of application

This information was used to assess whether NQTLs were comparable in design and applied no more stringently to MH/SUD benefits than to M/S benefits.

6.2 NQTL Classification

6.2.1 Non-Pharmacy NQTLs by MCO

Table 5 and Table 6 below list all NQTLs applicable to MH/SUD benefits and the benefits to which they apply in a classification. The following sub-sections describe how each NQTL

applied to MH/SUD benefits meets the parity requirements of comparability and stringency for associated processes, strategies, evidentiary standards, and other factors. Reviews of each NQTL are in Appendix F and grouped by MCO. Section 8.0 discusses compliance findings and recommendations.

Table 4: Inpatient Non-Pharmacy NQTLs by MCO

NQTL	Aetna	Highmark	THP	Wellpoint
Medical necessity criteria development	x	x	x	x
Prior authorization	x	x	x	x
Concurrent review	x	x	x	x
Retrospective Review	x	x	x	x
Practice guideline selection/criteria	x	x	x	x
Network size (patient-to-provider ratio, location, etc.)	x	x	x	x

Table 5: Outpatient Non-Pharmacy NQTLs by MCO

NQTL	Aetna	Highmark	THP	Wellpoint
Medical Necessity Criteria Development	x	x	x	x
Prior Authorization	x	x	x	x
Concurrent Review	x	x	x	
Retrospective Review	x	x		
Practice Guideline Selection/Criteria	x	x	x	x
Network Size (patient-to-provider ratio, location, etc.)	x	x	x	x

6.2.2 Pharmacy NQTLs

List of Pharmacy NQTLs:

- Prior Authorization (PA)
- Use of a Preferred Drug List (PDL)
- Prospective Review
- Retrospective Review
- Pharmacy Lock-In Program
- Suboxone: Limitation in Maintenance Dose
- Tobacco Cessation: Coaching Program; 12-Week Limit; Lapse in Treatment
- Step Therapy/Fail First
- PA Requirement Attention Deficit/Hyperactivity Disorder (ADHD)/

- Attention Deficit Disorder (ADD)
- Quantity Limits
- Off-Label Use

6.3 NQTL Analysis

Appendix F provides Aetna's (including Mountain Health Promise), Highmark's, THP's and Wellpoint's NQTL worksheets. The following Section provides common findings.

6.3.1 Medical Management

Under the MCO contract, the MCO must provide all contracted services that are medically necessary. Medical necessity determinations are based on federal and state law, member benefits, medical and scientific evidence, including peer-reviewed literature, and nationally recognized clinical criteria and guidelines, including:

- ASAM® Criteria
- InterQual® Criteria
- CMS
- BMS
- American Imaging Management (AIM) Clinical Guidelines
- MCG™ Guidelines
- IngenioRx
- Carelon Clinical Appropriateness Guidelines
- Agency for Healthcare Research and Quality (AHRQ)
- National Committee for Quality Assurance (NCQA)
- American Psychiatric Association
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- National Alliance on Mental Illness (NAMI)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Physician specialty society guidelines supported by peer-reviewed literature
- LOCUS (Level of Care Utilization System) and CALOCUS (Child and Adolescent Level of Care/Service Intensity Utilization System)

6.3.2 Utilization Review

All four MCOs perform utilization review (i.e., prior authorization, concurrent review, and retrospective review). For inpatient services, strategies for performing prior authorization for MH/SUD and M/S include confirming eligibility, managing costs by helping ensure requested services are medically necessary (e.g., to prevent overutilization), and, for MH/SUD, helping ensure patients are admitted to the least-restrictive environments. The same strategies apply for concurrent review but also include connecting patients with the needed resources in anticipation of discharge of the patient. Prior authorization is also performed for inpatient and outpatient services for patient safety reasons—to confirm the procedure is clinically indicated.

Starting with the last calendar quarter of 2021, MCOs submit quarterly data to BMS to identify mental health parity red flags (denials, appeals, overturned denials, credentialing termination and denials, and complaints by MH/SUD and M/S). BMS Pharmacy submits data related to denials, appeals, and overturned denials classified as MH/SUD and M/S.

All four MCOs require their utilization reviewers for MH/SUD and M/S to undergo regular interrater reliability (IRR) testing and have action plans in place to address any deficiencies. All four MCOs reported average interrater scores greater than 90% during their most recent testing period.[v]

6.3.3 Provider Networks

All four MCOs must meet network adequacy criteria, as detailed in the MCO contract. Current standards indicate that behavioral health and outpatient SUD providers must be accessible within 60 minutes or 45 miles, while hospitals are subject to shorter thresholds. To ensure access in areas with limited provider availability, MCOs may request exceptions to geographic access standards. Comparable efforts must be made to fill MH/SUD gaps as are made for M/S gaps. These strategies may include Single Case Agreements, reimbursement of out-of-network providers at the BMS rate, and other interim measures until gaps are resolved. MCOs are also contractually required to actively recruit providers and meet or exceed FFS credentialing standards. Recruitment efforts include local provider relations, streamlined enrollment through the Gainwell portal, and use of telehealth to address specialty care gaps, particularly in rural areas.[44]

6.3.4 In Operation Comparability Analysis

To ensure that NQTLs are applied no more stringently in operation for MH/SUD benefits than for M/S benefits, the State and MCOs conduct ongoing monitoring of operational data. This includes a comparative review of the following metrics across both benefit classifications:

- Denial Rates: Comparing the percentage of prior authorization and concurrent review denials for MH/SUD services against M/S services to identify potential disparate impacts.

[v] IRR testing frequency varied across the MCOs. Aetna and Wellpoint test annually, Highmark tests twice annually, and THP tests quarterly.

- Appeal Turnaround Times: Monitoring the timeliness of internal and external appeal resolutions to ensure comparable processing for all enrollees.
- IRR Testing: Reviewing annual IRR scores (as referenced in Appendix A) to confirm that clinical staff apply medical necessity criteria consistently and fairly across both MH/SUD and M/S requests.

6.3.5 Pharmacy

In 2023, the WV Suboxone policy was updated to include defined target dosing parameters.[45] While recommended target doses are generally 16mg per day or lower, the BMS Pharmacy team advised that doses between 16mg and 24mg per day may be approved through the Drug Utilization Review and Evaluation Program with reasonable clinical justification, reflecting the application of an NQTL through clinical review rather than a hard cap. Requests for doses above the target threshold are evaluated using the same clinical review processes, evidentiary standards, and approval pathways applied to other medications subject to dose optimization across both MH and M/S benefits, including consideration of the Food and Drug Administration's (FDA) labeling, peer-reviewed literature, and prescriber-submitted documentation. The policy does not impose a maximum duration of treatment, and Suboxone may be used on a long-term or lifelong basis when medically necessary, indicating the absence of a duration-based QTL. There is no absolute maximum dose or lifetime limit, and higher doses are not categorically denied but are subject to case-by-case clinical assessment.

Tobacco cessation benefits were updated in November 2024 to establish an initial 12-week treatment period for pharmacotherapies, including nicotine replacement therapy when prescribed by a provider. Continued access to tobacco cessation pharmacotherapies beyond the initial 12-week period requires prior authorization supported by prescriber documentation addressing treatment efficacy, the clinical rationale for extended therapy, and the member's readiness to quit. This continuation requirement functions as an NQTL based on medical necessity review rather than an absolute limit and does not impose a fixed annual cap on treatment duration. The policy allows coverage for multiple quit attempts per year when appropriate documentation is submitted and approved. Utilization review requirements for tobacco cessation are informed by FDA labeling, clinical guidelines, and peer-reviewed evidence and are consistent with the evidentiary standards applied to comparable utilization controls for M/S medications.[46]

7.0 WVCHIP: Summary of Information Related to Mental Health Parity and Deemed Compliance

7.1 WVCHIP Covered Services

There are three levels of WVCHIP coverage based on family income: WVCHIP Gold, WVCHIP Blue, and WVCHIP Premium Plan.

- **WVCHIP Gold:** WVCHIP enrollment group for children in families with incomes at/or below 150% of the federal poverty level (FPL).
- **WVCHIP Blue:** WVCHIP enrollment group for members in families with incomes between 150% and 211% of the FPL.
- **WVCHIP Premium:** WVCHIP enrollment group for members in families with incomes between 211% and 300% of the FPL that requires monthly premium payments.

Table 6, Table 7, and Table 8 provide plan types by family size.

Table 6: WVCHIP Gold Plan by Income and Family Size

Family Size	Monthly	Annual
2	$2,644	$31,725
3	$3,332	$39,947
4	$4,019	$48,225
5	$4,707	$56,475
6	$5,394	$64,725
7	$6,082	$72,975

Table 7: WVCHIP Blue Plan by Income and Family Size

Family Size	Monthly	Annual
2	$3,719	$44,627
3	$4,686	$56,232
4	$5,654	$67,837
5	$6,621	$79,442
6	$7,588	$91,047
7	$8,555	$102,652

Table 8: WVCHIP Premium Plan by Income and Family Size

Family Size	Monthly	Annual
2	$5,288	$63,450
3	$6,663	$79,950
4	$8,038	$96,450
5	$9,413	$112,950
6	$10,788	$129,450
7	$12,163	$145,950

Table 9 shows WVCHIP copayments by service. There are no copayments for behavioral health services.

Table 9: WVCHIP Copayments

Medical Services and Prescription Benefits	Gold	Blue	Premium Plan Copayment
Generic Prescriptions	No Copayment	No Copayment	No Copayment
Listed Brand Prescriptions	$5	$10	$15
Well Child Physician Visit	No Copayment	No Copayment	No Copayment
Physician Visit (PCP)	$5	$15	$20
Immunizations	No Copayment	No Copayment	No Copayment
Hospital/Inpatient Services	No Copayment	$25	$25
Outpatient Surgical Procedures	No Copayment	$25	$25
Emergency Room (waived if admitted)	No Copayment	$35	$35
Dental Services	No Copayment	No Copayment	$25 for some services
Vision Services	No Copayment	No Copayment	No Copayment

7.2 EPSDT Services

WVCHIP children receive the full range of EPSDT services, including:

- Preventive screening services
- Diagnostic services
- Medically necessary treatment services to correct or ameliorate physical and behavioral health conditions

This document supports the determination that WVCHIP children receiving services through Mountain Health Trust receive the full EPSDT benefits without annual or lifetime dollar limits.

7.3 EPSDT Services for Pregnant Individuals

Pregnancy-Related EPSDT Services
For pregnant members under age 21, EPSDT standards are applied based on age rather than on diagnosis, ensuring that pregnancy does not result in default application of adult maternity benefit rules. MCOs identify pregnant EPSDT eligible members through enrollment files, claims data, and care management workflows, with status flagged in internal systems to support appropriate application of EPSDT benefits. Pregnant EPSDT members are informed of their rights using the same communication methods as other EPSDT eligible children and adolescents. EPSDT coverage for pregnant members extends beyond routine prenatal, labor, and delivery services when additional medically necessary services are identified through an EPSDT screen, including MH/SUD services, therapies, and nutritional counseling. These services are reviewed under standard medical necessity criteria when prior authorization is required, with no categorical exclusions based on pregnancy status. When a member turns 21 during pregnancy, MCOs maintain continuity of care through established transition processes to the adult system of care. Data specific to approval, denial, and appeal rates for EPSDT services among pregnant members are not currently tracked separately, though overall EPSDT screening denial rates remain low and are primarily administrative in nature.

7.4 Pregnancy-Related Provisions

WVCHIP's state plan establishes broad protections and coverage for pregnant women.. There is no waiting period for eligible pregnant women, and pregnancy and maternity related services are covered without copayments. Pregnant women are subject to a monthly premium of $35 if family income exceeds 211% of FPL, but they have no other cost-sharing under the plan. Covered services for pregnant women mirror those for children across behavioral health, SUD, and medical services, including psychosocial treatment, MAT, intensive outpatient, partial hospitalization, residential treatment, emergency and crisis services, and inpatient care, with prior authorization and medical necessity review applied consistently where required.[47]

7.5 WVCHIP Pharmacy

Coverage criteria are grounded in nationally recognized clinical guidance and do not impose absolute coverage exclusions; continuity-of-care protections allow members who are stable on existing ADD or ADHD medications to continue therapy, even when a medication is not on the PDL, provided clinical criteria are met. Across pharmacy benefits, the processes, strategies, and evidentiary standards used to apply NQTLs are comparable for WVCHIP MH/SUD and M/S medications, and benefits are not subject to annual or lifetime dollar limits, consistent with parity requirements. WVCHIP benefits began to mirror Medicaid treatment benefits effective July 1, 2024. Please see the combined Medicaid/WVCHIP BMS NQTL Comparative Analyses in Appendix F.

7.6 Program Design and Delivery

WVCHIP provides coverage to children through MCOs operating under the Mountain Health Trust. Under this structure, WVCHIP enrollees receive the same benefits as WV Medicaid managed care that is subject to federal parity requirements.

7.7 WVCHIP Parity Framework

WVCHIP submitted a SPA in 2024 noting compliance with EPSDT requirements. This SPA is still pending CMS approval.

7.8 Mental Health Parity Protections

Mountain Health Trust MCOs were reviewed for compliance with 42 CFR Part 438, Subpart K, requiring parity between MH/SUD benefits and M/S benefits with respect to:

- FRs (including copayments)
- QTLS
- NQTLs

Parity was assessed across the required benefit classifications, including prescription drugs, outpatient, inpatient, and emergency services.

7.9 Summary

WVCHIP members receive full EPSDT benefits consistent with Medicaid requirements. Benefits are not subject to annual or lifetime dollar limits on MH/SUD services. Furthermore, services are not subject to service limitations.

8.0 Compliance Summary

The 2026 review of MCO documentation, RFI responses, and network standards supports compliance with mental health parity requirements across Mountain Health Trust MCOs.

8.1 Access to Behavioral Health Services

Across MCOs, member handbooks and provider manuals consistently state that members may self-refer for behavioral health and SUD services. Materials generally indicate that primary care provider referrals are not required for behavioral health access, and member services or primary care providers may assist with care coordination as needed.

The State monitors behavioral health access using enrollee experience surveys, complaints and grievances, appeals data, and secret shopper activities. These sources help assess real-world access, including appointment availability and wait times.

8.2 Emergency and Crisis Services

MCO materials indicate that emergency and crisis behavioral health services are available without advance referral. Some materials describe unit thresholds or post-service review for crisis stabilization or urgent services. These practices are generally framed as utilization management rather than access limitations.

8.3 Quantitative Limits and Medical Necessity

Review findings indicate that quantitative thresholds for MH/SUD services are treated as flexible and subject to medical necessity review rather than hard caps, particularly for EPSDT and ABA services.

8.4 Denial Trends and Monitoring

MCOs report that the most frequent reason for both MH/SUD and M/S inpatient and outpatient denials is lack of medical necessity, with similar patterns observed across Medicaid and WVCHIP populations. MCOs describe internal monitoring of denial trends.

8.5 Network Adequacy

Current standards indicate that behavioral health and outpatient SUD providers must be accessible within 60 minutes or 45 miles, while hospitals are subject to shorter thresholds. To ensure access in areas with limited provider availability, MCOs may request exceptions to geographic access standards. Network adequacy is monitored using time and distance standards, and when gaps are identified, MCOs must submit an access plan to BMS outlining strategies to ensure member access. These strategies may include Single Case Agreements, reimbursement of out-of-network providers at the Medicaid rate, and other interim measures until gaps are resolved. MCOs are also contractually required to actively recruit providers and meet or exceed FFS credentialing standards. Recruitment efforts include local provider

relations, streamlined enrollment through the Gainwell portal, and use of telehealth to address specialty care gaps, particularly in rural areas.[48]

8.6 Pharmacy Benefits

As described in RFI responses, the pharmacy benefits reflect consistent application of utilization management tools across MH, SUD, and M/S medications. Medicaid and WVCHIP operate under a single PDL, with uniform prior authorization, utilization management protocols, dose limits, and day supply limits applied based on clinical appropriateness, safety, and cost considerations rather than diagnosis category. Denial data for pharmacy services are monitored regularly, with monthly reporting to the State, public review through the Drug Utilization Review Board, and quarterly parity related reporting that stratifies denials and appeals by MH, SUD, and M/S categories. These processes support ongoing parity oversight and do not indicate differential application of NQTLs across pharmacy benefits.

8.7 Conclusion

Based on the documentation reviewed and the analyses conducted, the State has determined that WV's Medicaid and WVCHIP managed care program is compliant with federal mental health parity requirements. Parity is supported through consistent benefit design across MCOs, application of medical necessity criteria, and comparable management of MH/SUD and M/S benefits across classifications. The State continues to strengthen parity oversight through ongoing monitoring and quality improvement efforts. This includes the implementation of quarterly parity data reviews and the requirement that MCOs maintain internal mental health parity compliance plans documenting monitoring activities and corrective actions. These mechanisms support early identification of potential issues, and continuous improvement over time. Detailed trend analyses and supporting data are provided in the appendices to enhance transparency.

9.0 Quarterly Data Review

In Calendar Quarter 4 of 2021, three MCOs began submitting quarterly mental health parity data to support monitoring of managed care practices for potential mental health parity compliance issues. This data collection functions as an early warning system to identify trends and potential red flags that might indicate barriers to accessing MH/SUD services relative to M/S services. Analysis of the data enables monitoring of outpatient and inpatient service requests, denials, and denial rates for indications of potential parity concerns requiring further review. Highmark began submitting data in Calendar Quarter 3 of 2024.

The following charts reflect the aggregate data for the number of outpatient and inpatient PA requests, the number of outpatient and inpatient service denials, and the percentage of outpatient and inpatient service denials delineated by MH/SUD and M/S.

9.1 Medicaid Mountain Health Trust Charts

Figure 4: Medicaid Mountain Health Trust Outpatient Prior Authorization Requests by Calendar Quarter

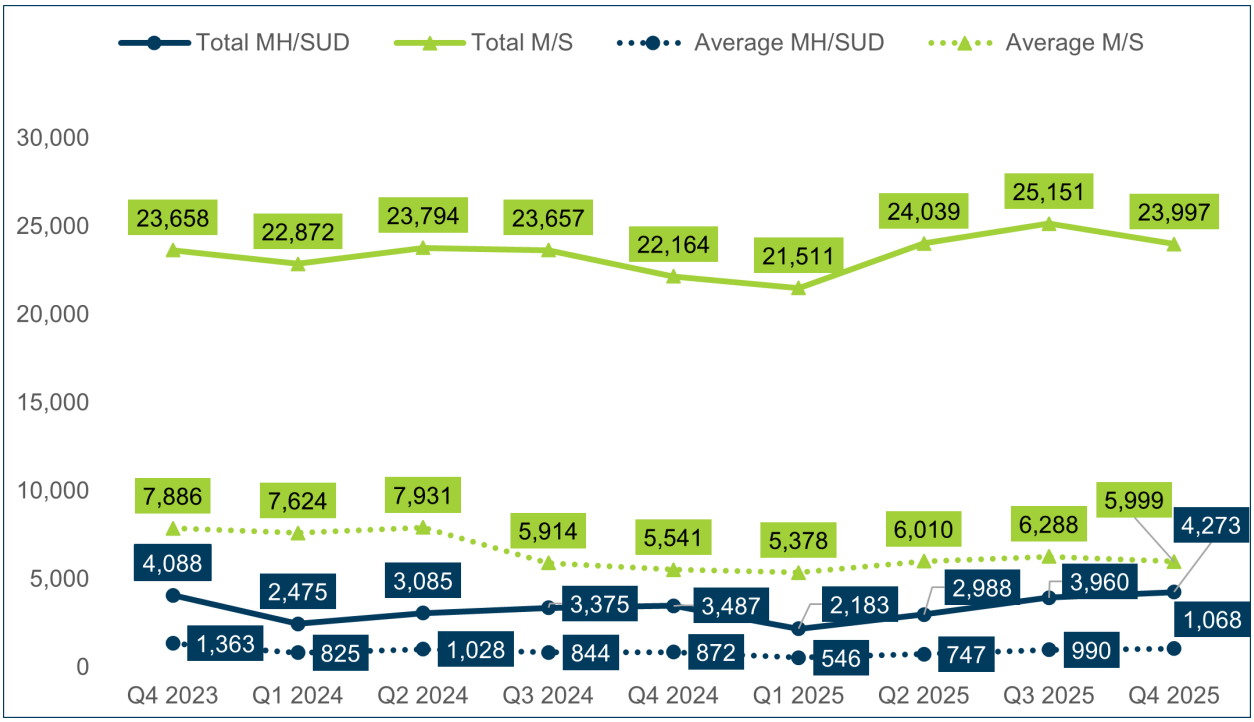


Figure 5: Medicaid Mountain Health Trust Outpatient Prior Authorization Requests Denied by Calendar Quarter

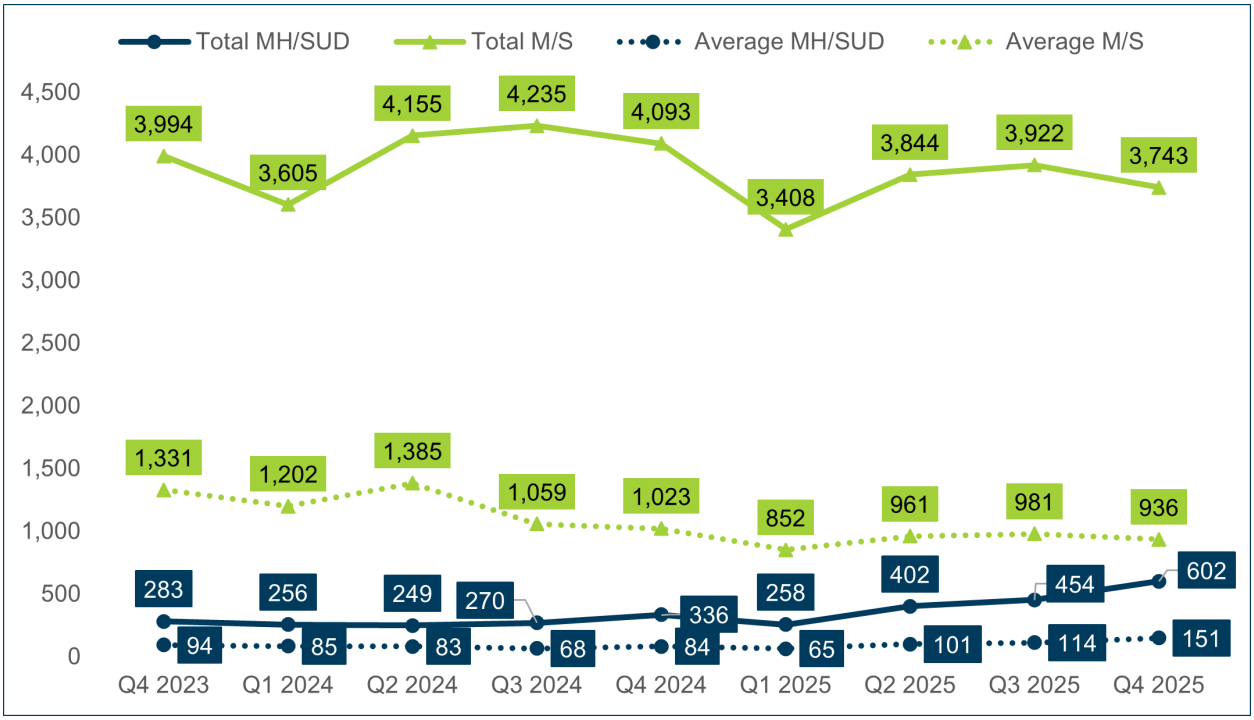


Figure 6: Medicaid Mountain Health Trust Outpatient Percentage of Prior Authorization Requests Denied by Calendar Quarter

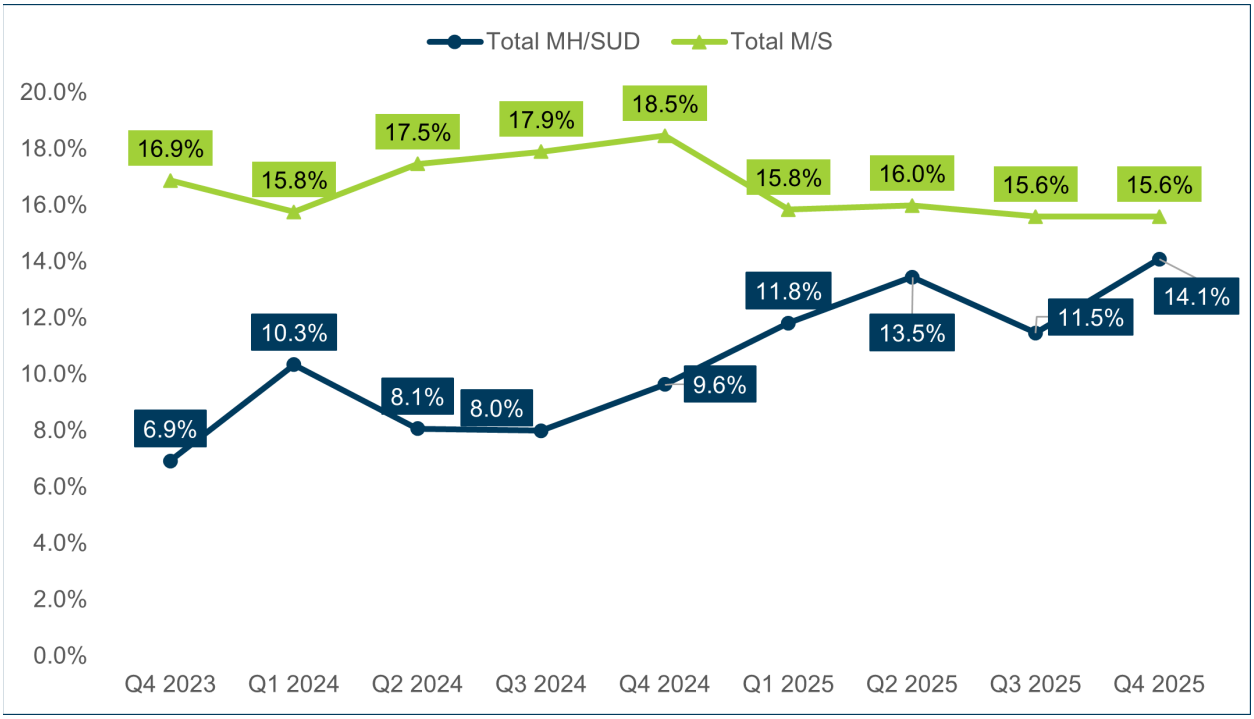


Figure 7: Medicaid Mountain Health Trust Inpatient Prior Authorization Requests by Calendar Quarter

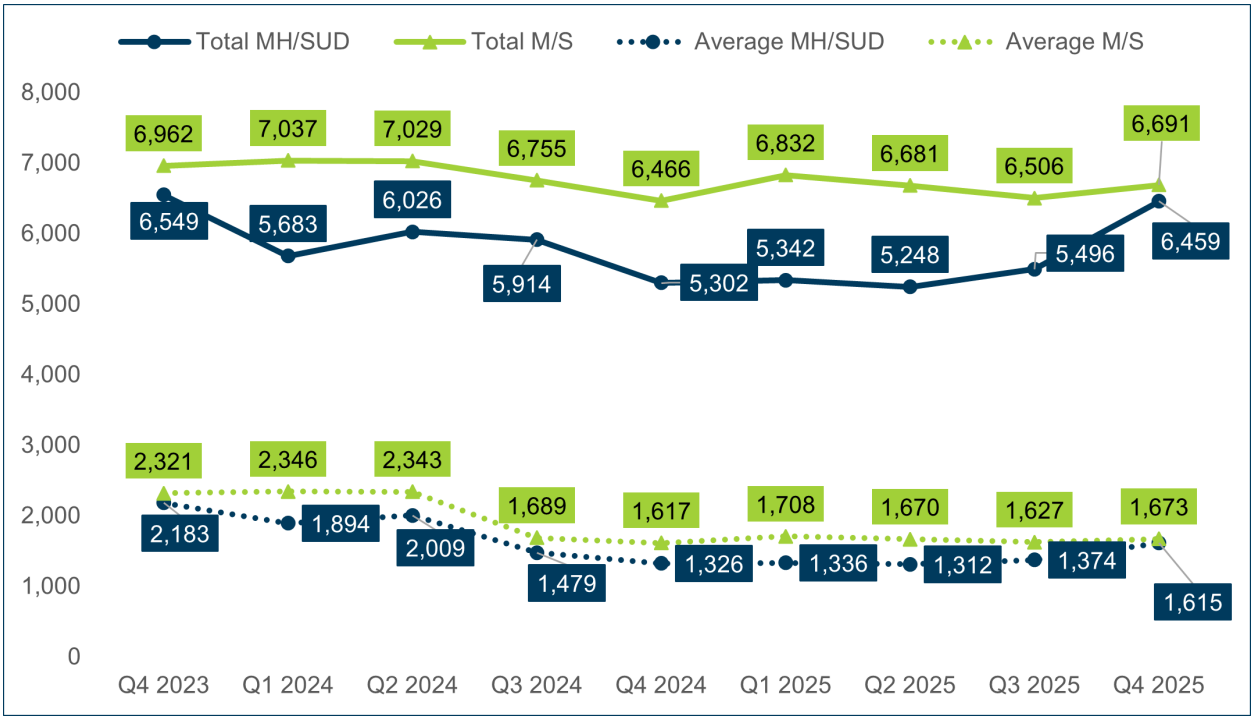


Figure 8: Medicaid Mountain Health Trust Inpatient Prior Authorization Requests Denied by Calendar Quarter

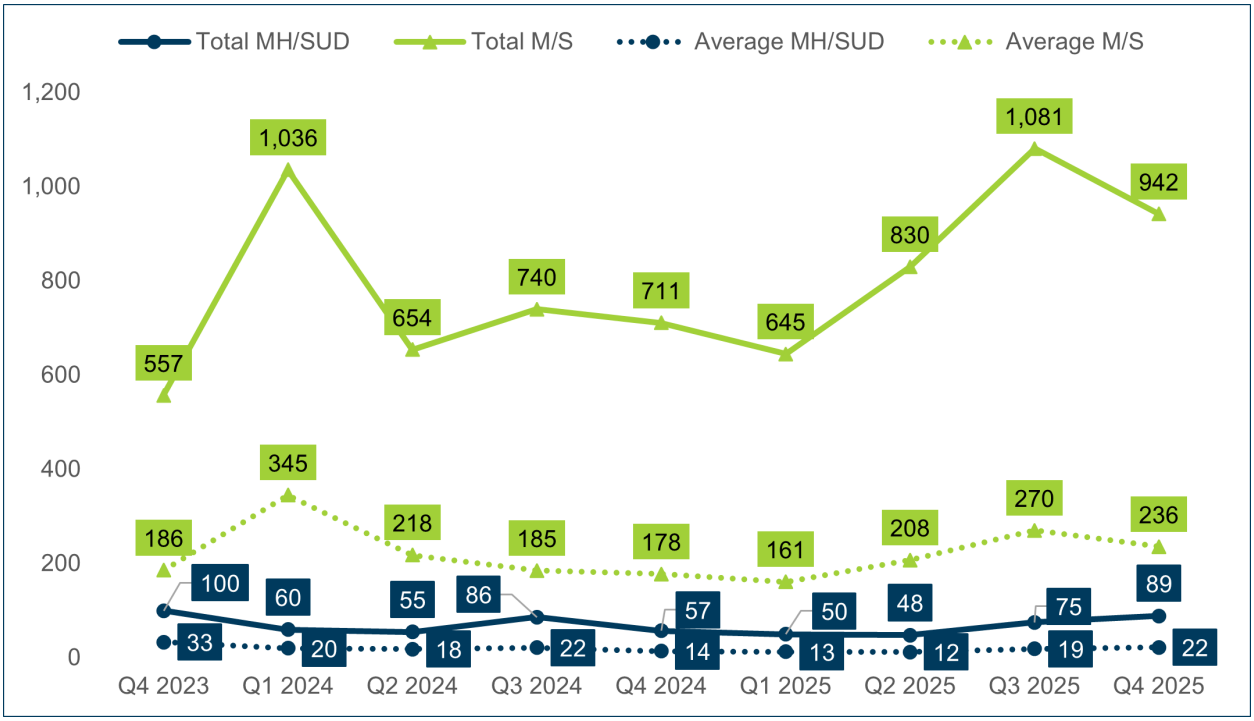
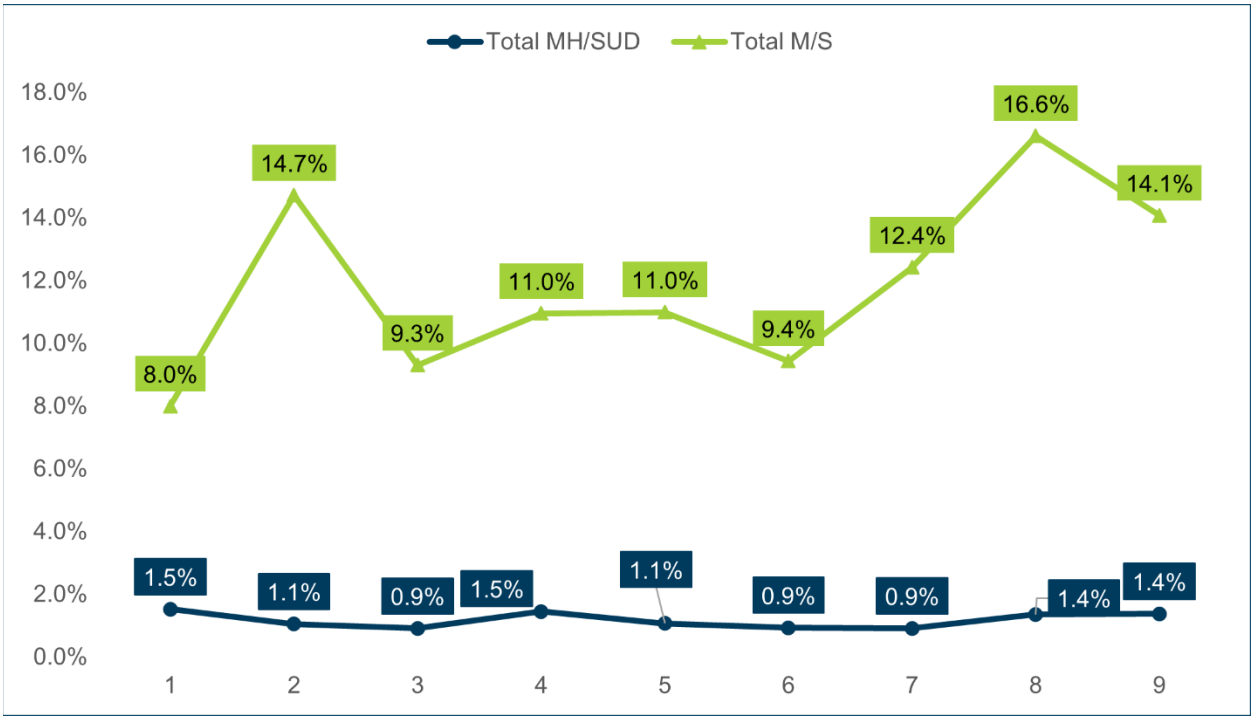


Figure 9: Medicaid Mountain Health Trust Inpatient Percentage of Prior Authorization Requests Denied by Calendar Quarter



9.2 WVCHIP Mountain Health Trust Charts

Figure 10: WVCHIP Mountain Health Trust Outpatient Prior Authorization Requests by Calendar Quarter

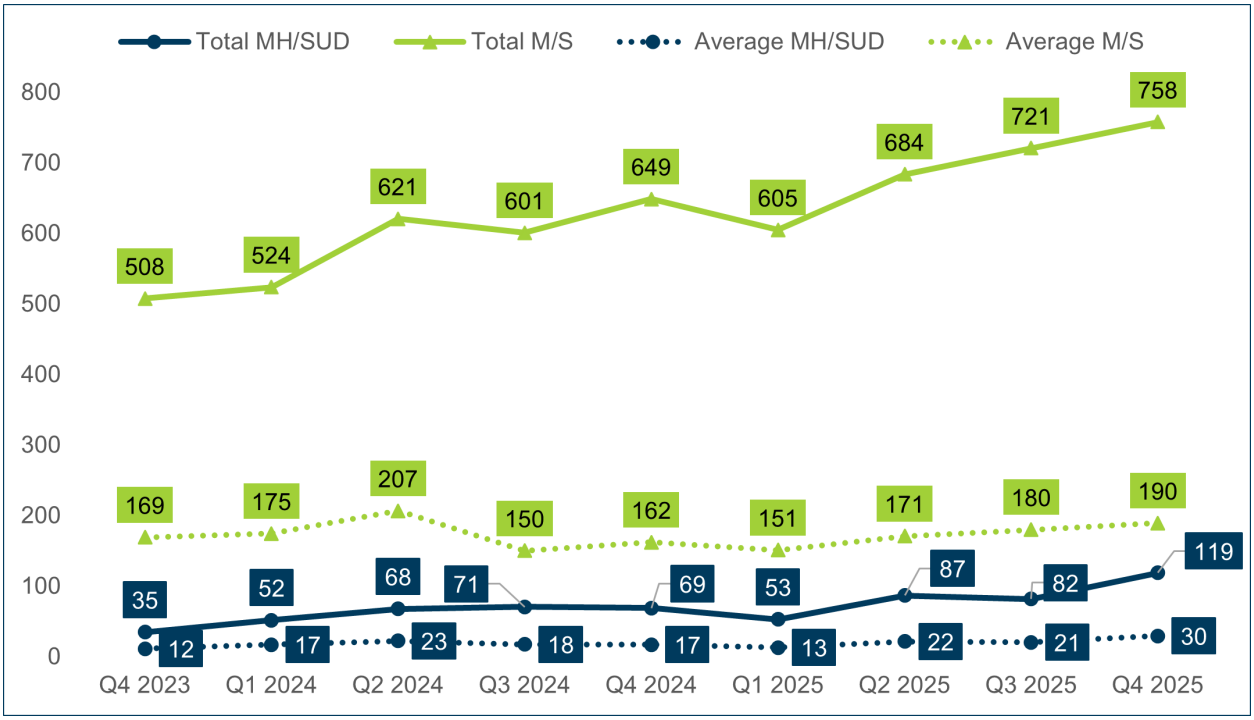


Figure 11: WVCHIP Mountain Health Trust Outpatient Prior Authorization Requests Denied by Calendar Quarter

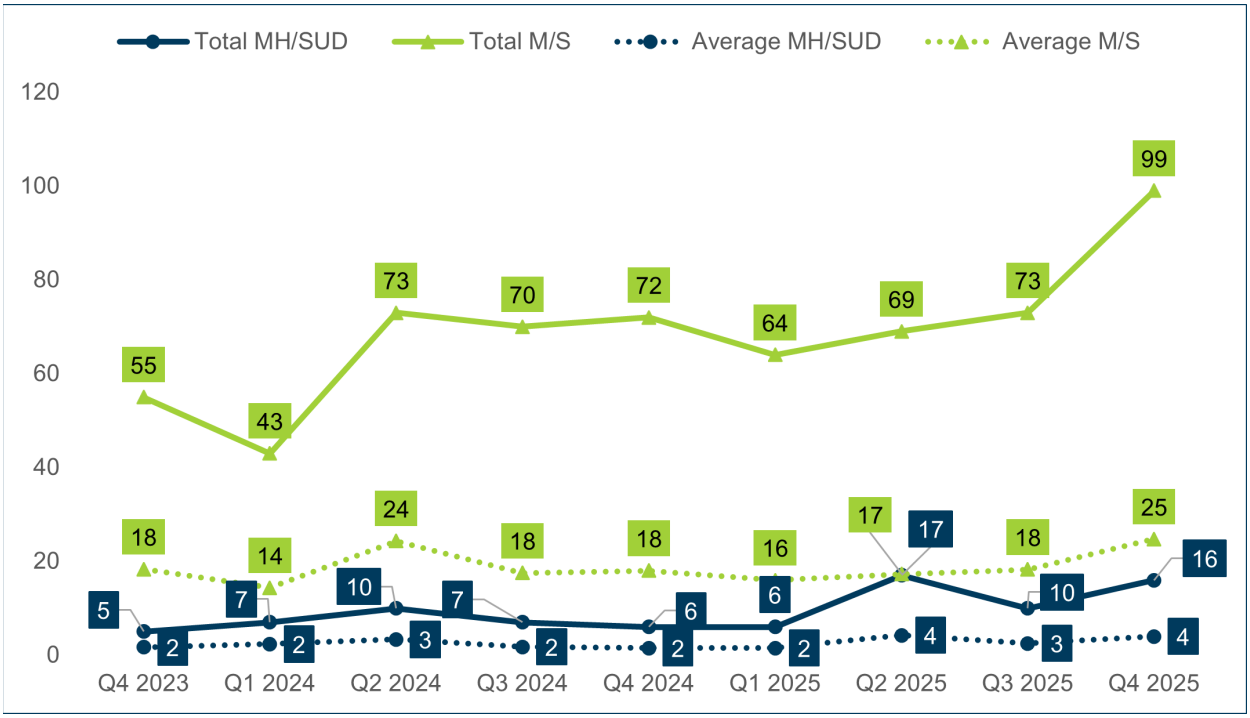


Figure 12: WVCHIP Mountain Health Trust Outpatient Percentage of Prior Authorization Requests Denied by Calendar Quarter

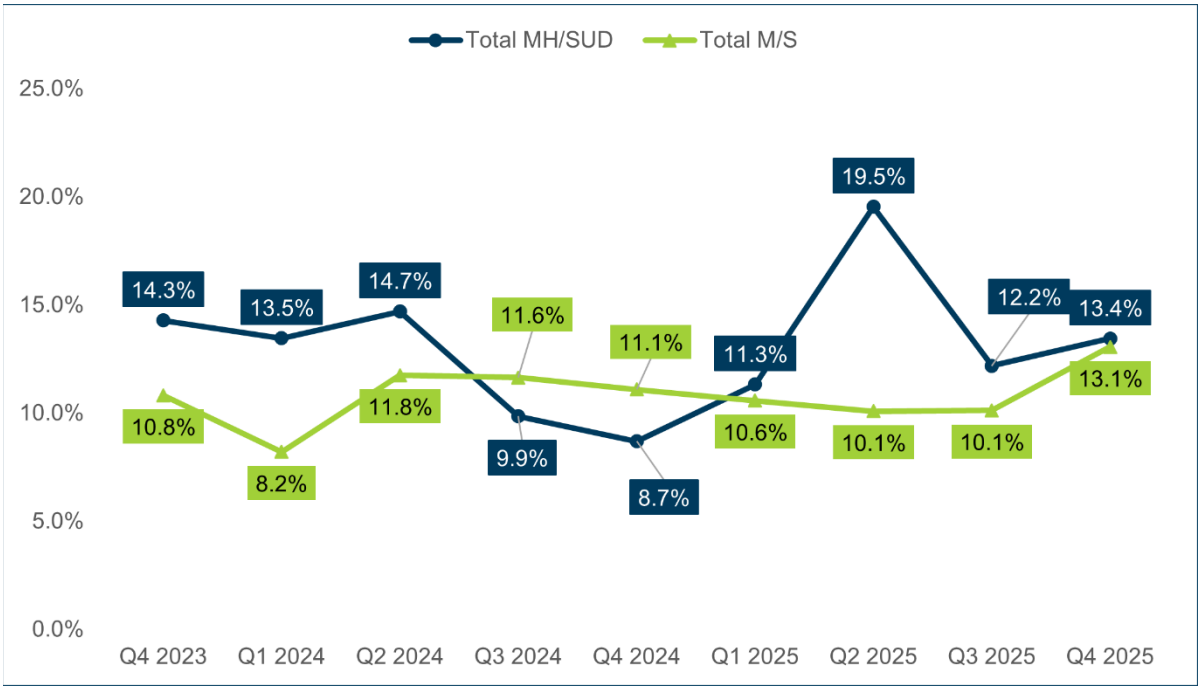


Figure 13: WVCHIP Mountain Health Trust Inpatient Prior Authorization Requests by Calendar Quarter

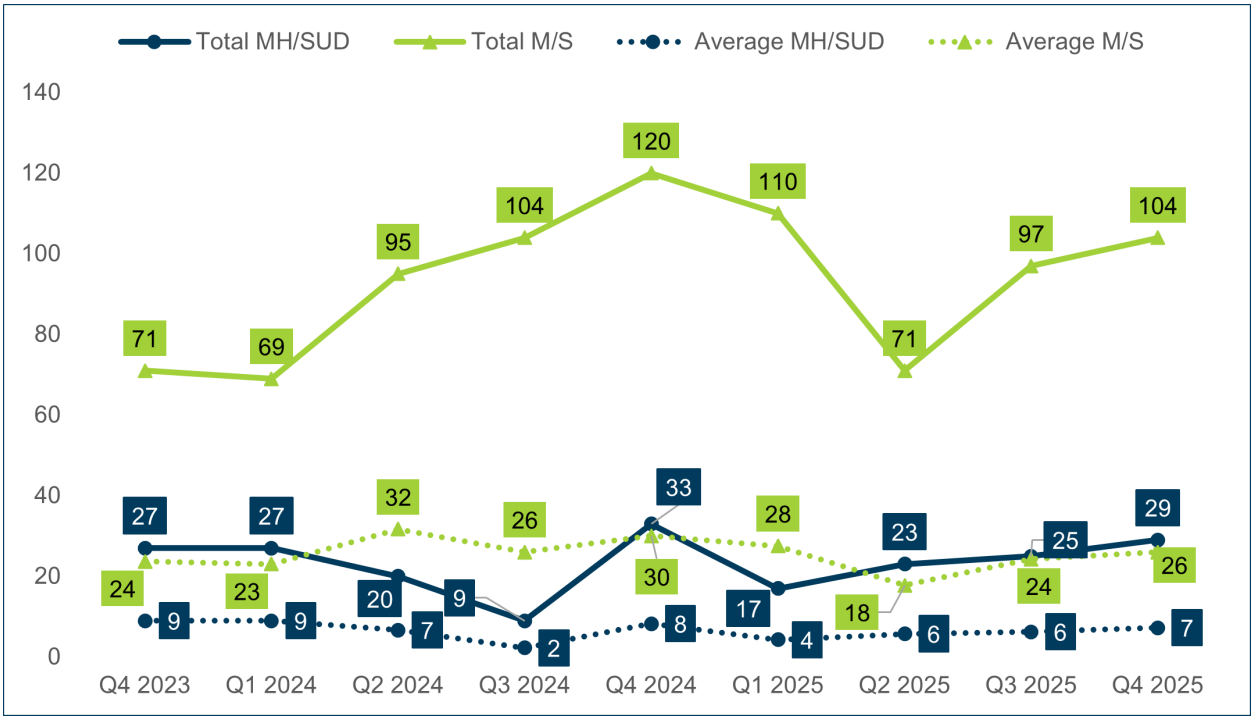


Figure 14: WVCHIP Mountain Health Trust Inpatient Prior Authorization Requests Denied by Calendar Quarter

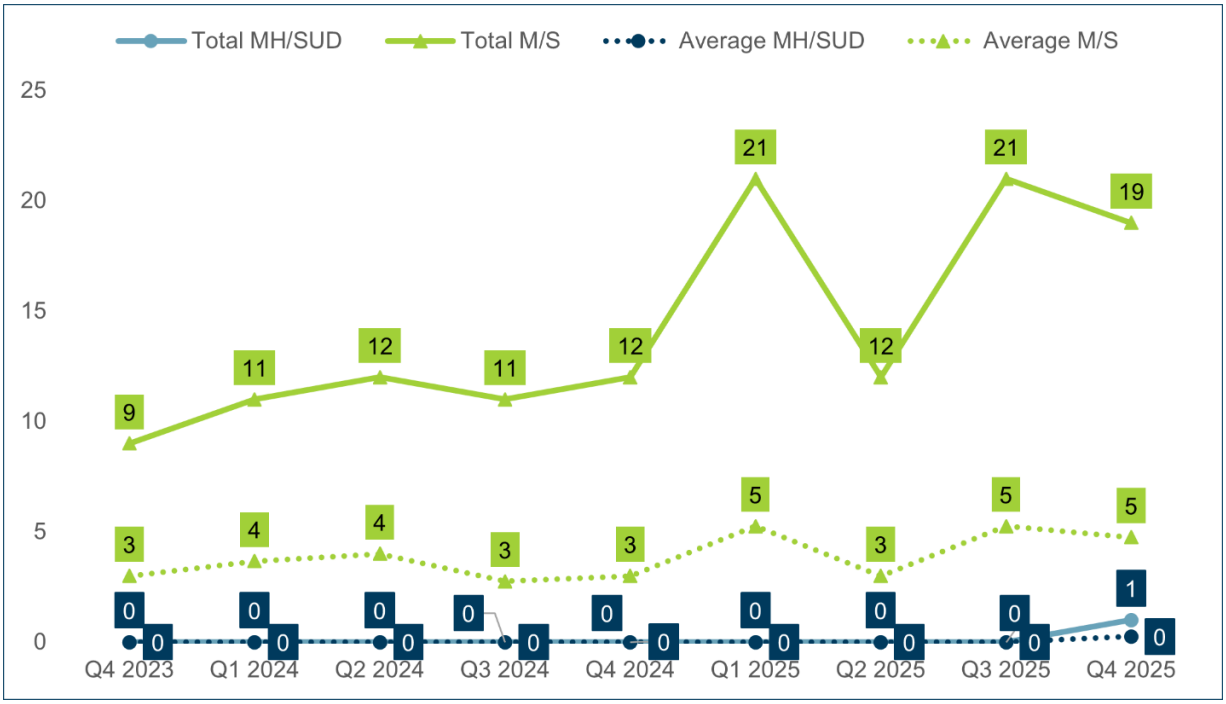
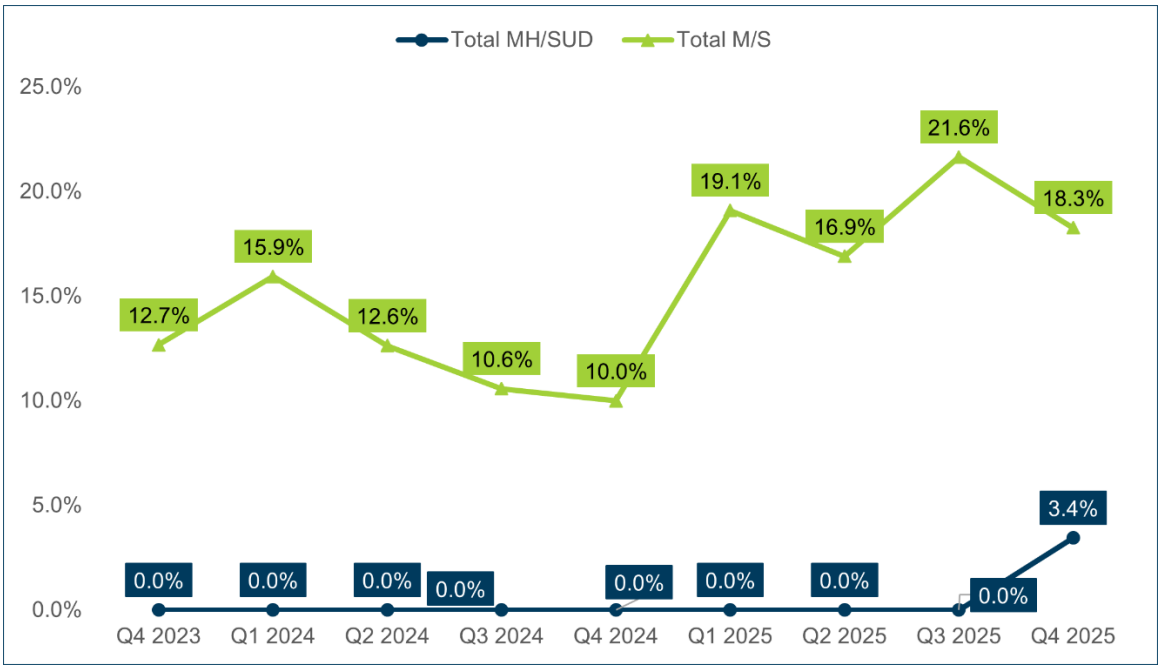


Figure 15: WVCHIP Mountain Health Trust Inpatient Percentage of Prior Authorization Requests Denied by Calendar Quarter



9.3 BMS Pharmacy Charts

Beginning in Q4 2023 (and Q4 2023 for WVCHIP), BMS Pharmacy began submitting quarterly pharmacy data. The data presented in these charts are used to identify utilization trends and monitor potential indicators of access barriers to MH/SUD medications relative to M/S medications.

Figure 16: BMS Pharmacy Prior Authorization Requests by Calendar Quarter

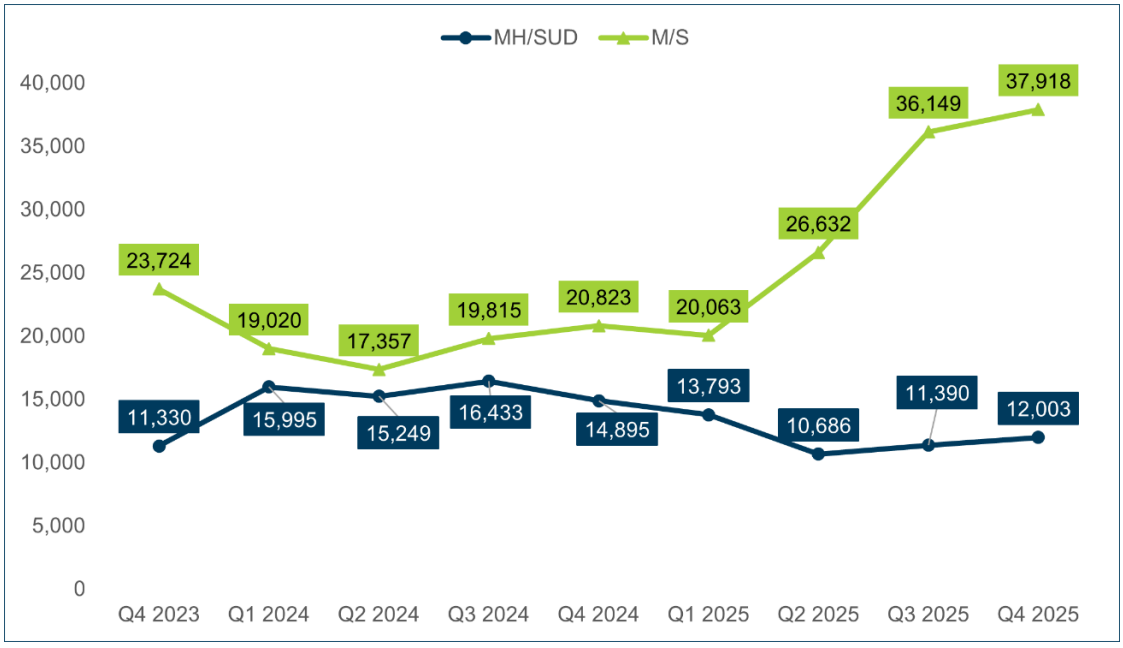


Figure 17: BMS Pharmacy Prior Authorization Requests Denied by Calendar Quarter

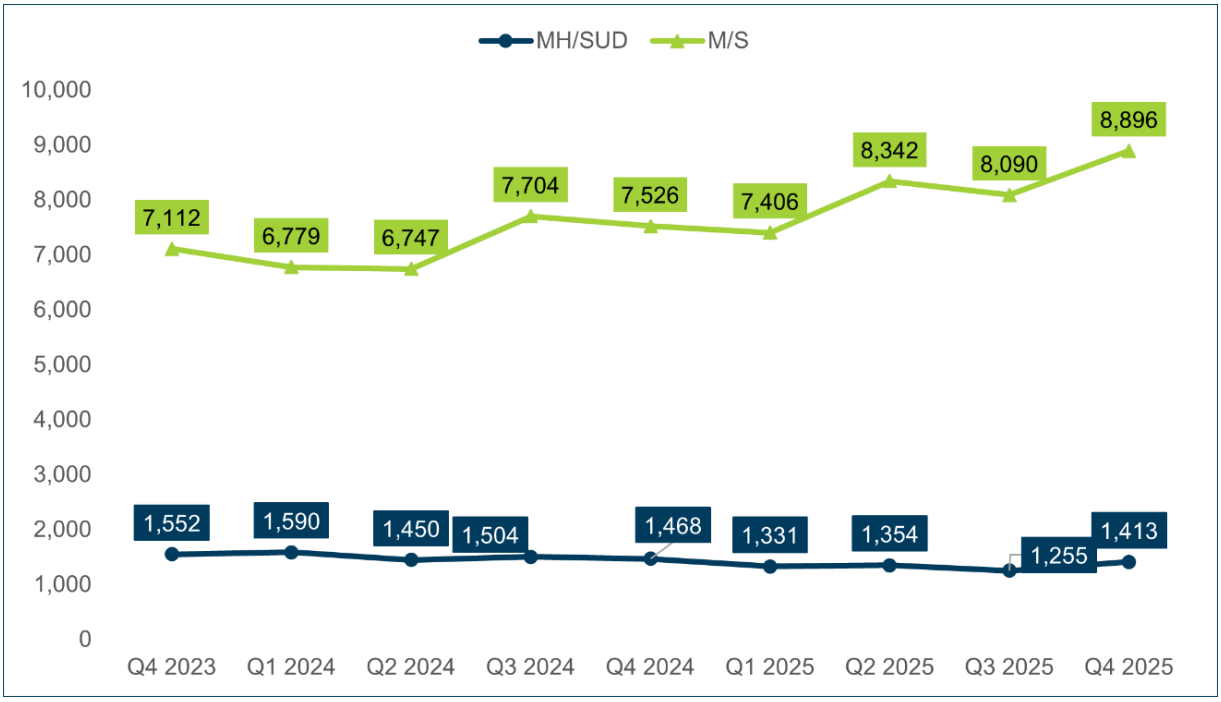
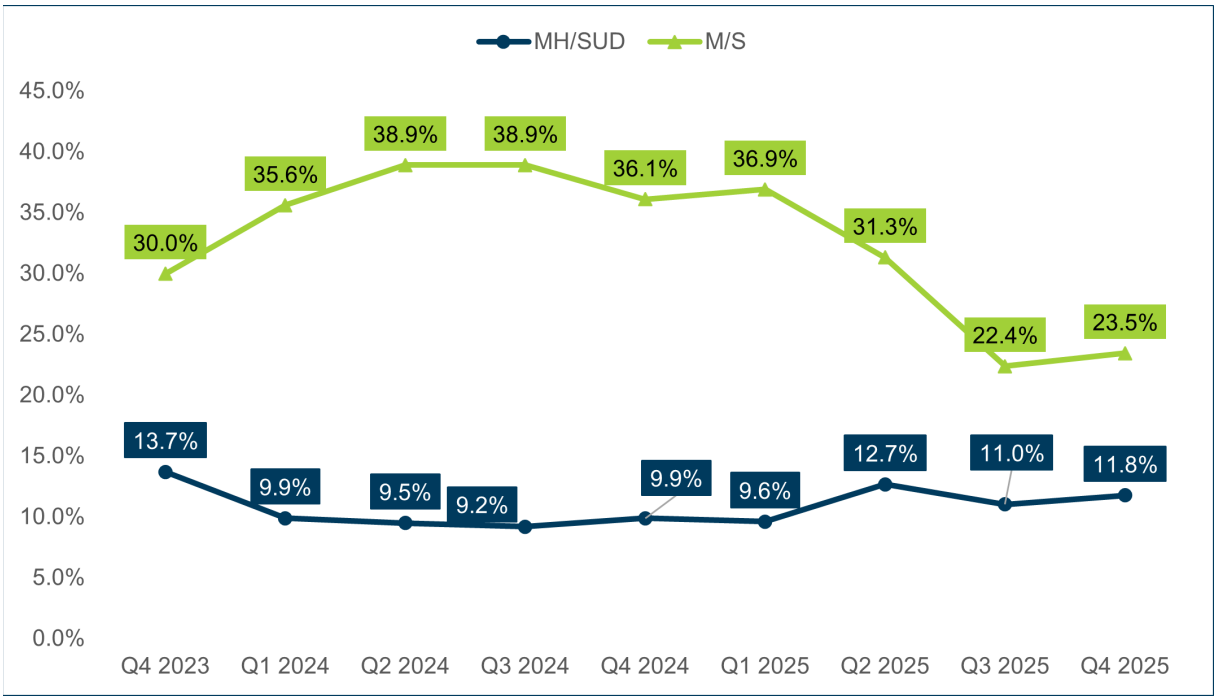


Figure 18: BMS Pharmacy Percentage of Prior Authorization Requests Denied by Calendar Quarter



9.4 WVCHIP Pharmacy Charts

Figure 19: WVCHIP Pharmacy Prior Authorization Requests by Calendar Quarter

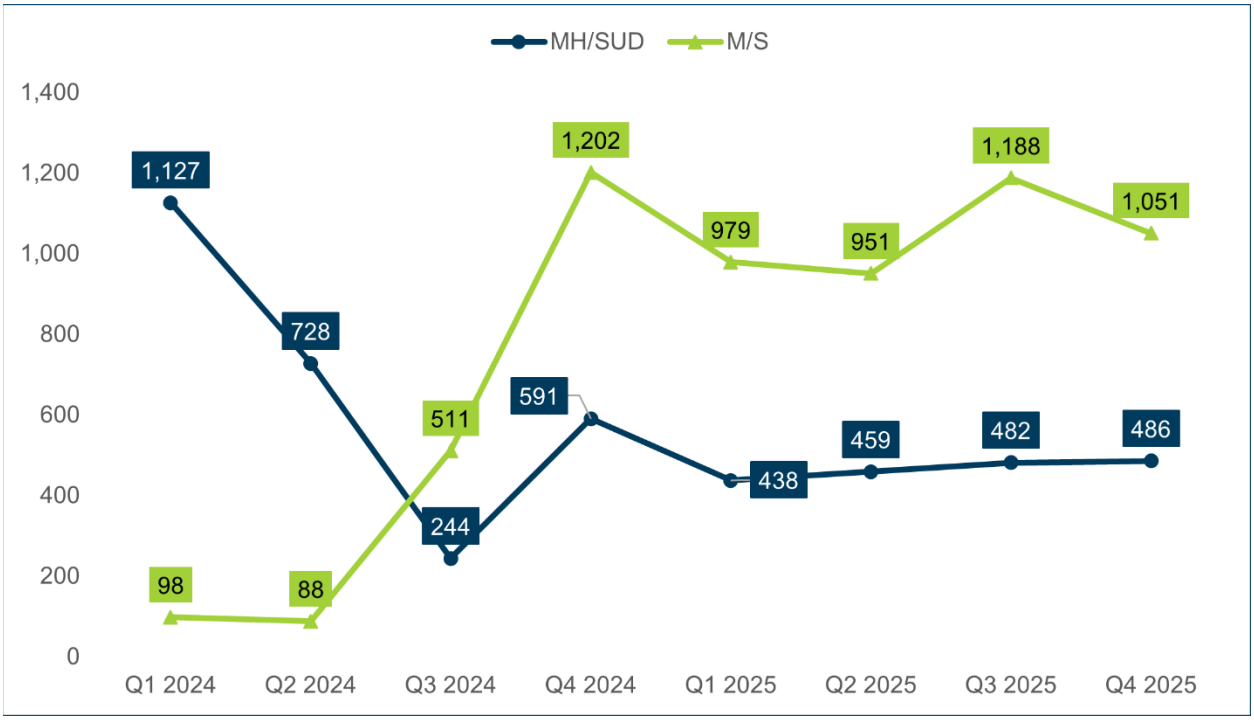


Figure 20: WVCHIP Pharmacy Prior Authorization Requests Denied by Calendar Quarter

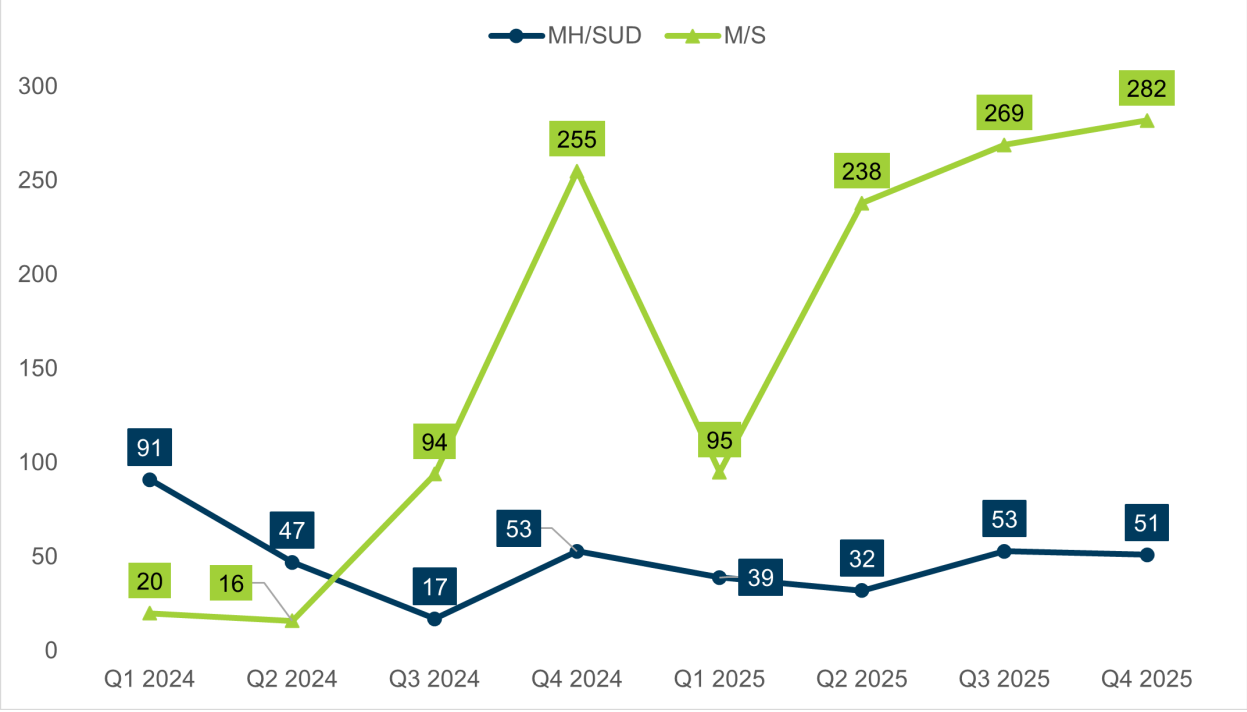
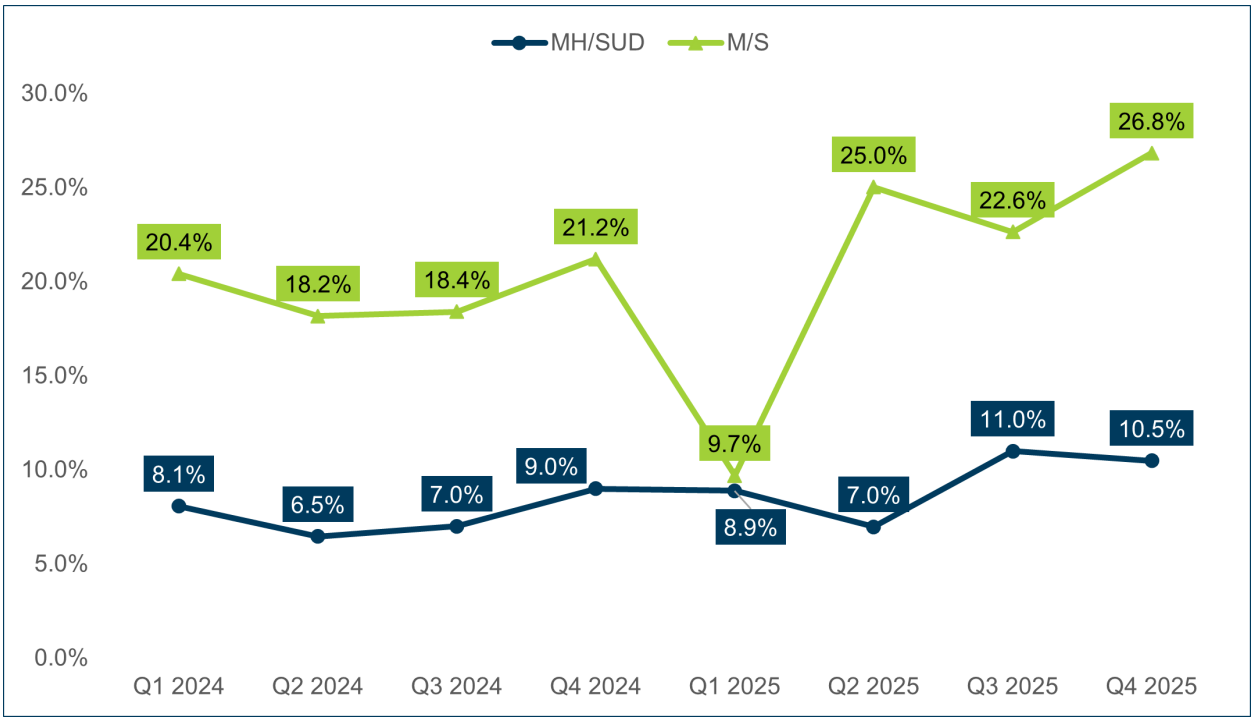


Figure 21: WVCHIP Pharmacy Percentage of Prior Authorization Requests Denied by Calendar Quarter



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State of West Virginia Department of Human Services Medicaid & CHIP Mental Health Parity Compliance Documentation

Version 1.1

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Appendix A MCO Contract Compliance

WV Medicaid's/WVCHIP State Fiscal Year (SFY) 2027 MCO contract[1] and the Mountain Health Promise SFY 2027 contract[2] includes the following provisions related to compliance with federal parity regulations.

References to "BMS" in the Mountain Health Trust contract and "the Department" in the Mountain Health Promise contract both refer to the State agency administering managed care, currently the Department of Human Services, Bureau for Medical Services. The terminology reflects contract-specific definitions rather than a substantive difference in authority or responsibility.

Mountain Health Trust Article II, Section 4.11/Mountain Health Promise Article II, Section 4.10: Utilization Review and Control

Mountain Health Trust: page 22 ; Mountain Health Promise: pages 33 - 34:

In accordance with 42 CFR §438.210(a)(4), the MCO may place appropriate limits on the covered services provided under this Contract on the basis of criteria applied under the Medicaid and WVCHIP [or BSS] State Plans, such as medical necessity or for the purpose of utilization control, provided that:

1. *MCO services can reasonably be expected to achieve the purpose for which such services are furnished;*
2. *Services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and*
3. *Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.*

The MCO must ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The MCO is prohibited from arbitrarily denying or reducing the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Notwithstanding the above, all covered services must be provided in compliance with the Mental Health Parity and Addiction Equity Act of 2008, and with EPSDT requirements, and the respective federal regulations.

Mountain Health Trust Article II, Section 5.14/Mountain Health Promise Article II, Section 5.14: Compliance with Applicable Laws, Rules, and Policies

Mountain Health Trust: pages 32 - 33; Mountain Health Promise: pages 45 - 46 43:

The MCO and its Subcontractors, in performing this contract, must comply with all applicable Federal and State laws, regulations, and written policies, including those pertaining to licensing

and including those affecting the rights of enrollees. MCO[s] must include provisions relating to compliance with such laws in Subcontracts with providers. Assessment of compliance must be included in the MCO[s'] credentialing procedures to the extent feasible.

Work performed under this Contract must conform to the federal requirements set forth in Title 45, CFR Part 74 and Title 42, Part 434. The MCO must also abide by all applicable Federal and State laws and regulations including but not limited to… [Additional language in the Mountain Health Promise contract: Chapter 9, Article 5 and Chapter 49, Articles 1, 2, and 4 of the West Virginia Code pertaining to the state's foster care program and transitioning the foster care population to an MCO (2019 WV House Bill 2010)]…Mental Health Parity and Addiction Equity Act of 2008…and other pertinent Federal, State, or local laws, regulations, or policies in the performance of this contract.

Mountain Health Trust Article III, Section 10.1/Mountain Health Promise Article III, Section 11.1: MCO Behavioral Services Administration

Mountain Health Trust: pages 205 - 206; Mountain Health Promise: pages 221 - 223:

The MCO must provide inpatient and outpatient behavioral services as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished. The benefit must be provided in accordance with 42 CFR part §438 Subpart K, Parity in Mental Health and SUD Benefits. The MCO must develop and maintain an ongoing Mental Health Parity Compliance Plan to be submitted to BMS [Mountain Health Promise: "The Department"] annually by June 30th. The MCO is not subject to implementation of parity requirement associated with quantitative treatment limits of prescription drugs, as this benefit is administered under FFS.

The MCO may place appropriate limits on a service on the basis of such criteria as medical necessity or utilization control, consistent with the terms of this Contract and clinical guidelines. The MCO may not impose an aggregate lifetime, annual dollar limits, or other cumulative financial limits on mental health or SUD services.

The MCO must not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of any type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees, to maintain compliance with the Bureau's Mental Health Parity Plan.

If an MCO enrollee is provided mental health or SUD benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or SUD benefits must be provided to the MCO enrollee in every classification in which medical/surgical benefits are provided.

The MCO may not impose quantitative or non-quantitative treatment limits (QTLs/NQTLs) for mental health or SUD benefits in any classification unless, under the policies and procedures of the MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or 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 for medical/surgical benefits in the classification.

The MCO may cover, in addition to services covered under the Medicaid and/or WVCHIP State Plan, any service necessary for compliance with the requirements for parity in mental health and SUD benefits in 42 CFR §457.496 and 42 CFR §438.910(d)(3).

A mental health screening shall be completed for any child not already known to be receiving mental health services when the child enters DoHS Youth Services, the child welfare system, or the juvenile justice system; or when the child or family requests mental health services or that a screen be conducted. Providers must incorporate the EPSDT HealthCheck screening questions into their mental health screening process as a critical means for determining trauma history and any current trauma-related symptoms. The MCO must provide outreach to families about mental health screening requirements. The MCO must provide a quarterly report of all mental health screenings and services requested and denied within the reporting period. As the MCO may not prior approve mental health screenings, reasons for denials must also be provided. Failure to meet outreach requirements may result in a liquidated damage, as defined within Appendix F.

The MCO must have an innovation plan to address behavioral health adolescents who may be at a higher risk for higher levels of care, which include, but are not limited to, a comprehensive adolescent behavioral health risk assessment, preventative strategies, and technology-enabled solutions.

Mountain Health Trust Article III, Section 10.2/Mountain Health Promise Article III, Section 11.2: Behavioral Health Director

Mountain Health Trust: page 206:

The MCO must employ or Contract with a qualified West Virginia licensed physician to serve as the Behavioral Health Director for the covered behavioral services in accordance with Article II, Section 5.10.1 (Key Staff Requirements). When employed or contracted, the Behavioral Director must be available for behavioral utilization review decisions and must be authorized and empowered to respond to behavioral clinical issues, utilization review, and behavioral quality of care inquiries.

Mountain Health Promise: page 223:

The MCO must employ or Contract with a qualified West Virginia licensed physician to serve as the Behavioral Health Director for the covered behavioral services in accordance with Article II, Section 5.10 (Key Staff Requirements). When employed or contracted, the Behavioral Director must be available for behavioral utilization review decisions and must be authorized and empowered to respond to behavioral clinical issues, utilization review, and behavioral quality of care inquiries.

Mountain Health Trust Article III, Section 10.3/Mountain Health Promise Section 11.3: Behavioral Health Covered Services

Mountain Health Trust: page 206:

The MCO covered behavioral services must be rendered by providers within the scope of their license and in accordance with all State and Federal requirements. Behavioral services include mental health outpatient services, mental health inpatient services, SUD outpatient services , targeted case management (TCM), behavioral health rehabilitation and clinic services, and psychiatric residential treatment services. The MCO must follow BMS FFS policies specific to the drug testing limit requirements contained in Chapter 529 of the WV Medicaid Provider Manual for drug screening services. The MCO may implement its own prior authorization requirements for these services.

Mountain Health Promise: page 223:

The MCO covered behavioral services must be rendered by providers within the scope of their license and in accordance with all State and Federal requirements. Behavioral services include mental health outpatient services, mental health inpatient services, SUD outpatient services, targeted case management (TCM), behavioral health rehabilitation and clinic services, and psychiatric residential treatment services, and all SUD treatment services provided under the Department's 1115 SUD waiver. The MCO must follow Department FFS policies contained in chapter 526 of the WV Medicaid Provider Manual for drug screening services.

Mountain Health Trust Article III, Section 10.5/Mountain Health Promise Section Article III, Section 11.4: Coordination of Care

Mountain Health Trust: page 207:

Notwithstanding internal coordination of care requirements outlined in Article III, Section 5.3 of this Contract, the MCO's PCP [primary care provider] must coordinate the enrollee's health services, as appropriate, with behavioral health providers.

The MCO must initiate care coordination services for enrollees being discharged from crisis stabilization units.

If an enrollee is identified as having a dependence disorder including alcohol, opiate, amphetamine, benzodiazepine, or poly substance, and in need of engagement of treatment, the MCO must assign the enrollee a MCO Care Coordinator, at a minimum, through the duration of the treatment process.

Mountain Health Promise: page 223:

Notwithstanding internal care coordination of care requirements outlined in Article III, Section 6.3 of this Contract, the MCO's PCP must coordinate the enrollee's health services, as appropriate, with behavioral health providers.

The MCO must initiate care coordination services for enrollees being discharged from crisis stabilization units.

If an enrollee is identified as having a dependence disorder including alcohol, opiate, amphetamine, benzodiazepine, or poly substance, and in need of engagement of treatment, the MCO must assign the enrollee a MCO Care Coordinator, at a minimum, through the duration of the treatment process. MCO Care Coordinators should coordinate with Assertive Community Treatment (ACT) Case Managers when the enrollee requires an intensive and highly integrated approach for community mental health service delivery.

Mountain Health Trust Article III, Section 10.11.2/Mountain Health Promise Article III, Section 11.10.2: SUD 1115 Demonstration Waiver

Mountain Health Trust: page 209; Mountain Health Promise: pages 225 – 226:

Building on legislative and health systems activities, the goal is to create a seamless continuum of care to support enrollees in their recovery. The MCO is expected to support the following goals:

1. *Improve quality of care and population health outcomes for Medicaid enrollees with SUD;*
2. *Increase enrollee access to and utilization of appropriate SUD treatment services based on American Society of Addiction Medicine (ASAM®) Criteria;*
3. *Decrease medically non-emergency and avoidable utilization of high-cost emergency department and hospital services by enrollees with SUD;*
4. *Improve care coordination and care transitions for Medicaid [Mountain Health Trust: and WVCHIP] enrollees with SUD; and*
5. *Follow the CMS standards and guidelines as stated in the Special Terms and Conditions of the West Virginia approved 1115 SUD Waiver.*

BMS [Mountain Health Promise: "The Department"] has established standards of care for SUD demonstration waiver services that incorporate industry standard benchmarks from the ASAM® Criteria for patient assessment and placement, service, and staffing specifications.

Mountain Health Trust Article III, Section 10.11.3/Mountain Health Promise: Article III, Section 11.10.3: SUD Services Continuum of Care

Mountain Health Trust: page 209:

The MCO will be responsible for a seamless continuum of care for SUD treatment to all West Virginia Medicaid and WVCHIP enrollees who meet medical necessity criteria for services. These services include standard SUD services authorized under the West Virginia Medicaid State Plan as well as SUD services authorized under the West Virginia Medicaid and WCHIP State Plans as well as SUD services authorized under West Virginia's SUD 1115 demonstration waiver. The MCO must follow all standards and criteria adopted by BMS regarding SUD services as outlined in the West Virginia Medicaid Provider Manual, Chapter 504: Substance Use Disorder Services. The MCO must make all reasonable efforts to contract with all SUD service providers.

Mountain Health Promise: page 226

The MCO will be responsible for a seamless continuum of care for SUD treatment to all West Virginia Medicaid enrollees who meet medical necessity criteria for services. These services include standard SUD services authorized under the West Virginia Medicaid State Plan as well as SUD services authorized under West Virginia's SUD 1115 demonstration waiver. The MCO must follow all standards and criteria adopted by the Department regarding SUD services as outlined in the West Virginia Medicaid Provider Manual, Chapter 504: Substance Use Disorder Services.

Mountain Health Trust Article III, Sectional 10.11.3.1; Mountain Health Promise Article III, Section 11.10.3.1: Medicaid Sate Plan SUD Services

Mountain Health Trust: page 210; Mountain Health Promise: page 226:

Medicaid [Mountain Health Trust: and WVCHIP] State Plan SUD services include:

- *TCM;*
- *Naloxone Administration Services [Mountain Health Trust: (non-covered MCO service)];*
- *Screening, Brief Intervention and Referral to Treatment (0.5 ASAM® Level of Care);*
- *Outpatient Services (1.0 ASAM® Level of Care);*
- *Intensive Outpatient Services (2.1 ASAM® Level of Care);*
- *Partial Hospitalization Services (2.5 ASAM® Level of Care);*
- *Medically Monitored Intensive Inpatient Services (3.7 ASAM® Level of Care);*
- *Medically Managed Intensive Inpatient Services (4.0 ASAM® Level of Care);*
- *Ambulatory Withdrawal Management Services (1-WM & 2-WM ASAM® Level of Care);*
- *Medically Monitored Inpatient Withdrawal Management Services (3.7-WM ASAM® Level of Care); and*
- *Non-Methadone Medication Assisted Treatment (MAT).*

Mountain Health Trust Article III, Section 10.11.2/Mountain Health Promise Article III, Section 11.10.3.2 SUD Demonstration Waiver Services

Mountain Health Trust: page 209; Mountain Health Promise: pages 226 – 227

At such time that BMS determines services will be implemented, the MCO must provide for services for enrollees and comply with all programmatic and reporting requirements. Upon request, the MCO must collaborate with BMS in planning for and implementation of these services. SUD 1115 demonstration waiver services include:

1. *Peer Recovery Support Specialist Services (PRSS) (1.0 ASAM® Level of Care);*
2. *Clinically Managed Low Intensity Residential Services (3.1 ASAM® Level of Care);*
3. *Clinically Managed High Intensity Residential Services (3.5 ASAM® Level of Care); (3.7 ASAM® Level of Care);*
4. *Medically Managed Residential Services (3.7 ASAM® Level of Care with expanded services for medically complex individuals); (3.7 ASAM® Level of Care with expanded services);*
5. *Clinically Managed Residential Withdrawal Management Services;*
6. *Expansion of Residential Treatment for Medically Complex Individuals*
7. *Supported Housing Services;*
8. *Recovery Related Support Services; and*
9. *Quick Response Teams (QRTs).*

Mountain Health Promise Article III; Section 11.11 Children with Serious Emotional Disorder (CSED) Waiver Services

Mountain Health Promise: page 229:

Children with Serious Emotional Disorder (CSED) is a §1915(c) Medicaid HCBS waiver that provides additional and non-duplicative HCBS beyond what is covered under the state's Medicaid State Plan. The CSED waiver permits the Department to provide an array of HCBS that supports a child/adolescent who would otherwise require institutionalization to remain in their home and community. The waiver intends to reduce the number of children/adolescents residing both in-state and out-of-state in PRTFs and shorten the lengths of stay for children/adolescents who require acute care.

Mountain Health Promise Article III, Section 11.11.1 SED HCBS Waiver Eligibility

Mountain Health Promise: page 230:

To be eligible for the waiver children must be at least three (3) years old and under twenty-one (21) and currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) or [International Classification of Disease] ICD equivalent that is current at the date of evaluation. The evaluation must state that the serious emotional disorder (SED) has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities.

The Department contracts with an Administrative Service Organization (ASO) and psychological practice to serve as the Medical Eligibility Contracted Agent (MECA) to determine CSED waiver eligibility and manage allotted waiver slots and enrollment into the MCO.

Mountain Health Promise Article III, Section 13.1 Provider Network

Mountain Health Promise: page 239:

The MCO is required to make all reasonable efforts to contract with all currently enrolled residential treatment facilities. The State shall define for the MCO the category by which each facility falls in alignment with [2018 Family First Prevention Services Act] FFPSA.

EPSDT- and MHP MHT MCO Contract-Related Provisions[i]

Mountain Health Trust Article II, Section 4.11/Mountain Health Promise Article II, Section 4.10: Utilization Review and Control

Mountain Health Trust: page 22; Mountain Health Promise: pages 33 - 34:

Notwithstanding the above [placing appropriate limits on covered services], all covered services must be provided in compliance with the MHPAEA, and with EPSDT requirements, and the respective federal regulations. The Department/BMS will have the authority to override any MCO utilization management guideline on a case-by-case basis.

[i] These provisions have been edited for clarity, as noted by [ ], or consolidated using appropriate acronyms. “The Department/BMS” is used to refer the State agency administering managed care, currently the Department of Human Services, Bureau for Medical Services. The terminology reflects contract-specific definitions rather than a substantive difference in authority or responsibility.

Mountain Health Trust Article II, Section 5.14/Mountain Health Promise Article II, Section 5.14: Compliance with Applicable Laws, Rules, and Policies

Mountain Health Trust: pages 32 - 33; Mountain Health Promise: pages 44 - 46:

Work performed under this contract must conform to the federal requirements set forth in Title 45, CFR Part 74 and Title 42, Part 434. The MCO must also abide by all applicable federal and state laws and regulations including but not limited to…

Title 42 Parts 438, 440, and 457 of the Code of Federal Regulations, pertaining to mental health parity and addiction equity…

Mountain Health Trust Article III, Section 1.2.1/Mountain Health Promise Article III, Section 2.2.3: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

Mountain Health Trust: pages 57 – 58; Mountain Health Promise: page 72:

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) mandated that all Medically Necessary services listed in Section 1905(a) of the Social Security Act be covered under Medicaid for the EPSDT benefit provided for Medicaid eligible children under the age of twenty-one (21). EPSDT services include all mandatory and optional Medically Necessary services (including treatment) and items listed in 42 USC 1396d(a) to correct or ameliorate defects, and physical and mental illness and conditions discovered by the HealthCheck screening. EPSDT services are included in the prepaid benefit package for all enrolled children and adolescents up to age twenty-one (21). [Mountain Health Trust: EPSDT services shall be provided to WVCHIP enrollees in the same manner as provided to Medicaid enrollees.] The federal government, through CMS, requires states to demonstrate an eighty percent (80%) compliance rate for EPSDT screening schedules…[Section includes specific requirements].

Mountain Health Trust Article III, Section 1.2.1.1/Mountain Health Promise Article III, Section 2.2.3.1: Provide Information on EPSDT and Notification of Screening Due Dates

Mountain Health Trust: pages 66 - 67; Mountain Health Promise: page 80:

The MCO must provide a combination of written and oral methods designed to effectively inform all EPSDT-eligible individuals, [Mountain Health Trust: or] their families, [Mountain Health Promise: and their foster care parents, and CPS worker if applicable] about the EPSDT program. The MCO must have an established process for ensuring all reminders, follow-ups,

and outreach to enrollees are accessible and culturally competent for all enrollee populations… [Section includes specific screenings and notification material requirements].

Mountain Health Trust Article III, Section 1.2.1.2 Perform the Screenings/Mountain Health Promise Article III, Section 2.2.3.2: Perform the EPSDT HealthCheck Screenings

Mountain Health Trust: page 67; Mountain Health Promise: pages 80 - 81:

The MCO/MCOs must provide screenings (periodic comprehensive child health assessments) according to the West Virginia Periodicity Schedule to all enrollees eligible to receive them. The schedule is maintained by the Office of Maternal and Child Health within the West Virginia Bureau for Public Health and corresponds to the AAP's [American Academy of Pediatrics] Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents.

Covered screening services are regularly scheduled examinations and evaluations of the general physical health and mental health, growth, development, and nutritional status of infants, children, and youth. [Section provides specific requirements of what must be provided at screenings].

Mountain Health Trust Article III, Section 1.2.1.3/Mountain Health Promise Article III, Section 2.2.3.3: Make the Necessary Referrals

Mountain Health Trust: page 68; Mountain Health Promise: page 81 - 82:

In addition to any diagnostic and treatment services included in the defined benefit package, the MCO must provide the following services to eligible EPSDT enrollees, if the need for such services is indicated by screening:

1. Diagnosis of and treatment for defects in vision and hearing;

2. Dental care (at as early an age as necessary) needed for relief of pain and infections, restoration of teeth, and/or maintenance of dental health;

3. Appropriate immunizations (if it is determined at the time of screening that immunization is needed and appropriate to provide at that time, then immunization treatment must be provided at the time of screening); and

4. Medically Necessary specialized treatment and/or BH services.

[Includes MCO responsibilities if a child needs a treatment that is not covered under the categories listed in Section 1905(a) of the Social Security Act]

Mountain Health Trust Article III, Section 1.2.1.4: Track Referrals and Treatments/Mountain Health Promise Article III, Section 2.2.3.4: Track Referrals and Treatments

Mountain Health Trust: pages 68 - 69; Mountain Health Promise: pages 82 -83:

The MCO must establish a tracking system that provides up-to-date information on compliance with EPSDT service provision requirements including a Periodicity Schedule of preventive services and standards of care in the following areas:

1. Initial visit for newborns. The initial EPSDT screen must be the newborn physical exam in the hospital, birthing center, home, or other setting. Based in part upon the results of the birth score procedure conducted through the hospital or birthing center under the governance of the Bureau for Public Health, the periodicity of preventive pediatric visits must follow the schedule recommended by the AAP or the accelerated visit schedule set for infants identified as "at risk" through the birth score system.

2. Preventive pediatric visits according to West Virginia's Periodicity Schedule up to age twenty-one (21).

3. Diagnosis and/or treatment, or other referral in accordance with EPSDT screen results. The MCO must employ processes to ensure timely initiation of treatment, if required, generally no more than six (6) months after the screening services.

4. Behavioral health, dental, and any other screenings performed for enrollees.

5. [Mountain Health Promise] Missed periodic and preventive visits and notification to enrollees and/or their authorized representative of missed visits.

Mountain Health Trust Article III, Section 1.2.1.5: Report the Results/Mountain Health Promise Article III, Section 2.2.3.5: Report Results

Mountain Health Trust: page 69; Mountain Health Promise: page 83:

The Department/BMS is responsible for ensuring that the MCO fulfills its contractual responsibilities to inform all families of the services available under EPSDT and how to access them.

The MCO must maintain data for medical, behavioral, and dental screenings in a standardized format to the extent feasible and appropriate. The MCO must review and ensure that data received from providers is accurate, timely, and complete. The MCO must facilitate routine tracking and trending of enrollee care issues to monitor, and assist in monitoring access, use and coordination of all services, including behavioral health services. [Also includes MCO reporting to Department/BMS requirements].

Mountain Health Trust Article III, Section 2.2.4/Mountain Health Promise Article III, Section 3.2.4: Types of Primary Care Providers (PCPs)

Mountain Health Trust: page 90; Mountain Health Promise: pages 105 - 106:

The MCO is required to contract with a mix of PCPs to ensure the primary care needs of adult and pediatric enrollees are met. The MCO may designate the following providers as PCPs, as appropriate:

- *Certified nurse midwives;*
- *Advanced practice nurses (e.g., nurse practitioners (NP));*
- *Physician Assistants (PA); and*
- *Physicians with the following specialties: General practice; Family practice; Internal medicine; Obstetrics/Gynecology; and Pediatrics.*

The MCO will be allowed to designate physicians outside of these specialties as PCPs for specific individuals including those within the disabled population whose underlying health conditions are best managed by specialists. The MCO must outreach to such specialists to provide information about responsibilities for EPSDT services, as set forth in [Mountain Health Trust: Article III, Section 1.2.1]/[Mountain Health Promise: Article III Section 2.2.3].

The MCO must permit any certified nurse midwife, advanced practice nurse, or PA who is otherwise permitted within the scope of their practice and who is a Medicaid/WVCHIP enrolled provider, to be designated a PCP for an enrollee and bill independently.

Mountain Health Trust Article III, Section 3.4.3.1/Mountain Health Promise Article III, Section 4.4.3.1: Enrollee Handbook Requirements

Mountain Health Trust: pages 116 - 118; Mountain Health Promise: pages 131 - 134:

The handbook must include the following information which must adhere to the standards set forth in this contract: … How to obtain EPSDT services…

Mountain Health Trust Article III, Section 3.8.5/Mountain Health Promise Article III, Section 4.8.5: State Fair Hearing

Mountain Health Trust: pages 133 - 134; Mountain Health Promise: page 149:

The MCO is responsible for cooperating with the State in the fair hearings process and is considered a party to state fair hearings. Other parties to the State fair hearing include the State, the enrollee and his or her representative or the representative of a deceased enrollee's estate. The MCO's responsibilities include, but are not limited to, the following requirements: ensuring and documenting that the enrollee's appeal is regarding MHT covered benefits or services, including EPSDT, in accordance with 42 CFR 431.220, providing any required documentation, participating in required meetings, and abiding by the State's final decisions, including decision to settle a case with the enrollee.

Mountain Health Trust Article III, Section 3.9.1/Mountain Health Promise Article III, Section 4.9.1: Services and Enrollees Exempt from Cost-Sharing Obligations

Mountain Health Trust: page 135; Mountain Health Promise: pages 150 - 151:

The MCO and the MCO's providers may not charge copays to the following MCO enrollees or on the following services: …

- *Emergency Services;*
- *Behavioral Health services;*
- *[Mountain Health Trust: Medicaid enrollees under age twenty-one (21)];*
- *[Mountain Health Promise: Enrollees up to age twenty-six (26)];*
- *Pregnant women (including the twelve (12) months postpartum period following the end of pregnancy);*
- *American Indians and Alaska Natives;*
- *Any additional enrollees or services excluded under [Mountain Health Trust: Medicaid or WVCHIP] State Plan authority; and*
- *Enrollees who have met their household maximum limit for the cost-sharing obligations per calendar quarter.*

[Mountain Health Trust: Copayments and/or cost-sharing should not be applied for primary care services for WVCHIP beneficiaries…][ii, 3]

[ii] Copayments and/or cost-sharing should not be applied for preventive services required in the EHB final rule for WVCHIP beneficiaries, in accordance with 78 FR No.135.

Mountain Health Trust Article III, Section 5.3/Mountain Health Promise Article III, Section 6.3: Continuity and Coordination of Care

Mountain Health Trust: pages 143 - 145; Mountain Health Promise: pages 159 - 161:

In accordance with 42 CFR §438.208(b)(1), the MCO must ensure an integrated approach to the continuity and coordination of care through use of an individual or entity that is formally designated as having primary responsibility for administering the enrollee's overall health care services; the MCO must provide the enrollee with information on how to contact the designated individual or entity….

The MCO's care coordination program must describe the following components:

- *…Processes to structure the care management system to serve the complex physical health and behavioral health needs of enrollees;*
- *…MCO's requirements related to required periodic EPSDT schedules;...*

Mountain Health Trust Article III, Section 5.3.2/Mountain Health Promise Article III, Section 6.3.2: Coordination of Care

Mountain Health Trust: pages 146 - 150; Mountain Health Promise: pages 161 - 166:

The MCO must have systems in place to ensure well-managed patient care, including at a minimum:

…Coordination and provision of EPSDT services as defined in Article III, Section [Mountain Health Trust:1.2, Mountain Health Promise: 2.2]….

In accordance with 42 CFR §438.208(c)(2), the MCO must implement mechanisms to assess each Medicaid and WVCHIP enrollee in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring…

…The MCO must have a risk stratification framework to review the enrollee's health risk assessment and other available information and to facilitate assignment of enrollees to the three (3) risk levels set forth below, according to criteria and thresholds for each level. Criteria and thresholds must include current and historical factors including, but not be limited to:

- *Acuity of chronic conditions;*
- *Behavioral health and SUDs;*
- *Prenatal risk for mother and baby (e.g., prior pre-term birth);*
- *Inpatient or emergency department utilization;*
- *[Social Determinants of Health] SDoH; and*

- *Safety risk factors*

The MCO must establish a care management program for pregnant women, which includes, but is not limited to the following:

1. Approach to providing health education (e.g., lead poisoning prevention/testing) and encouraging breastfeeding, nutrition, and exercise;

2. Promotion of prenatal care throughout the pregnancy and planning for postpartum services;

3. Communication with the OB/GYN and enrollee;

4. A process for risk stratification of pregnant women and for identifying high-risk mothers and babies to facilitate connections to services, community programs, and supports.

[Mountain Health Promise: The MCO should collaborate with the Department's pharmacy program to provide coordinated care for the enrollee, including, but not limited to, those enrollees accessing psychotropic medications, and ensuring that needed medications are available to the enrollee after leaving an inpatient facility or changing levels of care for applicable populations.]

For enrollees referred to PRTF services, the MCO shall establish an internal committee comprised of physicians and enrollees of the Department to determine if placement is most appropriate to meet the needs of the youth, or if outpatient and community-based resources can be established to meet the needs of the youth. The MCO shall also be required to implement a systematic administrative process to coordinate access to services, including non-capitated services, such as wraparound services or other programs offered by the Department to help keep the enrollee in their home and reduce residential placements. The MCO must coordinate with the Department to identify important resources to help enrollees in maintaining health and well-being.

The MCO must have a comprehensive written assessment procedure for enrollees accessing PRTF-levels of care, including development of a discharge plan. Each enrollee that enters a PRTF must have a thorough assessment completed by the provider, a subsequent plan of care, and a written discharge plan. The MCO must evaluate and prepare an enrollee for discharge through the following mechanisms:

1. Coordinate with the psychiatric residential treatment providers, treating professionals and the enrollee or guardian to plan enrollee's care and discharge;

2. Coordinate with the Department on Medicaid [Mountain Health Trust: /WVCHIP] and non-Medicaid [Mountain Health Trust: /WVCHIP] services, to be provided to the enrollee to help keep the enrollee in their setting of choice, as appropriate;

3. Coordinate community resources upon discharge;

4. Coordinate with non-PRTF providers to deliver MCO-covered services;…

Mountain Health Trust Article III, Section 5.3.4.1/Mountain Health Promise Article III, Section 6.3.4.1: Care Coordination with the Title V State Agency

Mountain Health Trust: pages 152 - 153; Mountain Health Promise: pages 168 - 169:

The MCO, through the Department/BMS, will coordinate with the Bureau for Public Health (BPH), Office of Maternal, Child and Family Health (OMCFH), to:

….Make all reasonable efforts to assure appropriate access to and receipt of the full range of screening, diagnostic, and treatment services covered under EPSDT…

Mountain Health Trust Article III, Section 5.9.11/Mountain Health Promise Article III, Section 6.10.12: Federal Reporting Requirements

Mountain Health Trust: page 161; Mountain Health Promise: page 181:

The MCO must comply with the following Federal reporting and compliance requirements for the services listed below and must submit applicable reports to the Department/BMS. (See Medicaid Physician Provider Manual for state requirements and procedures):…

…EPSDT services and reporting must comply with 42 CFR Section 441 Subpart B – Early and Periodic Screening, Diagnosis, and Treatment…

Mountain Health Trust Article III, Section 5.9.12/Mountain Health Promise Article III, Section 6.10.12: Mental Health Parity Report

Mountain Health Trust: pages 170 - 171; Mountain Health Promise: page 189:

The MCO must provide BMS with quarterly reports of mental health parity data in formats to be specified by BMS. The quarterly reports must include data for the following areas:

- *Outpatient PA counts by benefit type;*
- *Inpatient PA counts by benefit type;*
- *Enrollment/credentialing counts by provider type; and*
- *Enrollee complaints by National Committee on Quality Assurance (NCQA) category.*

The MCO must include in its report submission an explanation of any unfavorable mental health or [substance use disorder] SUD findings.

Mountain Health Trust Article III, Section 9.5/Mountain Health Promise Article III, Section 10.5: Coordination of Care

Mountain Health Trust: page 204; Mountain Health Promise: page 220:

Pursuant to 42 CFR §438.208, the MCO is responsible for the management of dental care and continuity of care for all affected MCO enrollees. The MCO or the MCO's PCP must urge enrollees to see their dental provider at least once every six (6) months for regular check-ups, preventive pediatric dental care, and any services necessary to meet the enrollee's diagnostic, preventive, restorative, surgical, and emergency dental needs. The MCO should intervene if an enrollee has not had a dental screening in over one (1) year.

Per Article III, Section [Mountain Health Trust: 1.2, Mountain Health Promise: 2.2], the MCO's PCP must coordinate care by providing a direct referral to a dentist for children beginning at six (6) months after the first tooth erupts or by twelve (12) months of age as a part of the EPSDT process. Dental screenings are covered for any child under the age of twenty-one (21) years per the recommended guidelines set forth by the American Academy of Pediatric Dentistry (AAPD) and Bright Futures.

Mountain Health Trust Article III, Section 10.1/Mountain Health Promise Article III, Section 11.1: MCO Behavioral Services Administration

Mountain Health Trust: pages 205 - 206; Mountain Health Promise: pages 221 - 222:

The MCO must provide inpatient and outpatient behavioral services as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished.[iii] *The benefit must be provided in accordance with 42 CFR part §438 Subpart K, Parity in Mental Health and SUD Benefits. The MCO must develop and maintain an ongoing Mental Health Parity Compliance Plan to be submitted to BMS annually by June 30th. The MCO is not subject to implementation of parity requirement associated with quantitative treatment limits of prescription drugs, as this benefit is administered under FFS…*

[This section details MHPAEA requirements regarding FRs, treatment limitations, aggregate lifetime limits, annual dollar limits, and other cumulative limits].

The MCO may cover, in addition to services covered under the Medicaid [Mountain Health Trust: and/or WVCHIP] State Plan, any service necessary for compliance with the requirements for parity in mental health and SUD benefits in 42 CFR §457.496…

[iii] 42 CFR § 438.210

A mental health screening shall be completed for any child not already known to be receiving MH services when the child enters [Mountain Health Trust: DoHS, Mountain Health Promise: Department] Youth Services, the child welfare system, or the juvenile justice system; or when the child or family requests mental health services or that a screen be conducted. Providers must incorporate the EPSDT HealthCheck screening questions into their mental health screening process as a critical means for determining trauma history and any current trauma-related symptoms. The MCO must provide outreach to families about mental health screening requirements. The MCO must provide a quarterly report of all mental health screenings and services requested and denied within the reporting period. As the MCO may not prior approve mental health screenings, reasons for denials must also be provided. Failure to meet outreach requirements may result in a liquidated damage, as defined within Appendix F.

EPSDT, Mountain Health Trust and Mountain Health Promise Reporting Contract Requirements

Table 1: EPSDT Contract Reporting Requirements

Reporting Requirement	Contract Page Number	Due Date
EPSDT Services and Reporting	Mountain Health Trust: Page E-3 Mountain Health Promise: Page D-3	Forty-five (45) days after each quarter
Mental Health Parity Report	Mountain Health Trust: Page E-3 Mountain Health Promise: Page D-5	Forty-five (45) days after end of each quarter
Parity in Mental Health and Substance Use Disorder (SUD) Benefits Compliance Plan	Mountain Health Trust: Page E-4 Mountain Health Promise: PageD-5	On or before June 30th

Appendix B: MCO and Pharmacy Quarterly Submissions to BMS

MHT, MHP, and WVCHIP

Each quarter, MCOs must submit data for the measures listed below, grouped by the type of request (MH/SUD or M/S). Data points pertaining to MCO membership reflect overall enrollment and are not classified by benefit type.

Outpatient Prior Authorization (PA) Counts by Benefit Type

- # of PA Requests Outpatient
- # of PA Requests Denied Outpatient
- % of PA Requests Denied Outpatient
- # of PA Denials Appealed Outpatient
- % of PA Denials Appealed Outpatient
- # of PA Denials Overturned Outpatient
- % of PA Denials Overturned Outpatient

Inpatient PA Counts by Benefit Type

- # of PA Requests Inpatient
- # of PA Requests Denied Inpatient
- % of PA Requests Denied Inpatient
- # of PA Denials Appealed Inpatient
- % of PA Denials Appealed Inpatient
- # of PA Denials Overturned Inpatient
- % of PA Denials Overturned Inpatient

Enrollment/Credentialing Counts by Provider Type

- Average # of Enrolled Providers

Membership

- Average # of Enrolled Members

Enrollee Complaints by NCQA Category

- # Access

- # Attitude and Service
- # Billing and Financial
- # Quality of Care
- # Quality of Practitioner Office Site

NQTL and Data Follow-up

- Please describe any changes impacting non-quantitative treatment limitations (NQTLs) since the 2023 mental health parity compliance review:
- For any unfavorable quarterly data points or overall trends related to mental health/substance use disorder services, please include an explanation as well as planned follow-up:

Wait Times

- Please provide an explanation of the methodology used to measure appointment wait times.
- # of Adult Outpatient Mental Health and Substance Use Disorder Referrals
- Mean Adult Wait Time (Business Days) from Mental Health and Substance Use Referral to Appointment
- # of Adult Referrals Taking Over 10 Business Days
- # of Pediatric Outpatient Mental Health and Substance Use Referrals
- Mean Pediatric Wait Time (Business Days) from Mental Health and Substance Use Referral to Appointment
- # of Pediatric Referrals Taking Over 10 Business Days
- Please provide an explanation for wait times in excess of 10 business days.

Pharmacy

Each quarter, BMS pharmacy submits data for the Medicaid and WVCHIP populations for the measures listed below. Data are grouped by the type of request (MH/SUD or M/S) and further classified by specified disorders: opioid use disorder, tobacco use disorder, and eating disorders.

Medication PA Counts by Benefit Type

- # of PA Requests Outpatient
- # of PA Requests Denied Outpatient
- % of PA Requests Denied Outpatient
- # of PA Denials Appealed Outpatient

- % of PA Denials Appealed Outpatient
- # of PA Denials Overturned Outpatient
- % of PA Denials Overturned Outpatient

NQTL and Data Follow-Up

- Please describe any changes impacting non-quantitative treatment limitations (NQTLs) since the 2023 mental health parity compliance review:
- For any unfavorable quarterly data points or overall trends related to mental health/substance use disorder services, please include an explanation as well as planned follow-up:

Appendix C: Documents Reviewed

Documents reviewed for this report. Publicly available documents have links provided.

Documents from Aetna

The following links provide access to publicly available documents if applicable:

- https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/west-virginia/pdf/abhwv_member_mountain_health_trust_handbook.pdf
- https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/west-virginia/provider/pdf/abhwv_provider_manual.pdf

List of Documents Reviewed

- A-WV 6200.10 Provider Claim Payment and Data Completeness 11.14.25
- A-WV 6400.06 Practitioner and Provider Availability Network Composition and Contracting Plan 11.14.25
- A-WV 7100.05 Prior Authorization Corp Policy, Amendment, Attestation 12.1.25
- A-WV QM 54 Credentialing Policy and Procedure Development Corp Policy & Amendment 06.13.25
- Medicaid_WCHIP_RFI_1-9-2026 Final ABHWV
- NET 1BCD Avail Practitioners Analysis 2025 template
- ABHWV_Member_Mountain_Health_Trust_Handbook
- ABHWV_Provider_Manual
- CHIP_Appendix_Aetna_20240811 Final 021326
- Mountain Health Promise RFI Final
- RE Mental Health Parity NQTL updates

Documents from Highmark

The following two links provide access to publicly available documents if applicable:

- https://www.highmark.com/content/dam/digital-marketing/en/highmark/highmarkhealthoptionswv/documents/HHO-WV-Quick-Guide-2025_508c.pdf.
- https://wv.highmarkhealthoptions.com/content/dam/digital-marketing/en/highmark/highmarkhealthoptionswv/member/HHOW-00029-Q1-2025-Medicaid-Member-Newsletter_FF_508c.pdf

List of Documents Reviewed

- CO-203-MD-WV Emergency Services and Authorizations Policy
- CO-218-MD WV Concurrent Review Policy
- CO-221-MD-WV Precertification Policy
- CO-225-MD-WV Medical Director Referrals Policy
- CO-239-MD-WV Request For MA Fee Schedule Program Exceptions Policy
- CO-250-MD-ALL Healthcare Professional Inter-Rater Reliability Audit Policy
- CO-252-MD-WV Application of Utilization Management Criteria Policy
- CO-261-MD-WV Obstetrical and Gynecological Authorizations Policy
- CO-298-MD-WV Substance Use Disorder Authorization Policy
- CO-299-MD-WV-Behavioral Health Mental Health Parity Policy
- CR-400-MD-WV Practitioner Performance Monitoring Policy
- CR-401-MD-WV Practitioner Credentialing Policy
- CR-415-MD-WV Credentialing of Physician Extenders Policy
- CR-418-MD-WV Confidentiality Policy
- CR-420-MD-WV Credentialing and Recredentialing of Therapy Providers Policy
- CR-421-MD-WV Due Process Procedure Policy
- CR-422-MD-WV Auditing of Providers and Organizational Providers
- FINAL HHOWV - CHIP and Medicaid Children NQTLs Table 1.28.2026
- FINAL HHOWV - Medicaid Adult NQTLs Table 1.26.2026
- FY 2025 MCO PNA Annual Submission Template for MHT and CHIP 1-27-2026
- HHO EPSDT Provider Flyer
- HHOWV EPSDT Adolescent Depression Screening
- HHOWV EPSDT Flyer
- HHOWV EPSDT Maternal Depression Screening
- HHOWV EPSDT Member Outreach Form
- HHOWV EPSDT Provider Doc-Lead Level Testing

- HHOWV MHP and EPSDT RFI Response - 1.30.2026
- HHO-WV-RP-2115 Medical & Reimbursement Policy
- HHO-WV-RP-2140 Telehealth
- HHO-WV-RP-2140_Telehealth
- HHO-WV-RP-2204 Medical and Reimbursement Policies
- MBU-CM-POL-0005 Early and Periodic Screening Diagnosis and Treatment Policy
- PC-200-MD-WV Default Pricing Policy
- PC-508-MD-WV Monitoring Network Adequacy Policy
- PC-606-MD-WV Network Oversight Policy
- PC-610-MD-WV Single Case Agreement (SCA) Guidelines Policy
- Telehealth - Non Covered - WV_MD
- West Virginia Adult Facility Maps 1-26-2026
- West Virginia Adult Provider Maps 1-26-2026
- West Virginia Pediatric Facility Maps 1-26-2026
- West Virginia Pediatric Provider Maps 1-26-2026
- West Virginia Mental Health Parity Review Annual 2025 IRR Exam
- 2025-2026-hhowv-member_handbook_en
- 2025-HHOWV-ProviderManual
- HHO-WV-Quick-Guide-2025_508c
- HHOW-00029-Q1-2025-Medicaid-Member-Newsletter_FF_508c

Documents from The Health Plan

No publicly available links were provided.

List of Documents Reviewed

- Assertive Community Treatment -ACT
- Assessing Network Adequacy through the Use of Member Experience
- Availability of Behavioral Healthcare Providers
- Availability Of Primary Care Practitioners

- Clinical Service Parity Review Plan (7)
- Coverage of Emergency and Post Stabilization Care (2)
- Credentialing of Providers- CR-01
- Gold Card Program
- Initial Credentialing and Recredentialing Process- CR-02
- Inpatient Utilization Management
- Interrater Review Reliability Monitor
- Interrater Scores
- Medicaid_WCHIP_RFI_1-9-2026
- Mountain Health Trust Availability and Access Standards
- Mountain Health Trust -MHT- -WV Medicaid - WVCHIP- Timeliness of UM Decisions and Notifications (2)
- Effective_July_1_2025_The_Health_Plan_Provider_Manual_Revised_November_24_2025
- MHT_Member_Handbook_SFY26_Clean_20250618
- 20251009 WV_ MCO CHIP Exception Request
- 20251009 WV_ MCO Medicaid Exception Request
- FY2025 MCO PNA Annual Submission Template for MHT MHP and CHIP
- WV CHIP FINAL 3
- WV Medicaid FINAL 3
- ABA Fees_Updated 7-25-2023
- WVCHIP The Health Plan 2026 Parity in Mental Health and SUD Benefits Compliance Plan_Annual

Documents from Wellpoint

The following links provide access to publicly available documents if applicable:

- WV BMS document provided below without clear alignment.
- WV BMS document provided below without clear alignment.
- WV BMS document provided below without clear alignment.
- WV BMS document provided below without clear alignment.
- WV BMS document provided below without clear alignment.

List of Documents Reviewed

- 2025 IP IRR Assessment Direct Report Scores
- 2025 PA Team IRR Assessment Direct Report Scores
- BH IRR 2025 Course Completion
- BMS_Provider Network Adequacy Template_FY2025_Wellpoint_Medicaid
- WV Medicaid Behavioral Health
- WV Medicaid Dental
- WV Medicaid Hospitals
- WV Medicaid Network
- WV_Behavioral_Health_Supporting_Data
- WV_Dental_Supporting_Data
- WV_Hospitals_Supporting_Data
- WV_Network_Supporting_Data
- CAC 541.2 CAC 541 Wellpoint- West Virginia (1)
- Cost Sharing (Copayments) for Services - WV
- Open Notebook.onetoc2
- Reimbursement at 100 Percent of Medicaid - WV
- Wellpoint Credentialing Summary 2026
- WV_PNXX_016 Standards for the Number & Geographic Distribution of Providers - WV
- WV_UMXX_003 Access to Specialty Care - WV
- WV_UMXX_010 Continued Stay Review_Care Coordination_Discharge Planning - WV
- WV_UMXX_013 Non-Authorization of Medical Services - WV
- WV_UMXX_020 Family Planning Services - Access To - WV
- WV_UMXX_025 Hospice Care - WV
- WV_UMXX_041 Pre-Service Authorization of Services - WV
- WV_UMXX_055 Post-Service Clinical Claims Review - WV
- WV_UMXX_065 Separation of Financial and Medical Necessity Decision Making - WV

- WV_UMXX_066 Standing Referral to a Specialist - WV
- WV_UMXX_071 Newborns and Mothers Health Act - WV
- WV_UMXX_081 Application of Utilization Management Criteria - WV
- WV_UMXX_082 Second Medical Opinion - WV
- WV_UMXX_101 24-Hour Access to Emergency Department Services - WV
- WV_UMXX_111 Confinement to an Inpatient Care Facility at Time of Enrollment and Disenrollment - WV
- WV_UMXX_115 Request for Medical Policies_Coverage Guidelines, Clinical Guidelines, Criteria or Benefits - WV
- WV_UMXX_116 Utilization Management Department Availability - WV
- WV_UMXX_117 Decision and Notification Timeframes - WV
- WV_UMXX_118 Utilization Management Decision Criteria - WV
- WV_UMXX_128 Health Plan Physician Availability for Communication with Emergency Room Personnel in the Post-stabilization Period - WV (1)
- BMS_Provider Network Adequacy Template_FY2025_Wellpoint_WVCHIP
- WV CHIP Behavioral Health
- WV CHIP Dental
- WV CHIP Hospitals
- WV CHIP Network
- WV_CHIP_Behavioral_Health_Supporting_Data
- WV_CHIP_Dental_Supporting_Data
- WV_CHIP_Hospitals_Supporting_Data
- WV_CHIP_Network_Supporting_Data
- Wellpoint Response - MHP RFI
- 13543044-1026187WVMENWLP-APEX-Rebrand-MHB-508-tagged-MKT-07-24 (1)
- WVWP-CD-PM-082374-25-2025-Annual-PM-Review_Final-with-Cover
- Chapter 506 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- Appendix 506A Covered DME Supplies

- Appendix 506B Covered O and P Supplies
- Appendix 506C Non-Covered DMEPOS Supplies
- Policy_519.17_Telehealth1.1.22
- BMS Manual Chapter 519.23
- CHIP Appendix Wellpoint 2025 redline
- Wellpoint_Medicaid_Appendix 2025 redline

Documents from BMS Pharmacy

No publicly available links were provided.

List of Documents Reviewed

- PDL Full File_01152025_52947
- PDL Full File_52947
- RFI_Draft_Pharmacy_20260130 for Mental Health Parity
- MHP HIC3 Classification
- CHIP_Appendix_WVCHIP Pharmacy_2026
- Pharmacy_Medicaid_2026

Appendix D: RFI

Request for Information (RFI): WV Mountain Health Trust Managed Care Organizations (MCOs) – Medicaid

As used in this document:

Table 2: Acronym Definitions

Acronym	Definition
ABA	Applied Behavioral Analysis
CPT®	Current Procedural Technology
FFS	Fee-for-service
HCPCS	Healthcare Common Procedure Coding System
MCO	Managed Care Organization
MH/SUD	Mental Health/Substance Use Disorder
M/S	Medical/Surgical
NQTL	Non-Quantitative Treatment Limitation
QTL	Quantitative Treatment Limitation
WVCHIP	West Virginia Children's Healthcare Insurance Program

Document Request

1. Please provide current medical management, utilization review, network adequacy, credentialing, provider reimbursement, and telehealth policies and procedures.
2. Please provide links to your provider and member manuals.

Data Request

1. Please provide interrater reliability testing scores for the past six months. What score is considered passing? What remediation steps were taken for non-passing scores? How frequently are individuals tested?
2. Please provide the most recent Medicaid network adequacy analysis.

Non-quantitative Treatment Limitations (NQTL) Analyses

Please note that you will receive your most recently submitted NQTL comparative analyses in a separate email to update. Please use Track Changes and add NQTLs as needed. Additional NQTLs could include, but are not limited to:

1. Refusal to pay for higher-cost therapies until a lower-cost therapy is shown to be ineffective (e.g., fail first or step therapy protocols).

2. Exclusions based on failure to complete a course of treatment.
3. Standards for provider admission to participate in a network.

General

1. Please provide the MCO's average monthly Mountain Health Trust membership for the past six months.
2. How is the lack of co-pays for behavioral health specifically communicated to members? Please share an example of a member communication.
3. What percent of the prevailing fee for service (FFS) Medicaid fee schedule does the MCO reimburse out-of-network MH/SUD providers? Out-of-network M/S providers?
4. How do the MCO's in-network reimbursement rates for MH/SUD compare to M/S reimbursement rates?
5. Please provide reimbursement rates for the following:

Table 3: WV Mountain Health Trust MCOs – Medicaid Reimbursement Rates

Specialty	Current Procedural Terminology (CPT)® Code	Reimbursement Rate
Psychiatrists	99203	$ (enter rate here)
Psychiatrists	99213	$ (enter rate here)
Psychologists	90832 (based on 1 hour)	$ (enter rate here)
Psychologists	90791 (based on ½ hour)	$ (enter rate here)
Licensed Clinical Social Worker (LCSW)	90832 (based on 1 hour)	$ (enter rate here)
Licensed Clinical Social Worker (LCSW)	90791 (based on ½ hour)	$ (enter rate here)
Internist	99203	$ (enter rate here)
Internist	99213	$ (enter rate here)
Family Practice MD	99203	$ (enter rate here)
Family Practice MD	99213	$ (enter rate here)
Nurse Practitioner	99203	$ (enter rate here)
Nurse Practitioner	99213	$ (enter rate here)
Physician Assistant	99203	$ (enter rate here)
Physician Assistant	99213	$ (enter rate here)

6. Describe how reimbursement rates for evaluation and management (E&M) services are established for M/S and MH/SUD providers. In your response, please:
    a. Identify the rate-setting methodology used for each provider type (e.g., Medicare benchmarks, State fee schedule),
    b. Describe any differences in methodologies or adjustment factors applied to MH/SUD versus M/S,
    c. Explain how the MCO assesses whether these reimbursement methodologies support comparable provider participation, network adequacy, and timely access to care for MH/SUD and M/S, and,
    d. Identify any monitoring or corrective actions taken if reimbursement levels are found to contribute to access barriers.
7. Does the MCO have any quantitative treatment limitations (QTLs) for MH/SUD benefits (e.g., the number of visits that may not be exceeded regardless of prior authorization—also known as “hard caps”)?
8. Do you have an annual or lifetime quantitative or financial limitation on any MH/SUD services/diagnoses? M/S services?
9. Please provide MH/SUD emergency care (e.g., ED visit, crisis intervention including mobile) procedure codes (i.e., CPT® and HCPCS codes) used by the MCO.
10. Do any MH/SUD emergency care procedure codes in Question 9 require prior authorization? If so, please describe.
11. Are there any limitations applied to MH/SUD emergency care services? If so, please explain.
12. Please provide any steps taken to address gaps in the MCO’s MH/SUD (e.g., Applied Behavior Analysis (ABA) providers) network and M/S providers (e.g., primary care).
13. How are MH/SUD and M/S denials monitored internally to ensure members are receiving appropriate access to care?
14. What is the most frequent reason for MH/SUD and M/S denials for the following?

Table 4: WV Mountain Health Trust MCOs – Medicaid Reasons for Inpatient and Outpatient Denials

Group	Top Reason for Inpatient Denials	Top Reason for Outpatient Denials
MH/SUD	(*Enter information here*)	(*Enter information here*)
M/S	(*Enter information here*)	(*Enter information here*)

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

1. Provide a comprehensive list of EPSDT-covered services and identify any services requiring:

    a. Prior authorization
    b. Medical director review
    c. Exception processes
2. Please provide any EPSDT coverage limitations (e.g., number of visits or financial).
3. Provide and describe “soft” visit limits or service caps, if any, and examples of how the MCO approves medically necessary services for Children's Health Insurance Program (CHIP) children that exceed these limits.
4. Please explain how you inform families about the EPSDT benefit.
5. Please explain how you ensure that children are screened at appropriate intervals.
6. Please explain how you ensure that children receive medically necessary treatment services.
7. How many members currently receive EPSDT services?
8. Are any of the EPSDT services provided via telehealth? How is it decided which services are covered? Please provide a list of services covered via telehealth.
9. Do members confront any barriers and/or delays accessing EPSDT services?
10. If there are access barriers and/or delays, please indicate the cause. Please provide steps the MCO is taking to address these barriers.
11. Explain how the MCO ensures medically necessary services are covered even when not specifically listed in the state plan.
12. Describe the medically necessary standard applied to EPSDT services and how it differs, if at all, from the standard used for adults.

Members 19 or 20 Years Old Eligible for EPSDT Who are Pregnant

1. Describe how the MCO identifies pregnant members who are EPSDT eligible (e.g., under the age of 21) including how this status Is flagged in care management and utilization systems.
2. Describe how pregnant EPSDT members are informed of their EPSDT rights.
3. Explain how the MCO ensures that EPSDT standards are applied to pregnant members, rather than defaulting to adult maternity benefit rules.
4. Describe how EPSDT is handled when a member turns 21 during pregnancy, including continuity of services.
5. Describe how the MCO ensures coverage of EPSDT services beyond routine prenatal, labor, and delivery care, including:
    a. MH/SUD services

b. Therapies (OT/PT/ST)

c. Nutritional counseling

6. Does the MCO provide EPSDT services for pregnant members that are not typically covered for adult pregnant beneficiaries? Please provide a list of services with procedure codes.
7. Please provide any data on approval, denial, and appeal rates for EPSDT service requests for pregnant members.

Telehealth

1. Is there a policy and procedure related to telehealth? If so, please provide.
2. Please explain any differences in the authorization or provision of MH/SUD versus M/S telehealth services.
3. Are you aware of any difficulty accessing telehealth services? If so, please explain.
4. Have there been any steps taken to assist with difficulties noted in Question 3? If so, please explain.

ABA Services

1. Please provide all services and codes associated with ABA services.
2. Please indicate which ABA services require prior authorization.
3. Do you require a treatment plan to receive ABA services? If so, please explain.
4. Are there any coverage limits associated with ABA services (e.g., number of visits or financial)?

West Virginia Children's Health Insurance Program (WVCHIP)

Document Request

1. Please provide current medical management, utilization review, network adequacy, credentialing, provider reimbursement, and telehealth policies and procedures.
2. Please provide links to your provider and member manuals.

Data Request

1. Please provide interrater reliability testing scores for the past six months. What score is considered passing? What remediation steps were taken for non-passing scores? How frequently are individuals tested?
2. Please provide the most recent Medicaid network adequacy analysis.

NQTL Analyses

Please note that you will receive your most recently submitted NQTL comparative analyses in a separate email to update. Please use track changes and add NQTLs as needed. Additional NQTLs could include, but are not limited to:

1. Refusal to pay for higher-cost therapies until a lower-cost therapy is shown to be ineffective (e.g., fail first or step therapy protocols).
2. Exclusions based on failure to complete a course of treatment.
3. Standards for provider admission to participate in a network.

General

1. Please provide the MCO's average monthly WVCHIP membership for the past six months.
2. How is the lack of co-pays for behavioral health specifically communicated to members? Please provide an example communication.
3. What percent of the prevailing FFS WVCHIP fee schedule does the MCO reimburse out-of-network MH/SUD providers? Out-of-network M/S providers?
4. How do the MCO's in-network reimbursement rates for MH/SUD compare to M/S reimbursement rates?
5. Please provide reimbursement rates for the following:

Table 5: WV CHIP Reimbursement Rates

Specialty	CPT® Code	Reimbursement Rate
Psychiatrists	99203	$ *(enter here)*
Psychiatrists	99213	$ *(enter here)*
Psychologists	90832 (based on 1 hour)	$ *(enter here)*
Psychologists	90791 (based on ½ hour)	$ *(enter here)*
Licensed Clinical Social Worker (LCSW)	90832 (based on 1 hour)	$ *(enter here)*
Licensed Clinical Social Worker (LCSW)	90791 (based on ½ hour)	$ *(enter here)*
Internist	99203	$ *(enter here)*
Internist	99213	$ *(enter here)*
Family Practice MD	99203	$ *(enter here)*
Family Practice MD	99213	$ *(enter here)*
Nurse Practitioner	99203	$ *(enter here)*

Specialty	CPT® Code	Reimbursement Rate
Nurse Practitioner	99213	$ *(enter here)*
Physician Assistant	99203	$ *(enter here)*
Physician Assistant	99213	$ *(enter here)*

6. Describe how reimbursement rates for E&M services are established for M/S and MH/SUD providers. In your response, please:
    a. Identify the rate-setting methodology used for each provider type (e.g., Medicare benchmarks, State fee schedule).
    b. Describe any differences in methodologies or adjustment factors applied to MH/SUD versus M/S.
    c. Explain how the MCO assesses whether these reimbursement methodologies support comparable provider participation, network adequacy, and timely access to care for MH/SUD and M/S, and,
    d. Identify any monitoring or corrective actions taken if reimbursement levels are found to contribute to access barriers.
7. Does the MCO have any QTLs for MH/SUD benefits (e.g., the number of visits that may not be exceeded regardless of prior authorization—also known as “hard caps”)?
8. Do you have an annual or lifetime quantitative or financial limitation on any MH/SUD services/diagnoses? M/S services?
9. Please provide MH/SUD emergency care (e.g., ED visit, crisis intervention, including mobile) procedure codes (i.e., CPT® and HCPCS codes) used by the MCO.
10. Do any MH/SUD emergency care procedure codes in Question 9 require prior authorization? If so, please describe.
11. Are there any limitations applied to MH/SUD emergency care services? If so, please explain.
12. Please provide any steps taken to address gaps in the MCO’s MH/SUD network (e.g., ABA providers).
13. How are MH/SUD and M/S denials monitored internally to ensure members are receiving appropriate access to care?
14. What is the most frequent reason for MH/SUD and M/S denials for the following?

Table 6: WV CHIP Reasons for Inpatient and Outpatient Denials

Group	Top Reason for Inpatient Denials	Top Reason for Outpatient Denials
MH/SUD	*(Enter information here)*	*(Enter information here)*
M/S	*(Enter information here)*	*(Enter information here)*

EPSDT

1. Provide a comprehensive list of EPSDT-covered services and identify any services requiring:
    a. Prior authorization
    b. Medical director review
    c. Exception processes
2. Please identify any differences between Medicaid EPSDT and WVCHIP coverage for children and explain how those differences are communicated to providers and families.
3. Describe the medical necessity standard applied to CHIP children and how it compares to:
    a. Medicaid EPSDT
    b. Adult medical necessity standards
4. Provide and describe “soft” visit limits or service caps, if any, and examples of how the MCO approves medically necessary services for CHIP children that exceed these limits.
5. Please explain how you inform families about the EPSDT benefit.
6. Please explain how you ensure that children are screened at appropriate intervals.
7. Please explain how you ensure that children receive medically necessary treatment services.
8. How many members currently receive EPSDT services?
9. Please provide any EPSDT coverage limitations.
10. For members who receive EPSDT services, please provide a complete list of services received.
13. Are any of the EPSDT services provided via telehealth? How is it decided which services are covered? Please provide a list of services covered via telehealth. Do members confront any barriers and/or delays accessing EPSDT services? Please provide steps the MCO is taking to address these barriers.
14. Explain how the MCO ensures medically necessary services are covered even when not specifically listed in the state plan.

Members 19 or 20 Years Old Eligible for EPSDT Who are Enrolled In Pregnancy Coverage

1. Describe how the MCO identifies pregnant members who are EPSDT eligible (e.g., under the age of 21) including how this status is flagged in care management and utilization systems.
2. Describe how pregnant EPSDT members are informed of their EPSDT rights.

3. Explain how the MCO ensures that EPSDT standards are applied to pregnant members, rather than defaulting to adult maternity benefit rules.
4. Describe how EPSDT is handled when a member turns 21 during pregnancy, including continuity of services.
5. Describe how the MCO ensures coverage of EPSDT services beyond routine prenatal, labor, and delivery care, including:
    a. MH/SUD services
    b. Therapies (OT/PT/ST)
    c. Nutritional counseling
6. Does the MCO provide EPSDT services for pregnant members that are not typically covered for adult pregnant beneficiaries? Please provide a list of services with procedure codes.
7. Please provide any data on approval, denial, and appeal rates for EPSDT service requests for pregnant members.

WVCHIP Behavioral Health Services

1. Are co-pays charged for any behavioral health services for children with WVCHIP coverage? If so, what services?

Telehealth

1. Is there a policy and procedure related to telehealth? If so, please provide.
2. Are there any differences in the authorization or provision of MH/SUD versus M/S telehealth services?
3. Are you aware of any difficulty accessing telehealth services? If so, please explain.
4. Have there been any steps taken to assist with difficulties noted in Question 3?

ABA Services

1. Which ABA services require prior authorization?
2. Do you require a treatment plan to receive ABA services? If so, please explain.

Request for Information: WV Mountain Health Promise Managed Care Organization (MCO)

As used in this document:

Table 7: Acronym Definitions

Acronym	Definition
ABA	Applied Behavioral Analysis
CPT®	Current Procedural Technology
FFS	Fee-for-service
HCPCS	Healthcare Common Procedure Coding System
MCO	Managed Care Organization
MH/SUD	Mental Health/Substance Use Disorder
M/S	Medical/Surgical
NQTL	Non-quantitative Treatment Limitation
QTL	Quantitative Treatment Limitation

For Mountain Health Promise, please answer the following questions only if the responses differ from those provided for Mountain Health Trust (MHT) Medicaid. If the answers are the same, you may simply note "See Medicaid."

Document Request

1. Please provide current medical management, utilization review, network adequacy, credentialing, provider reimbursement, and telehealth policies and procedures.
2. Please provide links to your provider and member manuals.

Data Request

1. Please provide interrater reliability testing scores for the past six months. What score is considered passing? What remediation steps were taken for non-passing scores? How frequently are individuals tested?
2. Please provide the most recent Mountain Health Promise network adequacy analysis.

Non-quantitative Treatment Limitations (NQTL) Analyses

BerryDunn recently sent your most recently submitted NQTL comparative analyses. In the previous review, Aetna combined MHT Medicaid and Mountain Health Promise. If it is easier to update them together again, you may do so, but please clearly identify any differences between the two programs.

When making updates, please use track changes and add additional NQTLs as needed. Examples of NQTLs that may need to be added include, but are not limited to:

1. Requirements to try lower-cost therapies before higher-cost options are covered (e.g., fail-first or step-therapy protocols).
2. Exclusions based on a member's failure to complete a prior course of treatment.
3. Standards for provider admission to a network.

General

1. Please provide the MCO's average monthly Mountain Health Promise membership for the past six months.
2. How is the lack of co-pays for behavioral health specifically communicated to members? Please share an example of a member communication.
3. What percent of the prevailing fee-for-service (FFS) Medicaid fee schedule does the MCO reimburse out-of-network MH/SUD providers? Out-of-network M/S providers?
4. How do the MCO's in-network reimbursement rates for MH/SUD compare to M/S reimbursement rates?
5. Please provide reimbursement rates for the following:

Table 8: WV Mountain Health Promise MCO Reimbursement Rates

Specialty	Current Procedural Terminology (CPT)® Code	Reimbursement Rate
Psychiatrists	99203	$ *(Enter Here)*
Psychiatrists	99213	$ *(Enter Here)*
Psychologists	90832 (based on 1 hour)	$ *(Enter Here)*
Psychologists	90791 (based on ½ hour)	$ *(Enter Here)*
Licensed Clinical Social Worker (LCSW)	90832 (based on 1 hour)	$ *(Enter Here)*
Licensed Clinical Social Worker (LCSW)	90791 (based on ½ hour)	$ *(Enter Here)*
Internist	99203	$ *(Enter Here)*
Internist	99213	$ *(Enter Here)*
Family Practice MD	99203	$ *(Enter Here)*
Family Practice MD	99213	$ *(Enter Here)*
Nurse Practitioner	99203	$ *(Enter Here)*
Nurse Practitioner	99213	$ *(Enter Here)*
Physician Assistant	99203	$ *(Enter Here)*

Specialty	Current Procedural Terminology (CPT)® Code	Reimbursement Rate
Physician Assistant	99213	$ *(Enter Here)*

6. Describe how reimbursement rates for evaluation and management (E&M) services are established for M/S and MH/SUD providers. In your response, please:
    a. Identify the rate-setting methodology used for each provider type (e.g., Medicare benchmarks, State fee schedule),
    b. Describe any differences in methodologies or adjustment factors applied to MH/SUD versus M/S,
    c. Explain how the MCO assesses whether these reimbursement methodologies support comparable provider participation, network adequacy, and timely access to care for MH/SUD and M/S, and,
    d. Identify any monitoring or corrective actions taken if reimbursement levels are found to contribute to access barriers.
7. Does the Mountain Health Promise have any quantitative treatment limitations (QTLs) for MH/SUD benefits (e.g., the number of visits that may not be exceeded regardless of prior authorization—also known as "hard caps") in its benefit package, including waiver services?
8. Do you have an annual or lifetime quantitative or financial limitation on any MH/SUD services/diagnoses? M/S services?
9. Please provide MH/SUD emergency care (e.g., ED visit, crisis intervention including mobile) procedure codes (i.e., CPT® and HCPCS codes) used by the MCO.
10. Do any MH/SUD emergency care procedure codes in Question 9 above require prior authorization? If so, please describe.
11. Are there any limitations applied to MH/SUD emergency care services? If so, please explain.
12. Please provide any steps taken to address gaps in the MCO's MH/SUD (e.g., Applied Behavior Analysis (ABA) providers) network and M/S providers (e.g., primary care).
13. How are MH/SUD and M/S denials monitored internally to ensure members are receiving appropriate access to care?
14. What is the most frequent reason for MH/SUD and M/S denials for the following?

Table 9: WV Mountain Health Promise MCO Reasons for Inpatient and Outpatient Denials

Group	Top Reason for Inpatient Denials	Top Reason for Outpatient Denials
MH/SUD	*(Enter information here)*	*(Enter information here)*
M/S	*(Enter information here)*	*(Enter information here)*

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

1. Provide a comprehensive list of EPSDT-covered services and identify any services requiring:
    a. Prior authorization
    b. Medical director review
    c. Exception processes
2. Please provide any EPSDT coverage limitations (e.g., number of visits or financial).
3. Provide and describe “soft” visit limits or service caps, if any, and examples of how the MCO approves medically necessary services for Mountain Health Promise members that exceed these limits.
4. Please explain how you inform families about the EPSDT benefit.
5. Please explain how you ensure that children are screened at appropriate intervals.
6. Please explain how you ensure that children receive medically necessary treatment services.
7. How many members currently receive EPSDT services?
8. Are any of the EPSDT services provided via telehealth? How is it decided which services are covered? Please provide a list of services covered via telehealth.
9. Do members confront any barriers and/or delays accessing EPSDT services?
10. If there are access barriers and/or delays, please indicate the cause. Please provide steps the MCO is taking to address these barriers.
11. Explain how the MCO ensures medically necessary services are covered even when not specifically listed in the state plan.
12. Describe the medically necessary standard applied to EPSDT services and how it differs, if at all, from the standard used for adults.

Members Under 21 Years Old Eligible for EPSDT Who are Pregnant

1. Describe how the MCO identifies pregnant members who are EPSDT eligible (e.g., under the age of 21) including how this status Is flagged in care management and utilization systems.
2. Describe how pregnant EPSDT members are informed of their EPSDT rights.
3. Explain how the MCO ensures that EPSDT standards are applied to pregnant members, rather than defaulting to adult maternity benefit rules.

4. Describe how EPSDT is handled when a member turns 21 during pregnancy, including continuity of services.
5. Describe how the MCO ensures coverage of EPSDT services beyond routine prenatal, labor, and delivery care, including:
    a. MH/SUD services
    b. Therapies (OT/PT/ST)
    c. Nutritional counseling
6. Does the MCO provide EPSDT services for pregnant members that are not typically covered for adult pregnant beneficiaries? Please provide a list of services with procedure codes.
7. Please provide any data on approval, denial, and appeal rates for EPSDT service requests for pregnant members.

Telehealth

1. Is there a policy and procedure related to telehealth? If so, please provide.
2. Please explain any differences in the authorization or provision of MH/SUD versus M/S telehealth services.
3. Are you aware of any difficulty accessing telehealth services? If so, please explain.
4. Have there been any steps taken to assist with difficulties noted in Question 3? If so, please explain.

ABA Services

1. Please provide all services and codes associated with ABA services.
2. Please indicate which ABA services require prior authorization.
3. Do you require a treatment plan to receive ABA services? If so, please explain.
4. Are there any coverage limits associated with ABA services (e.g., number of visits or financial)?

Additional HCBS Covered by Mountain Health Promise Under the CSED Waiver

1. For the following services, can limitations be exceeded if medically necessary?

Table 10: Limitations on Services

Row	Limitations on Services
Family Therapy	Up to eight (8) units per day, approximately fourteen (14) hours per week (fifty-six (56) units/week).

Row	Limitations on Services
In-Home Family Support	Up to two (2) hours per day (Eight (8) units per day), approximately fourteen (14) hours per week (fifty-six (56) units/week). All services are person-centered and the established service limits may be exceeded when medical necessity is established.
Peer Parent Support	Unit = fifteen (15) minutes; Up to two (2) hours/week (Eight (8) units/week), approximately eight (8) hours/month (thirty-two (32) units/month).
Extended Professional Services: Specialized Therapy	Unit is one dollar ($1). Up to one thousand dollars ($1000) per service plan year in combination with Assistive Equipment. If this service is not provided by the state plan or private insurance, then members can access these services through this waiver using up to one thousand (1000) units (one thousand dollars) ($1000) per Plan of Care service year; Specialized Therapy and Assistive Equipment share this source of funding.

Request for Information: Pharmacy – West Virginia Medicaid and WV Children's Health Insurance Program (WVCHIP)

General: Please include answers for both Medicaid and WVCHIP, or indicate the responses include both.

1. Please provide the average monthly WV Medicaid and WVCHIP membership counts covered under the pharmacy benefit for the past six months.
2. Please review the previous mental health parity NQTL comparative analyses for Medicaid and WVCHIP and update as needed. The previous NQTL comparative analyses will be provided in the same email as this RFI.
3. Describe any differences in member copayments for mental health (MH)/substance use disorder (SUD) medications versus medical/surgical (M/S) medications for Medicaid and WVCHIP for preferred versus nonpreferred medications. Please provide a comparison rate for preferred versus nonpreferred dispensed medications by MH/SUD and M/S.
4. Is the preferred drug list (PDL) posted on the website at WV BMS Preferred Drug List currently accurate for both Medicaid and WVCHIP? If possible, please provide an Excel spreadsheet of the PDL medications separated by MH/SUD and M/S including the respective National Drug Code (NDC). Please provide the Excel spreadsheet for both Medicaid and WVCHIP if they are different.
5. The WV Bureau for Medical Services Office of Pharmacy Services Preferred Drug List and Prior Authorization Criteria (PDL and PA Criteria), published 1/1/2026, provides *"Required trials of preferred agents are defined as "failed" or otherwise satisfied only when efficacy has not been observed despite patient adherence to a dose and duration which should have produced therapeutic effects."* Please explain any differences in this requirement, or in the way it is implemented, for MH/SUD versus M/S medications.

6. The PDL and PA Criteria indicates, *"Unless otherwise specified, all requests to 'grandfather' existing drug therapy will require clinical reasoning from the prescriber detailing why the patient cannot be transitioned to a preferred agent from the Medicaid PDL. Please note that this requirement includes therapy that may have been previously preferred on the Medicaid PDL but has since changed to non-preferred status."* Does this differ, in practice, for MH/SUD versus M/S medications, and if so, how?
7. The BMS Pharmacy website notes, "Drugs or drug classes which are found to be over utilized, abused, have significant safety concerns, or are costly are also candidates for prior authorization." Please provide what MH/SUD and M/S medications fall into this classification and how overutilization, abuse, and significant safety concerns are determined for MH/SUD and M/S medications.
8. Previously, the following NQTL comparative analyses were provided:
    a. WVCHIP
        i. Prior authorization
        ii. Step therapy
        iii. PA for all attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD) medications
    b. Medicaid
        i. Prior authorization
        ii. Use of a PDL
        iii. Prospective review
        iv. Retrospective review
        v. Lock-in program
        vi. Limitation on Suboxone dose
        vii. Tobacco session: Coaching requirement, 12-week limit, lapse in treatment

    Please update both WVCHIP/Medicaid with additional NQTLs as needed—including, but not limited to:

    c. Dose limits
    d. Day supply limits
    e. Step therapy or fail-first requirements
    f. Refill restrictions
    g. Lifetime or annual caps
9. How are pharmacy denials for MH/SUD and M/S medications monitored internally?

10. What is the most frequent reason for MH/SUD and M/S pharmacy denials for the following based on claim volume?

Table 11: Medicaid and WVCHIP Reasons for Inpatient and Outpatient Denials

Group	Top Reason for Inpatient Denials	Top Reason for Outpatient Denials
MH/SUD	*(Enter information here)*	*(Enter information here)*
M/S	*(Enter information here)*	*(Enter information here)*

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

1. Please describe how EPSDT standards are applied to pharmacy benefits.
2. Identify any MH/SUD medications covered under EPSDT that are not routinely covered for adults for Medicaid and WVCHIP.
3. Are any MH/SUD medications identified as being necessary as a result of EPSDT subject to prior authorization or soft limits? Please explain.
4. Describe how medically necessary medications are approved when not explicitly listed on the preferred drug list. Does the approval differ for MH/SUD and M/S medications?

Applied Behavioral Analysis (ABA) Related Medications

Please identify any medications commonly used to treat autism spectrum disorder that are subject to utilization management requirements.

Opioid Use Disorder (OUD) Related Medications

1. Describe the evidentiary standards and clinical guidelines used to develop medical necessity criteria for medications for OUD (MOUD), such as methadone, buprenorphine, and naltrexone, and compare them to the standards used for chronic M/S medications like insulin.
2. Identify any policies that limit the duration of MOUD treatment, such as tapering requirements, and explain how these policies compare to duration limits for long-term M/S maintenance drugs.
3. List any "fail-first" or step therapy requirements for MOUD (e.g., generic vs. brand-name buprenorphine).
4. In alignment with WV Code §9-5-32,[4] describe the process for ensuring a three-day emergency supply of MOUD for members discharged from inpatient or emergency department settings without a prior authorization on file.

Document Request

Please provide current pharmacy benefit policies and procedures, including medical necessity criteria, prior authorization, formulary management, reimbursement, and appeals. Please

provide any policies and procedures related specifically to MH/SUD medications, including opioid use disorder.

Data Request

Please provide pharmacy interrater reliability testing scores for the past six months, including passing thresholds and remediation steps for pharmacy utilization management reviewers.

Appendix E: West Virginia Medicaid Managed Care Organization - Mental Health Parity Compliance Plan

West Virginia Medicaid Managed Care Organization
Mental Health Parity Compliance Plan

A Template for Managed Care Organizations for Medicaid Beneficiaries

The managed care organization (MCO) contract with the Bureau for Medical Services (BMS) requires the MCO to submit a Mental Health Parity Compliance Plan annually. The purpose of the Mental Health Parity Compliance Plan is for the MCO to document the processes it has in place to monitor compliance with federal and contractual mental health requirements.

The MCO Mental Health Parity Compliance Plan must contain at a minimum the following sections and content. The MCO may provide additional information as desired.

1.0 Governance

1.1 Identify the role(s) at the MCO designated as responsible for mental health parity compliance and monitoring, including where that role fits in the organization chart.

1.2 Identify and define the roles and responsibilities of any other MCO positions, committees, workgroups, stakeholder groups, etc., involved in monitoring the MCO's mental health parity compliance. Please include an organizational chart that illustrates the flow of reporting from the different MCO areas to the mental health parity lead(s).

2.0 Processes

2.1 Describe the MCO's process for maintaining compliance with the following contractual and federal requirements:

1) The MCO may not impose an aggregate lifetime, annual dollar limits, or other cumulative financial limits on MH/SUD services.
2) The MCO may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or requirement limitation of any type applied to substantially all M/S benefits in the same classification furnished to enrollees, to maintain compliance with the Bureau's Mental Health Parity Plan.

2.2 Describe the MCO's process(es) for ensuring that non-quantitative treatment limits (NQTLs) to MH/SUD benefits reported to BMS annually are applied as written and in operation.

2.3 Describe the MCO's process(es) for: 1) identifying changes or additions to benefit design and/or operations that may impact mental health parity compliance, and 2) assessing their mental health parity compliance impacts.

2.4 Describe the MCO's process(es) for identifying, communicating internally, and addressing: 1) early warning signs of an access to MH/SUD care issue, and 2) red flags that an access to MH/SUD care issue is occurring.

2.5 Describe the MCO's process to ensure the requirements of availability of information:

1) Criteria for medical necessity determinations regarding MH/SUD benefits must be made available to enrollees, potential enrollees, and contracting providers upon request.
2) The reasons for any denials of reimbursement or payment for MH/SUD benefits must be made to the beneficiaries.

3.0 Data Collection and Reporting

3.1 Describe the MCO's process(es) for collecting and internal reporting of the required data elements for quarterly mental health parity reporting to BMS.

3.2 Describe what actions the MCO takes when disparate MH/SUD findings are identified.

Required Quarterly Reporting Data Elements:

Outpatient Prior Authorization (PA) Counts by Benefit Type and PA Disposition

- Data Source:
- Process for Compiling Data:

Inpatient Prior Authorization (PA) Counts by Benefit Type and PA Disposition

- Data Source:
- Process for Compiling Data:

Enrollment/Credentialing Counts and Results by Provider Type

- Data Source:
- Process for Compiling Data:

Enrollee Complaints by NCQA Category

- Data Source:
- Process for Compiling Data:

References

[1] West Virginia Department of Human Services. July 2027. *State Fiscal Year 2027 Model Purchase of Service Provider Agreement for Mountain Health Trust.*

[2] West Virginia Department of Human Services. *State Fiscal Year 2027 Model Purchase of Service Provider Agreement for Mountain Health Promise Between State of West Virginia Department of Human Services Bureau for Medical Services and Aetna Better Health of West Virginia*.

[3] 42 CFR Parts 431, 435, 436, 438, 440, 447, and 457. Accessed February 27, 2026. https://www.govinfo.gov/content/pkg/FR-2013-07-15/pdf/2013-16271.pdf.

[4] W. Va. Code §9-5-32. Accessed February 12, 2026. https://code.wvlegislature.gov/9-5-32/.

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1.0 Aetna – Medicaid, WVCHIP, and Mountain Health Promise

1.1 Aetna: Inpatient Prior Authorization

Inpatient Prior Authorization To which benefits is the NQTL assigned?

Category: MH/SUD

- MH/SUD Inpatient Services
- Psychiatric Residential Treatment Facilities

Medical services for the treatment of an emergency condition, including emergency transportation, crisis intervention/ stabilization, and mobile response, are permitted to be delivered in or out-of-network without obtaining prior authorization

Category M/S

- M/S Inpatient Hospital Care
- Inpatient Hospice Care, Out-of-Network

Medical services for the treatment of an emergency condition, including emergency transportation, are permitted to be delivered in or out-of-network without obtaining prior authorization

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- Ensure services are provided at an appropriate level of care and place of service
- Evaluate service requests that might be approved, potentially denied, or reduced on the basis of medical necessity
- Forward potential denials or reductions to the CMO or designated medical director for review
- Ensure the services are in the defined benefits and are appropriate, timely, and cost-effective
- Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished, and that the services are no less than the amount, duration, or scope for the same services furnished to members under the WV Children's Health Insurance Program (WVCHIP) FFS Program

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD

- The MCO adopts evidenced-based guidelines (e.g., MCG, ASAM® Criteria) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives

The following are clinical criteria/guidelines that might be used when making PA decisions:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- MCG™ (physical and behavioral health evidence-based clinical guidelines that are updated annually)
- Level of Care Utilization System (LOCUS), Children & Adolescent Service Intensity Instrument (CASII)
- ASAM® Criteria
- Aetna Clinical Policy Bulletins (CPBs), which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally-recognized professional healthcare organizations and government public health agencies
- Aetna Policy Council Review

The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high-quality, and cost-effective car

Category: M/S

- The MCO adopts evidenced-based guidelines (e.g., MCG) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives

The following are clinical criteria/guidelines that might be used when making prior authorizations decisions:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- MCG™ (physical and behavioral health evidence-based clinical guidelines that are updated annually)
- Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies
- Aetna Policy Council Review
- Other Specialty Criteria by contract

The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high-quality, and cost-effective care

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- PAs are performed by telephone or facsimile, and decisions are based on medical necessity
- For urgent pre-service approvals, decisions are based on need but no more than two calendar days from receipt of request
- For urgent pre-service denials, decisions are based on need but no more than two calendar days from receipt of request
- For non-urgent pre-service approvals, decisions are based on member's need but no more than seven calendar days from receipt of the request

For non-urgent pre-service approvals, decisions are based on member's need but no more than seven calendar days from receipt of the request

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- The MCO annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision-making
- A corrective education plan is put into place for staff members who score below Aetna's inter-rater reliability target (95%)

Evidentiary Standard: What evidence supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals, including:

- Number of service authorizations requested
- Number of service authorizations denied
- Number of denied service authorizations with member appeal
- Number of denied service authorizations with member appeal upheld
- Number of denied service authorizations with member appeal reversed
- Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site)
- The Service Improvement Committee (SIC) reviews all of the above for Parity Rule compliance concerns

1.2 Aetna: Outpatient Prior Authorization

Outpatient Prior Authorization To which benefits is the NQTL assigned?

Category: MH/SUD

- Partial Hospitalization (PH)
- Services from a Non-Participating Provider (except emergency services)
- Clinic Services
- Physician Services
- Rural Health Clinic Services Including FQHCs
- Specialty Care
- Behavioral Health Outpatient Services
- Psychological Services
- Outpatient Hospital Services
- Outpatient Psychiatric Treatment
- Speech Therapy
- Laboratory Services and Testing
- Nutritional Counseling
- Tobacco Cessation
- School-Based Services
- Primary Care Office Visit
- Nurse Practitioners' Services
- EPSDT
- Psychological Testing/Psychiatric Testing
- Development Testing: Limited
- Development Testing: Extended
- Neurobehavioral Status Exam
- Neuropsychological Testing Battery
- Individual Psychophysiological Biofeedback Training
- CSU
- Day Treatment
- Therapeutic Behavioral Services-Development and Implementation
- Targeted Case Management, Each 15 Minutes
- Comprehensive Community Support Services
- Psychiatric Diagnostic Evaluation Without Medical Services (Initial) or Medical Services
- Multifamily Psychotherapy
- Initial Evaluation Without Medication Services
- Individual Psychotherapy Services
- Psychotherapy Patient and Family with E&M Services
- Family Psychotherapy (Conjoint Psychotherapy) Occurs With and Without Patient Present
- Family Psychotherapy (with Patient Present) by Licensed Therapist
- IOP
- PHP

- ACT
- Behavioral Health Home Visits
- Psychological/Neuropsychological Testing
- Outpatient ECT
- Intensive Outpatient Testing
- Transcranial Magnetic Stimulation for Depression
- Psychiatric Diagnostic Interview
- Case Consultation
- Behavioral Health Counseling, Professional, Individual and Group
- MH Assessment (Non-Physician)
- MH Service Plan Development
- Crisis Intervention
- Screening by Licensed Psychologist
- Physician Coordinated Care Oversight Services
- Developmental Testing
- Nonemergency Medical Transportation

Medical services for the treatment of an emergency condition, including emergency transportation, crisis intervention/stabilization, and mobile response, are permitted to be delivered in or out-of-network without obtaining prior authorization

Category M/S

- Ambulatory Surgical Center Services
- Clinic Services
- Children with Special Healthcare Needs Services
- Physician Services
- Private Duty Nursing
- Right From the Start Services
- Rural Health Clinic Services including FQHCs
- Vision Services
- Dental Services
- Nurse Practitioners' Services
- Nurse Midwife Services
- Primary Care Office Visit
- Specialty Care
- Podiatry
- Chiropractic Services
- Diagnostic X-Ray
- Outpatient Hospital Services
- Hospice if Out-of-Network
- Outpatient/Maternity
- Physical Therapy
- Occupational Therapy
- Speech Therapy

- Cardiac Rehabilitation
- DME
- Orthotics and Prosthetics
- Home Healthcare Services
- Laboratory Services and Testing
- Diabetes Education
- Diabetes Management
- EPSDT
- Family Planning Services and Supplies
- Nutritional Counseling
- Tobacco Cessation
- Personal Care Services
- Abortion Services
- School-Based Services
- Organ Transplant Services
- AICD
- Biventricular Pacemaker
- Cardiac Catheterization
- Chemotherapy
- Clinical Trials
- CT Scans
- Dental Treatment for Dental Accidents (non-emergent)
- Genetic Testing
- Hyperbaric Oxygen
- Injectable and Self-Administered Injectable Drugs (if covered under M/S benefit)
- MRI/MRA/PET
- Molecular Diagnostic Testing
- Non-Implanted Prosthetic Devices
- Nuclear Radiology
- Nutritional Formulas and Supplements
- Oral Surgery
- Outpatient Polysomnograms
- Outpatient Surgery
- Pain Management Services/Programs including Epidural Steroid Injections
- SPECT MPI
- Virtual Colonoscopy
- Hysterectomy
- Tonsillectomy With or Without Adenoidectomy
- Sleep Studies
- Spinal Injections
- Video EEG

- Radiation Treatments
- Venous Ablation
- Septoplasty
- Nuclear Cardiology

Medical services for the treatment of an emergency condition, including emergency transportation, are permitted to be delivered in or out-of-network without obtaining prior authorization

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- MH/SUD and M/S
- Ensure services are provided at an appropriate level of care and place of service
- Evaluate service requests that might be approved, potentially denied, or reduced on the basis of medical necessity criteria
- Forward potential denials or reductions to the CMO or designated medical director for review
- Ensure requests are processed by urgency of request and provider and/or members are notified of the determination within required time frames
- Ensure the services are in the defined benefits, and are appropriate, timely, and cost-effective
- Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished, and that are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD

- The MCO adopts evidenced-based guidelines (e.g., MCGTM) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives

The following are clinical criteria/guidelines that might be used when making PA decisions:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- MCGTM (physical and behavioral health evidence-based clinical guidelines that are updated annually)
- LOCUS, CALOCUS (Child and Adolescent Level of Care Utilization System)
- ASAM® Criteria
- Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally-recognized professional healthcare organizations and government public health agencies
- Aetna Policy Council Review
- The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high-quality, and cost-effective care

Category: M/S

- The MCO adopts evidenced-based guidelines (e.g., MCGTM) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives

The following are clinical criteria/guidelines that might be used when making prior authorizations decisions:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- MCGTM (physical and behavioral health evidence-based clinical guidelines that are updated annually)

- Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally-recognized professional healthcare organization and government public health agencies
- Aetna Policy Council Review
- Other specialty criteria by contract

The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high-quality, and cost-effective care

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- PAs are performed by telephone or facsimile, and decisions are based on medical necessity
- For urgent pre-service approvals, decisions are based on need but no more than two calendar days from receipt of request
- For urgent pre-service denials, decisions are based on need but no more than two calendar days from receipt of request
- For non-urgent pre-service approvals, based on member's need but no more than seven calendar days from receipt of the request
- For non-urgent pre-service approvals, based on member's need but no more than seven calendar days from receipt of the request

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- Aetna annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision-making
- A corrective education plan and monitoring of staff members who score below Aetna's inter-rater reliability target (95%)

Evidentiary Standard: What evidence supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals, including:

- Number of service authorizations requested
- Number of service authorizations denied
- Number of denied service authorizations with member appeal
- Number of denied service authorizations with member appeal upheld
- Number of denied service authorizations with member appeal reversed
- Complaints by NCQA category (quality of care, access, attitude and service, billing and financial, and quality of office site)

The SIC reviews all the above for Parity Rule compliance concerns

1.3 Aetna: Inpatient and Outpatient Concurrent Review

Inpatient and Outpatient Concurrent Review To which benefits is the NQTL assigned?

Category: MH/SUD

- MH/SUD Inpatient Services
- Psychiatric Residential Treatment Facilities
- Rehabilitative Psychiatric Treatment (<21)

- Crisis Stabilization Unit
- Day Treatment
- IOP

Category: M/S

- M/S Inpatient Hospital Care
- Hospice Care (Inpatient)
- Hospice Care, Outpatient Services
- Hospital Inpatient/Maternity Services
- Organ Transplant Services

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- Ensure services are provided at an appropriate level of care and place of service
- Evaluate service requests that may be approved, potentially denied, or reduced on the basis of medical necessity
- Forward potential denials or reductions to the CMO or designated medical director for review
- Ensure requests are processed by urgency of request and provider and/or members are notified of the determination within require time frames
- Ensure the services are in the defined benefits and are appropriate, timely, and cost-effective
- Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MS/SUD

- Monthly, the CMO, in conjunction with the director of Medical Management, is responsible for analyzing utilization data, identifying areas of concern. The CMO presents quarterly summaries of this information to the QM/UM
- This information assists with updating the list of services requiring prior authorization/concurrent review and is updated at least annually and revised periodically as appropriate
- The QM/UM committee is responsible to provide feedback to the CMO and provide action plans including adjustments to the QAPI program
- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- MCG™ (physical and behavioral health evidence-based clinical guidelines that are updated annually)
- LOCUS, CALOCUS (Child and Adolescent Level of Care Utilization System)
- ASAM®
- Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally-recognized professional healthcare organization and government public health agencies
- Aetna Policy Council Review

People with mental health conditions should be treated in the least restrictive environment and in a manner designed to preserve their dignity and autonomy and to maximize the opportunities for recovery

Category: M/S

- Monthly, the CMO, in conjunction with the director of Medical Management, is responsible for analyzing utilization data, identifying areas of concern
- The CMO presents quarterly summaries of this information to the QM/UM

- This information assists with updating the list of services requiring prior authorization/concurrent review and is updated at least annually and revised periodically as appropriate
- The QM/UM committee is responsible to provide feedback to the CMO and provide action plans including adjustments to the QAPI program

The Clinical Review Hierarchy is as follows:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- MCG™ (physical and behavioral health evidence-based clinical guidelines that are updated annually)
- Aetna CPBs, which are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies
- Aetna Policy Council Review
- Other specialty criteria by contract

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Reviews are conducted of members' acute care hospitalizations as clinically indicated, either on-site or by telephone or facsimile, and decisions are based on medical necessity

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- Aetna annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision-making
- A corrective education plan and monitoring of staff members who score below Aetna's inter-rater reliability target

Evidentiary Standard: What evidence supports the frequency or rigor that is applied?

The SIC reviews all the above for Parity Rule compliance concerns

1.4 Aetna: Retrospective Review – Inpatient and Outpatient

Inpatient and Outpatient Retrospective Review To which benefits is the NQTL assigned?

Category: MH/SUD

- MH/SUD Inpatient Services
- Psychiatric Residential Treatment Facilities
- Inpatient Detoxification

Category: M/S

- M/S Inpatient Hospital Care
- Inpatient Maternity Care

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- Ensure services are provided at an appropriate level of care and place of service
- Evaluate service requests that may be approved, potentially denied, or reduced on the basis of medical necessity
- Forward potential denials or reductions to the CMO or designated medical director for review
- Ensure requests are processed by urgency of request and provider and/or members are notified of the determination within required time frames

- Ensure the services are in the defined benefits and are appropriate, timely, and cost-effective
- Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services that are furnished, at no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- The MCO adopts evidenced-based guidelines (e.g., MCG™) that are updated annually to support prospective, concurrent, and retrospective reviews, proactive care management, discharge planning, patient education, and quality initiatives
- The guidelines help assure utilization review decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high-quality, and cost-effective care

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Retrospective reviews are based solely on the medical information available to the attending physician or ordering practitioner/provider at the time the healthcare services were provided

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- The MCO annually evaluates the degree of consistency and objectivity with which staff apply criteria in decision-making
- A corrective education plan and monitoring of staff members who score below Aetna's inter-rater reliability target

1.5 Aetna: Medical Necessity Criteria

Medical Necessity Criteria To which benefits is the NQTL assigned?

Category: MH/SUD

Per MCO Contract: For Medicaid-covered medical or other health services to children under 21, "medically necessary" refers to services which are:

- Reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity, or limitation in function, cause illness or infirmity, endanger life, or worsen disability;
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions;
- Consistent with the diagnosis of the conditions;
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence, and e) will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.

Category: M/S

Per MCO Contract: For Medicaid-covered medical or other health services to children under 21, "medically necessary" refers to services which are:

- Reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity, or limitation in function, cause illness or infirmity, endanger life, or worsen disability;
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions;
- Consistent with the diagnosis of the conditions;
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence, and e) will assist the individual to achieve or maintain maximum

functional capacity in performing daily activities, taking into account the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.

Strategy: Why is the NQTL assigned to these services?

N/A

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD

The MCO uses the following criteria for physical health and behavioral health consulted in the order listed below, as applicable:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- MCG™ for physical and behavioral health criteria
- LOCUS, CALOCUS, or CASII for behavioral health
- ASAM®
- Aetna CPBs
- Aetna Clinical Policy Council Review

Category: M/S

The MCO uses the following criteria for physical health and behavioral health consulted in the order listed below, as applicable:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- MCG™ for physical and behavioral health criteria
- Aetna CPBs
- Aetna Clinical Policy Council Review
- Other specialty criteria by contract

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

MH/SUD and M/S

- Aetna is responsible for review and approval of the utilization management criteria used for 95 determinations
- Additionally, Aetna is responsible to confirm that medical necessity criteria are established in accordance with generally accepted standards of medical practice and are objective, based on medical evidence, and clinically appropriate for the member's condition and characteristics of the local delivery system.[1]
- Service authorization staff who make medical necessity determinations are trained on the criteria, and the criteria are accepted and reviewed according to Aetna policies and procedures
- Medical necessity initial and annual review processes consist of an evaluation of existing criteria, determination of any recommendations or changes, and final acknowledgment or acceptance of criteria
- The process involves appropriate practitioners in developing adopting and reviewing criteria per NCQA standards
- Annually, the UM Steering Committee reviews national criteria sets and the procedures for applying them against current clinical and medical evidence
- The UM Steering Committee comprises senior and plan medical directors representing a broad range of specialties such as emergency medicine, behavioral health, pediatrics, surgery, family medicine, and internal medicine

[1] NCQA HP 2020 UM2 A1-3

- The UM Steering Committee review and recommendations of criteria sets are then taken to the QM/UM Committee
- The QM/UM Committee membership includes local medical directors and community practitioners who review criteria sets in comparison to state requirements, update, and adopt final criteria sets as appropriate
- Adopted criteria are submitted to the Aetna Quality Management Oversight Committee for review and adoption
- If primary criteria are not clear enough to make a determination and the requested service is not addressed by the Aetna CPBs, the medical director may submit a request for a position determination to the Aetna Clinical Policy Council
- The policy council will research literature applicable to the specific request and, when a determination is reached, will respond to the medical director
- When criteria are present but unclear in relation to the situation, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area before making a determination of medical necessity[2].

Practitioners/providers are notified in the denial letter (i.e., Notice of Action) that they may request a peer-to-peer consultation to discuss denied authorizations, including behavioral health decisions with the medical director reviewer by calling Aetna.[3]

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- The determination of whether a service is medically necessary is made on a case-by-case basis, taking into account the individual needs of the member and allowing for consultation with requesting practitioners/providers when appropriate
- Aetna considers at least the following individual characteristics when applying criteria: age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable.[4]

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including:

- Number of service authorizations requested
- Number of service authorizations denied
- Number of denied service authorizations with member appeal
- Number of denied service authorizations with member appeal upheld
- Number of denied service authorizations with member appeal reversed
- Complaints by NCQA category (quality of care, access, attitude and service, billing and financial; and quality of office site)

The SIC reviews all the above for Parity Rule compliance concerns.

1.6 Aetna: Practice Guidelines

Practice Guidelines To which benefits is the NQTL assigned?

Category: MH/SUD

Practice guidelines provide decision-making criteria to practitioners, providers, and members

Category: M/S

Practice guidelines provide decision-making criteria to practitioners, providers, and members

[2] NCQA HP 2020 UM4 F1
[3] NCQA HP 2020 UM7A, D
[4] NCQA HP 2020 UM2 A2

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- To promote consistent application of evidence-based treatment methodologies
- Facilitate improvement of healthcare
- Reduce unnecessary variations in care

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

The MCO uses the following criteria for physical health and behavioral health consulted in the order listed below; as applicable:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- MCGTM for physical and behavioral health criteria
- LOCUS, CALOCUS, or CASII for behavioral health
- ASAM®
- Aetna CPBs
- Aetna Clinical Policy Council Review
- Other Specialty Criteria by contract

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Practice guidelines are made available to practitioners, providers, or members

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

Medical necessity decisions are determined by evidenced-based guidelines

1.7 Aetna: Network Size

Network Size To which benefits is the NQTL assigned?

Category: MH/SUD

All benefit services the MCO is contractually obligated to provide

Category: M/S

All benefit services the MCO is contractually obligated to provide

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

To develop and maintain a robust provider/practitioner network capable of meeting the healthcare needs of the MCO membership in an accessible, timely, and convenient manner and in accordance with plan contract requirements

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- The SIC, consisting of the managers of Member Services, Provider Relations, Medical Management, Quality Management, and The Health Plan Administration, meets at least quarterly to receive network data, analyze network data, identify opportunities for improvement, develop action items, and monitor outcomes of the changes for member access to services
- SIC tracks the nature of these issues and identifies trends that might be indicative of network need

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH

- The Network manager, with input from the National Medicaid Data and Reporting Team, plan departments and providers/practitioners, regularly monitors network adequacy parameters on both a scheduled and ad hoc basis

These parameters include:

- Accessibility of practitioners (telephone and ease of scheduling appointment)
- Availability of practitioners (extent to which practitioners are geographically distributed, and the presence of the right number and type of providers to meet the needs of its membership)
- Network adequacy
- GeoAccess Reports are analyzed to determine the geographic distribution and cultural background of providers/practitioners in relation to member demographics

To confirm the availability of practitioners who provide PCP services, including general and internal medicine, family practice, nurse practitioners, pediatrics, or other provider/practitioner types designated by government sponsor as a PCP, Aetna:

- Establishes measurable standards for the number of each type of practitioner providing primary care
- Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care
- Annually analyzes performance against the standards for the number of each type of practitioner providing primary care
- Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care
- During the network development process, Aetna will determine whether practitioners have capacity in their practice and are accepting new patients
- If a practitioner is a PCP, the maximum panel size will be 2,000 patients; Aetna reviews the availability of PCPs with an open panel annually, and the goal is <5% of PCPs having a closed panel
- Aetna's high-volume behavioral health practitioners are defined by BMS

To confirm the availability of high-volume BHPs within its delivery system, Aetna:

- Defines which practitioners serve as high-volume BHPs
- Establishes quantifiable and measurable standards for the number of each type of high-volume BHP
- Establishes quantifiable and measurable standards for the geographic distribution of each type of high-volume behavioral health provider
- Annually analyzes performance against the standards

Category: M/S

- The Network manager, with input from the National Medicaid Data and Reporting team, plan departments, and providers/practitioners, regularly monitors network adequacy parameters on both a scheduled and ad hoc basis

These parameters include:

- Accessibility of practitioners (telephone and ease of scheduling appointment)
- Availability of practitioners (extent to which practitioners are geographically distributed, and the presence of the right number and type of providers to meet the needs of its membership)
- Network adequacy
- GeoAccess reports are analyzed to determine the geographic distribution and cultural background of providers/practitioners in relation to member demographics

To confirm the availability of practitioners who provide PCP services, including general and internal medicine, family practice, nurse practitioners, pediatrics, or other provider/practitioner types designated by government sponsor as a PCP, Aetna:

- Establishes measurable standards for the number of each type of practitioner providing primary care

- Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care
- Annually analyzes performance against the standards for the number of each type of practitioner providing primary care
- Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care
- During the network development process, Aetna will determine whether practitioners have the capacity in their practice and are accepting new patients
- If a practitioner is a PCP, the maximum panel size will be 2,000 patients; Aetna reviews the availability of PCPs with an open panel annually, and the goal is <5% of PCPs having a closed panel

To confirm the availability of high-volume and high-impact specialists within its delivery system, Aetna:

- Defines which practitioners serve as high-volume and high-impact specialists. At minimum:
    - High-volume specialties include obstetrics/ gynecology
    - High-impact specialties include oncology
- Establishes measurable standards for the number of each type of high-volume and high-impact specialist
- Establishes measurable standards for the geographic distribution of each type of high-volume and high-impact specialist
- Annually analyzes performance against established standards

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The goal is to meet network adequacy goals 100% of the time

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- The SIC, consisting of the managers of Member Services, Provider Relations, Medical Management, Quality Management, and The Health Plan Administration, meets at least quarterly to receive network data, analyze network data, identify opportunities for improvement, develop action items, and monitor outcome of the changes for member access to services
- SIC tracks the nature of these issues and identifies trends that might be indicative of network need

Networks are monitored for adequacy by several methods:

- Number of service issues
- Number of providers/practitioners by type
- Percent outside acceptable ranges
- Ratio of practitioner/providers required per 1,000 members
- PCP panel status
- Network reporting:
    - Monthly provider/practitioner add/termination report to BMS
    - Annually Adequacy and GeoAccess reporting
    - Quarterly provider/practitioner panel size reporting
- Annual Assessment of Network Adequacy

2.0 Highmark – WVCHIP and Medicaid – Children

2.1 Highmark: Prior Authorization (PA), Concurrent Review – Inpatient

PA, Concurrent Review – Inpatient: To which benefits is the NQTL assigned?

PA is required for <u>ALL</u> inpatient benefits

Category: MH

- Inpatient Mental Health
- PRTF
- Residential Psychiatric Services

Category: SUD

- Inpatient Detoxification
- Residential Rehabilitation Services

Concurrent Review is required for the same benefits as PA.

Category: M/S

PA is required for <u>ALL</u> inpatient benefits

- Inpatient Acute Inpatient
- Inpatient Skilled Care (including skilled nursing facilities and skilled units within an acute care facility)
- Elective Inpatient
- Elective Transplant
- Maternity Inpatient
- Musculoskeletal (MSK) Inpatient
- NICU Inpatient
- Pediatric Skilled Nursing
- Post Acute Inpatient

A complete list of all services requiring prior authorization is available to view through our WV Provider Authorization Look up tool at: https://wv.highmarkhealthoptions.com/providers/prior-authorization-code-lookup.html

Concurrent Review is required for the same benefits as PA.

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

For inpatient services, strategies for performing PA include (for MH/SUD and M/S) to determine member eligibility, benefit coverage, medical necessity, location, and appropriateness of services and to ensure that services are safe and in the least restrictive setting.

The same strategies apply for concurrent review but also include planning for anticipated discharge.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Highmark Health Options of West Virginia (HHOWV) relies on nationally recognized, evidence-based criteria, as well as state specific guidelines, for all inpatient levels of care for MH/SUD **and** M/S services. Highmark considers the application of this criteria in the following order:

Category: MH

- West Virginia BMS (WVBMS) Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

Category: SUD

- WVBMS Policy Manual

- ASAM Criteria
- HHOWV internal medical policy

Category: M/S

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

To ensure the right treatment/services and level of care are provided at the right time to minimize waste, error and unnecessary medical practices/use and cost (e.g., to prevent overutilization).

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Requests for PA and/or concurrent review for MH/SUD **and** M/S may be submitted electronically via the online portal (should the electronic portal be unavailable; the provider may also submit requests through fax or phone).

If a member presents for Crisis Intervention Services, the provider/facility has 48 hours post-admission to request prior authorization to ensure member safety.

Information is required to support medical necessity. This includes, but is not limited to, diagnosis, medications, current symptom presentation, past medical history, treatment plan, and discharge plan.

Concurrent review includes collecting information about the member's condition, progress in treatment, determining coverage, identifying a discharge and continuing care plan early in the stay, assessing this plan, identifying and referring potential quality of care concerns, and identifying Members for referral to HHOWV's Care Coordination program.

All staff are West Virginia Licensed Registered Nurses, Licensed Clinical Social Workers (LCSW), and/or Licensed Social Workers (LSW).

Only medical directors are able to make clinical decisions to deny or reduce care, and they are West Virginia licensed medical or psychiatric physicians.

The medical director has discretion to approve or deny services based on medical necessity.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The Mental Health Parity and NQTL criteria are reviewed annually and approved via the QI/UM Committee.

Additionally, inter-rater auditing of care managers and medical directors is performed biannually (2x/year) to assess consistency. Passing inter-rater scores of 90% or above is required. If an individual scores less than 90%, additional training is provided and then a retesting is required with 90% or above result.

Root cause analysis is performed with development of corrective actions in instances when reviewers do not achieve inter-rater consistency.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Monthly/ quarterly/annual compliance reports including Mental Health Parity, Residential and PRTF, Institute Mental Diseases (IMD), SUD Finance, and an annual report of authorizations approved and denied for each NQTL category supports the frequency and rigor applied to NQTL's.

All reports are sent to the State of West Virginia (WV) in accordance with all federal, state, and contractual guidelines.

This ensures the right treatment/services and level of care is provided at the right time to minimize waste, error, and unnecessary medical practices/use and cost.

2.2 Highmark: Prior Authorization (PA), Concurrent Review – Outpatient

Prior Authorization (PA), Concurrent Review – Outpatient To which benefits is the NQTL assigned?

PA Outpatient Benefits Including:

Category: MH

- Partial Hospitalization
- Intensive Outpatient
- Psychological Testing
- Neuropsychological Testing
- Mental Health Assessment (as defined in WVBMS Policy Manual Chapter 504.12.1)
- Therapeutic Support for Families
- Crisis Intervention Services
- Parent-Child Interaction Therapy
- Assertive Community Treatment (ACT)

Category: SUD

- ASAM Level 2.5 Partial Hospitalization
- ASAM Level 2.1 Intensive Outpatient
- Targeted Case Management
- Peer Recovery Support Service

Concurrent Review is required for the same benefits as PA.

Category: M/S

- Outpatient Select Procedures
- Therapies (Physical /Occupational/Speech Pathology)
- Home Care
- Select DME
- Hospice
- Medically Necessary Transportation
- Select Diagnostic Testing
- Complex Imaging
- Non-Participating Specialty Visits
- Respite
- Clinical Consultation: Nursing
- Home or Vehicle Accessibility Adaptations
- Specialized Medical Equipment and Supplies
- Supported Living
- Orientation, Mobility, and Assistive Technology
- Personal Care
- Non-Medical Transportation

Concurrent review is required for the same benefits as PA

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

For outpatient services, strategies for performing PA include (for MH/SUD and M/S) to determine member eligibility, benefit coverage, medical necessity, location, and appropriateness of services and to ensure that services are safe and in the least restrictive setting.

To ensure the right treatment/services and level of care are provided at the right time to minimize waste, error, and unnecessary medical practices/use and cost (e.g., to prevent overutilization).

Concurrent reviews provide an opportunity for individualized treatment and discharge planning, which achieves better outcomes for individuals.

Evidentiary Standard: What evidence supports the rationale for the assignment?

HHOWV relies on nationally recognized, evidence-based criteria, as well as state specific guidelines, for outpatient levels of care for MH/SUD and M/S services. Highmark considers the application of this criteria in the following order:

Category: MH

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

Category: SUD

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

Category: M/S

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

PA/concurrent review is part of HHOWV's utilization management program for MH/SUD and M/S in which health care is reviewed as it is provided and is triggered when current services require additional days that are requested by the Provider.

If a member presents for Crisis Intervention Services, the provider/facility has 48 hours to request prior authorization to ensure member safety.

Requests for concurrent review may be submitted electronically via the online portal (should the electronic portal be unavailable; the Provider may also submit requests through fax and phone). Reviewers monitor appropriateness of the care, the setting, and the progress of discharge plans and determine if care is in the least restrictive environment in the right setting at the right time.

Concurrent review includes collecting information from the care team about the member's condition and progress, determining coverage based on this information, identifying a discharge and continuing care plan early in the stay, assessing this plan, identifying and referring potential quality of care concerns, and identifying members for referral to HHOWV's Care Coordination program.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The Mental Health Parity and NQTL criteria are reviewed quarterly and NQTL Mental Health Parity reports are submitted and approved via the Quality Insurance/Utilization Management (Quality Improvement (QI)/UM) Committee.

Additionally, inter-rater auditing of care managers and medical directors is performed at least biannually (2x per year) to assess consistency. Passing inter-rater scores of 90% or above is required. If an individual scores less than 90%, additional training is provided, and then retesting is required with 90% or above result.

Root cause analysis is performed with development of corrective actions in instances when reviewers do not achieve inter-rater consistency.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Monthly/ quarterly/annual compliance reports including Mental Health Parity, Residential and PRTF, IMD, SUD Finance, and an annual report of authorizations approved and denied for each NQTL category supports the frequency and rigor applied to NQTL's.

All reports are sent to the State of WV in accordance with all federal, state, and contractual guidelines.

2.3 Highmark: Retrospective Review – Inpatient/Outpatient

Retrospective Review- Inpatient/Outpatient To which benefits is the NQTL assigned?

Category: MH/SUD

Inpatient Benefits

MH:

See PA and concurrent review benefits above

SUD:

See PA and concurrent review benefits above

Outpatient Benefits

MH:

See PA and concurrent review benefits above

SUD:

See PA and concurrent review benefits above

Category: M/S

Inpatient benefits

See PA and concurrent review benefits above

Outpatient benefits

See PA and concurrent review benefits above

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

Retrospective review is an opportunity for the provider to have a denied service reconsidered when the required pre-authorization was not obtained (for emergent services when the required pre-authorization was not obtained after the initial 48 hours) for both MH/SUD and M/S services.

Retrospective reviews must meet exception criteria:

1. Evidence member presented with incorrect insurance
2. Contract exceptions
3. Emergent in nature (after 48 hours)
4. Member is incapacitated or is physically/mentally unable to provide insurance coverage information at time of admission.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Determinations of medical necessity criteria/medical appropriateness of services are made by using nationally recognized criteria, such as:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

A retrospective review is requested by a provider to perform a utilization review on a post-service when the required PA was not obtained.

The request must have supported documentation.

The request must meet state and contractual timeframes and guidelines for retrospective submission.

The reviews are completed by registered nurses, LCSWs, and/or LSWs. Only medical directors licensed in West Virginia are able to make clinical decisions to deny or reduce care.

The medical director has discretion to approve or deny services based on medical necessity.

Exception criteria are the basis for the retrospective review process. If the exception criteria are not met, the request may be administratively denied without a clinical review. This process may only be overridden by senior leadership based on extenuating circumstances.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

Determinations of medical appropriateness of services are made using nationally recognized criteria, such as:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

Provider education and follow-up are part of HHOWV's process to verify, track, and trend retrospective review. Provider education is ongoing; follow-up calls may occur with the provider when repeated requests for retrospective reviews are submitted without documentation that supports the exception; or at the request of the provider.

The appeal team works in collaboration with other HHOWV teams to identify trends, complaints, and provider dissatisfaction. This collaborative approach leads to quality improvements and overall satisfaction.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Retrospective review is an opportunity for the provider to have a denied service reconsidered when the required PA was not obtained (for emergent services when the required pre-authorization was not obtained after the initial 48 hours).

To ensure the right treatment/services and level of care is provided at the right time to minimize waste, error, and unnecessary medical practices/use and cost.

2.4 Highmark: Medical Necessity Criteria – Inpatient/Outpatient

Medical Necessity Criteria – Inpatient/Outpatient To which benefits is the NQTL assigned?

Category: MH/SUD

Inpatient Benefits

MH: See PA and current review benefits above

SUD: See PA and current review benefits above

Outpatient Benefits

MH: See PA and concurrent review benefits above

SUD: See PA and concurrent review benefits above

Prior authorization is required for specific physician administered outpatient drugs. Drugs requiring prior authorization can be found at: https://wv.highmarkhealthoptions.com/providers/prior-authorization-code-lookup.html

Category: M/S

Inpatient Benefits

See PA and current review benefits above

Outpatient Benefits: See PA and current review benefits above

Prior authorization is required for specific physician administered outpatient drugs. Drugs requiring prior authorization can be found at: https://wv.highmarkhealthoptions.com/providers/prior-authorization-code-lookup.html

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

HHOWV ensures that the right patients are receiving the right medical care at the right level of care and at the right time in the least restrictive environment for MH, SUD, and M/S services.

Clinical criteria use the philosophy that the most appropriate level of care for patients should be the safest and least restrictive possible.

The goal of treatment is to restore the patient to the best level of functioning and independence.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

HHOWV selects nationally recognized, evidence-based criteria for MH/SUD and M/S, such as Change Healthcare InterQual, WVBMS' Policy Manuals, and ASAM Criteria (for SUD only). For the specific physician administered outpatient drugs, clinical policies are aligned with criteria developed by BMS and additional criteria is created objectively, and with clinical evidence, from sources such as government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia.

The development of medical policies and subsequent policy revision is in accordance with current standards of care, federal and state mandates, and accreditation standards.

These include, but are not limited to, those of the NCQA and the Centers for Medicare & Medicaid Services (CMS).

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Medical necessity review is completed by registered nurses, LCSWs and/or LSWs with the utilization of evidence-based criteria applied in the following sequence:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

The reviews are completed by registered nurses, LCSWs, and/or LSWs. Only medical directors licensed in West Virginia are able to make clinical decisions to deny or reduce care.

The specific MH/SUD and M/S physician administered outpatient drugs are reviewed by registered pharmacists and the determination is made in accordance with approved policy. Only medical directors licensed in West Virginia are able to make clinical decisions to deny or reduce care subsequent to the pharmacist's initial determination.

The medical director has discretion to approve or deny services based on medical necessity.

Exception criteria are the basis for the retrospective review process. If the exception criteria are not met, the request may be administratively denied without a clinical review. This process may only be overridden by senior leadership based on extenuating circumstances.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

Medical policies and specific physician administered drug policies are reviewed and updated on an annual basis or more frequently as new evidence becomes available and are reviewed and approved by the appropriate committee(s) prior to publication.

The specific physician administered outpatient drug policies are applied consistently to all requests.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S
Policies and QI/UM Committee minutes demonstrate annual review and approval of clinical criteria, specific physician administered outpatient drug policies, and medical policies. Over- and under-utilization for MH/SUD and M/S services is reviewed annually. In addition, member and provider experience with utilization management is assessed through surveys and analysis of member and provider complaints

For the specific physician administered outpatient drugs, NCQA governs the consistency of policy application across membership (UM2, Element C). Both BMS and NCQA govern the frequency of the application of clinical criteria across membership.

2.5 Highmark: Network Size

Network Size To which benefits is the NQTL assigned?

Category: MH/SUD

All contracted MH/SUD providers.

Category: M/S

All contracted M/S providers.

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The network size is important to provide variations and equal access to treatment. To achieve this, HHOWV aims to consistently meet or exceed the accrediting and regulatory standards established by NCQA, WVBMS, and CMS.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

HHOWV's high quality, efficient network is evidenced by its ability to contain unit cost. Furthermore, HHOWV's network includes providers with known and predictable rates. This, in addition to value-based initiatives, allows HHOWV to work collaboratively with providers to deliver high-quality, predictable cost services.

HHOWV strives to provide a choice of in-network providers for covered services. Certain procedures or types of facilities may preclude a choice of in-network providers, as there may not be in-network (INN) providers in the member's service area. HHOWV strives to ensure all members' needs are met and services are available within the network. If services are not available with an INN provider, HHOWV finds alternative solutions including but not limited to allowing out-of-network (OON) providers the opportunity to join the network and/or creating single case agreements to meet the member's need.

HHOWV is committed to ensuring its network and contracts do not hinder access to quality mental and physical healthcare. HHOWV actively works with providers to offer a broad range of care options at reasonable costs.

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

As in the process for any authorization request, the requesting provider/member would submit the information based on medical necessity, including continuity of care.

Medical necessity for services provided OON is applied no differently than for INN providers.

Medical necessity review is completed by registered nurses, LCSWs, and/or LSWs with the utilization of evidence-based criteria applied in the following sequence:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

The reviews are completed by registered nurses, LCSWs, and/or LSWs. Only medical directors licensed in West Virginia are able to make clinical decisions to deny or reduce care.

The medical director has discretion to approve or deny services based on medical necessity.

Exception criteria are the basis for the retrospective review process. If the exception criteria are not met, the request may be administratively denied without a clinical review. This process may only be overridden by senior leadership based on extenuating circumstances.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The purpose of a provider network is assurance that providers are fully credentialed and contracted to follow all Medicaid/CHIP rules, including quality of care standards and accept specified contracted rates.

Network adequacy reviews are performed no less than annually. Appointment availability is considered. Frequency for reviewing requirements for geographic restrictions is conducted no less than annually.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Quality assurance activities are in place to maintain an ongoing, up-to-date credentialing and re-credentialing system that is compliant with NCQA, WVBMS, and CMS requirements/standards.

Member and provider complaints and requests for participation are also reviewed. Determinations are made either annually in the case of geographic access standard or on a case-by-case basis for requests for participation and/or member and provider complaints. Whether member or provider, complaints are processed with equal rigor.

OON criteria for MH/SUD and M/S are based on several factors including:

- Network Need
- Specialty Type
- Distance from Service Area
- Volume of Members, etc.

2.6 Highmark: Practive Guidelines – Inpatient/Outpatient

Practice Guidelines – Inpatient/Outpatient To which benefits is the NQTL assigned?

Category: MH/SUD

Inpatient Benefits

See PA and concurrent review benefits above

MH: See PA and concurrent review benefits above

SUD: See PA and concurrent review benefits above

Outpatient Benefits

See PA and concurrent review benefits above

SUD: See PA and concurrent review benefits above

Category: M/S

Inpatient Benefits

See PA and concurrent review benefits above

Outpatient Benefits

See PA and concurrent review benefits above

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

HHOWV ensures that the right patients are receiving the right medical care, at the right level of care, and at the right time in the least restrictive environment for MH, SUD, and M/S services.

Practice Guidelines use the philosophy that the most appropriate level of care for patients should be the safest and least restrictive possible.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Clinical Practice Guidelines can be used to help direct care based on best available evidence-based practices to reduce inappropriate variation in practice and provide the best care for members.

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Clinical Practice guidelines are used to aid the development of medical necessity guidelines specifically related to internal medical policies and procedures.

The development of medical policies and subsequent policy revision(s) is in accordance with current standards of care, federal, and state mandates, as well as accreditation standards. These include, but are not limited to, those of NCQA and the Centers for Medicare & Medicaid Services (CMS).

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

Medical policies are reviewed and updated on an annual basis or more frequently as new practice guidelines become available and are reviewed and approved by the appropriate committee(s) prior to publication.

Policies and QI/UM Committee minutes demonstrate annual review and approval of clinical criteria and medical policies. Over- and under-utilization for MH/SUD and M/S services is reviewed at least annually. In addition, member and provider experience with utilization management is assessed through surveys and analysis of member and provider complaints.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Practice Guidelines aids medical necessity criteria development to ensure consistent decisions are being made in accordance with evidence-based practices including:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

Federal and state mandates and accreditation standards. These include, but are not limited to, those of NCQA and CMS.

3.0 Highmark – Medicaid – Adult

3.1 Highmark: Prior Authorization (PA), Concurrent Review – Inpatient

Prior Authorization (PA), Concurrent Review – Inpatient To which benefits is the NQTL assigned?

Category: MH/SUD

PA is required for ALL inpatient benefits:

MH:

- Inpatient Mental Health
- PRTF
- Residential Psychiatric Services

SUD:

- Inpatient Detoxification
- Residential Rehabilitation Services

Concurrent review is required for the same benefits as PA.

Category: M/S

PA is required for ALL inpatient benefits:

- Acute Inpatient
- Inpatient Skilled Care (including skilled nursing facilities and skilled units within an acute care facility)
- Elective Inpatient
- Elective Transplant
- Maternity Inpatient
- Musculoskeletal (MSK) Inpatient
- NICU Inpatient
- Pediatric Skilled Nursing
- Post Acute Inpatient

A complete list of all services requiring prior authorization is available to view through our WV Provider Authorization Look Up Tool: https://wv.highmarkhealthoptions.com/providers/prior-authorization-code-lookup.html

Concurrent review is required for the same benefits as PA.

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

For inpatient services, strategies for performing PA include (for MH/SUD and M/S) to determine member eligibility, benefit coverage, medical necessity, location, and appropriateness of services and to ensure that services are safe and in the least restrictive setting.

The same strategies apply for concurrent review but also include planning for anticipated discharge.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

HHOWV relies on nationally recognized, evidence-based criteria, as well as state specific guidelines, for all inpatient levels of care for MH/SUD **and** M/S services. This includes:

MH:

- WVBMSPolicy Manual
- Change Healthcare InterQual

- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

To ensure the right treatment/services and level of care are provided at the right time to minimize waste, error and unnecessary medical practices/use and cost (e.g., to prevent overutilization).

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Requests for PA and/or concurrent review for MH/SUD and M/S may be submitted electronically via the online portal (should the electronic portal be unavailable, the provider may also submit requests through fax or phone).

If a member presents for Crisis Intervention Services, the provider/facility has 48 hours post-admission to request prior authorization to ensure members safety.

Information is required to support medical necessity. This includes, but is not limited to, diagnosis, medications, current symptom presentation, past medical history, treatment plan, and discharge plan.

Concurrent review includes collecting information about the member's condition and progress, determining coverage, identifying a discharge and continuing care plan early in the stay, assessing this plan, identifying and referring potential quality of care concerns, and identifying members for referral to HHOWV's Care Coordination program.

All staff are West Virginia licensed registered nurses, LCSW, and/or LSW.

Only medical directors are able to make clinical decisions to deny or reduce care, and they are West Virginia licensed medical or psychiatric physicians.

The medical director has discretion to approve or deny services based on medical necessity.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The Mental Health Parity and NQTL criteria are reviewed quarterly and NQTL Mental Health Parity reports are submitted and approved via the QI/UM Committee.

Additionally, inter-rater auditing of care managers and medical directors is performed ~~at least~~ biannually (2x's per year) to assess consistency. Passing inter-rater scores of 90% or above is required. If an individual scores less than 90%, additional training is provided and then a retesting is required with 90% or above result.

Root cause analysis is performed with development of corrective actions in instances when reviewers do not achieve inter-rater consistency.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Monthly/ quarterly/annual compliance reports including Mental Health Parity, Residential and PRTF, IMD, SUD Finance, and an annual report of authorizations approved and denied for each NQTL category supports the frequency and rigor applied to NQTLs.

All reports are sent to the State of WV in accordance with all federal, state, and contractual guidelines.

This ensures the right treatment/services and level of care is provided at the right time to minimize waste, error, and unnecessary medical practices/use and cost.

3.2 Highmark: Prior Authorization (PA), Concurrent Review – Outpatient

Prior Authorization (PA), Concurrent Review – Outpatient To which benefits is the NQTL assigned?

Category: MH/SUD

PA Benefits:

MH:

- Partial Hospitalization
- MH Intensive Outpatient
- Psychological Testing
- Neuropsychological Testing
- Mental Health Assessment (as defined in WVBMS Manual Chapter 504.12.1)
- Crisis Intervention Services
- Assertive Community Treatment (ACT)

SUD:

- ASAM Level 2.5 Partial Hospitalization
- ASAM Level 2.1 Intensive Outpatient
- Targeted Case Management
- Peer Recovery Support Service

Concurrent review is required for the same benefits as PA.

Category: M/S

PA Benefits:

- Outpatient Select Procedures
- Therapies (Physical /Occupational /Speech Pathology)
- Home Care
- Select DME
- Hospice
- Medically Necessary Transportation
- Select Diagnostic Testing
- Complex Imaging
- Non-Participating Specialty Visits
- Respite
- Clinical Consultation: Nursing
- Home or Vehicle Accessibility Adaptations
- Specialized Medical Equipment and Supplies
- Supported Living
- Orientation, Mobility, and Assistive Technology
- Personal Care
- Non-Medical Transportation

Concurrent review is required for the same benefits as PA.

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

For outpatient services, strategies for performing PA include (for MH/SUD and M/S) to determine member eligibility, benefit coverage, medical necessity, location, and appropriateness of services and to ensure that services are safe and in the least restrictive setting.

To ensure the right treatment/services and level of care are provided at the right time to minimize waste, error, and unnecessary medical practices/use and cost (e.g., to prevent overutilization).

Concurrent reviews provide an opportunity for individualized treatment and discharge planning, which achieves better outcomes for individuals.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

HHOWV relies on nationally recognized, evidence-based criteria, as well as state specific guidelines, for all inpatient levels of care for MH/SUD and M/S services. This includes Change:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

PA/concurrent review is part of HHOWV’s utilization management program for MH/SUD and M/S in which health care is reviewed as it is provided and is triggered when current services require additional days that are requested by the provider.

If a member presents for Crisis Intervention Services, the provider/facility has 48 hours to request prior authorization to ensure members safety.

Requests for concurrent review may be submitted electronically via the online portal (should the electronic portal be unavailable; the provider may also submit requests through fax and phone). Reviewers monitor appropriateness of the care, the setting, and the progress of discharge plans and determine if care is in the least restrictive environment in the right setting at the right time.

Concurrent review includes collecting information from the care team about the member’s condition and progress, determining coverage based on this information, identifying a discharge and continuing care plan early in the stay, assessing this plan, identifying and referring potential quality of care concerns, and identifying members for referral to HHOWV's Care Coordination program.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The Mental Health Parity and NQTL criteria are reviewed quarterly and NQTL Mental Health Parity reports are submitted and approved via the QI/UM Committee.

Additionally, inter-rater auditing of care managers and medical directors is performed at least biannually (2x per year) to assess consistency. Passing inter-rater scores of 90% or above is required. If an individual scores less than 90%, additional training is provided, and then r-testing is required with 90% or above result.

Root cause analysis is performed with development of corrective actions in instances when reviewers do not achieve inter-rater consistency.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Monthly/quarterly/annual compliance reports including Mental Health Parity, Residential and PRTF, IMD, SUD Finance, and an annual report of authorizations approved and denied for each NQTL category supports the frequency and rigor applied to NQTL's.

All reports are sent to the State of WV in accordance with all federal, state, and contractual guidelines.

To ensure the right treatment/services and level of care is provided at the right time to minimize waste, error, and unnecessary medical practices/use and cost.

3.3 Highmark: Retrospective Review – Inpatient/Outpatient

Retrospective Review- Inpatient/Outpatient To which benefits is the NQTL assigned?

Category: MH/SUD

ALL Inpatient Benefits:

MH: See PA and concurrent review benefits above

SUD: See PA and concurrent review benefits above

Outpatient Benefits:

MH: See PA and concurrent review benefits above

SUD: See PA and concurrent review benefits above

Category: M/S

ALL Inpatient Benefits:

See PA and concurrent review benefits above

Outpatient Benefits:: See PA and concurrent review benefits above

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

Retrospective review is an opportunity for the provider to have a denied service reconsidered when the required pre-authorization was not obtained (for emergent services when the required pre-authorization was not obtained after the initial 48 hours) for both MH/SUD and M/S services.

Retrospective reviews must meet exception criteria:

1. Evidence member presented with incorrect insurance
2. Contract exceptions
3. Emergent in nature (after 48 hours)
4. Member is incapacitated or is physically/mentally unable to provide insurance coverage information at time of admission

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Determinations of medical necessity criteria/medical appropriateness of services are made by using nationally recognized criteria, such as:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

A retrospective review is requested by a provider to perform a utilization review on a post-service when the required PA was not obtained.

The request must have supported documentation.

The request must meet state and contractual timeframes and guidelines for retrospective submission.

The reviews are completed by registered nurses, LCSWs, and/or LSWs. Only medical directors licensed in West Virginia are able to make clinical decisions to deny or reduce care.

The medical director has discretion to approve or deny services based on medical necessity.

Exception criteria are the basis for the retrospective review process. If the exception criteria are not met, the request may be administratively denied without a clinical review. This process may only be overridden by senior leadership based on extenuating circumstances.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

Determinations of medical appropriateness of services using nationally recognized criteria, such as:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

Provider education and follow-up are part of HHOWV's process to verify, track, and trend retrospective review. Provider education is ongoing; follow-up calls may occur with the provider when repeated requests for retrospective reviews are submitted without documentation that supports the exception or at the request of the provider.

The appeal team works in collaboration with other HHOWV teams to identify trends, complaints, and provider dissatisfaction. This collaborative approach leads to quality improvements and overall satisfaction.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Retrospective review is an opportunity for the provider to have a denied service reconsidered when the required PA was not obtained (for emergent services when the required pre-authorization was not obtained after the initial 48 hours).

To ensure the right treatment/services and level of care is provided at the right time to minimize waste, error, and unnecessary medical practices/use and cost.

3.4 Highmark: Medical Necessity Criteria – Inpatient/Outpatient

Medical Necessity Criteria – Inpatient/Outpatient To which benefits is the NQTL assigned?

Category: MH/SUD

ALL Inpatient Benefits:

MH: See PA and Concurrent Review Benefits above

SUD: See PA and Concurrent Review Benefits above

Outpatient Benefits

MH: See PA and Concurrent Review Benefits above

Prior authorization is required for specific physician administered outpatient drugs. Drugs requiring prior authorization can be found at: https://wv.highmarkhealthoptions.com/providers/prior-authorization-code-lookup.html

SUD: See PA and Concurrent Review Benefits above

Category: M/S

ALL Inpatient Benefits:

See PA and Concurrent Review Benefits above

Outpatient Benefits:

See PA and Concurrent Review Benefits above

Prior authorization is required for specific physician administered outpatient drugs. Drugs requiring prior authorization can be found at: https://wv.highmarkhealthoptions.com/providers/prior-authorization-code-lookup.html

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

HHOWV ensures that the right patients are receiving the right medical care at the right level of care—and at the right time in the least restrictive environment for MH, SUD, and M/S services.

Clinical criteria use the philosophy that the most appropriate level of care for patients should be the safest and least restrictive possible.

The goal of treatment is to restore the patient to the best level of functioning and independence.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

HHOWV selects nationally recognized, evidence-based criteria for MH/SUD and M/S, such as Change Healthcare InterQual, WVBMS' Policy Manuals, and ASAM Criteria (for SUD only).

For the specific physician administered outpatient drugs, clinical policies are aligned with criteria developed by BMS, and additional criteria is created objectively, and with clinical evidence, from sources such as government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia.

The development of medical policies and subsequent policy revision is in accordance with current standards of care, federal and state mandates, and accreditation standards.

These include, but are not limited to, those of the NCQA and the Centers for Medicare & Medicaid Services (CMS).

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Medical Necessity review is completed by Registered Nurses, LCSWs and/or LSWs with the utilization of evidence-based criteria applied in the following sequence:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

The reviews are completed by Registered Nurses, LCSWs, and/or LSWs. Only Medical Directors licensed in West Virginia are able to make clinical decisions to deny or reduce care.

The specific MH/SUD and M/S physician administered outpatient drugs are reviewed by Registered Pharmacists and the determination is made in accordance with approved policy. Only medical directors licensed in West Virginia are able to make clinical decisions to deny or reduce care subsequent to the pharmacist's initial determination.

The Medical Director has discretion to approve or deny services based on medical necessity.

Exception criteria are the basis for the retrospective review process. If the exception criteria are not met, the request may be administratively denied without a clinical review. This process may only be overridden by senior leadership based on extenuating circumstances.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

Medical policies and specific physician administered drug policies are reviewed and updated on an annual basis or more frequently as new evidence becomes available and are reviewed and approved by the appropriate committee(s) prior to publication.

The specific physician administered outpatient drug policies are applied consistently to all requests.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Policies and QI/UM Committee minutes demonstrate annual review and approval of clinical criteria, specific physician administered outpatient drug policies, and medical policies. Over- and under-utilization for MH/SUD and M/S services is reviewed at least annually. In addition, Member and Provider experience with utilization management is assessed through surveys and analysis of Member and Provider complaints.

For the specific physician administered outpatient drugs, NCQA governs the consistency of policy application across membership (UM2, Element C). Both BMS and NCQA govern the frequency of the application of clinical criteria across membership.

3.5 Highmark: Network Size

Network Size To which benefits the NQTL assigned?

Category: MH/SUD

All contracted MH/SUD providers.

Category: M/S

All contracted M/S providers.

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The network size is important to provide variations and equal access to treatment. To achieve this, HHOWV aims to consistently meet or exceed the accrediting and regulatory standards established by NCQA, WVBMS, and CMS.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

HHOWV's high quality, efficient network is evidenced by its ability to contain unit cost. Furthermore, HHOWV's network includes providers with known and predictable rates. This, in addition to value-based initiatives, allows HHOWV to work collaboratively with providers to deliver high-quality, predictable cost services.

HHOWV strives to provide a choice of in-network providers for covered services. Certain procedures or types of facilities may preclude a choice of in-network providers, as there may not be INN providers in the member's service area. HHOWV strives to ensure all members' needs are met and services are available within the network. If services are not available with an INN provider, HHOWV strives to find alternative solutions including, but not limited to, allowing OON providers the opportunity to join the network and/or create single case agreements to meet a member's need.

We're committed to ensuring our network and contracts don't hinder access to quality mental and physical healthcare. We actively work with providers to offer a broad range of care options at reasonable costs.

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

As in the process for any authorization request, the requesting Provider/Member would submit the information based on medical necessity, including continuity of care.

Medical Necessity for services provided OON is applied no differently than for INN providers.

Medical Necessity review is completed by Registered Nurses, LCSWs and/or LSWs with the utilization of evidence-based criteria applied in the following sequence:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

The reviews are completed by registered nurses, LCSWs, and/or LSWs. Only medical directors licensed in West Virginia are able to make clinical decisions to deny or reduce care.

The medical director has discretion to approve or deny services based on medical necessity.

Exception criteria are the basis for the retrospective review process. If the exception criteria are not met, the request may be administratively denied without a clinical review. This process may only be overridden by senior leadership based on extenuating circumstances.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The purpose of a Provider Network is assurance that providers are fully credentialed and contracted to follow all Medicaid/CHIP rules, including quality of care standards, and accept specified contracted rates.

Network adequacy reviews are performed no less than annually. Appointment availability is considered. Frequency for reviewing requirements for geographic restrictions is conducted no less than annually.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Quality assurance activities are in place to maintain an ongoing, up-to-date credentialing and re-credentialing system that is compliant with NCQA, WVBMS, and CMS requirements/standards.

Member and provider complaints and requests for participation are also reviewed. Determinations are made either annually in the case of geographic access standard or on a case-by-case basis for requests for participation and/or member and provider complaints. Whether member or provider, complaints are processed with equal rigor.

OON criteria for MH/SUD and M/S are based on several factors including:

- Network Need
- Specialty Type
- Distance from Service Area
- Volume of Members, etc.

3.6 Highmark: Clinical Practice Guidelines – Inpatient/Outpatient

Clinical Practice Guidelines – Inpatient/Outpatient To which benefits is the NQTL assigned?

Category: MH/SUD

Inpatient Benefits: See PA and Concurrent Review Benefits above

SUD: See PA and Concurrent Review Benefits above

Outpatient Benefits: See PA and Concurrent Review Benefits above

Category: M/S

Inpatient Benefits: See PA and Concurrent Review Benefits above)

Outpatient Benefits: See PA and Concurrent Review Benefits above

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

HHOWV ensures that the right patients are receiving the right medical care, at the right level of care, and at the right time in the least restrictive environment for MH, SUD, and M/S services.

Clinical Practice Guidelines use the philosophy that the most appropriate level of care for patients should be the safest and least restrictive possible.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Clinical Practice Guidelines can be used to help direct care based on best available evidence-based practices in order to reduce inappropriate variation in practice and provide best care for members.

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Clinical Practice guidelines are used to aid the development of medical necessity guidelines specifically related to internal medical policies and procedures.

The development of medical policies and subsequent policy revision(s) is in accordance with current standards of care, federal and state mandates, as well as accreditation standards.

These include, but are not limited to, those of NCQA and the Centers for Medicare & Medicaid Services (CMS).

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

Medical policies are reviewed and updated on an annual basis or more frequently as new practice guidelines become available and are reviewed and approved by the appropriate committee(s) prior to publication.

Policies and QI/UM Committee minutes demonstrate annual review and approval of clinical criteria and medical policies. Over- and under-utilization for MH/SUD and M/S services is reviewed at least annually. In addition, member and provider experience with utilization management is assessed through surveys and analysis of member and provider complaints.

Evidentiary Standard: What standard supports the frequency or rigor applied?

Category: MH/SUD and M/S

Practice Guidelines aids medical necessity criteria development to ensure consistent decisions are being made in accordance with evidence-based practices including:

MH:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy

SUD:

- WVBMS Policy Manual
- ASAM Criteria
- HHOWV internal medical policy

M/S:

- WVBMS Policy Manual
- Change Healthcare InterQual
- HHOWV internal medical policy
- Federal and state mandates
- Accreditation standards. These include, but are not limited to, those of NCQA and CMS.

4.0 The Health Plan – Medicaid and WVCHIP

4.1 The Health Plan: Prior Authorization and Concurrent/Review/Inpatient

Prior Authorization and Concurrent Review/Inpatient To which benefits is the NQTL assigned?

Category: MH/SUD

- Elective Inpatient
- Care
- Tertiary Care
- Out-of-Network
- Care
- SUD Rehabilitation
- PRTF <21 years of age

Category: M/S

- Elective Inpatient Care
- Tertiary Care
- Out-of-Network Care
- Elective Obstetric Care
- Medical Rehabilitation
- Long-Term Acute Care Hospital

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- Proactive assessment of the member receiving the most appropriate care and treatment at the most appropriate facility
- Medical necessity review of the elective service based on the individualized need of the member and coverage supported by the contracted benefit plan utilizing nationally recognized criteria
- Preauthorization of elective admission is performed to confirm eligibility, benefits, and appropriateness of services to be rendered and level of care to be utilized
- Continuing necessity review for inpatient level of care for oversight of efficacy and quality of care, coordination of care/discharge planning/transitional care planning to facilitate effective timely transition to appropriate lower level of care
- Concurrent review is performed to assist with discharge planning to ascertain quality of care and allows for identification of patients with potential discharge planning needs
- Patients are referred by the nurse inpatient navigator to the Behavioral Health (BH) Transition of Care (TOC) program upon admit for the TOC manager to work with the facilities on transition of care and safe discharge planning

MH/SUD

- Individuals with MH conditions should be treated in the least restrictive environment and in a manner designed to preserve their dignity and autonomy and to maximize the opportunities for recovery
- To ensure factors such as the member's age, living conditions, support systems, past medical/surgical history, and network capabilities are considered

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- Monthly, the CMO, in conjunction with the director of UM and director of clinical programs for analyzing utilization data and identifying areas of concern

- The CMO presents quarterly summaries of utilization information to the Continuous QI (CQI) Committee Utilization data assists with updating the list of services requiring PA and the list of services requiring PA is updated at least annually and revised periodically as appropriate
- The QM/UM committee is responsible to provide feedback to the CMO and provide action plans, including adjustments to the QAPI program
- Inpatient services are costlier than most outpatient services
- Review of preauthorization lists, denial rate reports, and out-of-network reports

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- Preauthorization is not required for urgent admissions; notification is required as soon as practically possible after admission
- Reviews are conducted of members' acute care hospitalizations as clinically indicated, by telephone, or facsimile, and decisions are based on medical necessity
- Concurrent review is performed telephonically or by facsimile and involves communication with practitioners, hospital Utilization Review (UR) and social services staff, and family members as necessary
- Gender affirming care: Assessment by two mental health professionals, with a written clinical evaluation by a mental health professional
- Gender affirming care: Review of documentation to determine required steps have been met prior to procedure (12 continuous month of living as transgender; 12 months continuous hormone therapy; follow up every 3 months during first year of hormone therapy; documentation of counseling about risks, benefits, etc. of procedure

MH/SUD

- Members of The Health Plan (THP) are afforded direct access to behavioral healthcare, meaning they have no need to obtain a preauthorization in times of crisis or to be directed for evaluation of a behavioral health issue

Concurrent Review – MH/SUD

- Concurrent review frequency is determined by InterQual criteria and acuity of member. Frequently occurs as often as every 1 – 2 days.

Concurrent Review – M/S

- Concurrent review is determined by InterQual criteria, acuity of the member, and input from the medical director. Frequently occurs as often as daily.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- Evidence-based criteria is the basis of all decisions
- Members are regarded as individuals with specific care needs (e.g., age, living conditions, support systems, etc., taken into consideration)
- Only a physician may make an exception or issue a denial related to a pre-service determination
- No vendors are utilized for MH/SUD or M/S concurrent review
- Each practitioner who makes medical review necessity decisions will have randomly selected cases evaluated quarterly; individual results will be tabulated and reviewed by the CMO and reported to the Executive Committee as part their oversight annually
- Collected scores will be used as a basis for individual assessment and for CQI within the group practitioner Inter-rater reviews:
    - Practitioner inter-rater review will be performed at least quarterly and analyzed annually
    - Compliance of 90% or greater is acceptable
    - Ad hoc reviews may be performed at any time as part of a performance evaluation
    - Annual results will be reported to MDOC and to the CQI committee

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- Complaints for MH/SUD and M/S enrollees are addressed and reviewed for opportunities for improvement
- Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the CQI Committee
    - Annual report of inter-rater reliability assessment results
    - Monthly monitoring of denials by type (administrative/medical necessity)
- Member complaints and appeals data are collected and analyzed for evidence that NQTLs are applied more stringently to MH/SUD

M/S

- The Health Plan has a 30-day readmission review policy to examine appropriate utilization practices in the inpatient setting

4.2 The Health Plan: Outpatient Prior Authorization

Outpatient Prior Authorization To which benefits is the NQTL assigned?

Category: MH/SUD

- Outpatient ECT
- Urine drug testing
- IOP (after 30 sessions/days)
- ACT
- Genetic, pharmacokinetic, pharmacogenomics, and pharmacodynamics testing
- Peer Review Recovery Support – 90 units of Peer Recovery Support Services (PRSS) is given without authorization at the beginning of each month, additional units require prior authorization
- Out-of-area and out of-network care
- PHP (after 30 sessions/days)
- CSU (after 144 units)
- (Emergent Care)
- Ambulance/ambulette - non-emergent

Category: M/S

- All out-of-network care per plan design
- All services require preauthorization per plan design (tertiary care)
- CT/MRI/MRA
- CT angiography (CTA) for Coronary Artery Disease (CAD)
- Cardiac Imaging (CT/MRI/PET)
- Urine drug testing
- CT/CTA
- MPI (Nuclear Stress)
- Echo/Echo Stress
- Medical procedures (including services related to spine management)
- Ambulatory services (including ambulatory blood pressure monitoring)
- Ancillary providers and services (including ambulance/ambulette – non-emergent)
- New medical technologies (including artificial urinary sphincter)

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

PA is required for the following reasons:

- Quality of care/Patient safety
- Correct level of care
- Coordination of care
- Overutilization
- Case management
- High-cost services
- Determine benefit limits
- Confirm most appropriate care, treatment and setting
- Perform medical necessity review of the service with consideration of the individualized need of the member
- All reviews for medical appropriateness by THP are determined by written criteria that are based on medical evidence

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- Utilization data is monitored monthly and annually to identify potential patterns of underutilization and overutilization
- Established thresholds are used to detect inappropriate utilization
- Contributing causes are identified, and effective interventions are developed
- A summary report of monthly referrals regarding the authorization of services and denials is reviewed to determine the rate of authorization and any need for continued preauthorization of the services
- Clinical Analytics program analyzes cost drivers, quality of services, and care delivery to provide support for PA assignment
- Review of preauthorization lists, pre-service denial reports
- Any outpatient pre-service that requires preauthorization is reviewed through the use of evidence-based criteria (InterQual, ASAM®, CMS/BMS criteria, Hayes, UpToDate) and/or expert medical review

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- The UM program specifies the use of qualified health professionals whose education and experience are commensurate with the UM reviews or member navigation they perform
- All care/complex case and chronic disease navigation, preauthorization, and inpatient navigation decisions are made by individuals who have knowledge and skills to evaluate working diagnoses and proposed treatment plans
- All registered nurses and social workers maintain, and show proof of, continued licensing and continuing education, credentialing, and certification, when appropriate
- Those who are certified complex case navigators maintain continued certification in complex case navigation
- All registered nurses in the medical and behavioral health units are hired as per the qualifications required in the job description for a nurse navigator
- A senior-level physician oversees the UM program, and a designated behavioral healthcare practitioner oversees the behavioral health aspects of the program
- Management staff (director, managers, supervisors) have day-to-day involvement in medical department and behavioral health activities daily and dedicated MH/SUD and MDs are available after regular business hours

- Management staff participate in staff training, conduct staff meetings with responsibility for agendas and minutes, and provide guidance during “grand rounds”
- Management staff complete inter-rater reliability review as per the Inter-Rater Review Reliability Monitoring Policy
- All non-authorizations of services that result from a determination of medical appropriateness are made by a licensed practitioner. This ensures that appropriate clinical judgment is used in making the denial determination. The practitioner(s) maintains continued licensing without restriction and board certification if applicable managed care experience in a managed care setting or behavioral health preferred
- Any non-authorization of care or service based on medical appropriateness is reviewed by a practitioner, dentist, behavioral health practitioner, or pharmacist, as appropriate; the non-authorization rationale is documented in the system with electronic practitioner signature, date, and time
- All cases that require clinical judgment outside the expertise of the medical directors are reviewed by AMR, THP’s specialty review company

The following staff may approve services:

- Staff who are under the supervision of an appropriately licensed health professional, when there are explicit UM criteria, and no clinical judgment is required
- Licensed healthcare professionals

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- Nationally recognized, evidence-based criteria is the basis of all decisions; however, review decisions are not made solely based on criteria. Members are regarded as individuals with specific care needs.
- Only a physician may make an exception or issue a denial related to a pre-service determination.
- EviCore is the only vendor performing M/S services for Medicaid member elective procedures, and their inpatient PA review is limited to spinal surgery. EviCore is NCQA accredited and subject to external audit in that fashion as well as sharing data with THP monthly
- Each practitioner who makes medical review necessity decisions will have randomly selected cases evaluated quarterly. Individual results will be tabulated and reviewed by the Medical Directors Oversight Committee and reported to the Executive Committee as part of their oversight annually. Collected scores will be used as a basis for individual assessment and for CQI within the group

Practitioner Inter-Rater reviews:

- Practitioner inter-rater review will be performed at least quarterly and analyzed annually
- Compliance of 90% or greater is acceptable
- Ad hoc reviews may be performed at any time as part of a performance evaluation
- Annual results will be reported to MDOC and to the CQI committee

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- Complaints for MH/SUD enrollees are addressed and reviewed for opportunities for improvement
- Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at a minimum of quarterly to the QM/UM Committee
- Annual report of inter-rater reliability assessment results
- Monthly monitoring of denials by type (administrative/medical necessity)

4.3 The Health Plan: Inpatient Retrospective Review

Inpatient Retrospective Review To which benefits is the NQTL assigned?

Category: MH/SUD

- Elective inpatient care
- Tertiary care
- Out-of-network care
- SUD

Category: M/S

- All elective inpatient care
- Out-of- network/out-of-area care
- All elective C-sections and all elective inductions
- Tertiary care

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

Retrospective review takes place to determine if a stay, in part or totally, was medically appropriate

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- See prior authorization and concurrent review.
- Retrospective review is for those stays that should have received prior authorization.

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- RN nurse navigators with five years of experience and behavioral medical director help navigate and make case determinations
- Any potential quality issues are directed to the QI department
- Any potential fraud issues are directed to the Special Investigations Unit (SIU) of the Compliance

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- Retrospective review is conducted only when THP is informed of an admission after the admission has taken place
- All inpatient admissions that are not initially authorized undergo
- retrospective review Department
- ASAM® Criteria, InterQual criteria, and BMS criteria are used

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- Members are held harmless if this retrospective review determines that the admission was medically inappropriate
- If a hospital has repeated admissions without prior authorization, the issue is referred to the Provider Relations Department
- Policies and procedures are reviewed annually
- If an admission is denied, the provider is advised of appeal rights
- Member complaints and appeals data are collected and analyzed for evidence that NQTLs are applied more stringently to MH/SUD

4.4 The Health Plan: Medical Necessity Criteria

Medical Necessity Criteria To which benefits is the NQTL assigned?

Category: MH/SUD

Refers to all contractually obligated services

Category: M/S

Refers to all contractually obligated services

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

N/A

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Nationally recognized criteria is utilized. Interqual, ASAM®, CMS/BMS, review of medical and scientific sources including peer-reviewed studies in medical journals that meet nationally recognized standards including sources such as Hayes Inc., National Institute of Health's National Library of Medicine, Federal Agency for Healthcare Research and Quality (AHRQ), National Comprehensive Cancer Network, and others

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Medical necessity reviews are performed during all utilization reviews (prior authorization, concurrent review, retrospective reviews)

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

All contractually obligated services must be medically necessary

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

Quarterly monitoring and reporting to appropriate committees of service authorizations and member complaints and appeals including:

- Number of service authorizations requested
- Number of service authorizations denied
- Number of denied service authorizations with member appeal
- Number of denied service authorizations with member appeal upheld
- Number of denied service authorizations with member appeal reversed
- Complaints by NCQA category (quality of care, access, attitude and service, billing and financial, and quality of office site)
- The Service Improvement Committees reviews all the above for Parity Rule compliance concerns
- If there are any indications of potential noncompliance with the Parity Rule exists, the underlying data will be comprehensively reviewed, and if necessary, the appropriate actions will be taken

4.5 The Health Plan: Practice Guidelines

Practice Guidelines To which benefits is the NQTL assigned?

Category: MH/SUD

Clinical guidelines topics are related to areas determined to be high risk, high volume, and/or problem prone areas are selected

Category: M/S

Clinical guidelines topics are related to areas determined to be high risk, high volume, and/or problem prone areas are selected

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- Clinical guidelines measure quality across the organization and ensure content is consistent for each condition managed as well as ensuring appropriate practitioner oversight of programs
- Evidence-based clinical guidelines are valuable to The Health Plan in analyzing performance, taking action for quality improvement and demonstrating improvement

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Evidentiary standard: Interqual, ASAM®, CMS/BMS, review of medical and scientific sources including peer-reviewed studies in medical journals that meet nationally recognized standards including sources such as Hayes Inc., National Institute of Health's National Library of Medicine, Federal AHRQ, National Comprehensive Cancer Network, and other

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Practice guidelines require a consistent and uniform approach to their development, accomplished through the following objectives:

Ensuring the involvement of the medical directors, the Quality Improvement Committee (QIC), and The Health Plan practitioners

Ensuring the distribution of the guidelines to all applicable practitioners. Our guidelines are on our website for practitioners to access. Practitioners are also notified of their availability

Ensuring the development of methods for the regular evaluation of the delivery of clinical care consistent with guidelines. Clinical practice guidelines will be researched, adopted, and distributed to appropriate participating practitioners to ensure the most current clinical practices are in place for the treatment of The Health Plan members

All practice guidelines adopted by The Health Plan are coordinated through the Physician Advisory Committee(s)

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- Two non-preventive behavioral health guidelines are available upon request
- Topics related to areas determined to be high risk, high volume, and/or problem prone areas are selected for additional guideline development
- Guidelines are made available to the appropriate practitioners, and they are provided with education

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

Topics related to areas determined to be high risk, high volume, and/or problem prone areas are selected for additional guideline development. This ensures that the topics selected are worthwhile, population-based, and deserving of resource commitment

4.6 The Health Plan: Network Size/Adequacy

Network Size/Adequacy To which benefits is the NQTL assigned?

Category: MH/SUD

All benefit services that THP is contractually obligated to provide

Category: M/S
All benefit services that THP is contractually obligated to provide

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

THP must ensure that all covered services including additional or supplemental services contracted by or on behalf of Mountain Health Trust (MHT) members, are available and accessible

- BMS has set minimum provider network adequacy standards that THP must meet or exceed in all areas in which THP operates. THP must comply with all the network adequacy standards in the MCO Contract
- The intent of the standards is to provide for access to services at least as good, if not better, than access to care under the traditional Medicaid program

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- To ensure a robust network of providers so enrollees have access to mental health services
- The THP provides ongoing care by ensuring availability of high-volume behavioral health practitioners within our delivery system
- The behavioral health practitioner network includes psychiatrists, psychologists, counselor/therapists, and social workers, some with sub-specialties
- Practitioners are available in all areas of THP network
- Services are monitored quarterly related to MH and SUD to help ensure that benefits are not more limited in availability, scope, or duration than medical or surgical services in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA)
- To ensure THP meets or exceeds all geographic network adequacy standards in the MCO contract

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- If THP is unable to provide certain covered services, enrollees may get out-of-network services, and the cost is no greater than in-network services would have been
- Enrollees may receive emergency care in- or out-of-network
- THP must meet network adequacy standards (adult and pediatric) behavioral health providers and facilities, SUD providers and facilities, and additional providers to promote the objectives of the Medicaid program as determined by CMS
- THP is required to comply with updated network standards within 90 calendar days of issuance unless otherwise agreed to in writing by BMS within 60 calendar days of issuance

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

THP's goal is to meet or exceed network adequacy goals 100% of the time

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- THP should meet network adequacy standards 100% of the time; however, in its sole discretion, BMS allows some exceptions to the provider access standards allowed under limited circumstances (e.g., if no appropriate provider types are located within the mileage standards)
- Out-of-network/out-of-area utilization reviews

5.0 Wellpoint – Medicaid

5.1 Wellpoint: Prior Authorization, Retrospective Review, and Concurrent Review – Inpatient

Prior Authorization, Concurrent Review, and Retrospective Review- Inpatient To which benefits is the NQTL assigned?

Category: MH/SUD

Only non-emergent inpatient services have PA

Inpatient hospital services include:

- PRTF
- Inpatient psychiatric
- Wellpoint does not require a prior authorization for placement in an Institution for Mental Diseases (IMD) the first 48 hours
- Inpatient detoxification
- Inpatient SUD treatment

Category: M/S

All inpatient services except emergency and obstetrical care including:

- Long-term acute care facility
- Rehabilitation facility admissions
- Inpatient hospice
- Newborn stays beyond federally mandated time frames

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

Inpatient services are assigned PA because:

- PA assures the least restrictive safe environment to promote dignity and function
- These are high-cost services and PA provides an opportunity to reduce unnecessary costs by preventing overutilization through medical necessity review and facilitating discharge planning
- High variability in length of stay
- Only non-emergent inpatient services have PA

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Evidence of the high cost of inpatient services includes monthly and annual cost and utilization reports
- For these services, high variability in length of stay

The following data sources may be used in utilization monitoring:

- Claims Reports
- Member Complaints, Denials, Approvals, and Appeals Analysis
- Authorization/cost reports
- Audits of appropriate clinical criteria
- Healthcare Effectiveness Data and Information Set (HEDIS) findings
- Focus Studies that evaluate access to care, use of preventative care services, and other services

Wellpoint staff reviewers use the following criteria when making a medical necessity determination:

- Applicable State and federal guidelines
- Member benefits
- Medical policy and clinical guidelines applicable to Wellpoint
- Physician Specialty Societies where publicly available for peer-reviewed literature, including AHRQ
- MCG™ Evidence-Based Clinical Guidelines
- American Society of Addiction (ASAM®)
- Carelon Rx Clinical Criteria
- Wellpoint policies and procedures
- Wellpoint behavioral health medical necessity criteria, as applicable
- Carelon Clinical Appropriateness Guidelines
- Member characteristics/factors/ circumstances
- Characteristics of the local delivery system that are available for the particular patient

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Prior authorization must be obtained prior to admission, except in the case of emergencies, when notification is required within 24 hours of admission. UM staff will request clinical information from the hospital on the same day they are notified of the member's admission
- All inpatient and residential services regardless of BH/Physical Health (PH) designation must be made via electronic portal per West Virginia Code 33-25A-8s
- Decision and screening criteria are designed to assist UM Program associates in assessing the appropriateness of care and length of stay for clinical health situations. Application of criteria is not absolute but based upon the individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems
- Wellpoint applies evidenced-based and consensus-driven criteria for UM screening and decisions in accordance with the member's specific benefit plan. Actively practicing physicians are involved in the development and adoption of the review criteria
- Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the Medical Policy Technology Assessment Committee (MPTAC) and the QIC
- In accordance with 42 CFR §438.210(c) and West Virginia Code § 33-25A-8s, Wellpoint must make authorization decisions and, in the event of an authorization denial, provide written notice to the requesting provider and enrollee as expeditiously as required by the enrollee's health condition and no later than five (5) business days of receiving the request for service for the purposes of standard authorization decisions
- In accordance with West Virginia Code § 33-25A-8s, if the information submitted is considered incomplete, Wellpoint must identify all deficiencies, and within two (2) business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the provider. The provider must provide the additional information requested within three (3) business days from the day the return request is received by the provider. Wellpoint must render a decision within two (2) business days after receipt of the additional information submitted by the provider. The total days cannot exceed seven calendar days. If the provider fails to submit additional information, a decision is made using the information available
- Wellpoint must make the expedited authorization decision and provide notice to the enrollee as expeditiously as the enrollee's health condition requires, but no later than two (2) business days after receipt of the request for service authorization. This two (2) day business period may be extended up to forty-eight (48) additional hours for expedited preservice authorizations and up to seventy-two (72) hours for expedited concurrent reviews upon request of the enrollee or if Wellpoint justifies to BMS in advance and in writing a need for additional information and that the enrollee will benefit from such extension

- For Emergency Stabilization and Post-Stabilization, the emergency department's treating physician determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's physician must contact the member's PCP for authorization of further services. The member's PCP is noted on the identification (ID) card. If the PCP does not respond within one hour, all necessary services will be considered authorized
- Non-clinical administrative staff gathers information and conducts pre-review screening under the guidance and direction of licensed health professionals
- Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care)
- The clinician reviewer can approve the requested services after establishing medical necessity. If the clinical information submitted does not allow an approval decision to be made, the reviewer will forward the request to a peer clinical reviewer
- Only a Wellpoint-authorized, appropriately licensed practitioner can deny a request for services for lack of medical necessity
- The provider may request a peer-to-peer to discuss the care, submit a reconsideration, and/or can appeal the decision
- Wellpoint's peer-to-peer consultation process for denied prior authorization requests is in accordance with West Virginia Code § 33-25A-8s. Wellpoint completes the peer-to-peer appeal process within five (5) business days from the date of the request by a provider for the consultation
- Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement
- Per the Post-Service Clinical Claims Review policy, providers can submit clinical information with the claim if it has been more than three business days since discharge but the provider believes there is an administrative exception.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Initial authorization limits vary based on medical necessity review
- The duration of initial authorizations for acute inpatient care vary based on medical necessity review

When a member's hospital stay is expected to exceed the number of days authorized during pre-service review, or when the inpatient stay did not have pre-service review, the hospital must contact Wellpoint for continued stay review. Wellpoint requires clinical reviews on all members admitted as inpatients to:

- Acute care hospitals
- Intermediate facilities
- Inpatient rehabilitation facilities

The decision to approve, deny or modify post-service requests is made within 30 calendar days of Post-Service Clinical Claim Review Unit's (PSCCR) receipt of request. If the decision is a denial or modification, the provider is also notified electronically or in writing within 30 days of the receipt of the request

Evidentiary Standard: What standard supports the frequency or right that is applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability. These results are analyzed and reported to the UM Committee. Reviewers must score 90% or above. If reviewers do not pass the Inter-Rater Reliability (IRR) exam, an action plan is put into place which includes various interventions which could include additional training, additional IRR scenarios, and mentoring as needed as identified by the manager.
- Utilization Management staff participate in training related to the Mental Health Parity and Equity Act.
- Wellpoint continues to monitor for needed changes and/or additions to benefit design or operations that may impact Mental Health Parity Compliance. If a change is recommended for a prior authorization requirement, Wellpoint is required to complete a Mental Health Parity Application Tool,

which is then reviewed and approved by the UM Auth Rule Operations Workgroup (AROW). This tool ensures that Wellpoint examines the change in authorization request to ensure it is in compliance with the Mental Health Parity and Addiction Act.

- Data is pulled quarterly for MH and Medical/Surgical (MS) Parity Submissions and submitted to BMS. Data is analyzed and reported to the Clinical Service Committee (CSC) workgroup to discuss findings, identify disparities, and discuss needed action steps as applicable. Data includes authorization data, denial rates, Case Management outcomes, Performance Improvement and Enhancement Measures, Inter-Rater Reliability Scores, among others.
- If a disparity was noted during monitoring of data related to MH/SUD Parity, action would be taken by Wellpoint to make appropriate notifications to BMS. Immediate measures would include, but not be limited to, analysis of the system failure, and development of a corrective action plan to remediate any disparities noted. Wellpoint would follow principles that MH/SUD Parity supersedes UM efficiency and ensure care management practices are compliant with our Mental Health Parity Compliance Plan. While the responsible business areas for each affiliated Wellpoint and line of business are responsible for complying with MHPAEA, the Elevance Parity Governance Committee, will also evaluate the adequacy of the assessment process to capture, track, and address risks, gaps, and changes needed to adhere to Elevance policy objectives, and determine whether controls and processes are designed to effectively monitor continued adherence.

5.2 Wellpoint: Outpatient Prior Authorization

Outpatient Prior Authorization To which benefits is the NQTL assigned?

Category: MH/SUD

- Partial Hospitalization Program
- Intensive Outpatient Services
- Psychology and Neuropsychology Testing
- Community Psychiatric Supportive Treatment after first three days of treatment
- Out-of-Network services
- Transcranial magnetic stimulation (TMS)

Category: M/S

- Advanced radiology services, CT, MRI, PET scan
- All out-of-network services
- DME
- Genetic testing
- Home health care services, including hospice care
- Drug screenings

Select outpatient surgeries/procedures including:

- Hysterectomy
- Bariatric surgery
- Spinal procedures
- Potentially cosmetic or investigational procedures

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Because of their potential for overutilization
- For patient safety (i.e., bariatric surgery)
- To control costs
- To avoid waste and abuse of Medicaid funds

- To ensure services are meeting their objectives

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

Evidence of the utilization of outpatient services includes monthly and annual cost and utilization reports

- In Wellpoint's experience, psychological and neuropsychological testing, IOP, and CSU are frequently ordered inappropriately
- In Wellpoint's experience, hysterectomy, DME, advanced radiology, nuclear cardiology and septoplasty are frequently ordered inappropriately
- For advanced radiology services (CT, CTA, MRI, PET), medical research shows patient risks from exposure to radiation and contrast media
- For spinal injections, medical research shows that spinal injections are frequently used for patients without the appropriate indications and/or for patients for whom they present a serious risk

The following data sources may be used in utilization monitoring:

- Claims reports
- Member complaints and appeals analysis
- HEDIS findings
- Focus Studies that evaluate access to care, use of preventative care services, and other services

Medical necessity is based on evidence- based national guidelines and reviewed annually by the internal medical advisory committee

For patient safety, nationally recognized, evidence-based standards of care and practice from sources including:

- NCQA
- American Psychiatric Association
- ASAM® Treatment
- National Alliance on Mental Illness
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- American Board of Medical Specialties. Specialty and Subspecialty Certificates physician specialty societies
- AHRQ
- National Comprehensive Cancer Network®. NCCN Drugs & Biologic Compendium
- Cumulative professional expertise and experience

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

Wellpoint staff reviewers use the following criteria when making a medical necessity determination:

- Applicable State and federal guidelines
- Member benefits
- Medical policy and clinical guidelines applicable to Wellpoint
- Physician Specialty Societies where publicly available for peer-reviewed literature, including AHRQ
- Carelon Rx Clinical Criteria
- MCG™ Evidence-Based Clinical Guidelines
- American Society of Addiction (ASAM®)
- Wellpoint policies and procedures

- Wellpoint behavioral health medical necessity criteria, as applicable
- Carelon Clinical Appropriateness Guidelines
- Member characteristics/factors/ circumstances
- Characteristics of the local delivery system that are available for the particular patient
- Decision and screening criteria are designed to assist UM Program associates in assessing the appropriateness of care and length of stay for clinical health situations. Application of criteria is not absolute but based upon the individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems
- Wellpoint applies evidenced-based and consensus-driven criteria for UM screening and decisions in accordance with the member's specific benefit plan. Actively practicing physicians are involved in the development and adoption of the review criteria
- Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the QIC
- The treating physician or provider initiates a pre-service/urgent pre-service request prior to rendering services to the member
- The provider must submit prior authorization requests via electronic portal per West Virginia Code 33-25A-8s
- Wellpoint only collects information necessary to perform utilization review and only requires submission of the section(s) of the medical record necessary for each case reviewed so not to be overly burdensome for the member, provider, or the healthcare delivery organization's staff
- Pre-Review Process: Non-clinical administrative staff gather information and conduct pre-review screening under the guidance and direction of licensed health professionals
- Review of Medical Necessity: Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care)
- The clinician reviewer can approve the requested services after establishing medical necessity. If the clinical information submitted does not allow for an approval decision to be made, the clinician will forward the request to a peer clinical reviewer
- In accordance with 42 CFR §438.210(c) and West Virginia Code § 33-25A-8s, Wellpoint must make authorization decisions and, in the event of an authorization denial, provide written notice to the requesting provider and enrollee as expeditiously as required by the enrollee's health condition, and no later than five (5) business days of receiving the request for service for the purposes of standard authorization decisions.
- In accordance with West Virginia Code § 33-25A-8s, if the information submitted is considered incomplete, Wellpoint must identify all deficiencies, and within two (2) business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the provider. The provider must submit the additional information requested within three (3) business days from the day the return request is received by the provider. Wellpoint must render a decision within two (2) business days after receipt of the additional information submitted by the provider. The total days cannot exceed seven calendar days. If the provider fails to submit additional information a decision is made using the information available
- Wellpoint must make the expedited authorization decision and provide notice to the enrollee as expeditiously as the enrollee's health condition requires, but no later than two (2) business days after receipt of the request for service authorization. This two (2) day business period may be extended up to forty-eight (48) additional hours for expedited preservice authorizations and up to seventy-two (72) hours for expedited concurrent reviews upon request of the enrollee or if Wellpoint justifies to BMS in advance and in writing a need for additional information and that the enrollee will benefit from such extension
- Only a Wellpoint authorized appropriately licensed practitioner can deny a request for services for lack of medical necessity
- The provider may request a peer-to-peer to discuss the care, submit a reconsideration, and/or can appeal the decision
- Wellpoint's peer-to-peer consultation process for denied prior authorization requests is in accordance with West Virginia Code § 33-25A-8s. Wellpoint completes the peer-to-peer appeal process within five (5) business days from the date of the request by a provider for the consultation.

- Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Initial authorization limits vary based on medical necessity review
- Some services require continued review after a predetermined visits (e.g., physical, occupational, and speech therapy, the “soft limit” is 10 visits before authorization is required)
- The Pre-Service Continued Review Process enables the extension of previously approved, ongoing courses of treatment. It follows the same process as described above

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability and these results are analyzed and reported to the UM Committee. Clinicians must obtain a 90% passing score. If reviewers do not pass the IRR exam, an action plan is put into place which includes various interventions which could include additional training, additional IRR scenarios, and mentoring as needed as identified by the manager.
- Utilization Management staff participate in training related to the Mental Health Parity and Equity Act.
- Wellpoint continues to monitor for needed changes and/or additions to benefit design or operations that may impact Mental Health Parity Compliance. If a change is recommended for a prior authorization requirement, Wellpoint is required to complete a Mental Health Parity Application Tool, which is then reviewed and approved by the UM AROW. This tool ensures that Wellpoint examines the change in authorization request to ensure it is in compliance with the Mental Health Parity and Addiction Act.
- Data is pulled quarterly for MH and MS Parity Submissions and submitted to BMS. Data is analyzed and reported to the CSC workgroup to discuss findings, identify disparities and discuss needed action steps as applicable. Data includes authorization data, denial rates, Case Management outcomes, Performance Improvement and Enhancement Measures, Inter-Rater Reliability Scores, among others.
- If a disparity was noted during monitoring of data related to MH/SUD Parity, action would be taken by Wellpoint to make appropriate notifications to BMS. Immediate measures would include, but not be limited to, analysis of the system failure and development of a corrective action plan to remediate any disparities noted. Wellpoint would follow principles that MH/SUD Parity supersedes UM efficiency and ensure care management practices are compliant with our Mental Health Parity Compliance Plan. While the responsible business areas for each affiliated Wellpoint and line of business are responsible for complying with MHPAEA, the Elevance Parity Governance Committee, will also evaluate the adequacy of the assessment process to capture, track, and address risks, gaps, and changes needed to adhere to Elevance policy objectives, and determine whether controls and processes are designed to effectively monitor continued adherence.

5.3 Wellpoint: Medical Necessity Criteria

Medical Necessity Criteria To which benefits is the NQTL assigned?

Category: MH/SUD

Refers to all contractually obligated services

Category: M/S

Refers to all contractually obligated services

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

N/A

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Review of denials/approvals, appeals/overturned appeals, along with authorization volume/cost and the continued presence of appropriate clinical criteria, are done on a semi-annual basis for each service on PA
- Medical necessity criteria based on national guidelines are reviewed annually by the internal medical advisory committee

The Clinical Review Hierarchy is as follows:

- Federal and state mandates
- Member benefits (contract language, including definitions and specific contract provisions/exclusions)
- Wellpoint Medical Policies
- Carelon Clinical Appropriateness Guidelines (diagnostic imaging, sleep diagnostic and treatment management guidelines), and others developed by Carelon Clinical Appropriateness Guidelines are approved for use by MPTAC
- Wellpoint Clinical UM Guidelines
- MCG care guidelines
- American Society of Addiction (ASAM®)
- Carelon Rx Clinical Criteria

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD

- Prior authorization is performed by a registered nurse, LCSW, LICSW, psychologist, or licensed professional counselor (LPC).
- If the registered nurse, LCSW, LICSW, psychologist, or LPC cannot approve the service based on medical necessity criteria review, the case will go to the physician for review.
- Only a Wellpoint authorized, appropriately licensed practitioner can deny a request for services for lack of medical necessity
- PRTF admissions require a mandatory physician review upon admission
- Policies and Procedures reflect this process.

Category: M/S

- Prior authorization is performed by a registered nurse.
- If the registered nurse cannot approve the service based on medical necessity criteria, prior authorization is performed by a registered nurse.
- If the registered nurse cannot approve the service based on medical necessity criteria review, the case will go to the physician for review.
- Only a Wellpoint authorized, appropriately licensed practitioner can deny a request for services for lack of medical necessity.
- Long term acute care hospital (LTAC) admission requires a mandatory physician review.
- Length of stay over 14 days requires a mandatory physician review.
- Policies and procedures reflect this process.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

Medical necessity criteria based on national guidelines and reviewed annually by the internal medical advisory committee

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability, and these results are analyzed and reported to the UM Committee. Clinicians must obtain a 90% passing score. If reviewers do not pass the IRR exam, an action plan is put into place which includes various interventions which could include additional training, additional IRR scenarios, and mentoring as needed as identified by the manager.
- Utilization Management staff participate in training related to the Mental Health Parity and Equity Act.
- Wellpoint continues to monitor for needed changes and/or additions to benefit design or operations that may impact Mental Health Parity Compliance. If a change is recommended for a prior authorization requirement, Wellpoint is required to complete a Mental Health Parity Application Tool, which is then reviewed and approved by the UM AROW. This tool ensures that Wellpoint examines the change in authorization request to ensure it is in compliance with the Mental Health Parity and Addiction Act.

5.4 Wellpoint: Practice Guidelines

Practice Guidelines To which benefits is the NQTL assigned?

Category: MH/SUD

Practice guidelines are available for a variety of behavioral health disorders commonly seen

Category: M/S

Practice guidelines are available for a variety of medical conditions

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- To base care on evidenced-based medical literature and reduce variation in care
- To improve outcomes

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Wellpoint adopts nationally recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of members

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- The guidelines, which Wellpoint uses for quality and disease management programs, are based on reasonable medical evidence. Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the QIC.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Physicians are encouraged to utilize available guidelines

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Guidelines are updated when changes are made in national guidelines, new technology advances are made, and/or changes in recent medical resource

5.5 Wellpoint: Network Size

Network Size To which benefits is the NQTL assigned?

Category: MH/SUD

Wellpoint is obligated to meet required patient-to-provider ratios for all services it is contractually obligated to provide

Category: M/S

Wellpoint is obligated to meet required patient-to-provider ratios for all services it is contractually obligated to provide

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- To develop and maintain an adequate provider/practitioner network capable of meeting the healthcare needs of Wellpoint membership in an accessible way and in accordance with plan contract requirements

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Wellpoint must establish a sufficient number of providers to maintain sufficient access in accordance with BMS's managed care network standards, state regulations, and accreditation standards for all enrollees
- To be included in the network, a provider must meet all credentialing requirements (in accordance with NCQA and state/Wellpoint requirements) and sign a contract agreeing to all Wellpoint policies/regulations and rates

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Wellpoint allows out-of-state providers to join the network if they are located in states bordering WV
- Wellpoint uses the time/distance requirements in the MCO Contract
- If no in-network provider is available to provide the medically appropriate care or the member meets continuity of care criteria, Wellpoint will authorize out-of-network care
- Members may access emergency care in- or out-of-network

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

Wellpoint is required to meet BMS' managed care network standards for all enrollees; exceptions are permitted when travel time to a provider is better than what exists in the community at large

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Annually, Wellpoint reviews the geographic market, network adequacy for specialties; these are reviewed by the health plan, network relations, and modified as needed

6.0 Wellpoint – WVCHIP

6.1 Wellpoint: Prior Authorization, Retrospective Review, and Concurrent Review

Prior Authorization, Concurrent Review, and Retrospective Review – Inpatient To which benefits is the NQTL assigned?

Category: MH/SUD

Only non-emergent inpatient services have PA

Inpatient hospital services include:

- PRTF
- Inpatient psychiatric
- Wellpoint does not require a prior authorization for placement in an Institution for Mental Diseases (IMD) the first 48 hours
- Inpatient detoxification
- Inpatient SUD treatment

Category: M/S

All inpatient services except emergency and obstetrical care including:

- Long-term acute care facility
- Rehabilitation facility admissions
- Inpatient hospice
- Newborn stays beyond federally mandated time frames

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

Inpatient services are assigned PA because:

- PA assures the least restrictive safe environment to promote dignity and function
- These are high-cost services, and PA provides an opportunity to reduce unnecessary costs by preventing overutilization through medical necessity review and facilitating discharge planning
- High variability in length of stay
- Only non-emergent inpatient services have PA

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Evidence of the high cost of inpatient services includes monthly and annual cost and utilization reports
- For these services, high variability in length of stay

The following data sources may be used in utilization monitoring:

- Claims reports
- Member complaints, denials, approvals, and appeals analysis
- Authorization/cost reports
- Audits of appropriate clinical criteria
- HEDIS findings
- Focus studies that evaluate access to care, use of preventative care services, and other services

Wellpoint staff reviewers use the following criteria when making a medical necessity determination:

- Applicable state and federal guidelines
- Member benefits
- Medical policy and clinical guidelines applicable to Wellpoint
- Physician Specialty Societies where publicly available for peer-reviewed literature, including AHRQ
- MCG™ Evidence-Based Clinical Guidelines
- American Society of Addiction (ASAM®)
- Carelon Rx Clinical Criteria
- Wellpoint policies and procedures
- Wellpoint behavioral health medical necessity criteria, as applicable
- Carelon Clinical Appropriateness Guidelines
- Member characteristics/factors/ circumstances
- Characteristics of the local delivery system that are available for the particular patient

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Prior authorization must be obtained prior to admission, except in the case of emergencies, when notification is required within 24 hours of admission. UM staff will request clinical information from the hospital on the same day they are notified of the member's admission
- All inpatient and residential services regardless of BH/Physical Health (PH) designation must be made via electronic portal per West Virginia Code 33-25A-8s
- Decision and screening criteria are designed to assist UM Program associates in assessing the appropriateness of care and length of stay for clinical health situations. Application of criteria is not absolute but based upon the individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems
- Wellpoint applies evidenced-based and consensus-driven criteria for UM screening and decisions in accordance with the member's specific benefit plan. Actively practicing physicians are involved in the development and adoption of the review criteria
- Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the QIC
- In accordance with 42 CFR §438.210(c) and West Virginia Code § 33-25A-8s, Wellpoint must make authorization decisions and, in the event of an authorization denial, provide written notice to the requesting provider and enrollee as expeditiously as required by the enrollee's health condition, and no later than five (5) business days of receiving the request for service for the purposes of standard authorization decisions
- In accordance with West Virginia Code § 33-25A-8s, if the information submitted is considered incomplete, Wellpoint must identify all deficiencies, and within two (2) business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the provider. The provider must provide the additional information requested within three (3) business days from the day the return request is received by the provider. Wellpoint must render a decision within two (2) business days after receipt of the additional information submitted by the provider. The total days cannot exceed seven calendar days. If the provider fails to submit additional information, a decision is made using the information available
- Wellpoint must make the expedited authorization decision and provide notice to the enrollee as expeditiously as the enrollee's health condition requires but no later than two (2) business days after receipt of the request for service authorization. This two (2) day business period may be extended up to forty-eight (48) additional hours for expedited preservice authorizations and up to seventy-two (72) hours for expedited concurrent reviews upon request of the enrollee or if Wellpoint justifies to BMS in advance and in writing a need for additional information and that the enrollee will benefit from such extension

- For Emergency Stabilization and Post-Stabilization, the emergency department's treating physician determines the services needed to stabilize the member's emergency medical condition. After the member is stabilized, the emergency department's physician must contact the member's PCP for authorization of further services. The member's PCP is noted on the identification (ID) card. If the PCP does not respond within one hour, all necessary services will be considered authorized
- Non-clinical administrative staff gathers information and conducts pre-review screening under the guidance and direction of licensed health professionals
- Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care)
- The clinician reviewer can approve the requested services after establishing medical necessity. If the clinical information submitted does not allow an approval decision to be made, the reviewer will forward the request to a peer clinical reviewer
- Only a Wellpoint-authorized, appropriately licensed practitioner can deny a request for services for lack of medical necessity
- The provider may request a peer-to-peer to discuss the care, submit a reconsideration, and/or can appeal the decision
- Wellpoint's peer-to-peer consultation process for denied prior authorization requests is in accordance with West Virginia Code § 33-25A-8s. Wellpoint completes the peer-to-peer appeal process within five (5) business days from the date of the request by a provider for the consultation
- Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement
- Per the Post-Service Clinical Claims Review policy, provider can submit clinical information with the claim if it has been more than three business days since discharge but the provider believes there is an administrative exception.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Initial authorization limits vary based on medical necessity review
- The duration of initial authorizations for acute inpatient care vary based on medical necessity review

When a member's hospital stay is expected to exceed the number of days authorized during pre-service review, or when the inpatient stay did not have pre-service review, the hospital must contact Wellpoint for continued stay review. Wellpoint requires clinical reviews on all members admitted as inpatients to:

- Acute care hospitals
- Intermediate facilities
- Inpatient rehabilitation facilities

The decision to approve, deny or modify post-service requests is made within 30 calendar days of PSCCR receipt of request. If the decision is a denial or modification, the provider is also notified electronically or in writing within 30 days of the receipt of the request

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability. These results are analyzed and reported to the UM Committee. Reviewers must score 90% or above. If reviewers do not pass the IRR exam, an action plan is put into place which includes various interventions which could include additional training, additional IRR scenarios, and mentoring as needed as identified by the Manager.
- Utilization Management staff participate in training related to the Mental Health Parity and Equity Act.
- Wellpoint continues to monitor for needed changes and/or additions to benefit design or operations that may impact Mental Health Parity Compliance. If a change is recommended for a Prior Authorization requirement, Wellpoint is required to complete a Mental Health Parity Application Tool, which is then

reviewed and approved by the UM AROW. This tool ensures that Wellpoint examines the change in authorization request to ensure it is in compliance with the Mental Health Parity and Addiction Act.

- Data is pulled quarterly for MH and MS Parity Submissions and submitted to BMS. Data is analyzed and reported to the CSC workgroup to discuss findings, identify disparities and discuss needed action steps as applicable. Data includes authorization data, denial rates, Case Management outcomes, Performance Improvement and Enhancement Measures, Inter-Rater Reliability Scores, among others.
- If a disparity was noted during monitoring of data related to MH/SUD Parity, action would be taken by Wellpoint to make appropriate notifications to BMS. Immediate measures would include, but not be limited to, analysis of the system failure and development of a corrective action plan to remediate any disparities noted. Wellpoint would follow principles that MH/SUD Parity supersedes UM efficiency and ensure care management practices are compliant with our Mental Health Parity Compliance Plan. While the responsible business areas for each affiliated Wellpoint and line of business are responsible for complying with MHPAEA, the Elevance Parity Governance Committee, will also evaluate the adequacy of the assessment process to capture, track, and address risks, gaps, and changes needed to adhere to Elevance policy objectives, and determine whether controls and processes are designed to effectively monitor continued adherence.

6.2 Wellpoint: Outpatient Prior Authorization

Outpatient Prior Authorization To which benefits is the NQTL assigned?

Category: MH/SUD

- Partial Hospitalization Program
- Intensive Outpatient Services
- Psychology and Neuropsychology Testing
- Community Psychiatric Supportive Treatment, after first three days of treatment
- Out-of-network services
- Transcranial magnetic stimulation (TMS)

Category: M/S

- Advanced radiology services, CT, MRI, PET scan
- All out-of-network services
- DME
- Genetic testing
- Home health care services, including hospice care
- Drug screenings

Select outpatient surgeries/procedures including:

- Hysterectomy
- Bariatric surgery
- Spinal procedures
- Potentially cosmetic or investigational procedures

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Because of their potential for overutilization
- For patient safety (i.e., bariatric surgery)
- To control costs
- To avoid waste and abuse of Medicaid funds
- To ensure services are meeting their objectives

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

Evidence of the utilization of outpatient services includes monthly and annual cost and utilization reports

- In Wellpoint's experience, psychological and neuropsychological testing, IOP, and CSU are frequently ordered inappropriately
- In Wellpoint's experience, hysterectomy, DME, advanced radiology, nuclear cardiology, and septoplasty are frequently ordered inappropriately
- For advanced radiology services (CT, CTA, MRI, PET), medical research shows patient risks from exposure to radiation and contrast media
- For spinal injections, medical research shows that spinal injections are frequently used for patients without the appropriate indications and/or for patients for whom they present a serious risk

The following data sources may be used in utilization monitoring:

- Claims reports
- Member complaints and appeals analysis
- HEDIS findings
- Focus studies that evaluate access to care, use of preventative care services, and other services

Medical necessity is based on evidence- based national guidelines and reviewed annually by the internal medical advisory committee

For patient safety, nationally recognized, evidence-based standards of care and practice from sources including:

- NCQA
- American Psychiatric Association
- ASAM® Treatment
- National Alliance on Mental Illness
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- American Board of Medical Specialties. Specialty and Subspecialty Certificates physician specialty societies
- AHRQ
- National Comprehensive Cancer Network®. NCCN Drugs & Biologic Compendium
- Cumulative professional expertise and experience

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

Wellpoint staff reviewers use the following criteria when making a medical necessity determination:

- Applicable state and federal guidelines
- Member benefits
- Medical policy and clinical guidelines applicable to Wellpoint
- Physician Specialty Societies where publicly available for peer-reviewed literature, including AHRQ
- Carelon Rx Clinical Criteria
- MCG™ Evidence-Based Clinical Guidelines
- American Society of Addiction (ASAM®)
- Wellpoint policies and procedures
- Wellpoint behavioral health medical necessity criteria, as applicable

- Carelon Clinical Appropriateness Guidelines
- Member characteristics/factors/ circumstances
- Characteristics of the local delivery system that are available for the particular patient
- Decision and screening criteria are designed to assist UM Program associates in assessing the appropriateness of care and length of stay for clinical health situations. Application of criteria is not absolute but based upon the individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems
- Wellpoint applies evidenced-based and consensus-driven criteria for UM screening and decisions in accordance with the member's specific benefit plan. Actively practicing physicians are involved in the development and adoption of the review criteria
- Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the QIC
- The treating physician or provider initiates a pre-service/urgent pre-service request prior to rendering services to the member
- The provider must submit prior authorization requests via electronic portal per West Virginia Code 33-25A-8s
- Wellpoint only collects information necessary to perform utilization review and only requires submission of the section(s) of the medical record necessary for each case reviewed so not to be overly burdensome for the member, provider, or the healthcare delivery organization's staff
- Pre-Review Process: Non-clinical administrative staff gather information and conduct pre-review screening under the guidance and direction of licensed health professionals
- Review of Medical Necessity: Clinicians make decisions that require medical clinical judgment (e.g., assessing if a member's reported condition meets medical necessity criteria for treatment and determining the appropriate level and intensity of care)
- The clinician reviewer can approve the requested services after establishing medical necessity. If the clinical information submitted does not allow for an approval decision to be made, the clinician will forward the request to a peer clinical reviewer
- In accordance with 42 CFR §438.210(c) and West Virginia Code § 33-25A-8s, Wellpoint must make authorization decisions and, in the event of an authorization denial, provide written notice to the requesting provider and enrollee as expeditiously as required by the enrollee's health condition and no later than five (5) business days of receiving the request for service for the purposes of standard authorization decisions.
- In accordance with West Virginia Code § 33-25A-8s, if the information submitted is considered incomplete, Wellpoint must identify all deficiencies, and within two (2) business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the provider. The provider must submit the additional information requested within three (3) business days from the day the return request is received by the provider. Wellpoint must render a decision within two (2) business days after receipt of the additional information submitted by the provider. The total days cannot exceed seven calendar days. If the provider fails to submit additional information a decision is made using the information available
- Wellpoint must make the expedited authorization decision and provide notice to the enrollee as expeditiously as the enrollee's health condition requires but no later than two (2) business days after receipt of the request for service authorization. This two (2) day business period may be extended up to forty-eight (48) additional hours for expedited preservice authorizations and up to seventy-two (72) hours for expedited concurrent reviews upon request of the enrollee or if Wellpoint justifies to BMS in advance and in writing a need for additional information and that the enrollee will benefit from such extension
- Only a Wellpoint authorized appropriately licensed practitioner can deny a request for services for lack of medical necessity
- The provider may request a peer-to-peer to discuss the care, submit a reconsideration, and/or can appeal the decision
- Wellpoint's peer-to-peer consultation process for denied prior authorization requests is in accordance with West Virginia Code § 33-25A-8s. Wellpoint completes the peer-to-peer appeal process within five (5) business days from the date of the request by a provider for the consultation.
- Except in an emergency, failure to obtain prior authorization may result in a denial for reimbursement

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Initial authorization limits vary based on medical necessity review.
- Some services require continued review after a predetermined visits (e.g., physical, occupational, and speech therapy; the “soft limit” is 10 visits before authorization is required).
- The Pre-Service Continued Review Process enables the extension of previously approved, ongoing courses of treatment. It follows the same process as described above.

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability, and these results are analyzed and reported to the UM Committee. Clinicians must obtain a 90% passing score. If reviewers do not pass the IRR exam, an action plan is put into place which includes various interventions which could include additional training, additional IRR scenarios, and mentoring as needed as identified by the manager.
- Utilization Management staff participate in training related to the Mental Health Parity and Equity Act.
- Wellpoint continues to monitor for needed changes and/or additions to benefit design or operations that may impact Mental Health Parity Compliance. If a change is recommended for a prior authorization requirement, Wellpoint is required to complete a Mental Health Parity Application Tool, which is then reviewed and approved by the UM AROW. This tool ensures that Wellpoint examines the change in authorization request to ensure it is in compliance with the Mental Health Parity and Addiction Act.
- Data is pulled quarterly for MH and MS Parity Submissions and submitted to BMS. Data is analyzed and reported to the CSC workgroup to discuss findings, identify disparities, and discuss needed action steps as applicable. Data includes authorization data, denial rates, Case Management outcomes, Performance Improvement and Enhancement Measures, Inter-Rater Reliability Scores, among others.
- If a disparity was noted during monitoring of data related to MH/SUD Parity, action would be taken by Wellpoint to make appropriate notifications to BMS. Immediate measures would include, but not be limited to, analysis of the system failure and development of a corrective action plan to remediate any disparities noted. Wellpoint would follow principles that MH/SUD Parity supersedes UM efficiency and ensure care management practices are compliant with our Mental Health Parity Compliance Plan. While the responsible business areas for each affiliated Wellpoint and line of business are responsible for complying with MHPAEA, the Elevance Parity Governance Committee will also evaluate the adequacy of the assessment process to capture, track, and address risks, gaps, and changes needed to adhere to Elevance policy objectives and determine whether controls and processes are designed to effectively monitor continued adherence.

6.3 Wellpoint: Medical Necessity Criteria

Medical Necessity Criteria To which benefits is the NQTL assigned?

Category: MH/SUD

Refers to all contractually obligated services

Category: M/S

Refers to all contractually obligated services

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

N/A

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Review of denials/approvals, appeals/overturned appeals, along with authorization volume/cost and the continued presence of appropriate clinical criteria, are done on a semi-annual basis for each service on PA
- Medical necessity criteria based on national guidelines are reviewed annually by the internal medical advisory committee

The Clinical Review Hierarchy is as follows:

- Federal and state mandates
- Member benefits (contract language, including definitions and specific contract provisions/exclusions)
- Wellpoint Medical Policies
- Carelon Clinical Appropriateness Guidelines (diagnostic imaging, sleep diagnostic and treatment management guidelines), and others developed by Carelon Clinical Appropriateness Guidelines are approved for use by MPTAC
- Wellpoint Clinical UM Guidelines
- MCG care guidelines
- American Society of Addiction (ASAM®)
- Carelon Rx Clinical Criteria

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD

- Prior authorization is performed by a registered nurse, LCSW, LICSW, Psychologist, or LPC.
- If the registered nurse, LCSW, LICSW, psychologist, or LPC cannot approve the service based on medical necessity criteria review, the case will go to the physician for review.
- Only a Wellpoint authorized, appropriately licensed practitioner can deny a request for services for lack of medical necessity
- PRTF admissions require a mandatory physician review upon admission
- Policies and procedures reflect this process.

Category: M/S

- Prior authorization is performed by a registered nurse.
- If the registered nurse cannot approve the service based on medical necessity criteria, prior authorization is performed by a registered nurse.
- If the registered nurse cannot approve the service based on medical necessity criteria review, the case will go to the physician for review.
- Only a Wellpoint authorized, appropriately licensed practitioner can deny a request for services for lack of medical necessity
- LTAC admission requires a mandatory physician review.
- Length of stay over 14 days requires a mandatory physician review.
- Policies and procedures reflect this process.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Medical necessity criteria based on national guidelines and reviewed annually by the internal medical advisory committee

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- The clinician reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability, and these results are analyzed and reported to the UM Committee. Clinicians must obtain a 90% passing score. If reviewers do not pass the IRR exam, an action plan is put into place which includes various interventions which could include additional training, additional IRR scenarios, and mentoring as needed as identified by the manager.
- Utilization Management staff participate in training related to the Mental Health Parity and Equity Act.
- Wellpoint continues to monitor for needed changes and/or additions to benefit design or operations that may impact Mental Health Parity Compliance. If a change is recommended for a prior authorization requirement, Wellpoint is required to complete a Mental Health Parity Application Tool, which is then reviewed and approved by the UM AROW. This tool ensures that Wellpoint examines the change in authorization request to ensure it is in compliance with the Mental Health Parity and Addiction Act.

6.4 Wellpoint: Practice Guidelines

Practice Guidelines To which benefits is the NQTL assigned?

Category: MH/SUD

Practice guidelines are available for a variety of behavioral health disorders commonly seen

Category: M/S

Practice guidelines are available for a variety of medical conditions

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- To base care on evidence-based medical literature and reduce variation in care
- To improve outcomes

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Wellpoint adopts nationally recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of members

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- The guidelines, which Wellpoint uses for quality and disease management programs, are based on reasonable medical evidence. Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the MPTAC and the QIC.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Physicians are encouraged to utilize available guidelines

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Guidelines are updated when changes are made in national guidelines, new technology advances are made, and/or changes in recent medical resource

6.5 Wellpoint: Network Size

Network Size To which benefits is the NQTL assigned?

Category: MH/SUD

Wellpoint is obligated to meet required patient-to-provider ratios for all services it is contractually obligated to provide

Category: M/S

Wellpoint is obligated to meet required patient-to-provider ratios for all services it is contractually obligated to provide

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- To develop and maintain an adequate provider/practitioner network capable of meeting the healthcare needs of Wellpoint membership in an accessible way and in accordance with plan contract requirements

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Wellpoint must establish a sufficient number of providers to maintain sufficient access in accordance with BMS's managed care network standards, state regulations, accreditation standards for all enrollees
- To be included in the network, a provider must meet all credentialing requirements (in accordance with NCQA and state/Wellpoint requirements) and sign a contract agreeing to all Wellpoint policies/regulations and rates

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Wellpoint allows out-of-state providers to join the network if they are located in states bordering WV
- Wellpoint uses the time/distance requirements in the MCO Contract
- If no in-network provider is available to provide the medically appropriate care or the member meets continuity of care criteria, Wellpoint will authorize out-of-network care
- Members may access emergency care in- or out-of-network

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Wellpoint is required to meet BMS' managed care network standards for all enrollees; exceptions are permitted when travel time to a provider is better than what exists in the community at large

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The following statements apply to both MH/SUD and M/S.

- Annually, Wellpoint reviews the geographic market, network adequacy for specialties; these are reviewed by the health plan, network relations, and modified as needed

7.0 Pharmacy

7.1 Pharmacy: Prior Authorization (PA)

Prior Authorization (PA) To which benefits is the NQTL assigned?

Category: MH/SUD

All non-preferred drugs or drugs requiring a PA that are in therapeutic classes not included on the preferred drug list (PDL)

All antipsychotic agents require prior authorization for members under 18, with requests for children 6 and under reviewed by a consultant psychiatrist

Category: M/S

All non-preferred drugs or drugs requiring a PA that are in therapeutic classes not included on the PDL

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- The two primary objectives of Drug Utilization Review (DUR) systems are to improve quality of care and assist in containing costs
- The DUR program ensures prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Specific PA criteria are based on review of:

- The most current clinical information available from clinical guidelines and peer reviewed studies.
- Food and Drug Administration (FDA)-approved indications
- Manufacturers' recommendations

The above criteria are reviewed by the Medicaid Utilization Review (DUR) Board and recommended to the Bureau for Medical Services (BMS)

The potential of chronic side effects from antipsychotics (metabolic syndrome, tardive dyskinesia, etc.) in addition to historical issues with polypharmacy in this category led to additional antipsychotic agent review

Substantial utilization of these medications was noted in the foster care population, which is routinely subject to closer utilization review given its heightened vulnerability

These medications are frequently prescribed to children on an off label basis. BMS recognizes that clinical conditions for which antipsychotics are not indicated could nevertheless require multiple medications to address presenting symptoms. Given this complexity, BMS sought to ensure that specialist oversight was in place for children.

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- The PA process requires non-preferred drugs meet specified criteria to be reimbursed by BMS
- PA requests may be made by telephone, fax, or mail
- Clinical pharmacists employed by the PA vendor have discretion for approval and usually obtain more clinical information from the prescriber
- A three-day emergency supply of prior-authorized drugs can be dispensed by a pharmacy until authorization is completed
- If PA is needed and not obtained, or PA is not approved, the prescription is not filled for the member
- Prior authorization decisions are made within 24 hours and appeals of denied prior authorizations are processed within three business days of receipt. In emergent situations, a 72-hour supply of medication is made available to members while the prior authorization process is completed

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- PA for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance
- Trial criteria, PA criteria, and duration of PA are determined by the DUR Board with clinical recommendations provided by a vendor
- PA is used in cases when a patient is treatment naïve, but a non-preferred psychiatric medication was chosen with no clinical rationale as to why a formulary option cannot be used
- PA may be applied when a medication is prescribed for a non-FDA-indicated use that does not have clinical data supporting its usage or if the dosing is outside of the FDA-recommended dose

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- MH/SUD members do not have their MH/SUD medications transitioned to PDL medications if they are well controlled on the current regimen
- Greater percentage of PAs are granted for MH/SUD medications

7.2 Pharmacy: Use of a PDL

Use of a PDL To which benefits is the NQTL assigned?

Category: MH/SUD

- The PDL only addresses certain drug classes
- Some classes of drugs will not be reviewed for preferential agents because of no or limited cost savings
- Drugs that have historically been covered by Medicaid and are not listed on the PDL will continue to be covered

Category: M/S

- The PDL only addresses certain drug classes
- Some drug classes will not be reviewed for preferential agents because of no or limited cost savings
- Drugs that have historically been covered by Medicaid and are not listed on the PDL will continue to be covered

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- Drugs are designated as “preferred” for their clinical significance and overall cost efficiencies
- Rebate negotiations and net cost considerations are applied after clinical equivalence is established, consistent with WV Medicaid PDL development practices

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- The State Medicaid program Pharmaceutical and Therapeutics (P&T) Committee is committed to:
    - Objectively recommending drugs for inclusion on the WV that are effective and cost efficient, while providing maximum safety—the Institute for Clinical and Economic (ICER) recommendations are researched
    - Examining the scientific literature (found in labeling, drug compendia, and peer-reviewed clinical literature) for sound clinical evidence that supports selecting specific drugs to be included on the PDL
    - Helping to ensure the PDL provides medically appropriate drug therapies for use in the general Medicaid population, allowing healthcare providers to care for the majority of their patients without a PA request
- A vendor provides clinical monographs to validate equal therapeutic effectiveness of drugs in the class and solicits rebates for drugs that are to be preferred

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- Each drug is reviewed on its clinical merits relative to other medications in the same therapeutic class
- Published, peer-reviewed clinical trials are the primary source of information used by the State's PDL vendor for this review
- Data regarding efficacy, effectiveness, adverse effects, and tolerability is analyzed and compared to other drugs within the therapeutic class
- From this analysis, the clinical staff determines an agent's superiority, equivalency, or inferiority relative to the comparator drugs
- After the clinical review, a financial analysis is performed; this analysis incorporates utilization data from the State as well as net drug costs from the manufacturers
- With this data, the financial staff determines the fiscal impact of the PDL status (preferred or non-preferred) of each medication
- Incorporating all this information, the PDL vendor makes suggestions to the State's Medicaid P&T Committee regarding the PDL status of each medication
- After reviewing and discussing these suggestions, the P&T Committee makes recommendations to BMS for final decisions
- The DUR Board then recommends PA criteria to the State
- Some classes are eliminated when there are no longer savings in the class
- The P&T Committee meets three times per year, and as necessary, to review the PDL and new drugs as they become available
- New drugs introduced into the marketplace in therapeutic classes that have been reviewed will be considered non-preferred until the annual review of the particular therapeutic class
- Exceptions to this policy will be made for drugs that the U.S. FDA has given priority status

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- The trial criteria and exceptions for a PDL drug are established based on clinical evidence and the recommendations of the BMS Department of Pharmacy Services, which are reviewed and approved by the WV DUR Board
- Therapeutic classes are reviewed, at a minimum, annually; classes could be reviewed more often if new drugs are introduced to the class
- The PDL is reviewed in total annually and updated quarterly
- If a therapeutic class has been reviewed by the P&T Committee, and the secretary of DHHR has approved the recommended drugs in that category, new chemical entities must be listed in First Data Bank (FDB) for six months prior to the next scheduled P&T Committee meeting to be eligible for review
- Until that time, the new drug will be non-preferred and available via the PA process; in addition, the new drug will not be listed on the PDL until officially reviewed

If a new drug is considered unique and has been classified as a priority drug by the FDA, the BMS and the P&T chair may, based on clinical judgment, exempt the drug from the six-month rule

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- Compliance rates with the PDL for MH/SUD and M/S are consistently >90% and higher for both M/S and MH/SUD. M/S consistently has higher compliance rates because new members do not have their MH/SUD medications transitioned to PDL medications if they are well controlled on the current regimen

7.3 Pharmacy: Prospective Review

Prospective Review To which benefits is the NQTL assigned?

Category: MH/SUD

All prescriptions

Category: M/S

All prescriptions

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- The two primary objectives of DUR systems are to improve quality of care and assist in containing costs
- The DUR program assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes
- Prescription claims are screened to identify potential drug therapy problems of the following types:
    - Therapeutic duplication
    - Ingredient duplication
    - Adverse drug-drug interactions
    - Early refill
    - Late refill
    - High dosage
    - Low dosage
    - Incorrect duration of drug treatment
    - Age/gender precaution
    - Pregnancy precaution
    - Breast-feeding precaution

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- The DUR Board and BMS DUR pharmacists review the criteria regularly using surveys of current peer-reviewed literature and recommendations from FDB (creator of edits), DrugDex, MicroMedex, and the American Hospital Formulary Drug Service
- Lexicomp and UpToDate are clinical subscription services to which pharmacists have access and regularly use during the course of their work

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- Due to the 2017 pharmacy carve-out, processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing
- Pharmacists filling the prescriptions, clinical pharmacists at RDTP, and the DUR pharmacist at BMS are responsible for applying the policies
- Claims denied for early refills, therapeutic duplications, ingredient duplications, or inappropriate dosages; or require additional review if they are flagged for these edits
- Clinical personnel have discretion to make exceptions to the policy depending on the clinical information provided by the prescriber
- Prescribers may appeal to the BMS medical director who works in conjunction with the BMS DUR pharmacist

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing
- Prescribers may appeal to the BMS medical director who works in conjunction with the BMS DUR pharmacist
- Edit thresholds (e.g., dose limits, interaction severity) are standardized and not condition-specific

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- Required by federal regulation
- Patient safety

7.4 Pharmacy: Retrospective Review

Retrospective Review To which benefits is the NQTL assigned?

Category: MH/SUD

DUR votes on types of reviews based on issues identified during surveys of enrollee medications

Category: M/S

DUR votes on types of reviews based on issues identified during surveys of enrollee medications

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- The reason for retrospective is for patient safety
- Enrollee medications are checked for interactions, contraindications, appropriate drug/dose for age range, appropriate dosing, and drug duplication
- “Grandfathered” behavioral drugs, narrow therapeutic windows (difference between harm and benefit small)

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- Diagnoses are not always known when enrollee picks up medication, and there might be contraindications
- Surveys of enrollee medications identify a particular issue (e.g., a patient not treating a chronic condition during a public health emergency)

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- DUR committee reviews certain medications
- Coding edit will not catch the diagnosis
- Look at compliance retrospectively
- Send message to provider
- Performed once a month
- The system is built over time, reviewing claims and diagnoses, internal rating systems, and additional encounter data
- Performed by Marshall University

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- Retrospective reviews are used only to improve clinical benefits (identify contraindications with diagnoses or other medications)
- Behavioral health is difficult to treat, so no changes are recommended unless patient safety is an issue; the same is true for medications for rheumatoid arthritis and anticonvulsants

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

Surveys identify potential issues or conditions that should be reviewed

7.5 Pharmacy: Lock-In Program

Lock-In Program To which benefits is the NQTL assigned?

Category: MH/SUD

- As determined by the Retrospective DUR (RDUR) Committee through review of member drug utilization profiles:
    - Members who may be at risk for adverse effects due to the potential overutilization of controlled substances
    - Members who use pharmacy services excessively or inappropriately

Category: M/S

- As determined by the RDUR Committee through review of member drug utilization profiles:
    - Members who may be at risk for adverse effects due to the potential overutilization of controlled substances
    - Members who use pharmacy services excessively or inappropriately

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- Patient safety, prevention of drug diversion, and cost containment

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- Criteria for lock-in are reviewed and approved by the DUR Board and the RDUR Committee, which meets monthly
- WV Safe & Effective Management of Pain Guidelines (SEMP) 2021

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- The RDUR Committee, composed of practicing healthcare professionals, meets monthly to review members' prescription and medical profiles that have been identified for drug utilization issues
- The State Medicaid program contracts with Health Information Design (HID) to conduct the initial reviews and referrals for the committee
- A series of warning letters is sent to the physician and the patient stating that continued overutilization of controlled substances might result in the member being restricted to a single pharmacy provider
- If the lock-in criteria are met, and the prescribing pattern does not change related to the warning letters, the member is asked to select a single pharmacy for future controlled substance prescriptions
- The chosen pharmacy’s participation is voluntary; the pharmacists at these locations are asked to use their professional judgment when filling controlled substances for the member

At the end of the 12-month period, the RDUR Committee reviews the member’s prescription profile to determine if the lock-in should be continued for another 12-month period

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- On a monthly basis, the RDUR Committee reviews member profiles that have been selected because of therapeutic criteria exceptions, including potential overutilization of controlled substances
- A prescriber can request an override for a lock-in to ensure patient access to treatment

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- The lock-in program is designed for patient safety, prevention of drug diversion, and cost containment—and it can be overridden to ensure patient access to treatment

7.6 Pharmacy: Suboxone: Limitation in Maintenance Dose

Suboxone: Limitation in Maintenance Dose To which benefits is the NQTL assigned?

Category: MH/SUD

- All MH/SUD medications have dose optimization standards and not-to-exceed dosages

Category: M/S

- All M/S medications have dose optimization standards and not-to-exceed dosages
- PA required to exceed maximum dose
- Medications exceeding the FDA- recommended dosage need medical director approval

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- All medications are reviewed for quality of patient care/safety and cost savings
- The lowest dose that provides the therapeutic effect is recommended to minimize side effects

MH/SUD

Buprenorphine with naloxone reduces misuse and diversion, and has been found to be safe for pregnant women and their neonates.[5]

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

M/S and MH/SUD

- Scientific literature, including in labeling, drug compendia, and peer-reviewed clinical literature
- The lowest therapeutic dose is the goal for both MH/SUD and M/S medications for several reasons: 1) lower risk of side effects, especially long-term side effects, and 2) by not treating the patient with the maximum dose, the prescriber can reserve higher doses during times of stress (e.g., M/S migraine medications for increased headaches; MH/SUD suboxone for stressful times of substance use disorder triggers)

MH/SUD

Suboxone

- FDA package insert indicates the recommended target maintenance dosage of suboxone is 16 mg/day
- Maintenance doses higher than 24mg have not been demonstrated to provide any clinical advantage

[5] Lofwall Michelle R. and Sharon L. Walsh. September/October 2015. "A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences From Around the World." *Journal of Addiction Medicine* 8(5): 315 – 326. Accessed April 11, 2023. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4177012/

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

- The claims processing system applies DUR edits to pharmacy claims as they are processing to check for safety, therapeutic dose, interactions, and contraindications
- Claims might be denied for early refills, therapeutic duplications, ingredient duplications, or inappropriate dosages; claims require additional review if they are flagged for these edits
- Clinical personnel have discretion to make exceptions to the policy depending on the clinical information provided by the prescriber
- Prescribers may appeal to the BMS medical director who works in conjunction with the BMS DUR pharmacist

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- All medications are reviewed for safety, interactions, and contraindications
- Formulary options are encouraged
- Excursions above 16 mg/day and back to a maximum of 24 mg/day of suboxone are allowed at the discretion of the medical director
- In 2025, 1,471 override requests were submitted, of which 401 members were approved for doses exceeding 16 mg/day

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- Prescriber can appeal a denial
- The medical literature does not support maintenance doses of 24 mg/day or higher
- Lowest therapeutic dose is supported by the literature—16 mg/day is the target dose

7.7 Pharmacy: Tobacco Cessation: Coaching Program; 12-Week Limit; Lapse in Treatment

Tobacco Cessation: Coaching Program; 12-Week Limit; Lapse in Treatment To which benefits is the NQTL assigned?

Category: MH/SUD

- Tobacco cessation agents

Category: M/S

- No direct M/S comparison, although all M/S medications have dosage optimization standards

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

- A coaching program is required to provide support and structure to the tobacco cessation attempt
- Requiring an appeal for repeated attempts prevents beneficiaries from sustained periods of tobacco cessation product use without a plan to quit

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

- Medical research supports the combination of support and cessation agents
- CDC recommends support through a quit-line
- The 12-week limit is to ensure patient commitment—tobacco cessation agents are ineffective for continuous usage; repeated attempts allowed

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and Requirements)

Category: MH/SUD and M/S

- Beneficiaries first sign up for a quit-line program
- Tobacco cessation services more than 12 weeks, or in the case of a greater than a five-day lapse in treatment, require a written appeal with documentation of efficacy and patient compliance

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

- Generally, beneficiaries are required to sign up for an approved phone coaching program; however, if a beneficiary is being discharged from the hospital, or there is other sense of urgency, beneficiaries are permitted to receive agents prior to signing up for the quit-line
- Initial approval is for 12 weeks, and additional therapy may be approved

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

- Tobacco cessation program limits are in place to encourage success, and beneficiaries are permitted multiple attempts

7.8 Pharmacy: Step Therapy/Fail First

Step Therapy/Fail First To which benefits is the NQTL assigned?

Category: MH/SUD

All drugs in drug classes subject to PDL step therapy requirements where proof of prior treatment failure is required as a precondition for PA, including:

1. Antidepressants (SSRIs, SNRIs, atypicals): trial and failure of preferred agents required before non-preferred approval
2. Atypical antipsychotics: two-preferred-agent failure required for non-preferred approval
3. Vraylar (cariprazine) for MDD: failure of two preferred antidepressants required (cross-class)
4. Opiate Dependence Treatments (buprenorphine products): PA criteria require clinical documentation
5. SNRIs and second-generation non-SSRI antidepressants, and non-preferred agents require separate 30-day trials of both a preferred agent in that subclass and an SSRI before approval
6. Non-preferred atypical antipsychotics require 30-day trials of two preferred agents
7. Vraylar (cariprazine) requires a 30-day trial and failure of two preferred antidepressants for the MDD indication

Category: M/S

All drugs in M/S drug classes subject to PDL step therapy requirements where prior treatment failure is documented, including:

1. Analgesics, Narcotic Long-Acting: failure of three chemically distinct preferred agents required
2. Analgesics, Narcotic Short-Acting: failure of four chemically distinct preferred agents required
3. Angiotensin Modulators: failure of preferred agent(s) in subclass required (14-day trials)
4. Antibiotics (inhaled): 28-day trial and documented therapeutic failure of preferred agent required
5. Anticoagulants: trial of preferred agent in subclass required
6. Cytokine/CAM Antagonists (biologics): clinical PA criteria; prior DMARD or conventional therapy failure often required

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

Fail-first requirements serve the same dual objectives as step therapy:

(1) Ensuring that patients receive clinically established, cost-effective first-line treatments before escalating to higher-cost alternatives

(2) Cost containment through formulary discipline. The same policy rationale is applied across all drug classes without regard to whether the indication is MH/SUD or M/S

Step therapy protocols are based on clinical guidelines and comparative effectiveness rather than diagnosis type

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

WV BMS PDL Q2 v3 (Effective 4/1/2026); FDA labeling; peer-reviewed clinical literature; drug compendia; clinical practice guidelines

Criteria developed by DUR Board and BMS Department of Pharmacy Services; reviewed and approved by WV P&T Committee (meets three times per year)

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

PA requests may be made by telephone, fax, or electronic request

A three-day emergency supply may be dispensed

Documentation of prior treatment failure must be provided by the prescriber

Clinical pharmacists review documentation and may obtain supplemental clinical information

Prescribers may appeal to the BMS medical director working with the BMS DUR pharmacist

Trial durations and number of required failures vary by drug class based on clinical evidence and safety considerations

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

Fail-first requirements are applied at comparable rates of stringency across MH/SUD and M/S drug classes, as documented by PA approval data

In some cases, M/S drug classes impose more fail-first steps than MH/SUD classes (e.g., four-agent failure required for short-acting narcotics vs. two-agent failure for non-preferred antipsychotics)

Patients are not asked to switch to a preferred MH/SUD therapy upon becoming a member or in the event of a PDL change if the patients are well maintained on their current MH/SUD regimen

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The number of required prior failures and trial duration are calibrated to the clinical evidence base for each drug class

M/S analgesic classes require more prior failures than MH/SUD classes due to the breadth of available preferred alternatives and the acute safety risks associated with escalating opioid dosing

For MH/SUD, the legacy “grandfathering” provisions and shorter required trial durations reflect clinical evidence that psychiatric medication transitions carry higher discontinuation risk

7.9 Pharmacy: PA Requirement Attention-Deficit/Hyperactivity Disorder (ADHD)/Attention-Deficit Disorder (ADD)

PA Requirement Attention-Deficit/Hyperactivity Disorder (ADHD)/Attention-Deficit Disorder (ADD) To which benefits is the NQTL assigned?

Category: MH/SUD

All ADHD and ADD medications on formulary

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

The NQTL was applied to this category to ensure patients were evaluated in person by a physician initially and on an annual basis to assess the need for drug therapy and monitor non-medication treatment alternatives, comorbid disorders, dosage titration, adverse effects, and drug diversion and misuse. It is also to ensure the patient’s age is within the FDA-approved age range for the prescribed medication and the diagnosis was made using an evidence-based assessment method for ADHD/ADD.

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Given this high prevalence, it is not surprising the number of stimulant medications prescribed within the state was similarly elevated

According to the Maternal and Child Health Services Title V Block Grant: West Virginia, 11 FY2019 Annual Report, for some counties in WV, up to one in four children within certain age groups were prescribed a stimulant (WVDHHR, Maternal and Child Services Title V Block Grant West Virginia, 2020)

The American Academy of Pediatrics recommends at least three – four scheduled visits per year for patients on ADHD/ADD medication therapy; therefore, requiring a yearly assessment is not unreasonable

Additionally, stimulants are Schedule II-controlled substances due to their risk for abuse, dependence, and potential for diversion (Drug Enforcement Administration, 2022). Therefore, the following are considered upon review:

- FDA product labeling
- Published peer-review clinical literature
- Approved drug compendia
- Accepted clinical practice guidelines, consensus statements, or comparable publications
- Standards of care noted in clinical literature, medical or pharmacy societies, and standard clinical drug references
- Appropriate clinical drug information from other sources as applicable
- Comparison of similar drugs in terms of safety and efficacy

Processes: Describe the NQTL procedures (e.g. steps, timeliness, and requirements)

Category: MH/SUD and M/S

Development of criteria includes a coverage summary and algorithm of questions that, when completed, render a coverage decision

Criteria include coverage for uses supported by evidence-based medicine and Standard of Care sources. Coverage conditions are based on safety considerations in black-box warnings and/or contraindications in the product labeling if these situations can be effectively managed through a PA process

Additional safety-related concerns could be added at the recommendation of the external clinical expert(s). Standard UM criteria are developed based on published clinical evidence supporting the different uses of a drug, and coverage conditions are not affected or altered by the medication’s intended area of utilization

PA may be obtained by either a provider or a pharmacist annually via phone, fax. Intelligent prior authorizations (iPAs) are also accepted, which function similarly to electronic PAs, by automatically evaluating claims through a series of steps to determine whether a patient qualifies for a drug based on medication history, diagnosis codes, age, and indication

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

WVCHIP has a formulary (PDL) for this category that is consistent with other medication categories—whether for MH or medical/surgical categories

The requested product must be a generic or a preferred brand on the WVCHIP formulary; otherwise, clinical justification must be made for approval of non-preferred products

Using previously approved drugs for the non-formulary ADHD drugs applies

If a child was established on a non-formulary drug before coming to WVCHIP, they can continue the non-formulary drug

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

The development of PA is based on comparable processes, strategies, evidentiary standards, and factors for therapeutic drug classes used to treat MH/SUD and M/S conditions

7.10 Pharmacy: Quantity Limits

Quantity Limits To which benefits is the NQTL assigned?

Category: MH/SUD

MH/SUD drugs subject to quantity limits, including:

1. Buprenorphine/naloxone (Suboxone): maintenance dose target of 16 mg/day; doses above 16 mg/day require clinical review; doses above 24 mg/day require medical director approval
2. All antipsychotic agents: quantity per 30 days consistent with FDA-approved dosing; PA required to exceed maximum dose
3. All antidepressant agents: quantity per 30 days consistent with FDA dosing optimization standards
4. ADHD/stimulant medications: quantity limits per 30-day dispensing consistent with scheduled substance controls and FDA labeling

Category: M/S

M/S drugs subject to quantity limits per the current PDL (Q2 v3, 4/1/2026), including:

1. Short-acting opioid analgesics: all short-acting solid narcotic forms limited to 120 tablets per 30 days (except cancer pain); immediate-release tramadol limited to 240 tablets per 30 days
2. Long-acting opioid analgesics: PA required for all agents; quantity consistent with FDA-approved dosing
3. Fentanyl buccal/nasal/sublingual: authorized only for cancer diagnosis as adjunct to long-acting agent (use-case quantity restriction)
4. All M/S medications: dose optimization standards and not-to-exceed dosages apply; PA required to exceed maximum dose.

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

Quantity limits serve to:

1. Ensure patients receive the lowest therapeutically effective dose, minimizing adverse effects and long-term safety risks;
2. Prevent excessive dispensing of controlled substances, reducing diversion risk
3. Preserve dose escalation options for times of clinical need
4. Contain program costs. These objectives are applied consistently across MH/SUD and M/S drug classes

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

WV BMS PDL Q2 v3 (4/1/2026); FDA product labeling (primary source for not-to-exceed doses); published peer-reviewed clinical literature; WV SEMP Guidelines 2021; DUR Board recommendations; BMS Department of Pharmacy Services clinical review.

For buprenorphine: FDA package insert (target maintenance dose 16 mg/day; >24 mg/day not demonstrated to provide clinical advantage)

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Claims processing system applies DUR edits to pharmacy claims as they process. Claims for quantities exceeding limits are flagged for: automatic denial (if clearly outside FDA parameters), or additional clinical review (if within plausible clinical range but above routine threshold)

Clinical pharmacists have discretion to make exceptions with prescriber clinical documentation.

Prescribers might appeal to BMS medical director plus BMS DUR pharmacist.

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

Quantity limits are applied at comparable rates of stringency across MH/SUD and M/S drug classes.

M/S short-acting opioid limit (120 tablets/30 days) is an explicit, hard coded limit in the PDL with the same appeals process available to MH/SUD prescribers

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

Quantity limits for both MH/SUD and M/S drugs are grounded in FDA-approved labeling and clinical evidence supporting dose optimization

The lowest dose providing therapeutic effect minimizes adverse effect risk

Reserve-dose capacity is preserved for clinical escalation needs (e.g., buprenorphine for SUD triggers; short-acting narcotics for cancer pain exacerbations)

7.11 Pharmacy: Off-Label Use

Off-Label Use To which benefits is the NQTL assigned?

Category: MH/SUD

MH/SUD drugs subject to prior authorization when prescribed for off-label use (i.e., indications not included in FDA labeling or supported compendia

Category: M/S

M/S drugs subject to prior authorization when prescribed for off-label use (i.e., indications not included in FDA labeling or supported compendia

Strategy: Why is the NQTL assigned to these services?

Category: MH/SUD and M/S

Off-label use review is applied to:

1. Ensure clinically appropriate and evidence-supported prescribing
2. Promote patient safety
3. Encourage adherence to FDA-approved indications unless sufficient evidence supports alternative use
4. Manage program integrity and costs. These objectives are applied consistently across MH/SUD and M/S drug classes

Evidentiary Standard: What evidence supports the rationale for the assignment?

Category: MH/SUD and M/S

Claims system flags off-label use based on diagnosis-drug indication mismatch

Claims either automatically denied (if unsupported) or routed for prior authorization (PA)

Prescriber must submit clinical documentation (diagnosis, rationale, supporting evidence, prior treatment history)

Clinical pharmacist review; escalation to medical director as needed

Appeals process available

Processes: Describe the NQTL procedures (e.g., steps, timeliness, and requirements)

Category: MH/SUD and M/S

Diagnosis-drug mismatch triggers PA review rather than quantity thresholds

Claims processing system applies DUR edits to pharmacy claims as they process

Claims for quantities exceeding limits are flagged for: automatic denial (if clearly outside FDA parameters) or additional clinical review (if within plausible clinical range but above routine threshold)

Clinical pharmacists have discretion to make exceptions with prescriber clinical documentation

Prescribers may appeal to BMS medical director plus BMS DUR pharmacist

In Operation: How frequently or strictly is the NQTL applied?

Category: MH/SUD and M/S

Off-label use review is applied with comparable rigor across MH/SUD and M/S drug classes:

1. PA required for off-label use in both categories
2. Systematic enforcement via claims edits and clinical review
3. Exceptions granted when supported by sufficient clinical evidence

Frequency varies by prescribing patterns, but the same review framework is used across benefit types

Evidentiary Standard: What standard supports the frequency or rigor that is applied?

Category: MH/SUD and M/S

FDA-approved indications serve as the baseline standard for determining off-label use

Recognized compendia and peer-reviewed literature guide medical acceptance of off-label use

DUR Board and BMS clinical oversight ensure consistent application

The same evidentiary hierarchy (FDA labeling, compendia, literature) is applied across MH/SUD and M/S drugs to ensure parity in rigor

Appendix G

The tables below include the detailed data shown in the charts in the State of West Virginia Department of Human Services Medicaid & CHIP Mental Health Parity Compliance Documentation.

Table 1: West Virginia Medicaid Membership by MCO (Section 1)

MCO	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Aetna	137,166	140,561	139,266	136,752	136,883	137,090
Highmark	13,079	15,262	15,212	15,104	15,613	16,043
The Health Plan	96,374	98,393	97,069	95,040	94,967	94,620
Wellpoint	140,659	142,590	140,570	137,450	137,200	136,343

Table 2: WVCHIP Membership by MCO (Section 1)

MCO	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Aetna	8,079	8,117	8,193	8,205	8,213	8,195
Highmark	1,153	1,168	1,162	1,186	1,196	1,218
The Health Plan	5,445	5,474	5,502	5,477	5,469	5,437
Wellpoint	9,065	9,175	9,221	9,169	9,143	9,154

Table 4: Medicaid Mountain Health Trust Outpatient Prior Authorization Requests by Calendar Quarter (Section 9.1)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	4,088	2,475	3,085	3,375	3,487	2,183	2,988	3,960	4,273
Total M/S	23,658	22,872	23,794	23,657	22,164	21,511	24,039	25,151	23,997
Average MH/SUD	1,363	825	1,028	844	872	546	747	990	1,068
Average M/S	7,886	7,624	7,931	5,914	5,541	5,378	6,010	6,288	5,999

Table 5: Medicaid Mountain Health Trust Outpatient Prior Authorization Requests Denied by Calendar Quarter (Section 9.1)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	283	256	249	270	336	258	402	454	602
Total M/S	3,994	3,605	4,155	4,235	4,093	3,408	3,844	3,922	3,743
Average MH/SUD	94	85	83	68	84	65	101	114	151
Average M/S	1,331	1,202	1,385	1,059	1,023	852	961	981	936

Table 6: Medicaid Mountain Health Trust Outpatient Percentage of Prior Authorization Requests Denied by Calendar Quarter (Section 9.1)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	6.9%	10.3%	8.1%	8.0%	9.6%	11.8%	13.5%	11.5%	14.1%
Total M/S	16.9%	15.8%	17.5%	17.9%	18.5%	15.8%	16.0%	15.6%	15.6%

Table 7: Medicaid Mountain Health Trust Inpatient Prior Authorization Requests by Calendar Quarter (Section 9.1)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	6,549	5,683	6,026	5,914	5,302	5,342	5,248	5,496	6,459
Total M/S	6,962	7,037	7,029	6,755	6,466	6,832	6,681	6,506	6,691
Average MH/SUD	2,183	1,894	2,009	1,479	1,326	1,336	1,312	1,374	1,615
Average M/S	2,321	2,346	2,343	1,689	1,617	1,708	1,670	1,627	1,673

Table 8: Medicaid Mountain Health Trust Inpatient Prior Authorization Requests Denied by Calendar Quarter (Section 9.1)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	100	60	55	86	57	50	48	75	89
Total M/S	557	1,036	654	740	711	645	830	1,081	942
Average MH/SUD	33	20	18	22	14	13	12	19	22
Average M/S	186	345	218	185	178	161	208	270	236

Table 9: Medicaid Mountain Health Trust Inpatient Percentage of Prior Authorization Requests Denied by Calendar Quarter (Section 9.1)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	1.5%	1.1%	0.9%	1.5%	1.1%	0.9%	0.9%	1.4%	1.4%
Total M/S	8.0%	14.7%	9.3%	11.0%	11.0%	9.4%	12.4%	16.6%	14.1%

Table 10: WVCHIP Mountain Health Trust Outpatient Prior Authorization Requests by Calendar Quarter (Section 9.2)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	35	52	68	71	69	53	87	82	119
Total M/S	508	524	621	601	649	605	684	721	758
Average MH/SUD	12	17	23	18	17	13	22	21	30
Average M/S	169	175	207	150	162	151	171	180	190

Table 11: WVCHIP Mountain Health Trust Outpatient Prior Authorization Requests Denied by Calendar Quarter (Section 9.2)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	5	7	10	7	6	6	17	10	16
Total M/S	55	43	73	70	72	64	69	73	99
Average MH/SUD	2	2	3	2	2	2	4	3	4
Average M/S	18	14	24	18	18	16	17	18	25

Table 12: WVCHIP Mountain Health Trust Outpatient Percentage of Prior Authorization Requests Denied by Calendar Quarter (Section 9.2)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	14.2%	13.4%	14.7%	9.9%	8.7%	11.3%	19.5%	12.2%	13.4%
Total M/S	10.8%	8.2%	11.7%	11.6%	11.1%	10.6%	10.1%	10.1%	13.1%

Table 13: WVCHIP Mountain Health Trust Inpatient Prior Authorization Requests by Calendar Quarter (Section 9.2)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	27	27	20	9	33	17	23	25	29
Total M/S	71	69	95	104	120	110	71	97	104
Average MH/SUD	9	9	7	2	8	4	6	6	7
Average M/S	24	23	32	26	30	28	18	24	26

Table 14: WVCHIP Mountain Health Trust Inpatient Prior Authorization Requests Denied by Calendar Quarter (Section 9.2)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	0	0	0	0	0	0	0	0	1
Total M/S	9	11	12	11	12	21	12	21	19
Average MH/SUD	0	0	0	0	0	0	0	0	0
Average M/S	3	4	4	3	3	5	3	5	5

Table 15: WVCHIP Mountain Health Trust Inpatient Percentage of Prior Authorization Requests Denied by Calendar Quarter (Section 9.2)

Measure	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Total MH/SUD	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%
Total M/S	12.7%	15.9%	12.6%	10.6%	10%	19.1%	16.9%	21.6%	18.3%

Table 16: BMS Pharmacy Prior Authorization Requests by Calendar Quarter (Section 9.3)

Category	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
MH/SUD	11,330	15,995	15,249	16,433	14,895	13,793	10,686	11,390	12,003
M/S	23,724	19,020	17,357	19,815	20,823	20,063	26,632	36,149	37,918

Table 17: BMS Pharmacy Prior Authorization Requests Denied by Calendar Quarter (Section 9.3)

Category	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
MH/SUD	1,552	1,590	1,450	1,504	1,468	1,331	1,354	1,255	1,413
M/S	7,112	6,779	6,747	7,704	7,526	7,406	8,342	8,090	8,896

Table 18: BMS Pharmacy Percentage of Prior Authorization Requests Denied by Calendar Quarter (Section 9.3)

Category	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
MH/SUD	13.7%	9.9%	9.5%	9.2%	9.9%	9.6%	12.7%	11.0%	11.8%
M/S	30.0%	35.6%	38.9%	38.9%	36.1%	36.9%	31.3%	22.4%	23.5%

Table 19: WVCHIP Pharmacy Prior Authorization Requests by Calendar Quarter (Section 9.4)

Category	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
MH/SUD	1,040	1,127	728	244	591	438	459	482	486
M/S	96	98	88	511	1,202	979	951	1,188	1,051

Table 20: WVCHIP Pharmacy Prior Authorization Requests Denied by Calendar Quarter (Section 9.4)

Category	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
MH/SUD	95	91	47	17	53	39	32	53	51
M/S	25	20	16	94	255	95	238	269	282

Table 21: WVCHIP Pharmacy Percentage of Prior Authorization Requests Denied by Calendar Quarter (Section 9.4)

Category	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
MH/SUD	9.1%	8.1%	6.5%	7.0%	9.0%	8.9%	7.0%	11.0%	10.5%
M/S	26.0%	20.4%	18.2%	18.4%	21.2%	9.7%	25.0%	22.6%	26.8%