ATTACHMENT 3 - 6.2.6.1- NQTL ANALYSIS UNITEDHEALTHCARE COMMUNITY PLAN

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ATTACHMENT 3 - 6.2.6.1- NQTL ANALYSIS UNITEDHEALTHCARE COMMUNITY PLAN

MH/SUD	M/S
1A – Development/Modification/Addition of Medical Necessity/Medical Appropriateness/Level of Care Guidelines – Inpatient – Adult	
Benefits: Managed by MCO: • Inpatient Mental Health • MH Residential (18-21 only)	**Benefits:** Managed by MCO: • Cognitive Services (LTSS) • Nursing Facility Care (LTSS) • Community-Based Residential alternatives that Include Assisted Living Facilities (LTSS) • Bariatric surgery • Bone growth stimulator • BRCA genetic testing • Breast reconstruction (non-mastectomy) • Cardiology • Chemotherapy • Cochlear and other auditory implants • Cosmetic and reconstructive procedures • Gender dysphoria treatment • Enteral services • Experimental or investigational • Femoroacetabular impingement syndrome (FAI) • Functional endoscopic sinus surgery (FESS) • Injectable medications • Joint replacement • Orthognathic surgery • Private duty nursing • Proton beam therapy • Radiology • Rhinoplasty and septoplasty • Sinuplasty • Sleep apnea procedures and surgeries • Sleep studies

MH/SUD	M/S
	• Spinal stimulator for pain management • Spinal surgery • Transplants • Vagus nerve stimulation • Vein procedures • Ventricular assist devices • Wound vac
Processes: MCO Processes: On an annual basis, the MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When new information becomes available, the MCO will review this information during the annual review and update medical policies/level of care guidelines as necessary. The Senior Director Network Quality & Clinical Sciences Institute or the Senior Director's designee is responsible for developing the MCO's standard clinical policies and guidelines. The MCO uses a three-stage process to develop and approve the Level of Care Guidelines, Behavioral Clinical Policies, Coverage Determination Guidelines, and Psychological and Neuropsychological Testing Guidelines. 1. Policies and guidelines are drafted using information derived from governmental sources, national guidelines, consensus statements, clinical position papers of professional specialty societies, literature reviews, and other published scientific evidence. 2. Input is sought from clinical staff, providers and members. The MCO allows at least a 30 calendar day period for providers to	**Processes:** MCO Processes: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The Clinical Services Medical Policy Development Team develops and modifies medical policies in the following way: 1. Prospective policy topics are identified by: business need, service utilization, published notices from U.S. Food and Drug Administration (FDA), new information from peer reviewed literature or technology assessment reports, or new/changed guidance from Medicare and Medicaid Services (CMS) and National Coverage Determination (NCD). 2. New policies are considered when they are submitted to the Medical Policy Analysis Committee (MPAC). MPAC will review/discuss identify barriers/issues related to policy implementation, system update requirements, modifications to

MH/SUD	M/S
provide written comments and/or recommendations. The MCO does not consult with providers who have financial relationships with the review agency other than direct patient care and reasonable compensation for the consultation. 3. After the policies/guidelines are drafted, they are presented to the Utilization Management Committee (UMC) for approval.	internal processes such as creation/modification requirements, and reference/support documentation requirements. MPAC may require corresponding claim impact data is analyzed and an Operational Impact Assessment (OIA) is performed. 3. Should a new policy be warranted, the development team will review clinical evidence and provide supporting evidence to the National Medical Director for review. 4. Following the National Medical Director's review, the policy and supporting reference documents are submitted to the Medical Technology Assessment Committee (MTAC) for review which includes, reviewing key articles obtained during the review of the clinical evidence, reviewing technology assessment reports published and/or provided by Hayes Inc. or other research organizations (e.g., ECRI Institute), and identifying key questions for the MTAC meeting.
The MCO developed a hierarchy of evidence for the MCO's standard clinical policies and guidelines as noted in the following order. 1. Governmental sources such as the Centers for Medicare & Medicaid Services (CMS) National Coverage Decisions (NCDs); 2. National guidelines and consensus statements; 3. Clinical position papers of professional specialty societies when their statements are based upon referenced clinical evidence; 4. Graded reviews of the literature such as Hayes reviews; and 5. Well-designed research that has been published in peer-reviewed journals.	The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies.

MH/SUD	M/S
Strategies: MCO Strategies: The MCO maintains a standard set of evidence-based clinical policies and guidelines that are used to standardize coverage determinations, promote evidence-based practices, and support members recovery, resiliency and well-being. The MCO develops evidence-based clinical policies and guidelines or adopts externally developed clinical policies and guidelines when required to do so by contract or regulation. The standard set of clinical policies and guidelines includes: • Level of Care Guidelines, • Behavioral Clinical Policies, • Coverage Determination Guidelines, • Medicare Coverage Summaries, • Psychological and Neuropsychological Testing Policies and Guidelines, • The MCO's Best Practice Guidelines. The MCO maintains policies and procedures for updating/modifying clinical criteria including: • Hierarchy of Clinical Evidence, • Behavioral Policy Update and Revision, • CTAC function and structure, • Specialty society review.	**Strategies:** MCO Strategies: Medical policies are developed in accordance with clinical evidence in published peer-reviewed medical literature in order to promote access to safe and effective medical services (subject to benefit design), and ensure compliance with applicable regulatory requirements. Medical policies provide clinical conclusions regarding the safety and/or efficacy of a device, service or technology. The MCO maintains policies and procedures for updating/modifying clinical criteria including: • Hierarchy of Clinical Evidence, • Medical Policy Update and Revision, • MTAC function and structure, • Specialty society review.
Evidentiary Standards: MCO Evidentiary Standards: Clinical criteria were developed based on generally accepted standards of medical practice or if none exist, on physician specialty society recommendations or professional standards of care. The MCO relies on the following resources to maintain their standard set of evidence-based clinical policies and guidelines: • Input from clinical staff, providers and members; • Standards of practice from governmental sources such as the Centers for Medicare & Medicaid Services' (CMS) National Coverage	**Evidentiary Standards:** MCO Evidentiary Standards: The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute

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Determinations and Local Coverage Determinations; • National guidelines, consensus statements, and other published scientific evidence. • Criteria are also based on guidelines from the American Society of Addiction Medicine (ASAM) guidelines. • Best Practice Guidelines developed by the American Psychiatric • Associations and the American Academy of Child and Adolescent Psychiatry. The MCO may use additional literature or guidelines available from other organizations to support medical necessity decisions.	facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com
Compliance Determination MCO MH/SUD to MCO M/S: For MH/SUD, the MCO maintains a standard set of evidence-based clinical policies and guidelines to standardize coverage determinations, promote evidence-based practices, and support members recovery, resiliency and well-being. For M/S, the MCO develops clinical guidelines in order to promote access to safe and effective medical services and ensure compliance with applicable regulatory requirements. For MH, the MCO develops its own criteria based on generally accepted standards of medical practice including but not limited to, CMS National Coverage Determinations, Local Coverage Determinations, and best practice guidelines from American Psychiatry Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). The MCO uses ASAM to determine medical necessity for SUD benefits. For M/S, the MCO relies primarily on MCG Care guidelines or other nationally recognized guidelines (e.g., Hayes, ECRI Institute) as the basis for the development/modification of their clinical criteria and to assist clinicians in making informed decisions in health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations. The processes applied by the MCO to both MH/SUD and M/S to develop and modify medical policies and clinical guidelines are similar. The MCO utilize clinical committees and established clinical hierarchies in the development/modification of new criteria. The MCO reviews and modifies criteria on an annual basis and has robust policy/procedures to develop or modify clinical criteria. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
1A – Development/Modification/Addition of Medical Necessity/Medical Appropriateness/Level of Care Guidelines – Inpatient – PROMISE	
Benefits: Managed by MCO: Same as 1A – Inpatient - Adult	**Benefits:** Managed by MCO: Same as 1A – Inpatient - Adult
Processes: MCO Processes:	**Processes:** MCO Processes:

MH/SUD	M/S
Same as 1A – Inpatient - Adult	Same as 1A – Inpatient - Adult
Strategies: MCO Strategies: Same as 1A – Inpatient - Adult	**Strategies:** MCO Strategies: Same as 1A – Inpatient - Adult
Evidentiary Standards: MCO Evidentiary Standards: Same as 1A – Inpatient - Adult	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 1A – Inpatient - Adult
Compliance Determination MCO MH/SUD to MCO M/S: Same as 1A – Inpatient – Adult	
1A – Development/Modification/Addition of Medical Necessity/Medical Appropriateness/Level of Care Guidelines – Inpatient – Children*	
Benefits: Managed by DSCYF: • Inpatient Mental Health • Psychiatric Residential Treatment Facility • Residential Rehabilitation Services, Mental Health • Crisis Residential Bed Services	**Benefits:** Managed by MCO: • Bariatric surgery • Bone growth stimulator • BRCA genetic testing • Breast reconstruction (non-mastectomy) • Cardiology • Chemotherapy • Cochlear and other auditory implants • Cosmetic and reconstructive procedures • Gender dysphoria treatment • Enteral services • Experimental or investigational • Femoroacetabular impingement syndrome (FAI) • Functional endoscopic sinus surgery (FESS) • Injectable medications • Joint replacement • Orthognathic surgery • Private duty nursing • Proton beam therapy • Radiology • Rhinoplasty and septoplasty

MH/SUD	M/S
	• Sinuplasty • Sleep apnea procedures and surgeries • Sleep studies • Spinal stimulator for pain management • Spinal surgery • Transplants • Vagus nerve stimulation • Vein procedures • Ventricular assist devices • Wound vac
Processes: DSCYF Processes: Medical necessity criteria apply to all DSCYF inpatient benefits (see list above), except in cases of an emergency. The Department's Division of Prevention and Behavioral Health Services is responsible for the developing and revising medical necessity and level of care guidelines. DSCYF' has an identified group of professionals charged with developing new and revising existing documents. The group, comprised of a psychiatrist, licensed behavioral health professional(s), and other qualified individuals, selects practice guidelines for adoption and reviews annually. The group develops, adopts, and revises policy/guidelines that are: • Based on valid and reliable evidence (scientific and peer-reviewed literature); • Appropriate for population served and their needs; • Generally accepted practices; • Professional association guidelines; • Adopted in consultation with experts; and • Support consistent decisions for utilization management and coverage of services/service determinations. The Division Director appoints the DSCYF team responsible for reviewing policies and guidelines. All policies and guidelines are review at a minimum annually; however, if new evidence or guidance suggests the need to	**Processes:** MCO Processes: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The Clinical Services Medical Policy Development Team develops and modifies medical policies in the following way: 1. Prospective policy topics are identified by: business need, service utilization, published notices from U.S. Food and Drug Administration (FDA), new information from peer reviewed literature or technology assessment reports, or new/changed guidance from Medicare and Medicaid Services (CMS), National Coverage Determination (NCD). 2. New policies are considered when they are submitted to the Medical Policy Analysis Committee (MPAC). MPAC will review/discuss identify barriers/issues related to policy implementation, system update requirements, modifications to internal processes such as creation/modification requirements, and

MH/SUD	M/S
review, a review will be scheduled. New policies and guidelines must be approved by DSCYF and DSCYF leadership. If a service is not covered as a result of medical necessity there is an appeal process available. The appeal policy can be found at: http://kids.delaware.gov/policies/pbh/cs005-Appeals-Policy-Procedure.pdf. Beneficiaries are also provided with DSCYF Client Appeal Procedure in the PBH Handbook. For a client to meet medical necessity, DSCYF requires evidence to support that the individual meets the criteria for a particular service intensity level. DSCYF staff collects information from providers, families, clinical records and the data base as needed to complete the Child and Adolescent Service Intensity Instrument (CASII) or the ASAM criteria. A licensed behavioral health practitioner determines if the medical necessity criteria are met using information collected, instrument's score, and professional judgement. Professional discretion and clinical judgement of licensed behavioral health practitioners are allowed. Their use enhances service planning by assisting in determining the most appropriate level of care and identifying services to meet the needs of the client. There are exceptions to the criteria. For example, if a certain treatment is court-ordered or departmental decision is made to fund a service for which the client does not meet clinical necessity.	reference/support documentation requirements. MPAC may require corresponding claim impact data is analyzed and an Operational Impact Assessment (OIA) is performed. 3. Should a new policy be warranted, the development team will review clinical evidence and provide supporting evidence to the National Medical Director for review. 4. Following the National Medical Director's review, the policy and supporting reference documents are submitted to the Medical Technology Assessment Committee (MTAC) for review which includes, reviewing key articles obtained during the review of the clinical evidence, reviewing technology assessment reports published and/or provided by Hayes Inc. or other research organizations (e.g., ECRI Institute), and identifying key questions for the MTAC meeting. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies.
Strategies: DSCYF Strategies: Medical necessity and level of care guidelines support consistent medical decision-making across staff. Medical necessity and level of care guidelines ensure utilization of services are reasonable, necessary and delivered in the most appropriate setting. The DSCYF medical necessity criteria is developed, modified, and updated if: new services are added under the Division's provision; public concern is expressed; support by peer-reviewed or evidence-based literature, changes to practice standards and/or updates in instruments or tools used by the division.	**Strategies:** MCO Strategies: Medical policies are developed in accordance with clinical evidence in published peer-reviewed medical literature in order to promote access to safe and effective medical services (subject to benefit design), and ensure compliance with applicable regulatory requirements. Medical policies provide clinical conclusions regarding the safety and/or efficacy of a device, service or technology. The MCO maintains policies and procedures for updating/modifying clinical criteria including: • Hierarchy of Clinical Evidence, • Medical Policy Update and Revision,

MH/SUD	M/S
DSCYF has an identified group of professionals, including licensed behavioral health practitioners and a psychiatrist that is responsible for developing, reviewing, and updating the medical necessity criteria for services under the provision of the division. This group determines when these criteria should be reviewed/modified.	• MTAC function and structure, • Specialty society review.
Evidentiary Standards: DSCYF Evidentiary Standards: To develop medical necessity, DSCYF identified a group of qualified professionals (e.g., psychiatrists, licensed behavioral health practitioners) to develop the medical necessity criteria using documents from professional associations such as American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), and American Society of Addiction Medicine (ASAM), peer-reviewed and research-based literature, and practice standards. DSCYF uses two evidence-based instruments to guide medical necessity determinations. The CASII was developed by AACAP as a tool to provide a standard for determining the appropriate level of services needed for the individual. DSCYF uses the CASII for children and adolescents presenting with psychiatric, psychosocial and/or developmental concerns. The ASAM Criteria is a national set of criteria for providing treatment for substance use and co-occurring disorders. Using evidence-based tools provides consistency in decision-making. DSCYF staff has been trained on the use of the CASII and ASAM by qualified instructors to ensure consistency in its use.	**Evidentiary Standards:** MCO Evidentiary Standards: The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer- reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com

<table>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td colspan="2"><u>Compliance Determination DSCYF MH/SUD to MCO M/S:</u>
For MH/SUD, DSCYF develops clinical criteria to ensure a standard decision making process is applied to medical necessity determinations and to ensure the member is receiving benefits that are safe and appropriate for their specific needs. For M/S, the MCO develops clinical guidelines in order to promote access to safe and effective medical services and ensure compliance with applicable regulatory requirements. DSCYF developed their criteria based on documents from professional associations such as American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), and American Society of Addiction Medicine (ASAM), peer-reviewed and research-based literature, and practice standards. For M/S, the MCO relies primarily on MCG Care guidelines or other nationally recognized guidelines (e.g., Hayes, ECRI Institute) as the basis for their development/modification of their clinical criteria and to assist clinicians in making informed decisions in health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations. DSCYF has a dedicated group of clinicians (licensed behavioral health practitioners, psychiatrist) who develop/update medical necessity criteria annually or as needed. DSYCF also utilizes the CASII and ASAM (adolescents only) criteria to support medical necessity determinations and level of care needs. The MCO has clinical committees and established clinical hierarchies to develop/modify new criteria. The MCO reviews and modifies criteria on an annual basis and has robust policy/procedures to develop or modify clinical criteria. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.</td></tr>
<tr><td colspan="2">1B – Development/Modification/Addition of Medical Necessity/Medical Appropriateness/Level of Care Guidelines – Outpatient – Adult</td></tr>
<tr><td>Benefits:
Managed by MCO:
• MH Partial Hospitalization
• MH Intensive Outpatient
• Outpatient ECT
• Psychological/Neuropsychological Testing</td><td>Benefits:
Managed by MCO:
• Adult Day (LTSS)
• Cognitive Services (LTSS)
• Day Habilitation (LTSS)
• Home-Delivered Meals (LTSS)
• Abdominal paracentesis
• Bariatric surgery
• Bone growth stimulator
• BRCA genetic testing
• Breast reconstruction (non-mastectomy)
• Cardiology
• Cardiovascular
• Carpal tunnel surgery
• Cataract surgery
• Chemotherapy</td></tr>
</table>

MH/SUD	M/S
	• Cochlear and other auditory implants • Colonoscopy • Cosmetic and reconstructive procedures • Durable medical equipment • Gender dysphoria treatment • Ear, nose and throat procedures • Enteral services • Experimental or investigational • Femoroacetabular impingement syndrome (FAI) • Functional endoscopic sinus surgery (FESS) • Gynecologic procedures • Hernia repair • Home health care • Injectable medications • Joint replacement • Liver biopsy • Miscellaneous services • Non-emergent air ambulance transport • Ophthalmologic • Orthognathic surgery • Orthotics and prosthetics • Private duty nursing • Proton beam therapy • Radiology • Rhinoplasty and septoplasty • Sinuplasty • Sleep apnea procedures and surgeries • Sleep studies • Spinal stimulator for pain management • Spinal surgery • Tonsillectomy and adenoidectomy • Transplants • Upper gastrointestinal endoscopy

MH/SUD	M/S
	• Urologic procedures • Vagus nerve stimulation • Vein procedures • Ventricular assist devices • Wound vac
Processes: MCO Processes: On an annual basis, the MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When new information becomes available, the MCO will review this information during the annual review and update medical policies/level of care guidelines as necessary. The Senior Director Network Quality & Clinical Sciences Institute or the Senior Director's designee is responsible for developing the MCO's standard clinical policies and guidelines. The MCO uses a three-stage process to develop and approve the Level of Care Guidelines, Behavioral Clinical Policies, Coverage Determination Guidelines, and Psychological and Neuropsychological Testing Guidelines. 1. Policies and guidelines are drafted using information derived from governmental sources, national guidelines, consensus statements, clinical position papers of professional specialty societies, literature reviews, and other published scientific evidence. 2. Input is sought from clinical staff, providers and members. The MCO allows at least a 30 calendar day period for providers to provide written comments and/or recommendations. The MCO does not consult with providers who have financial relationships with the review agency other than direct patient care and	**Processes:** MCO Processes: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The Clinical Services Medical Policy Development Team develops and modifies medical policies in the following way: 1. Prospective policy topics are identified by: business need, service utilization, published notices from U.S. Food and Drug Administration (FDA), new information from peer reviewed literature or technology assessment reports, or new/changed guidance from Medicare and Medicaid Services (CMS), National Coverage Determination (NCD). 2. New policies are considered when they are submitted to the Medical Policy Analysis Committee (MPAC). MPAC will review/discuss identify barriers/issues related to policy implementation, system update requirements, modifications to internal processes such as creation/modification requirements, and reference/support documentation requirements. MPAC may require corresponding claim impact data is analyzed and an Operational Impact Assessment (OIA) is performed. 3. Should a new policy be warranted, the development team will review clinical evidence and provide supporting evidence to the

MH/SUD	M/S
reasonable compensation for the consultation. 3. After the policies/guidelines are drafted, they are presented to the Utilization Management Committee (UMC) for approval. The MCO developed a hierarchy of evidence for the MCO's standard clinical policies and guidelines as noted in the following order. 1. Governmental sources such as the Centers for Medicare & Medicaid Services (CMS) National Coverage Decisions (NCDs); 2. National guidelines and consensus statements; 3. Clinical position papers of professional specialty societies when their statements are based upon referenced clinical evidence; 4. Graded reviews of the literature such as Hayes reviews; and 5. Well-designed research that has been published in peer-reviewed journals.	National Medical Director for review. 4. Following the National Medical Director's review, the policy and supporting reference documents are submitted to the Medical Technology Assessment Committee (MTAC) for review which includes, reviewing key articles obtained during the review of the clinical evidence, reviewing technology assessment reports published and/or provided by Hayes Inc. or other research organizations (e.g., ECRI Institute), and identifying key questions for the MTAC meeting. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies.
Strategies: MCO Strategies: The MCO maintains a standard set of evidence-based clinical policies and guidelines that are used to standardize coverage determinations, promote evidence-based practices, and support members recovery, resiliency and well-being. The MCO develops evidence-based clinical policies and guidelines or adopts externally developed clinical policies and guidelines when required to do so by contract or regulation. The standard set of clinical policies and guidelines includes: • Level of Care Guidelines, • Behavioral Clinical Policies, • Coverage Determination Guidelines, • Medicare Coverage Summaries, • Psychological and Neuropsychological Testing Policies and Guidelines, • The MCO's Best Practice Guidelines. The MCO maintains policies and procedures for updating/modifying clinical criteria including:	**Strategies:** MCO Strategies: Medical policies are developed in accordance with clinical evidence in published peer-reviewed medical literature in order to promote access to safe and effective medical services (subject to benefit design), and ensure compliance with applicable regulatory requirements. Medical policies provide clinical conclusions regarding the safety and/or efficacy of a device, service or technology. The MCO maintains policies and procedures for updating/modifying clinical criteria including: • Hierarchy of Clinical Evidence, • Medical Policy Update and Revision, • MTAC function and structure, • Specialty society review.

MH/SUD	M/S
• Hierarchy of Clinical Evidence, • Behavioral Policy Update and Revision, • CTAC function and structure, • Specialty society review.	
Evidentiary Standards: MCO Evidentiary Standards: Clinical criteria were developed based on generally accepted standards of medical practice or if none exist, on physician specialty society recommendations or professional standards of care. The MCO relies on the following resources to maintain their standard set of evidence-based clinical policies and guidelines: • Input from clinical staff, providers and members; • Standards of practice from governmental sources such as the Centers for Medicare & Medicaid Services' (CMS) National Coverage Determinations and Local Coverage Determinations; • National guidelines, consensus statements, and other published scientific evidence. • Criteria are also based on guidelines from the American Society of Addiction Medicine (ASAM) guidelines. • Best Practice Guidelines developed by the American Psychiatric Associations and the American Academy of Child and Adolescent Psychiatry. The MCO may use additional literature or guidelines available from other organizations to support medical necessity decisions.	**Evidentiary Standards:** MCO Evidentiary Standards: The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer- reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com

<table>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td colspan="2"><u>Compliance Determination MCO MH/SUD to MCO M/S:</u>
For MH/SUD, the MCO maintains a standard set of evidence-based clinical policies and guidelines to standardize coverage determinations, promote evidence-based practices, and support members recovery, resiliency and well-being. For M/S, the MCO develops clinical guidelines in order to promote access to safe and effective medical services and ensure compliance with applicable regulatory requirements. For MH, the MCO develops its own criteria based on generally accepted standards of medical practice including but not limited to, CMS National Coverage Determinations, Local Coverage Determinations, and best practice guidelines from American Psychiatry Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP). The MCO uses ASAM to determine medical necessity for SUD benefits. For M/S, the MCO relies primarily on MCG Care guidelines or other nationally recognized guidelines (e.g., Hayes, ECRI Institute) as the basis for the development/modification of their clinical criteria and to assist clinicians in making informed decisions in health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations. The processes applied by the MCO to both MH/SUD and M/S to develop and modify medical policies and clinical guidelines are similar. The MCO utilize clinical committees and established clinical hierarchies in the development/modification of new criteria. The MCO reviews and modifies criteria on an annual basis and has robust policy/procedures to develop or modify clinical criteria. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.</td></tr>
<tr><td colspan="2">1B – Development/Modification/Addition of Medical Necessity/Medical Appropriateness/Level of Care Guidelines – Outpatient – PROMISE*</td></tr>
<tr><td>Benefits:
Managed by DSAMH:
PROMISE
• Benefits Counseling
• Community Psychiatric Support and Treatment (CPST)
• Psychosocial Rehabilitation (PSR)
• Small Group and Supported Employment
• Personal Care
• Peer Supports
• Individual Supported Employment
• Assertive Community Treatment (ACT)
• Nursing Services
• Respite Services
• Community Transition Services (Client Assistance Funds)
• IADLs
• Non-medical transport</td><td>Benefits:
Managed by MCO:
• Same as 1B – Outpatient – Adult</td></tr>
</table>

MH/SUD	M/S
• Group Homes, Community Based Residential Alternatives, SAP • Care Management MH • Psychotherapy with Patient • Psychoanalysis • Health and Behavior Assessment • Health and Behavior Intervention • Psychiatric Diagnostic Evaluations	
Processes: DSAMH Processes: PROMISE services and SUD benefits require the application of the NQTL (Development/Modification/Adoption of Medical Necessity/Appropriateness Criteria) prior to the delivery of the benefit. Medical Necessity is used to apply the least-restricted environment. Historically, those in need of SUD services were provided the strictest level of care for an extended length of stay. These practices did not necessarily provide high recovery rates upon discharge. Individualized treatment settings provide better outcomes as individuals can apply skills in their own environment. All services listed above require the application of the NQTL prior to the delivery of the service. Clients present to an authorized provider. The provider assesses need according to DE ASAM for medical necessity. Dr. Mee Lee (author of ASAM) specifically adapted Delaware ASAM to add ASAM based elements that would determine need for mental health services (ASAM was not modified for any component of SUD services). The modification of Delaware ASAM was done with Dr. Mee Lee who is one of the original creators of the ASAM tool. DSAMH defers to Dr. Mee Lee as is relates to any updates of medical necessity criteria. Dr. Mee Lee is a nationally known educator and author of the ASAM.	**Processes:** MCO Processes: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The Clinical Services Medical Policy Development Team develops and modifies medical policies in the following way: 1. Prospective policy topics are identified by: business need, service utilization, published notices from U.S. Food and Drug Administration (FDA), new information from peer reviewed literature or technology assessment reports, or new/changed guidance from Medicare and Medicaid Services (CMS), National Coverage Determination (NCD). 2. New policies are considered when they are submitted to the Medical Policy Analysis Committee (MPAC). MPAC will review/discuss identify barriers/issues related to policy implementation, system update requirements, modifications to internal processes such as creation/modification requirements, and reference/support documentation requirements. MPAC may require corresponding claim impact data is analyzed and an Operational

MH/SUD	M/S
	Impact Assessment (OIA) is performed. 3. Should a new policy be warranted, the development team will review clinical evidence and provide supporting evidence to the National Medical Director for review. 4. Following the National Medical Director's review, the policy and supporting reference documents are submitted to the Medical Technology Assessment Committee (MTAC) for review which includes, reviewing key articles obtained during the review of the clinical evidence, reviewing technology assessment reports published and/or provided by Hayes Inc. or other research organizations (e.g., ECRI Institute), and identifying key questions for the MTAC meeting. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies.
Strategies: DSAMH Strategies: Medical Necessity is used to apply the least-restricted environment. Historically, those in need of SUD services were provided the strictest level of care for an extended length of stay. These practices did not necessarily provide high recovery rates upon discharge. Individualized treatment settings provide better outcomes as individuals can apply skills in their own environment. Medical Necessity is also used to help mitigate the use of unnecessary costly services that inhibit the individual accessing treatment in the least restrictive environment and to determine eligibility. Delaware revised the ASAM to apply to all behavioral health components and has not been modified since Dr. Mee Lee created it. Frequency of medical necessity and appropriateness reviews are based on ensuring that each client receives individualized treatment services in the least-restricted environment. Medical necessity and appropriateness criteria are reviewed	**Strategies:** MCO Strategies: Medical policies are developed in accordance with clinical evidence in published peer-reviewed medical literature in order to promote access to safe and effective medical services (subject to benefit design), and ensure compliance with applicable regulatory requirements. Medical policies provide clinical conclusions regarding the safety and/or efficacy of a device, service or technology. The MCO maintains policies and procedures for updating/modifying clinical criteria including: • Hierarchy of Clinical Evidence, • Medical Policy Update and Revision, • MTAC function and structure, • Specialty society review.

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and updated as often as evidence based practices are updated (i.e., fidelity scales) or feedback is provided from federal sponsor (SAMHSA).	
Evidentiary Standards: DSAMH Evidentiary Standards: PROMISE and SUD services use Delaware ASAM for SUD and MH for level of care determination. Dr. Mee Lee (https://www.changecompanies.net/bios/david_mee_lee.php) specifically adapted Delaware ASAM to add ASAM elements that would determine the need for mental health services. Individualized treatment settings provide better outcomes as individuals can apply skills in their own environment. Medical necessity is determined via Delaware ASAM. SUD providers including clinical Supervisors and EEU staff oversee the application of medical necessity to ensure consistency. For more information on PROMISE please see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/de/de-dshp-fs.pdf. Success is measured by frequency of relapse, frequency of treatment episodes, and length of stay.	**Evidentiary Standards:** MCO Evidentiary Standards: The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer- reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com
Compliance Determination DSAMH MH/SUD to MCO M/S: DSAMH applies ASAM (SUD) and DE ASAM (MH) criteria to ensure benefits are provided in the least-restrictive environment for the member with a focus on individualized treatment outcomes. For M/S, the MCO develops clinical guidelines in order to promote access to safe and effective medical services and ensure compliance with applicable regulatory requirements. For MH, DSAMH worked with Dr. Mee Lee, to design an ASAM model specific to Delaware (DE ASAM). DSAMH uses ASAM to determine medical necessity for SUD benefits. For M/S, the MCO relies primarily on MCG Care guidelines or other nationally recognized guidelines (e.g., Hayes, ECRI Institute) as the basis for the development/modification of their clinical criteria and to assist clinicians in making informed decisions in health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations. DSAMH updates and reviews criteria as often as evidence based practices are updated (i.e., fidelity scales) or feedback is provided from federal sponsor (SAMHSA). The MCO utilize clinical committees and established clinical hierarchies in the development/modification of new criteria. The MCO reviews and modifies criteria on an annual basis and has robust policy/procedures to develop or modify clinical criteria. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
1B – Development/Modification/Addition of Medical Necessity/Medical Appropriateness/Level of Care Guidelines – Outpatient – Children*	
Benefits:	**Benefits:**

MH/SUD	M/S
Managed by MCO: • MH Intensive Outpatient • Psychological Testing • Neuropsychological Testing • Behavioral Health Assessment • Specialist/Treatment Plan Development Managed by DSCYF: • MH Partial Hospitalization • Outpatient, Mental Health • Therapeutic Support for Families (CPST, FPSS, and PSR) • Evidence Based Practices (MST, DBT, FBMHS, FFT) • Day Treatment, Mental Health • Crisis Intervention Services	Managed by MCO: • Abdominal paracentesis • Bariatric surgery • Bone growth stimulator • BRCA genetic testing • Breast reconstruction (non-mastectomy) • Cardiology • Cardiovascular • Carpal tunnel surgery • Cataract surgery • Chemotherapy • Cochlear and other auditory implants • Colonoscopy • Cosmetic and reconstructive procedures • Durable medical equipment • Gender dysphoria treatment • Ear, nose and throat procedures • Enteral services • Experimental or investigational • Femoroacetabular impingement syndrome (FAI) • Functional endoscopic sinus surgery (FESS) • Gynecologic procedures • Hernia repair • Home health care • Injectable medications • Joint replacement • Liver biopsy • Miscellaneous services • Non-emergent air ambulance transport • Ophthalmologic • Orthognathic surgery • Orthotics and prosthetics • Private duty nursing

MH/SUD	M/S
	• Proton beam therapy • Radiology • Rhinoplasty and septoplasty • Sinuplasty • Sleep apnea procedures and surgeries • Sleep studies • Spinal stimulator for pain management • Spinal surgery • Tonsillectomy and adenoidectomy • Transplants • Upper gastrointestinal endoscopy • Urologic procedures • Vagus nerve stimulation • Vein procedures • Ventricular assist devices • Wound vac
Processes: MCO Processes: On an annual basis, The MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When new information becomes available, the MCO will review this information during the annual review and update medical policies/level of care guidelines as necessary. The Senior Director Network Quality & Clinical Sciences Institute or the Senior Director's designee is responsible for developing The MCO's standard clinical policies and guidelines. The MCO uses a three-stage process to develop and approve the Level of Care Guidelines, Behavioral	**Processes:** MCO Processes: On an annual basis, the MCO develops and maintains clinical policies. United's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The Clinical Services Medical Policy Development Team develops and modifies medical policies in the following way: 1. Prospective policy topics are identified by: business need, service utilization, published notices from U.S. Food and Drug Administration (FDA), new information from peer reviewed literature or technology assessment reports, or new/changed guidance from Medicare and Medicaid Services (CMS), National Coverage

MH/SUD	M/S
Clinical Policies, Coverage Determination Guidelines, and Psychological and Neuropsychological Testing Guidelines. 1. Policies and guidelines are drafted using information derived from governmental sources, national guidelines, consensus statements, clinical position papers of professional specialty societies, literature reviews, and other published scientific evidence. 2. Input is sought from clinical staff, providers and members. The MCO allows at least a 30 calendar day period for providers to provide written comments and/or recommendations. The MCO does not consult with providers who have financial relationships with the review agency other than direct patient care and reasonable compensation for the consultation. 3. After the policies/guidelines are drafted, they are presented to the Utilization Management Committee (UMC) for approval. The MCO developed a hierarchy of evidence for the MCO's standard clinical policies and guidelines as noted in the following order. 1. Governmental sources such as the Centers for Medicare & Medicaid Services (CMS) National Coverage Decisions (NCDs); 2. National guidelines and consensus statements; 3. Clinical position papers of professional specialty societies when their statements are based upon referenced clinical evidence; 4. Graded reviews of the literature such as Hayes reviews; and 5. Well-designed research that has been published in peer-reviewed journals. DSCYF Processes: Medical necessity criteria apply to all DSCYF outpatient benefits (see list above), except in cases of an emergency. The Departments' Division of Prevention and Behavioral Health Services is responsible for the developing and revising medical necessity and level of care guidelines. DSCYF' has an identified group of professionals charged with developing new and revising existing documents. The group, comprised of a psychiatrist, licensed	Determination (NCD). 2. New policies are considered when they are submitted to the Medical Policy Analysis Committee (MPAC). MPAC will review/discuss identify barriers/issues related to policy implementation, system update requirements, modifications to internal processes such as creation/modification requirements, and reference/support documentation requirements. MPAC may require corresponding claim impact data is analyzed and an Operational Impact Assessment (OIA) is performed. 3. Should a new policy be warranted, the development team will review clinical evidence and provide supporting evidence to the National Medical Director for review. 4. Following the National Medical Director's review, the policy and supporting reference documents are submitted to the Medical Technology Assessment Committee (MTAC) for review which includes, reviewing key articles obtained during the review of the clinical evidence, reviewing technology assessment reports published and/or provided by Hayes Inc. or other research organizations (e.g., ECRI Institute), and identifying key questions for the MTAC meeting. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies.

MH/SUD	M/S
behavioral health professional(s), and other qualified individuals, selects practice guidelines for adoption and reviews annually. The group develops, adopts, and revises policy/guidelines that are: • Based on valid and reliable evidence (scientific and peer-reviewed literature); • Appropriate for population served and their needs; • Generally accepted practices; • Professional association guidelines; • Adopted in consultation with experts; and • Support consistent decisions for utilization management and coverage of services/service determinations. The Division Director appoints the DSCYF team responsible for reviewing policies and guidelines. All policies and guidelines are review at a minimum annually; however, if new evidence or guidance suggests the need to review, a review will be scheduled. New policies and guidelines must be approved by DSCYF and DSCYF leadership. If a service is not covered as a result of medical necessity there is an appeal process available. The appeal policy can be found at: http://kids.delaware.gov/policies/pbh/cs005-Appeals-Policy-Procedure.pdf. Beneficiaries are also provided with DSCYF Client Appeal Procedure in the PBH Handbook. For a client to meet medical necessity, DSCYF requires evidence to support that the individual meets the criteria for a particular service intensity level. DSCYF staff collects information from providers, families, clinical records and the data base as needed to complete the Child and Adolescent Service Intensity Instrument (CASII) or the ASAM criteria. A licensed behavioral health practitioner determines if the medical necessity criteria are met using information collected, instrument's score, and professional judgement. Professional discretion and clinical judgement of licensed behavioral health practitioners are allowed. Their use enhances service planning by assisting in determining the most appropriate level of care and identifying services to meet the needs of the client. There are	

MH/SUD	M/S
exceptions to the criteria. For example, if a certain treatment is court-ordered or departmental decision is made to fund a service for which the client does not meet clinical necessity.	
Strategies: MCO Strategies: The MCO maintains a standard set of evidence-based clinical policies and guidelines that are used to standardize coverage determinations, promote evidence-based practices, and support members recovery, resiliency and well-being. The MCO develops evidence-based clinical policies and guidelines or adopts externally developed clinical policies and guidelines when required to do so by contract or regulation. The standard set of clinical policies and guidelines includes: • Level of Care Guidelines, • Behavioral Clinical Policies, • Coverage Determination Guidelines, • Medicare Coverage Summaries, • Psychological and Neuropsychological Testing Policies and Guidelines, • The MCO's Best Practice Guidelines. The MCO maintains policies and procedures for updating/modifying clinical criteria including: • Hierarchy of Clinical Evidence, • Behavioral Policy Update and Revision, • CTAC function and structure, • Specialty society review. DSCYF Strategies: Medical necessity and level of care guidelines support consistent medical decision-making across staff. Medical necessity and level of care guidelines ensure utilization of services are reasonable, necessary and delivered in the most appropriate setting. The DSCYF medical necessity criteria is developed, modified, and updated if: new services are added under the Division's provision; public concern is expressed; support by peer-reviewed	**Strategies:** MCO Strategies: Medical policies are developed in accordance with clinical evidence in published peer-reviewed medical literature in order to promote access to safe and effective medical services (subject to benefit design), and ensure compliance with applicable regulatory requirements. Medical policies provide clinical conclusions regarding the safety and/or efficacy of a device, service or technology. The MCO maintains policies and procedures for updating/modifying clinical criteria including: • Hierarchy of Clinical Evidence, • Medical Policy Update and Revision, • MTAC function and structure, • Specialty society review.

MH/SUD	M/S
or evidence-based literature, changes to practice standards and/or updates in instruments or tools used by the division. DSCYF has an identified group of professionals, including licensed behavioral health practitioners and a psychiatrist that is responsible for developing, reviewing, and updating the medical necessity criteria for services under the provision of the division. This group determines when these criteria should be reviewed/modified.	
Evidentiary Standards: MCO Evidentiary Standards: Clinical criteria were developed based on generally accepted standards of medical practice or if none exist, on physician specialty society recommendations or professional standards of care. The MCO relies on the following resources to maintain their standard set of evidence-based clinical policies and guidelines: • Input from clinical staff, providers and members; • Standards of practice from governmental sources such as the Centers for Medicare & Medicaid Services' (CMS) National Coverage Determinations and Local Coverage Determinations; • National guidelines, consensus statements, and other published scientific evidence. • Criteria are also based on guidelines from the American Society of Addiction Medicine (ASAM) guidelines. • Best Practice Guidelines developed by the American Psychiatric Associations and the American Academy of Child and Adolescent Psychiatry. The MCO may use additional literature or guidelines available from other organizations to support medical necessity decisions. DSCYF Evidentiary Standards: To develop medical necessity, DSCYF identified a group of qualified professionals (e.g., psychiatrists, licensed behavioral health practitioners) to develop the medical necessity criteria using documents from professional associations such as American Psychiatric Association (APA), American	**Evidentiary Standards:** MCO Evidentiary Standards: The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer- reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com.

MH/SUD	M/S
Academy of Child and Adolescent Psychiatry (AACAP), and American Society of Addiction Medicine (ASAM), peer-reviewed and research-based literature, and practice standards. DSCYF uses two evidence-based instruments to guide medical necessity determinations. The CASII was developed by AACAP as a tool to provide a standard for determining the appropriate level of services needed for the individual. DSCYF uses the CASII for children and adolescents presenting with psychiatric, psychosocial and/or developmental concerns. The ASAM Criteria is a national set of criteria for providing treatment for substance use and co-occurring disorders. Using evidence-based tools provides consistency in decision-making. DSCYF staff has been trained on the use of the CASII and ASAM by qualified instructors to ensure consistency in its use.	
Compliance Determination MCO MH/SUD to MCO M/S: Same as 1B – Outpatient – Adult **Compliance Determination DSCYF MH/SUD to MCO M/S:** For MH/SUD, DSCYF develops clinical criteria to ensure a standard decision making process is applied to medical necessity determinations and to ensure the member is receiving benefits that are safe and appropriate for their specific needs. For M/S, the MCO develops clinical guidelines in order to promote access to safe and effective medical services and ensure compliance with applicable regulatory requirements. DSCYF developed their criteria based on documents from professional associations such as American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), and American Society of Addiction Medicine (ASAM), peer-reviewed and research-based literature, and practice standards. For M/S, the MCO relies primarily on MCG Care guidelines or other nationally recognized guidelines (e.g., Hayes, ECRI Institute) as the basis for the development/modification of their clinical criteria and to assist clinicians in making informed decisions in health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations. DSCYF has a dedicated group of clinicians (licensed behavioral health practitioners, psychiatrist) who develop/update medical necessity criteria annually or as needed. DSYCF also utilizes the CASII and ASAM (adolescents only) criteria to support medical necessity determinations and level of care needs. The MCO has clinical committees and established clinical hierarchies to develop/modify new criteria. The MCO reviews and modifies criteria on an annual basis and has robust policy/procedures to develop or modify clinical criteria. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
2A – Prior Authorization – Inpatient – Adult	
Benefits: Managed by MCO:	**Benefits:** Managed by MCO:

MH/SUD	M/S
• Inpatient Mental Health • MH Residential (18-21 only)	• Cognitive Services (LTSS) • Nursing Facility Care (LTSS) • Community-Based Residential alternatives that Include Assisted Living Facilities (LTSS) • Bariatric surgery • Bone growth stimulator • BRCA genetic testing • Breast reconstruction (non-mastectomy) • Cardiology • Chemotherapy • Cochlear and other auditory implants • Cosmetic and reconstructive procedures • Gender dysphoria treatment • Enteral services • Experimental or investigational • Femoroacetabular impingement syndrome (FAI) • Functional endoscopic sinus surgery (FESS) • Injectable medications • Joint replacement • Orthognathic surgery • Private duty nursing • Proton beam therapy • Radiology • Rhinoplasty and septoplasty • Sinuplasty • Sleep apnea procedures and surgeries • Sleep studies • Spinal stimulator for pain management • Spinal surgery • Transplants • Vagus nerve stimulation • Vein procedures • Ventricular assist devices

MH/SUD	M/S
	• Wound vac
Processes: MCO Processes: Prior authorization (PA) is required for all MH inpatient benefits. To request authorization for MH inpatient services, the provider submits a request online or by phone or fax. The request must include specified clinical information demonstrating medical necessity. The PUMA IFR form captures member demographic, clinical and other biopsychosocial information. The request is reviewed by clinical staff such as independently licensed mental health clinician (i.e., RN, LPCC, LISW, etc.). Only a peer clinical reviewer can make an adverse benefit determination. Failure to request PA for MH inpatient services requiring PA will result in claim denial. However, there is a grace period of 48 hours or next business day over the weekends. Should a provider appeal a denial, the provider will need to establish proof of authorization or document mitigating circumstances. Following a review for medical necessity the claim may be paid in full. Unplanned admissions that are emergent or urgent and did not receive prior authorization for admission are reviewed retrospectively. Per SB109, the MCO may not require prior authorization for inpatient SUD. However, the MCO may conduct concurrent review after a specified number of days (see 3A – Concurrent Review – Inpatient – Adults), and may conduct a medical necessity review of inpatient SUD services using ASAM.	**Processes**: MCO Processes: PA is required for all M/S inpatient benefits. To request authorization for M/S inpatient services, the provider submits a request online or by phone or fax. The PA form captures (1) member demographic data, (2) requesting provider's information, and (3) requested benefits which must include specified clinical information demonstrating medical necessity. The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions. The request is reviewed by clinical staffs who are independently licensed Medical clinicians (i.e., RN). Only a peer clinical reviewer can make an adverse benefit determination. Failure to request PA for inpatient M/S services requiring PA will result in claim denial. However, there is a grace period of 48 hours or the next business day. Should a provider appeal a denial, the provider will need to establish proof of authorization or document mitigating circumstances. Following a review for medical necessity the claim may be paid in full. Unplanned admissions that are emergent or urgent and did not receive prior authorization for admission are reviewed retrospectively.
Strategies: MCO Strategies: PA is required for all MH benefits because inpatient care is expensive and high-intensity. PA ensures medical necessity is met and that the least restrictive and least intrusive appropriate supply/level of service is provided to a member. PA ensures MH provided on an inpatient basis only in instances where the member's symptoms or conditions required treatment that cannot be safely and effectively provided in a less restrictive setting. The number of visits or length of authorization is determined based on medical necessity criteria. On an annual basis, The MCO develops and	**Strategies**: MCO Strategies: PA is assigned to M/S inpatient services based on cost and potential for inappropriate utilization. The purpose of PA is to ensure that services are utilized appropriately. The number of visits or length of authorization is determined based on medical necessity criteria. The Medical Technology Assessment Committee (MTAC) and the National Medical Care Management Committee (NMCMC) review nationally recognized clinical practice and preventive guidelines. Maintenance of guidelines is completed by the Medical Policy Development Team and is performed annually.

MH/SUD	M/S
maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These policies are reviewed annually for accuracy or updates. The MCO's Clinical Technology Assessment Committee (CTAC) serves as the parallel arm to the MTAC committee described on Medical and functions within behavioral to review mental health technology as it emerges. Although inpatient SUD benefits are also expensive and high intensity, the MCO cannot apply PA to inpatient SUD benefits per SB109.	Medical policies (including technology assessments) are developed based on scientific evidence, where such evidence exists. In the absence of incontrovertible scientific evidence, medical policies may be based upon national consensus statements by recognized authorities. The MCO develops medical policies based upon clinical evidence published in peer-reviewed medical literature.
Evidentiary Standards: MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. The MCO's clinical criteria can be requested from the Case Reviewer and are available online at www.providerexpress.com/html/guidelines/index.html Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the MCO's Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. As new information becomes available this is reviewed annually in the level of care guidelines and will therefore be revised accordingly. The plan analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The plan also incorporates feedback on provider and consumer satisfaction in choosing services that require PA. The MCO reviews items for cost savings	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, the MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com.

MH/SUD	M/S
or potential cost savings versus the resource costs for prior authorization when it makes review decisions. These analyses are proprietary documents. It also applies any prior authorization requirements from Medicaid rules or the Managed Care provider agreement.	The plan analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The plan also incorporates feedback on provider and consumer satisfaction in choosing services that require PA. The MCO reviews items for cost savings or potential cost savings versus the resource costs for prior authorization when it makes review decisions. These analyses are proprietary documents. It also applies any prior authorization requirements from Medicaid rules or the Managed Care provider agreement.
Compliance Determination MCO MH/SUD to MCO M/S: Per SB109, the MCO may not require prior authorization of inpatient SUD; therefore the following only applies to MH benefits. Prior authorization is required for all MH and M/S inpatient benefits. PA is applied to inpatient MH benefits due to their high-cost and high-intensity. Similarly, PA is applied to inpatient M/S benefits due to high-cost and to monitor inpatient utilization. For both MH and M/S the MCO analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA .The PA processes, including the form, required documentation, options for making the request, review processes, and consequences for failure to request PA, are similar for both MH and M/S benefits. On an annual basis, for MH IP benefits the MCO develops and maintains clinical policies, which are developed by the MCO based on thorough reviews of professional/scientific journals and research, as well as input from the provider community. For M/S benefits the MCO relies on MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
2A – Prior Authorization – Inpatient – PROMISE	
Benefits: Managed by MCO: Same as 2A – Inpatient - Adult	**Benefits:** Managed by MCO: Same as 2A – Inpatient - Adult
Processes: MCO Processes: Same as 2A – Inpatient - Adult	**Processes**: MCO Processes: Same as 2A – Inpatient - Adult
Strategies: MCO Strategies: Same as 2A – Inpatient – Adult	**Strategies**: MCO Strategies: Same as 2A – Inpatient – Adult
Evidentiary Standards: MCO Evidentiary Standards:	**Evidentiary Standards:** MCO Evidentiary Standards:

<table>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td>Same as 2A – Inpatient – Adult</td><td>Same as 2A – Inpatient – Adult</td></tr>
<tr><td colspan="2"><u>Compliance Determination MCO MH/SUD to MCO M/S:</u>
Same as 2A – Inpatient – Adult</td></tr>
<tr><td colspan="2">2A – Prior Authorization – Inpatient – Children*</td></tr>
<tr><td>Benefits:
Managed by DSCYF:
• Inpatient Mental Health
• Psychiatric Residential Treatment Facility
• Residential Rehabilitation Services, Mental Health
• Crisis Residential Bed Services</td><td>Benefits:
Managed by MCO:
• Bariatric surgery
• Bone growth stimulator
• BRCA genetic testing
• Breast reconstruction (non-mastectomy)
• Cardiology
• Chemotherapy
• Cochlear and other auditory implants
• Cosmetic and reconstructive procedures
• Gender dysphoria treatment
• Enteral services
• Experimental or investigational
• Femoroacetabular impingement syndrome (FAI)
• Functional endoscopic sinus surgery (FESS)
• Injectable medications
• Joint replacement
• Orthognathic surgery
• Private duty nursing
• Proton beam therapy
• Radiology
• Rhinoplasty and septoplasty
• Sinuplasty
• Sleep apnea procedures and surgeries
• Sleep studies
• Spinal stimulator for pain management
• Spinal surgery
• Transplants</td></tr>
</table>

MH/SUD	M/S
	• Vagus nerve stimulation • Vein procedures • Ventricular assist devices • Wound vac
Processes: DSCYF Processes: Prior authorization is required for non-emergent inpatient MH benefits. Providers must receive a prior authorization from DSCYF before rendering services or the claims may be denied for reimbursement. Request for prior authorization must be submitted by fax or email to DSCYF for review. Specific forms are required. Specific forms are required and used to gather information on the child, the family/caregiver, insurance information, treatment history, agency information, brief assessment (risk of harm, functional status, co-occurring, recovery environment, resiliency and/or response to services and involvement in services), DSM-5 System Measure and signed consent documents. Prior authorizations are reviewed by licensed behavioral health professionals and responses are provided within two calendar days. Adverse determinations (denial) are made by DSCYF Medical Director. Per SB109, DSCYF may not require prior authorization for inpatient SUD. However, DSCYF may conduct concurrent review after a specified number of days (see 3A – Concurrent Review – Inpatient – Children), and may conduct a medical necessity review of inpatient SUD services using ASAM.	**Processes**: MCO Processes: PA is required for all M/S inpatient benefits. To request authorization for M/S inpatient services, the provider submits a request online or by phone or fax. The PA form captures (1) member demographic data, (2) requesting provider's information, and (3) requested benefits which must include specified clinical information demonstrating medical necessity. The request consists of (1) member demographic data, (2) requesting provider's information, and (3) requested benefits which must include specified clinical information demonstrating medical necessity. The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions. The request is reviewed by clinical staffs who are independently licensed Medical clinicians (i.e., RN). Only a peer clinical reviewer can make an adverse benefit determination. Failure to request PA for inpatient M/S services requiring PA will result in claim denial. However, there is a grace period of 48 hours or the next business day. Should a provider appeal a denial, the provider will need to establish proof of authorization or document mitigating circumstances. Following a review for medical necessity the claim may be paid in full. Unplanned admissions that are emergent or urgent and did not receive prior authorization for admission are reviewed retrospectively.
Strategies: DSCYF Strategies: Prior authorization is used to confirm eligibility, coverage, medical necessity, and appropriateness of services. The process also safeguards against unnecessary use of services, assures appropriate and quality treatment, manages risks, promotes coordinated case management and supports cost management. Prior authorization policy and procedure are reviewed annually by DSCYF to determine updates and revisions and	**Strategies**: MCO Strategies: PA is assigned to M/S inpatient services based on cost and potential for inappropriate utilization. The purpose of PA is to ensure that services are utilized appropriately. The number of visits or length of authorization is determined based on medical necessity criteria. The Medical Technology Assessment Committee (MTAC) and the National Medical Care Management Committee (NMCMC) review nationally recognized clinical

MH/SUD	M/S
approve via UQM Program. Although DSCYF's strategy for applying prior authorization to inpatient MH applies to inpatient SUD benefits, PA is not applied to SUD benefits per SB109.	practice and preventive guidelines. Maintenance of guidelines is completed by the Medical Policy Development Team and is performed annually. Medical policies (including technology assessments) are developed based on scientific evidence, where such evidence exists. In the absence of incontrovertible scientific evidence, medical policies may be based upon national consensus statements by recognized authorities. The MCO develops medical policies based upon clinical evidence published in peer-reviewed medical literature.
Evidentiary Standards: DSCYF Evidentiary Standards: DSCYF uses guidelines based on nationally recognized practices and standardized tools (ASAM and CASII). DSCYF adheres to Federal and State regulations to support the application of prior authorization as a strategy for quality and cost management. As a CARF accredited agency and good steward of the public dollar, DSCYF is required to implement a utilization and quality management program. DSCYF also uses the process to support quality and cost management through monitoring access and appropriate use of services.	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, the MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at

<table>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td></td><td>www.unitedhealthcareonline.com.

The plan analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The plan also incorporates feedback on provider and consumer satisfaction in choosing services that require PA. The MCO reviews items for cost savings or potential cost savings versus the resource costs for prior authorization when it makes review decisions. These analyses are proprietary documents. It also applies any prior authorization requirements from Medicaid rules or the Managed Care provider agreement.</td></tr>
<tr><td colspan="2"><u>Compliance Determination DSCYF MH/SUD to MCO M/S:</u>
Per SB109, DSCYF may not require the prior authorization of inpatient SUD benefits; therefore, the following only applies to MH benefits. Prior authorization is required for all MH and M/S inpatient benefits for children. For MH benefits, prior authorization is used to confirm eligibility, coverage, medical necessity, and appropriateness of services. For M/S benefits, PA is assigned based on cost and potential for inappropriate utilization. PA requirements for MH and M/S benefits are based on nationally-recognized, evidence-based criteria for inpatient levels of care for medical, behavioral health and substance abuse services. Both DSCYF and the MCO use nationally recognized guidelines including ASAM (adolescents only) and the CASII for MH and MCG for M/S benefits. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.</td></tr>
<tr><td colspan="2">2B – Prior Authorization – Outpatient – Adult</td></tr>
<tr><td>Benefits:
Managed by MCO:
• MH Partial Hospitalization
• MH Intensive Outpatient
• Outpatient ECT
• Psychological/Neuropsychological testing
• Peer Support Services
• Ambulatory Detox</td><td>Benefits:
Managed by MCO:
• Adult Day (LTSS)
• Cognitive Services (LTSS)
• Day Habilitation (LTSS)
• Home-Delivered Meals (LTSS)
• Abdominal paracentesis
• Bariatric surgery
• Bone growth stimulator
• BRCA genetic testing
• Breast reconstruction (non-mastectomy)
• Cardiology</td></tr>
</table>

MH/SUD	M/S
	• Cardiovascular • Carpal tunnel surgery • Cataract surgery • Chemotherapy • Cochlear and other auditory implants • Colonoscopy • Cosmetic and reconstructive procedures • Durable medical equipment • Gender dysphoria treatment • Ear, nose and throat procedures • Enteral services • Experimental or investigational • Femoroacetabular impingement syndrome (FAI) • Functional endoscopic sinus surgery (FESS) • Gynecologic procedures • Hernia repair • Home health care • Injectable medications • Joint replacement • Liver biopsy • Miscellaneous services • Non-emergent air ambulance transport • Ophthalmologic • Orthognathic surgery • Orthotics and prosthetics • Private duty nursing • Proton beam therapy • Radiology • Rhinoplasty and septoplasty • Sinuplasty • Sleep apnea procedures and surgeries • Sleep studies • Spinal stimulator for pain management

MH/SUD	M/S
	• Spinal surgery • Tonsillectomy and adenoidectomy • Transplants • Upper gastrointestinal endoscopy • Urologic procedures • Vagus nerve stimulation • Vein procedures • Ventricular assist devices • Wound vac Managed by DDDS (Lifespan 1915(c) HCBS waiver): • Day Habilitation • Personal Care • Prevocational Services • Respite • Supported Employment – Individual • Supported Employment – Small Group • Assistive Technology • Clinical Consultation: Behavioral • Clinical Consultation: Nursing • Home or Vehicle Accessibility Adaptations • Specialized Medical Equipment and Supplies • Supported Living Managed by DDDS (State Plan Rehab Services): • Individual Supported Employment • Group Supported Employment • Pre-Vocational Services • Day Habilitation Managed by DDDS and other agencies (Pathways to Employment (1915(i))): • Employment Navigation

MH/SUD	M/S
	• Financial Coaching Plus • Benefits Counseling • Non-Medical Transportation • Orientation, Mobility, and Assistive Technology • Career Exploration and Assessment • Small Group Supported Employment • Individual Supported Employment • Personal Care
Processes: MCO Processes: PA is required for certain MH OP benefits. To request authorization for MH outpatient services, the provider submits a request online or by phone or fax. The request must include specified clinical information demonstrating medical necessity. The PUMA IFR form captures member demographic, clinical and other biopsychosocial information. The request is reviewed by clinical staffs who are an independently licensed mental health clinician (i.e., RN, LPCC, and LISW). Only a peer clinical reviewer can make an adverse benefit determination. Failure to request PA for MH inpatient services requiring PA will result in claim denial. However, there is a grace period of 48 hours or next business day over the weekends. Should a provider appeal a denial, the provider will need to establish proof of authorization or document mitigating circumstances, following a review for medical necessity the claim may be paid in full. Unplanned admissions that are emergent or urgent and did not receive prior authorization for admission are reviewed retrospectively. Per SB109, the MCO may not require prior authorization for outpatient SUD. However, the MCO may conduct concurrent review after a specified number of days for certain OP SUD services (see 3A – Concurrent Review – Outpatient – Adults), and may conduct a medical necessity review of outpatient SUD services using ASAM.	**Processes:** MCO Processes: PA is required for certain M/S OP benefits. To request authorization for M/S outpatient services, the provider submits a request online or by phone or fax. The PA form captures (1) member demographic data, (2) requesting provider's information, and (3) requested benefits which must include specified clinical information demonstrating medical necessity. The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions. The request is reviewed by clinical staffs who are independently licensed Medical clinicians (i.e., RN). Only a peer clinical reviewer can make an adverse benefit determination. Failure to request PA for inpatient M/S services requiring PA will result in claim denial. However, there is a grace period of 48 hours or the next business day. Should a provider appeal a denial, the provider will need to establish proof of authorization or document mitigating circumstances. Following a review for medical necessity the claim may be paid in full. Unplanned admissions that are emergent or urgent and did not receive prior authorization for admission are reviewed retrospectively. DDDS Processes (Lifespan Waiver): All Lifespan waiver services must be prior authorized by DDDS. DDDS enters prior authorizations into the MMIS based on the waiver participant's person-centered plan (PCP), which is developed by the participant and his/her team in collaboration with the participant's care manager based on a

MH/SUD	M/S
	comprehensive assessment. Information on the amount, duration and frequency of each waiver service included in the PCP is entered into the MMIS. When a claim for a waiver service is submitted, the MMIS checks the claim against the prior authorization in the MMIS. If there is a match, the claim will process. Otherwise, the claim will be denied. DDDS Processes (State Plan Rehab Services): All DDDS state plan rehab services must be prior authorized by DDDS. DDDS enters prior authorizations into the MMIS based on the individual's plan of care, which is developed by the individual and his/her team in collaboration with the participant's care manager based on a completed comprehensive medical/psycho-social evaluation. Information on the amount, duration and frequency of each state plan rehab service included in the plan of care is entered into the MMIS. When a claim for a state plan rehab service is submitted, the MMIS checks the claim against the prior authorization in the MMIS. If there is a match, the claim will process. Otherwise, the claim will be denied. Managed by DDDS and other agencies (Pathways to Employment): All Pathways services must be prior authorized. Each Employment Navigator enters prior authorizations into the MMIS for all Pathways services based on the client's Employment Plan. The Employment plan is developed by the client and his/her team in collaboration with the participant's Employment Navigator and based on an independent assessment of the client. If a service has not been authorized, the claim will be denied.

MH/SUD	M/S
Strategies: MCO Strategies: PA is assigned to certain MH outpatient services based on cost and potential for inappropriate utilization. PA ensures medical necessity is met and that the least restrictive and least intrusive appropriate supply/level of service is provided to a member. PA ensures MH provided on an inpatient basis only in instances where the member's symptoms or conditions required treatment that cannot be safely and effectively provided in a less restrictive setting. The number of visits or length of authorization is determined based on medical necessity criteria. On an annual basis, the MCO develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These policies are reviewed annually for accuracy or updates. The MCO's Clinical Technology Assessment Committee (CTAC) serves as the parallel arm to the MTAC committee described on Medical and functions within behavioral to review mental health technology as it emerges. Although the MCO's strategy for applying prior authorization to outpatient MH benefits applies to certain outpatient SUD benefits, PA is not applied to outpatient SUD benefits per SB109.	**Strategies**: MCO Strategies: PA is assigned to certain M/S outpatient services based on cost and potential for inappropriate utilization. The purpose of PA is to ensure that services are utilized appropriately. The number of visits or length of authorization is determined based on medical necessity criteria. The Medical Technology Assessment Committee (MTAC) and the National Medical Care Management Committee (NMCMC) review nationally recognized clinical practice and preventive guidelines. Maintenance of guidelines is completed by the Medical Policy Development Team and is performed annually. Medical policies (including technology assessments) are developed based on scientific evidence, where such evidence exists. In the absence of incontrovertible scientific evidence, medical policies may be based upon national consensus statements by recognized authorities. The MCO develops medical policies based upon clinical evidence published in peer-reviewed medical literature. DDDS Strategies (Lifespan Waiver): Delaware requires prior authorization of Lifespan waiver services in order to meet federal requirements in 42 CFR 441.301 and ensure services are provided in accordance with a participant's PCP. DDDS Strategies (State Plan Rehab Services): PA is used to ensure that state plan rehab services are provided in accordance with the support hours indicated by the approved assessment tool (ICAP) and are provided in accordance with the individual's plan of care. DDDS and Other Agencies Strategies (Pathways to Employment): Delaware requires prior authorization of Pathways services in order to meet federal requirements in 42 CFR 441.745 and ensure participants receive services in accordance with their Employment Plan.

MH/SUD	M/S
Evidentiary Standards: MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. The MCO's clinical criteria can be requested from the Case Reviewer and are available online at www.providerexpress.com/html/guidelines/index.html Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the MCO's Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. As new information becomes available this is reviewed annually in the level of care guidelines and will therefore be revised accordingly. The plan analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The plan also incorporates feedback on provider and consumer satisfaction in choosing services that require PA. The MCO reviews items for cost savings or potential cost savings versus the resource costs for prior authorization when it makes review decisions. These analyses are proprietary documents. It also applies any prior authorization requirements from Medicaid rules or the Managed Care provider agreement.	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, the MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com. The plan analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The plan also incorporates feedback on provider and consumer satisfaction in choosing services that require PA. The MCO reviews items for cost savings or potential cost savings versus the resource costs for prior authorization when it makes review decisions. These analyses are proprietary documents. It also applies any prior authorization requirements from Medicaid rules or the Managed Care provider agreement. DDDS Evidentiary Standards (Lifespan Waiver):

MH/SUD	M/S
	Pursuant to 42 CFR 441.201(b)(1), Lifespan services must be provided under a written person-centered plan. In order to comply with this requirement, DDDS prior authorizes all Lifespan services based on each participant's PCP. DDDS Evidentiary Standards (State Plan Rehab Services): These services are unique in the manner that they are provided as they are directly related to the individual's support needs, which makes the number of hours quiet varied in order to yield the appropriate results for each person. These services must be prior authorized to ensure each individual receives the appropriate frequency and duration of the service for desired outcomes. DDDS Evidentiary Standards (Pathways to Employment): Pursuant to 42 CFR 441.745, the State must grant access to all 1915(i) services assessed to be needed in accordance with a service plan (Employment Plan), subject to the State's determination that provided services meet medical necessity criteria. In order to meet these requirements, Delaware prior authorizes all Pathways services based on each participant's service plan (Employment Plan).
Compliance Determination MCO MH/SUD to MCO M/S: Per SB109, the MCO may not require prior authorization for outpatient SUD benefits; therefore the following only applies to MH benefits. The MCO applies PA to certain outpatient MH benefits due to their high-cost and high-intensity, and PA is applied to certain outpatient M/S benefits due to high-cost and for monitoring utilization. The State also requires PA for certain outpatient M/S FFS services, but those strategies are not comparable to the strategies for MH/SUD benefits and therefore do not impact parity. For both MH and M/S the MCO analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The PA processes, including the form, required documentation, options for making the request, review processes, and consequences for failure to request PA, are similar for both MH and M/S benefits. On an annual basis, for MH IP benefits the MCO develops and maintains clinical policies, which are developed by the MCO based on thorough reviews of professional/scientific journals and research, as well as input from the provider community. For M/S benefits the MCO relies on MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	

MH/SUD	M/S
2B – Prior Authorization – Outpatient – PROMISE*	
Benefits: Managed by DSAMH: PROMISE • Benefits Counseling • Community Psychiatric Support and Treatment (CPST) • Psychosocial Rehabilitation (PSR) • Small Group and Supported Employment • Personal Care • Peer Supports • Individual Supported Employment • Assertive Community Treatment (ACT) • Nursing Services • Respite Services • Community Transition Services (Client Assistance Funds) • IADLs • Non-medical Transport • Group Homes, Community Based Residential Alternatives, SAP • Care Management MH • Psychotherapy with Patient • Psychoanalysis • Health and Behavior Assessment • Health and Behavior Intervention • Psychiatric Diagnostic Evaluations	**Benefits:** Managed by MCO: • Same as 2B – Outpatient – Adult Managed by DDDS: • Same as 2B – Outpatient – Adult
Processes: DSAMH Processes: Prior authorization is required before the delivery of certain OP services to PROMISE members. Authorized providers assess members according to Delaware medical necessity and ASAM criteria. PROMISE members are screened initially by the Eligibility and Enrollment Unit (EEU) using a brief screen to determine benefit coverage for PROMISE services. If clients are	**Processes:** MCO Processes: PA is required for certain M/S OP benefits. To request authorization for M/S outpatient services, the provider submits a request online or by phone or fax. The PA form captures (1) member demographic data, (2) requesting provider's information, and (3) requested benefits which must include specified clinical information demonstrating medical necessity. The request

MH/SUD	M/S
eligible for services then the brief screen and client information is referred to the PROMISE program. PROMISE Care Managers will assess for specific needs to include medical necessity determination and then PROMISE Care Managers develop a recovery plan that is re-assessed monthly/quarterly and plan and approved services are revised as necessary. For PROMISE members, the authorization process is managed by the EEU, who approve/deny authorizations. The State denies coverage when there is a failure to obtain prior authorization and a lack of medical necessity with no exceptions. PROMISE screenings by EEU that determine PA can occur in person or by phone; assessments for ACT, ICM or other PROMISE services are done in person by the PROMISE Assessment Center. Staff reviewing prior authorization requests for PROMISE members include RNs and Psychiatric Social Workers; some but not all are licensed. The DSAMH Medical Director can apply clinical discretion to change an authorization. Per SB109, DSMAH may not require prior authorization for outpatient SUD. However, DSAMH may conduct concurrent review after a specified number of days for certain OP SUD services (see 3A – Concurrent Review – Outpatient – PROMISE), and may conduct a medical necessity review of outpatient SUD services using ASAM.	consists of (1) member demographic data, (2) requesting provider's information, and (3) requested benefits which must include specified clinical information demonstrating medical necessity. The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions. The request is reviewed by clinical staffs who are independently licensed Medical clinicians (i.e., RN). Only a peer clinical reviewer can make an adverse benefit determination. Failure to request PA for inpatient M/S services requiring PA will result in claim denial. However, there is a grace period of 48 hours or the next business day. Should a provider appeal a denial, the provider will need to establish proof of authorization or document mitigating circumstances. Following a review for medical necessity the claim may be paid in full. Unplanned admissions that are emergent or urgent and did not receive prior authorization for admission are reviewed retrospectively. DDDS Processes (Lifespan Waiver): All Lifespan waiver services must be prior authorized by DDDS. DDDS enters prior authorizations into the MMIS based on the waiver participant's person-centered plan (PCP), which is developed by the participant and his/her team in collaboration with the participant's care manager based on a comprehensive assessment. Information on the amount, duration and frequency of each waiver service included in the PCP is entered into the MMIS. When a claim for a waiver service is submitted, the MMIS checks the claim against the prior authorization in the MMIS. If there is a match, the claim will process. Otherwise, the claim will be denied. DDDS Processes (State Plan Rehab Services): All DDDS state plan rehab services must be prior authorized by DDDS. DDDS enters prior authorizations into the MMIS based on the individual's plan of care, which is developed by the individual and his/her team in collaboration with the participant's care manager based on a completed comprehensive medical/psycho-social evaluation. Information on the amount, duration and frequency of each state plan rehab service included in

MH/SUD	M/S
	the plan of care is entered into the MMIS. When a claim for a state plan rehab service is submitted, the MMIS checks the claim against the prior authorization in the MMIS. If there is a match, the claim will process. Otherwise, the claim will be denied. Managed by DDDS and other agencies (Pathways to Employment): All Pathways services must be prior authorized. Each Employment Navigator enters prior authorizations into the MMIS for all Pathways services based on the client's Employment Plan. The Employment plan is developed by the client and his/her team in collaboration with the participant's Employment Navigator and based on an independent assessment of the client. If a service has not been authorized, the claim will be denied.
Strategies: DSAMH Strategies: For PROMISE benefits, PA is necessary to ensure that the correct modality of services is applied to a specific target population that uses hospitalization at a higher rate. For MH benefits, PA is used to apply the least-restrictive environment. Additionally, PA acts as cost-containment by avoiding unnecessary higher levels of care. Member outcomes historically did not show better outcomes with more restrictive levels of care for extended periods. All services listed above in this classification are subject to this NQTL. Medical necessity and appropriateness criteria are reviewed and updated as often as evidence based practices are updated (i.e., fidelity scales) or feedback is provided from SAMHSA. Although DSAMH's strategy for applying prior authorization to outpatient MH benefits applies to certain outpatient SUD benefits, PA is not applied to outpatient SUD benefits per SB109.	**Strategies**: MCO Strategies: PA is assigned to certain M/S outpatient services based on cost and potential for inappropriate utilization. The purpose of PA is to ensure that services are utilized appropriately. The number of visits or length of authorization is determined based on medical necessity criteria. The Medical Technology Assessment Committee (MTAC) and the National Medical Care Management Committee (NMCMC) review nationally recognized clinical practice and preventive guidelines. Maintenance of guidelines is completed by the Medical Policy Development Team and is performed annually. Medical policies (including technology assessments) are developed based on scientific evidence, where such evidence exists. In the absence of incontrovertible scientific evidence, medical policies may be based upon national consensus statements by recognized authorities. The MCO develops medical policies based upon clinical evidence published in peer-reviewed medical literature. DDDS Strategies (Lifespan Waiver): Delaware requires prior authorization of Lifespan waiver services in order to meet federal requirements in 42 CFR 441.301 and ensure services are

MH/SUD	M/S
	provided in accordance with a participant's PCP. DDDS Strategies (State Plan Rehab Services): PA is used to ensure that state plan rehab services are provided in accordance with the support hours indicated by the approved assessment tool (ICAP) and are provided in accordance with the individual's plan of care. DDDS and Other Agencies Strategies (Pathways to Employment): Delaware requires prior authorization of Pathways services in order to meet federal requirements in 42 CFR 441.745 and ensure participants receive services in accordance with their Employment Plan.
Evidentiary Standards: DSAMH Evidentiary Standards: PROMISE and MH services use Delaware ASAM. In order to continue the PROMISE waiver program, cost-effectiveness must be demonstrated as compared to hospitalization costs. Success of PROMISE services is measured by frequency of hospitalizations and how many people obtain employment and housing. MH success is measured by frequency of relapse, frequency of treatment episodes, and length of stay. For more information on PROMISE please see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/de/de-dshp-fs.pdf. ACT is specifically designed for individuals diagnosed with SPMI and a history of multiple hospitalizations. ACT is surveyed using the TMACT Fidelity Scale to ensure compliance with this EBP. No modification has been made to TMACT. http://www.store.samhsa.gov/shin/content//SMA08-4345/GettingStarted-ACT.pdf	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the

MH/SUD	M/S
	guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com. The plan analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The plan also incorporates feedback on provider and consumer satisfaction in choosing services that require PA. The MCO reviews items for cost savings or potential cost savings versus the resource costs for prior authorization when it makes review decisions. These analyses are proprietary documents. It also applies any prior authorization requirements from Medicaid rules or the Managed Care provider agreement. DDDS Evidentiary Standards (Lifespan Waiver): Pursuant to 42 CFR 441.201(b)(1), Lifespan services must be provided under a written person-centered plan. In order to comply with this requirement, DDDS prior authorizes all Lifespan services based on each participant's PCP. DDDS Evidentiary Standards (State Plan Rehab Services): These services are unique in the manner that they are provided as they are directly related to the individual's support needs, which makes the number of hours quiet varied in order to yield the appropriate results for each person. These services must be prior authorized to ensure each individual receives the appropriate frequency and duration of the service for desired outcomes. DDDS Evidentiary Standards (Pathways to Employment): Pursuant to 42 CFR 441.745, the State must grant access to all 1915(i) services assessed to be needed in accordance with a service plan

MH/SUD	M/S
	(Employment Plan), subject to the State's determination that provided services meet medical necessity criteria. In order to meet these requirements, Delaware prior authorizes all Pathways services based on each participant's service plan (Employment Plan).
Compliance Determination DSAMH MH/SUD to MCO M/S: Per SB109, DSAMH may not require prior authorization for outpatient SUD benefits; therefore, the following only applies to MH benefits. PA is applied to outpatient MH benefits due to their high-cost and high-intensity and to ensure that the correct modality of services is applied to a specific target population that uses hospitalization at a higher rate. For M/S, the MCO assign PA to certain benefits based on cost and potential inappropriate utilization. The State also requires PA for certain outpatient M/S FFS services, but those strategies are not comparable to the strategies for MH benefits and therefore do not impact parity. Both DSAMH (MH) and the MCO (M/S) analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The number of visits or length of authorization is determined based on medical necessity criteria. For both MH and M/S, providers are required to provide documentation supporting the PA request including meeting medical necessity requirements and program eligibility. DSAMH relies on the DE ASAM criteria for medical necessity determinations whereas the MCO rely on MCG and other generally accepted standards. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
2B – Prior Authorization – Outpatient – Children*	
Benefits: Managed by MCO: • MH Intensive Outpatient • Psychological Testing • Neuropsychological Testing • Behavioral Health Assessment • Specialist/Treatment Plan Development Managed by DSCYF: • MH Partial Hospitalization • Outpatient, Mental Health • Therapeutic Support for Families (CPST, FPSS, and PSR) • Evidence Based Practices (MST, DBT, FBMHS, FFT) • Day Treatment, Mental Health • Crisis Intervention Services	**Benefits:** Managed by MCO: • Abdominal paracentesis • Bariatric surgery • Bone growth stimulator • BRCA genetic testing • Breast reconstruction (non-mastectomy) • Cardiology • Cardiovascular • Carpal tunnel surgery • Cataract surgery • Chemotherapy • Cochlear and other auditory implants • Colonoscopy • Cosmetic and reconstructive procedures

MH/SUD	M/S
• Parent-Child Interaction Therapy (PCIT)	• Durable medical equipment • Gender dysphoria treatment • Ear, nose and throat procedures • Enteral services • Experimental or investigational • Femoroacetabular impingement syndrome (FAI) • Functional endoscopic sinus surgery (FESS) • Gynecologic procedures • Hernia repair • Home health care • Injectable medications • Joint replacement • Liver biopsy • Miscellaneous services • Non-emergent air ambulance transport • Ophthalmologic • Orthognathic surgery • Orthotics and prosthetics • Private duty nursing • Proton beam therapy • Radiology • Rhinoplasty and septoplasty • Sinuplasty • Sleep apnea procedures and surgeries • Sleep studies • Spinal stimulator for pain management • Spinal surgery • Tonsillectomy and adenoidectomy • Transplants • Upper gastrointestinal endoscopy • Urologic procedures • Vagus nerve stimulation • Vein procedures

MH/SUD	M/S
	• Ventricular assist devices • Wound vac Managed by DDDS (Lifespan 1915c HCBS waiver): • Day Habilitation • Personal Care • Prevocational Services • Respite • Supported Employment – Individual • Supported Employment – Small Group • Assistive Technology • Clinical Consultation: Behavioral • Clinical Consultation: Nursing • Home or Vehicle Accessibility Adaptations • Specialized Medical Equipment and Supplies • Supported Living Managed by DDDS (State Plan Rehab Services): • Individual Supported Employment • Group Supported Employment • Pre-Vocational Services • Day Habilitation Managed by DDDS and other agencies (Pathways to Employment (1915(i))): • Employment Navigation • Financial Coaching Plus • Benefits Counseling • Non-Medical Transportation • Orientation, Mobility, and Assistive Technology • Career Exploration and Assessment • Small Group Supported Employment • Individual Supported Employment

MH/SUD	M/S
	• Personal Care Managed by DMMA: • Prescribed Pediatric Extended Care (PPEC)
Processes: MCO Processes: PA is required for certain MH OP benefits. To request authorization for MH outpatient services, the provider submits a request online or by phone or fax. The request must include specified clinical information demonstrating medical necessity. The PUMA IFR form captures member demographic, clinical and other biopsychosocial information. The request is reviewed by clinical staffs who are an independently licensed mental health clinician (i.e., RN, LPCC, and LISW). Only a peer clinical reviewer can make an adverse benefit determination. Failure to request PA for MH inpatient services requiring PA will result in claim denial. However, there is a grace period of 48 hours or next business day over the weekends. Should a provider appeal a denial, the provider will need to establish proof of authorization or document mitigating circumstances, following a review for medical necessity the claim may be paid in full. Unplanned admissions that are emergent or urgent and did not receive prior authorization for admission are reviewed retrospectively. Per SB109, the MCO may not require prior authorization for outpatient SUD. However, the MCO may conduct concurrent review after a specified number of days for certain OP SUD services (see 3A – Concurrent Review – Outpatient – Children), and may conduct a medical necessity review of outpatient SUD services using ASAM. DSCYF Processes: Prior authorization is required for certain outpatient mental health benefits. Services subject to prior authorization are non-emergent. Providers must receive a prior authorization from DSCYF before rendering services or the claims may be denied for reimbursement. Request for prior authorization	**Processes:** MCO Processes: PA is required for certain M/S OP benefits. To request authorization for M/S outpatient services, the provider submits a request online or by phone or fax. The PA form captures (1) member demographic data, (2) requesting provider's information, and (3) requested benefits which must include specified clinical information demonstrating medical necessity. The request consists of (1) member demographic data, (2) requesting provider's information, and (3) requested benefits which must include specified clinical information demonstrating medical necessity. The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions. The request is reviewed by clinical staffs who are independently licensed Medical clinicians (i.e., RN). Only a peer clinical reviewer can make an adverse benefit determination. Failure to request PA for inpatient M/S services requiring PA will result in claim denial. However, there is a grace period of 48 hours or the next business day. Should a provider appeal a denial, the provider will need to establish proof of authorization or document mitigating circumstances. Following a review for medical necessity the claim may be paid in full. Unplanned admissions that are emergent or urgent and did not receive prior authorization for admission are reviewed retrospectively. DDDS Processes (Lifespan Waiver): All Lifespan waiver services must be prior authorized by DDDS. DDDS enters prior authorizations into the MMIS based on the waiver participant's person-centered plan (PCP), which is developed by the participant and his/her team in collaboration with the participant's care manager based on a comprehensive assessment. Information on the amount, duration and frequency of each waiver service included in the PCP is entered into the

MH/SUD	M/S
must be submitted by fax or email to DSCYF for review, specific forms are required. Specific forms are required and used to gather information on the child, the family/caregiver, insurance information, treatment history, agency information, brief assessment (risk of harm, functional status, co-occurring, recovery environment, resiliency and/or response to services and involvement in services), DSM-5 System Measure and signed consent documents. Prior authorizations are reviewed by licensed behavioral health professionals and responses are provided within two calendar days. Adverse determinations (denial) are made by DSCYF Medical Director. Per SB109, DSCYF may not require prior authorization for outpatient SUD. However, DSCYF may conduct concurrent review after a specified number of days for certain OP SUD services (see 3A – Concurrent Review – Outpatient – Children), and may conduct a medical necessity review of outpatient SUD services using ASAM.	MMIS. When a claim for a waiver service is submitted, the MMIS checks the claim against the prior authorization in the MMIS. If there is a match, the claim will process. Otherwise, the claim will be denied. DDDS Processes (State Plan Rehab Services): All DDDS state plan rehab services must be prior authorized by DDDS. DDDS enters prior authorizations into the MMIS based on the individual's plan of care, which is developed by the individual and his/her team in collaboration with the participant's care manager based on a completed comprehensive medical/psycho-social evaluation. Information on the amount, duration and frequency of each state plan rehab service included in the plan of care is entered into the MMIS. When a claim for a state plan rehab service is submitted, the MMIS checks the claim against the prior authorization in the MMIS. If there is a match, the claim will process. Otherwise, the claim will be denied. Managed by DDDS and other agencies (Pathways to Employment): All Pathways services must be prior authorized. Each Employment Navigator enters prior authorizations into the MMIS for all Pathways services based on the client's Employment Plan. The Employment plan is developed by the client and his/her team in collaboration with the participant's Employment Navigator and based on an independent assessment of the client. If a service has not been authorized, the claim will be denied. DMMA Processes (PPEC): All PPEC services must be prior authorized. Each request is reviewed on an individual basis, using policies established by the State. The attending physician requests a referral to evaluate for payment of PPEC services by submitting a letter to the State's Medical Evaluation Team (MET) that documents required information, including that the child would need inpatient hospital or nursing home care without PPEC services, and estimated time/duration of required services. Parents must provide

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	documentation that their child is severely disabled (must meet Delaware's Children Community Alternative Disability Program Eligibility requirement or be considered disabled under the Social Security Administration regulations) along with the most recent Individual Family Service Plan (IFSP) or Individualized Education Plan (IEP) as applicable. The MET evaluates the child and completes a scoring sheet to determine the reimbursable PPEC level of care (half day or full day). In general, the State will deny payment for services that are provided without prior authorization.
Strategies: MCO Strategies: PA is assigned to certain MH outpatient services based on cost and potential for inappropriate utilization. PA ensures medical necessity is met and that the least restrictive and least intrusive appropriate supply/level of service is provided to a member. PA ensures MH provided on an inpatient basis only in instances where the member's symptoms or conditions required treatment that cannot be safely and effectively provided in a less restrictive setting. The number of visits or length of authorization is determined based on medical necessity criteria. On an annual basis, the MCO develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These policies are reviewed annually for accuracy or updates. The MCO's Clinical Technology Assessment Committee (CTAC) serves as the parallel arm to the MTAC committee described on Medical and functions within behavioral to review mental health technology as it emerges. Although the MCO's strategy for applying prior authorization to outpatient MH benefits applies to certain outpatient SUD benefits, PA is not applied to outpatient SUD benefits per SB109. DSCYF Strategies: Prior authorization is used to confirm eligibility, coverage, medical	**Strategies**: MCO Strategies: PA is assigned to certain M/S outpatient services based on cost and potential for inappropriate utilization. The purpose of PA is to ensure that services are utilized appropriately. The number of visits or length of authorization is determined based on medical necessity criteria. The Medical Technology Assessment Committee (MTAC) and the National Medical Care Management Committee (NMCMC) review nationally recognized clinical practice and preventive guidelines. Maintenance of guidelines is completed by the Medical Policy Development Team and is performed annually. Medical policies (including technology assessments) are developed based on scientific evidence, where such evidence exists. In the absence of incontrovertible scientific evidence, medical policies may be based upon national consensus statements by recognized authorities. The MCO develops medical policies based upon clinical evidence published in peer-reviewed medical literature. DDDS Strategies (Lifespan Waiver): Delaware requires prior authorization of Lifespan waiver services in order to meet federal requirements in 42 CFR 441.301 and ensure services are provided in accordance with a participant's PCP. DDDS Strategies (State Plan Rehab Services): PA is used to ensure that state plan rehab services are provided in accordance with the support hours indicated by the approved assessment

MH/SUD	M/S
necessity, and appropriateness of services. The process also safeguards against unnecessary use of services, assures appropriate and quality treatment, manages risks, promotes coordinated case management and supports cost management. Prior authorization policy and procedure are reviewed annually by DSCYF to determine updates and revisions and approve via UQM Program. Although DSCYF's strategy for applying prior authorization to outpatient MH benefits applies to certain outpatient SUD benefits, PA is not applied to outpatient SUD benefits per SB109.	tool (ICAP) and are provided in accordance with the individual's plan of care. DDDS and Other Agencies Strategies (Pathways to Employment): Delaware requires prior authorization of Pathways services in order to meet federal requirements in 42 CFR 441.745 and ensure participants receive services in accordance with their Employment Plan. DMMA Strategies (PPEC): PPEC is an expensive service designed for children who have intensive needs and meet specified criteria. Prior authorization allows Delaware to ensure that the children receiving PPEC meet the applicable criteria and receive the appropriate level of care.
Evidentiary Standards: MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. The MCO's clinical criteria can be requested from the Case Reviewer and are available online at www.providerexpress.com/html/guidelines/index.html Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the MCO's Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. As new information becomes available this is reviewed annually in the level of care guidelines and will therefore be revised accordingly. The plan analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The plan also incorporates	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, the MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty

MH/SUD	M/S
feedback on provider and consumer satisfaction in choosing services that require PA. The MCO reviews items for cost savings or potential cost savings versus the resource costs for prior authorization when it makes review decisions. These analyses are proprietary documents. It also applies any prior authorization requirements from Medicaid rules or the Managed Care provider agreement. DSCYF Evidentiary Standards: DSCYF uses guidelines based on nationally recognized practices and standardized tools (ASAM and CASII). DSCYF adheres Federal and State regulations to support the application of prior authorization as a strategy for quality and cost management. As a CARF accredited agency and good steward of the public dollar, DSCYF is required to implement a utilization and quality management program. DSCYF also uses the process to support quality and cost management through monitoring access and appropriate use of services.	organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com. The plan analyzes data relevant to the reasons for assigning PA (e.g., high cost, over-utilization) to determine what services are assigned PA. The plan also incorporates feedback on provider and consumer satisfaction in choosing services that require PA. The MCO reviews items for cost savings or potential cost savings versus the resource costs for prior authorization when it makes review decisions. These analyses are proprietary documents. It also applies any prior authorization requirements from Medicaid rules or the Managed Care provider agreement. DDDS Evidentiary Standards (Lifespan Waiver): Pursuant to 42 CFR 441.201(b)(1), Lifespan services must be provided under a written person-centered plan. In order to comply with this requirement, DDDS prior authorizes all Lifespan services based on each participant's PCP. DDDS Evidentiary Standards (State Plan Rehab Services): These services are unique in the manner that they are provided as they are directly related to the individual's support needs, which makes the number of hours quiet varied in order to yield the appropriate results for each person. These services must be prior authorized to ensure each individual receives the appropriate frequency and duration of the service for desired outcomes. DDDS Evidentiary Standards (Pathways to Employment): Pursuant to 42 CFR 441.745, the State must grant access to all 1915(i)

MH/SUD	M/S
	services assessed to be needed in accordance with a service plan (Employment Plan), subject to the State's determination that provided services meet medical necessity criteria. In order to meet these requirements, Delaware prior authorizes all Pathways services based on each participant's service plan (Employment Plan). DMMA Evidentiary Standards (PPEC): In comparison to traditional day care facilities, PPECs are staffed by registered nurses, occupational therapists, physical therapists, and dieticians, which makes them more expensive than traditional day care facilities.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 2B – Outpatient – Adult **Compliance Determination DSCYF MH/SUD to MCO M/S.** Per SB109, DSCYF may not require prior authorization for outpatient SUD benefits; therefore, the following only applies to MH benefits. For listed MH benefits, DSCYF apply prior authorization to confirm eligibility, coverage, medical necessity, and appropriateness of services. For M/S benefits, the MCO apply PA based on cost and potential for inappropriate utilization. The State also requires PA for certain outpatient M/S FFS services, but those strategies are not comparable to the strategies for MH/SUD benefits and do not impact parity. DMMA require PA for PPEC benefits since these are expensive services designed for children who meet specific criteria and have a high level of need. PA requirements for both MH and M/S benefits are based on nationally-recognized, evidence-based criteria for outpatient levels of care for medical and mental health services. Both DSCYF and the MCO use nationally recognized guidelines including ASAM (adolescents only) and the CASII for MH and MCG for M/S benefits. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
2D – Prior Authorization – Prescription Drugs – All Benefit Packages (Adults, PROMISE, and Children)	
Benefits: Managed by MCO: Certain MH/SUD prescription Drugs	**Benefits:** Managed by MCO: Certain M/S prescription Drugs
Processes: MCO Processes: Prior authorization is required when a provider prescribes non-formulary/non-PDL medication or certain formulary medications that have precursor therapies, specific indications, or not routinely covered due to	**Processes:** MCO Processes: Prior authorization is required when a provider prescribes non-formulary/non-PDL medication or certain formulary medications that have precursor therapies, specific indications, or not routinely covered due to

MH/SUD	M/S
plan Benefit Limitations or Exclusions. To obtain prior authorization for a drug, the prescriber may either call the request in to the MCO's prior authorization phone line or fax a completed request form to the MCO. The MCO also allows for pharmacy prior authorization requests to be submitted via the web. The prior authorization request is received by the pharmacy prior authorization unit and a clinical review for medical necessity is conducted. The request is reviewed against the applicable clinical policy and must be completed in the amount of time allotted based upon the urgency of the request. Requests for prior authorization will be evaluated within 24 hours by pharmacy staff. If required, a 72-hour emergency supply can be dispensed if a request is submitted after business hours and the delay in therapy will result in loss of life, limb or organ functions. Prior to a denial, an outbound telephone call is performed to the provider to obtain all clinical information required to support approval of the request. Once the review is complete notice of action is sent to both the member and provider. If the notice of action is a denial then the member and provider are advised of their options and Appeals Rights.	plan Benefit Limitations or Exclusions. To obtain prior authorization for a drug, the prescriber may either call the request in to the MCO's prior authorization phone line or fax a completed request form to the MCO. The MCO also allows for pharmacy prior authorization requests to be submitted via the web. The prior authorization request is received by the pharmacy prior authorization unit and a clinical review for medical necessity is conducted. The request is reviewed against the applicable clinical policy and must be completed in the amount of time allotted based upon the urgency of the request. Requests for prior authorization will be evaluated within 24 hours by pharmacy staff. If required, a 72-hour emergency supply can be dispensed if a request is submitted after business hours and the delay in therapy will result in loss of life, limb or organ functions. Prior to a denial, an outbound telephone call is performed to the provider to obtain all clinical information required to support approval of the request. Once the review is complete notice of action is sent to both the member and provider. If the notice of action is a denial then the member and provider are advised of their options and Appeals Rights.

MH/SUD	M/S
Strategies: MCO Strategies: Circumstances leading the DUR board to recommend the requirement of prior authorization include, but are not limited to, the following: • Medical necessity is not clearly evident. • Potential for diversion, misuse and abuse. • High cost of care relative to similar therapies. • Opportunity for unlabeled use defined as the use of a drug product in doses, patient populations, indications, or routes of administration that are not reflected in the FDA approved product labeling. • Medications may be limited to the maximum FDA approved dose. • Medications may be limited to the minimum FDA approved age limitations. • Drug classes where there is an identified potential for not keeping within the DMMA policy guidelines. • New drugs that come to market that are in one of the therapeutic categories covered by the Preferred Drug List. • The cost of the dispensed prescription exceeds $500.	**Strategies:** MCO Strategies: Circumstances leading the DUR board to recommend the requirement of prior authorization include, but are not limited to, the following: • Medical necessity is not clearly evident. • Potential for diversion, misuse and abuse. • High cost of care relative to similar therapies. • Opportunity for unlabeled use defined as the use of a drug product in doses, patient populations, indications, or routes of administration that are not reflected in the FDA approved product labeling. • Medications may be limited to the maximum FDA approved dose. • Medications may be limited to the minimum FDA approved age limitations. • Drug classes where there is an identified potential for not keeping within the DMMA policy guidelines. • New drugs that come to market that are in one of the therapeutic categories covered by the Preferred Drug List. • The cost of the dispensed prescription exceeds $500.
Evidentiary Standards: MCO Evidentiary Standards: • The Social Security Act, section 1927(d) (1) allows prior authorization as a permissible restriction for covered outpatient drugs. • Certain drugs, for example those in Social Security Act section 1927(d)(2), may have both medically-necessary indications and lifestyle indications. In these cases, in order to verify medical necessity, prior authorization is required. • Pain medications such as opioids have a high street value and are prone to addiction and misuse. One recent case involving 12 U.S. attorneys' offices resulted in $150 million in DEA civil penalties against McKesson Corp., a distributor of pharmaceuticals, to address its failure to report suspicious opioid orders. Prior authorization for drugs with this potential helps to manage and monitor the quantity being dispensed. • In Step Therapy, cost-effective treatments are preferred over more	**Evidentiary Standards**: MCO Evidentiary Standards: • The Social Security Act, section 1927(d) (1) allows prior authorization as a permissible restriction for covered outpatient drugs. • Certain drugs, for example those in Social Security Act section 1927(d)(2), may have both medically-necessary indications and lifestyle indications. In these cases, in order to verify medical necessity, prior authorization is required. • Pain medications such as opioids have a high street value and are prone to addiction and misuse. One recent case involving 12 U.S. attorneys' offices resulted in $150 million in DEA civil penalties against McKesson Corp., a distributor of pharmaceuticals, to address its failure to report suspicious opioid orders. Prior authorization for drugs with this potential helps to manage and monitor the quantity being dispensed. • In Step Therapy, cost-effective treatments are preferred over more

MH/SUD	M/S
expensive equivalent treatments. To gain exception to trying and failing the cost-effective option, prior authorization may be used. • Opportunity exists for unlabeled use defined as the use of a drug product in doses, patient populations, indications, or routes of administration that are not reflected in the FDA approved product labeling. – Medications may be limited to the maximum FDA approved dose. – Medications may be limited to the minimum FDA approved age limitations. Newer or brand drugs often have a high cost relative to similar therapies.	expensive equivalent treatments. To gain exception to trying and failing the cost-effective option, prior authorization may be used. • Opportunity exists for unlabeled use defined as the use of a drug product in doses, patient populations, indications, or routes of administration that are not reflected in the FDA approved product labeling. – Medications may be limited to the maximum FDA approved dose. – Medications may be limited to the minimum FDA approved age limitations. Newer or brand drugs often have a high cost relative to similar therapies.
Compliance Determination MCO MH/SUD TO MCO M/S: Prior authorization for prescription drugs can be recommended based on factors where medical necessity is not clearly evident, when there is potential for diversion, misuse and abuse, when a drug is high cost compared to other similar therapies, when a drug is being used for an unlabeled use, when a drug is being prescribed outside of the recommended dose and age ranges, or when the drug is on the Preferred Drug List. Section 1927(d)(1) of the Social Security Act, allows for prior authorization of prescription drugs. The Food and Drug Administration (FDA) provides guidelines on clinically appropriate use of prescription drugs. Prior authorization criteria for the appropriate use of prescription drugs are developed according to the guidelines established under the federal regulation as well as the guidelines established by the FDA for clinically appropriate drug use. Prior authorization requirements are established similarly for both MH/SUD and M/S prescription drugs. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
3A – Concurrent Review – Inpatient – Adult	
Benefits: Managed by MCO: • Same as 2A – Inpatient – Adult • Inpatient Substance Abuse Residential Detoxification • Substance Abuse Rehabilitation • SA Residential Treatment Facility	**Benefits:** Managed by MCO: • Same as 2A – Inpatient - Adult
Processes: MCO Processes: Concurrent reviews follow the same process as a standard prior authorization request. Concurrent reviews are applied when a certain benefit is requested by a provider, facility and or member to extend beyond	**Processes:** MCO Processes: Concurrent reviews follow the same process as a standard prior authorization request. Concurrent reviews are applied when a certain benefit is requested by a provider, facility and or member to extend beyond

MH/SUD	M/S
the initial authorization period or, for inpatient SUD, per the concurrent review requirements of SB109. The request is reviewed by the MCO's clinical staff (independently licensed mental health clinician i.e., RN, LPCC, LISW, etc.) and usually begins the first business day following admission to a program. Clinical information is solicited from facilities and providers as required and peer-to-peer consultations are also utilized. The review is conducted by telephone or on-site and may include a review of Electronic Medical Records (EMR) as needed. Should a reviewer believe that an admission or continued stay is not an appropriate use of benefit coverage; the attending physician/facility may be required to furnish more information concerning the treatment and case management plan. The reviewer may also refer the case to the MCO's Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. The attending physician/facility has sole authority and responsibility for the medical care of patients and the MCO never directs providers to discharge patients following a medical necessity review. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy. Per SB109, concurrent review does not occur for SUD benefits until after the first 14 days of an inpatient/residential admission or five days of inpatient withdrawal management. The treating facility is required to notify the MCO of the admission and the initial treatment plan within 48 hours of a member's admission. Each treating facility is required to use ASAM criteria for SUD benefits to establish the appropriate level of care for a member.	the initial authorization period. The request is reviewed by the MCO's clinical staff (independently licensed medical clinicians i.e., RN) and usually begins the first business day following admission to a program. Clinical information is solicited from facilities and providers as required and peer-to-peer consultations are also utilized. The review is conducted by telephone or on-site and may include a review of Electronic Medical Records (EMR) as needed. Should a reviewer believe that an admission or continued stay is not an appropriate use of benefit coverage; the attending physician/facility may be required to furnish more information concerning the treatment and case management plan. The reviewer may also refer the case to the Plan's Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. The attending physician/facility has sole authority and responsibility for the medical care of patients and the MCO never directs providers to discharge patients following a medical necessity review. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy.
Strategies: MCO Strategies: Concurrent review is part of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period or, for inpatient SUD benefits, per the concurrent review requirements in	**Strategies:** MCO Strategies: Concurrent review is part of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period. Concurrent reviews are also applied to gather/review information needed for

MH/SUD	M/S
SB109. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. Medical necessity determinations are based on clinical guidelines developed by the MCO or ASAM. The number of visits or length of authorization is determined based on medical necessity criteria and the plan's clinical guidelines. Hospitalizations are also reviewed to identify and better manage over- and under-utilization and to determine whether ongoing treatment is consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines.	discharge planning, quality improvement and referrals to case management. Medical necessity determinations are based on the MCO's generally accepted standards of medical practice. The number of visits or length of authorization is determined based on medical necessity criteria and the plan's clinical guidelines. Hospitalizations are also reviewed to identify and better manage over- and under-utilization and to determine whether ongoing treatment is consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines.
Evidentiary Standards: MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. The MCO's clinical criteria can be requested from the Case Reviewer and are available online at www.providerexpress.com/html/guidelines/index.html. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the MCO's Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. As new information becomes available this is reviewed annually in the level of care guidelines and will therefore be revised accordingly. This includes treatment provided in an inpatient or residential setting and inpatient withdrawal management per SB109.	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, the MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all

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	necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com.
Compliance Determination MCO MH/SUD to MCO M/S: Concurrent review is a component of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period or, for inpatient SUD benefits, per concurrent review requirements of SB109. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. Medical necessity and clinical criteria are based on the MCO's clinical guidelines and ASAM for MH/SUD benefits and nationally recognized clinical guidelines for M/S benefits. Concurrent reviews follow the same process as prior authorizations and are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period or, for SUD benefits that cannot be prior authorized pursuant to SB109, per the concurrent review requirements in SB109. The process is the same for MH/SUD and M/S benefits and reviews are conducted by qualified staff either via telephone or onsite. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
3A – Concurrent Review – Inpatient – PROMISE*	
Benefits: Managed by MCO: • Same as 2A – Inpatient – PROMISE • Medically managed intensive inpatient detoxification Managed by DSAMH: • Subacute Detoxification, Inpatient • Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) • Alcohol and Drug Treatment Program (Residential Rehab)	**Benefits:** Managed by MCO: • Same as 2A – Inpatient – Adult
Processes: MCO Processes: Concurrent reviews follow the same process as a standard prior authorization request. Concurrent reviews are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period or, for inpatient SUD, per the concurrent review requirements of SB109. The request is reviewed by The MCO's	**Processes:** MCO Processes: Concurrent reviews follow the same process as a standard prior authorization request. Concurrent reviews are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period. The request is reviewed by the MCO's clinical staff (independently licensed medical clinicians i.e., RN) and usually

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clinical staff (independently licensed mental health clinician i.e., RN, LPCC, LISW, etc.) and usually begins the first business day following admission to a program. Clinical information is solicited from facilities and providers as required and peer-to-peer consultations are also utilized. The review is conducted by telephone or on-site and may include a review of Electronic Medical Records (EMR) as needed. Should a reviewer believe that an admission or continued stay is not an appropriate use of benefit coverage; the attending physician/facility may be required to furnish more information concerning the treatment and case management plan. The reviewer may also refer the case to the MCO's Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. The attending physician/facility has sole authority and responsibility for the medical care of patients and the MCO never directs providers to discharge patients following a medical necessity review. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy. Per SB109, the MCO does not conduct concurrent review until after five days of inpatient withdrawal management. The treating facility is required to notify the MCO of the admission and the initial treatment plan within 48 hours of a member's admission. Each treating facility is required to use ASAM criteria for SUD benefits to establish the appropriate level of care for a member. DSAMH Processes: Codes listed above require the application of the NQTL prior to the delivery of the service after the initial authorization period has ended or, for SUD inpatient, per the concurrent review requirements of SB109. A concurrent review is scheduled, prior to the end of the initial authorization period. The provider assesses continued need according to DE ASAM for medical necessity. The provider will submit SUD-DE ASAM and EEU packet for the	begins the first business day following admission to a program. Clinical information is solicited from facilities and providers as required and peer-to-peer consultations are also utilized. The review is conducted by telephone or on-site and may include a review of Electronic Medical Records (EMR) as needed. Should a reviewer believe that an admission or continued stay is not an appropriate use of benefit coverage; the attending physician/facility may be required to furnish more information concerning the treatment and case management plan. The reviewer may also refer the case to the Plan's Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. The attending physician/facility has sole authority and responsibility for the medical care of patients and the MCO never directs providers to discharge patients following a medical necessity review. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy.

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concurrent review. The EEU receives and reviews continued stay requests and will approve or deny authorization for services as required by the processes and timelines noted in the DSAMH billing manual. EEU staffing allows for different positions such as RN and Psychiatric Social Workers but all staff members may not necessarily be licensed. EEU applies clinical discretion for authorization determinations. Clinical discretion is based on alternate information if it appears there is underreporting of symptomology such as prior treatment history; third party feedback; other lab tests, etc. The SUD provider counselor, Clinical Supervisors, and EEU staff are empowered to use their clinical discretion as it applies to medical necessity. Validation practices are done through a tiered process via the staff named above. There are no exception processes. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy. Per SB109, concurrent review does not occur for SUD benefits until after the first 14 days of an inpatient/residential admission or five days of inpatient withdrawal management for SUD benefits. The treating facility is required to notify DSAMH of the admission and the initial treatment plan within 48 hours of a member's admission. Each treating facility is required to use ASAM criteria for SUD benefits to establish the appropriate level of care for a member.	
Strategies: MCO Strategies: Concurrent review is part of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period or, for inpatient SUD benefits, per the concurrent review requirements in SB109. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. Medical necessity determinations are based on clinical guidelines developed by the MCO. The number of visits or length of authorization is determined based on medical necessity criteria and the	**Strategies:** MCO Strategies: Concurrent review is part of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. Medical necessity determinations are based on the MCO's generally accepted standards of medical practice. The number of visits or length of authorization is determined based on medical necessity criteria and the plan's clinical guidelines. Hospitalizations are also reviewed to

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plan's clinical guidelines. Hospitalizations are also reviewed to identify and better manage over- and under-utilization and to determine whether ongoing treatment is consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. DSAMH Strategies: Authorization is used to apply the least-restricted environment. Individualized treatment settings provide better outcomes as individuals can apply skills in their own environment. Concurrent Review also acts as cost-containment by avoiding unnecessary higher levels of care. The frequency of the application of medical necessity and appropriateness reviews are based on the need to ensure that clients receive individualized treatment services in the least-restricted environment and, for SUD benefits, per SB109. This criteria is updated as often as evidence based practices are updated (i.e., fidelity scales) or feedback is provided from a federal sponsor (SAMHSA).	identify and better manage over- and under-utilization and to determine whether ongoing treatment is consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines.
Evidentiary Standards: MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. The MCO's clinical criteria can be requested from the Case Reviewer and are available online at www.providerexpress.com/html/guidelines/index.html Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the MCO's Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. As new information becomes available this is reviewed annually in the level of care	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, the MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in

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guidelines and will therefore be revised accordingly. This includes treatment provided in an inpatient or residential setting and inpatient withdrawal management per SB109. DSAMH Evidentiary Standards: SUD/MH services apply Delaware ASAM for SUD and Mental Health Services for level of care services. PROMISE Services are specifically designed for individuals diagnosed with SPMI with history of multiple hospitalizations. PROMISE and SUD services use Delaware ASAM for SUD and MH for level of care determination. Dr. Mee Lee (https://www.changecompanies.net/bios/david_mee_lee.php) specifically adapted Delaware ASAM to add elements that would determine the need for mental health services as well as services for SUDs. Individualized treatment settings provide better outcomes as individuals can apply skills in their own environment. Medical necessity is determined via DE ASAM. SUD providers including clinical Supervisors and EEU staff oversee the application of medical necessity to ensure consistency. For more information on PROMISE please see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/de/de-dshp-fs.pdf. Success is measured by frequency of relapse, frequency of treatment episodes, and length of stay.	making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com.

<table>
<tr><th>MH/SUD</th><th>M/S</th></tr>
<tr><td colspan="2"><u>Compliance Determination MCO MH/SUD to MCO M/S:</u>
Same as 3A – Inpatient – Adult
<u>Compliance Determination DSAMH MH/SUD to MCO M/S:</u>
DSAMH applies concurrent reviews to MH/SUD benefits to ensure members are being served in the least restrictive environment (meeting medical necessity) and to contain costs. For inpatient SUD benefits, DSAMH follow concurrent review requirements of SB109. For M/S benefits concurrent review is a component of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. DSAMH use the DE ASAM for MH/SUD benefits, and the MCO relies on nationally recognized clinical guidelines (e.g., MCG) for M/S benefits. Concurrent reviews follow the same process as prior authorizations and are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period or, for SUD benefits that cannot be prior authorized per SB109, the concurrent review requirements of SB109.The processes employed by the MCO and DSAMH when conducting concurrent review is similar. For both DSAMH and the MCO, the timeframes to provide a review and response are reasonable and contract driven. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.</td></tr>
<tr><td colspan="2">3A – Concurrent Review – Inpatient – Children*</td></tr>
<tr><td>Benefits:
Managed by MCO:
MCOs do not manage inpatient MH/SUD benefits for children.

Managed by DSCYF:
• Same as 2A – Inpatient – Children
• Residential Rehabilitation Services, Substance Use</td><td>Benefits:
Managed by MCO:
• Same as 2A – Inpatient – Children</td></tr>
<tr><td>Processes:
DSCYF Processes:
All services in the inpatient classification (see list above) are subject to concurrent review. A concurrent review is required before service authorization expires or, for inpatient SUD, per the concurrent review requirements of SB109. DSCYF uses concurrent review to confirm services provided are still medically necessary and to ensure there is enough information for the reauthorization of services. This includes an overview of current services, review of deliverables, client clinical status, educational progress, use of community resources, client engagement and participation</td><td>Processes:
MCO Processes:
Concurrent reviews follow the same process as a standard prior authorization request. Concurrent reviews are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period. The request is reviewed by the MCO clinical staff (independently licensed medical clinicians i.e., RN) and usually begins the first business day following admission to a program. Clinical information is solicited from facilities and providers as required and peer-to-peer consultations are also utilized. The review is conducted by telephone or on-</td></tr>
</table>

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and progress in treatment. Providers and other sources provide information that is used to complete the progress review and confirm or revise medical necessity and service intensity. Each client is served by a DSCYF team that may include a treatment care coordinator, psychiatric social worker, and oversight by licensed behavioral health practitioners. If the NQTL is not met reimbursement for the services is in jeopardy. Professional discretion and clinical judgement of licensed behavioral health practitioners is used and enhances service planning by assisting in determining the most appropriate level of care and locating services. There are exceptions to the criteria such as court-orders or departmental decision is made for cross-division funding. In addition, the length of authorization varies by benefit, for example bed-based and day hospital benefits are shorter in duration than OP benefits. Variation also reflects whether there is a definite discharge date involved (e.g., family is moving to Texas in 20 days), and whether there are concerns about the provider, the treatment quality, or client deterioration. Per SB109, concurrent review does not occur for inpatient SUD benefits until the first 14 days of an inpatient/residential admission. The treating facility is required to notify DSCYF of the admission and the initial treatment plan within 48 hours of a member's admission. Each treating facility is required to use ASAM criteria for SUD benefits to establish the appropriate level of care for a member.	site and may include a review of Electronic Medical Records (EMR) as needed. Should a reviewer believe that an admission or continued stay is not an appropriate use of benefit coverage; the attending physician/facility may be required to furnish more information concerning the treatment and case management plan. The reviewer may also refer the case to the Plan's Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. The attending physician/facility has sole authority and responsibility for the medical care of patients and the MCO never directs providers to discharge patients following a medical necessity review. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy.
Strategies: DSCYF Strategies: The NQTL confirms medical necessity and ensures appropriate modality of services is available for the individual client in the least restrictive environment. The NQTL safeguards against unnecessary use of services, assures appropriate and quality treatment, manages risk, promotes coordinated case management and supports cost management. Concurrent reviews provide an opportunity for individualized treatment planning, which provides better outcomes for individuals. DSCYF does not have a schedule for reviewing its concurrent review process; however, if research, best practices, or industry standards reflect a change is needed, DSCYF will use	**Strategies:** MCO Strategies: Concurrent review is part of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. Medical necessity determinations are based on the MCO's generally accepted standards of medical practice. The number of visits or length of authorization is determined based on medical necessity criteria and the plan's clinical guidelines. Hospitalizations are also reviewed to

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an identified group to review and revise its practices. DSCYF complies with the concurrent review requirements in SB109 for SUD benefits.	identify and better manage over- and under-utilization and to determine whether ongoing treatment is consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines.
Evidentiary Standards: DSCYF Evidentiary Standards: DSCYF identified a group of qualified professionals, including licensed behavioral health practitioners and a psychiatrist, to develop medical necessity criteria using documents from professional associations such as the American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), and American Society of Addiction Medicine (ASAM), peer-reviewed and research-based literature, and practice standards. Specifically, DSCYF uses CASII and ASAM, evidence-based tools, to assist in the decision making process for concurrent review. DSCYF supervisors and managers are responsible for monitoring the use of concurrent reviews and the consistency and outcomes. DSCYF's database system tracks this information and can report this data, if requested.	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, the MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com.

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Compliance Determination DSCYF MH/SUD to MCO M/S: DSCYF applies concurrent reviews to MH/SUD benefits to confirm services provided are still medically necessary, obtain information regarding the reauthorization of services, promote coordinated case management, and to assure appropriate and quality treatment. DSCYF follow concurrent requirements in SB109 for SUD services. For M/S benefits, concurrent review is a component of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. DSCYF developed their own evidentiary standards to monitor concurrent review criteria for MH/SUD child benefits based on information from professional associations, research-based literature, and practice standards. The MCO relies on nationally recognized clinical guidelines (e.g., MCG) for M/S benefits. Concurrent reviews follow the same process as prior authorizations noted above. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
3B – Concurrent Review – Outpatient – Adult	
Benefits: Managed by MCO: • Same as 2B – Outpatient – Adult • SA Partial Hospitalization • SA Intensive Outpatient	**Benefits:** Managed by MCO: • Same as 2B – Outpatient – Adult
Processes: MCO Processes: Concurrent reviews follow the same process as a standard prior authorization request. Concurrent reviews are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period or, for outpatient SUD, per the concurrent review requirements of SB109. The request is reviewed by the MCO's clinical staff (independently licensed mental health clinician i.e., RN, LPCC, LISW, etc.) and usually begins the first business day following admission to a program. Clinical information is solicited from facilities and providers as required and peer-to-peer consultations are also utilized. The review is conducted by telephone or on-site and may include a review of Electronic Medical Records (EMR) as needed. Should a reviewer believe that an admission or continued stay is not an appropriate use of benefit coverage; the attending physician/facility may be required to furnish more information	**Processes:** MCO Processes: Concurrent reviews follow the same process as a standard prior authorization request. Concurrent reviews are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period. The request is reviewed by the MCO's clinical staff (independently licensed medical clinicians i.e., RN) and usually begins the first business day following admission to a program. Clinical information is solicited from facilities and providers as required and peer-to-peer consultations are also utilized. The review is conducted by telephone or on-site and may include a review of Electronic Medical Records (EMR) as needed. Should a reviewer believe that an admission or continued stay is not an appropriate use of benefit coverage; the attending physician/facility may be required to furnish more information concerning the treatment and case management plan. The reviewer may also refer the case to the Plan's

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concerning the treatment and case management plan. The reviewer may also refer the case to the MCO's Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. The attending physician/facility has sole authority and responsibility for the medical care of patients and the MCO never directs providers to discharge patients following a medical necessity review. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy. Per SB109, concurrent review does not occur for outpatient SUD benefits until after the first 30 days of an intensive outpatient program. The treating agency/facility is required to notify the MCO of the admission and the initial treatment plan within 48 hours of a member's admission. Each treating facility is required to use ASAM criteria for SUD benefits to establish the appropriate level of care for a member. In addition, each treating facility is required to perform a daily clinical review of the member to ensure medical necessity requirements are met.	Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. The attending physician/facility has sole authority and responsibility for the medical care of patients and the MCO never directs providers to discharge patients following a medical necessity review. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy.
Strategies: MCO Strategies: Concurrent review is part of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period or, for outpatient SUD benefits, per the concurrent review requirements in SB109. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. Medical necessity determinations are based on clinical guidelines developed by the MCO. The number of visits or length of authorization is determined based on medical necessity criteria and the plan's clinical guidelines. Hospitalizations are also reviewed to identify and better manage over- and under-utilization and to determine whether ongoing treatment is consistent with the member's coverage, medically	**Strategies:** MCO Strategies: Concurrent review is part of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. Medical necessity determinations are based on the MCO's generally accepted standards of medical practice. The number of visits or length of authorization is determined based on medical necessity criteria and the plan's clinical guidelines. Hospitalizations are also reviewed to identify and better manage over- and under-utilization and to determine whether ongoing treatment is consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines.

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appropriate and consistent with evidence-based guidelines.	
Evidentiary Standards: MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. The MCO's clinical criteria can be requested from the Case Reviewer and are available online at www.providerexpress.com/html/guidelines/index.html. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the MCO's Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. As new information becomes available this is reviewed annually in the level of care guidelines and will therefore be revised accordingly. This includes treatment provided in an intensive outpatient setting per SB109.	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, the MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com.

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Compliance Determination MCO MH/SUD to MCO M/S: The MCO's concurrent review for outpatient benefits is a component of the plan's overall utilization management program and is applied to ensure medical necessity and coverage determinations for MH/SUD and M/S benefits extending beyond the initial authorization period and, for outpatient SUD benefits, per concurrent review requirements of SB109. Concurrent reviews are also applied to gather/review information needed for quality improvement and referrals to case management. Medical necessity and clinical criteria are based on the MCO's clinical guidelines and ASAM for MH/SUD and nationally recognized clinical guidelines for M/S benefits. Concurrent reviews follow the same process as prior authorizations and are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period, or for SUD benefits that cannot be prior authorized, in accordance with the concurrent review requirements in SB109. The process is the same for MH/SUD and M/S benefits and reviews are conducted by qualified staff either via telephone or onsite. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
3B – Concurrent Review – Outpatient – PROMISE*	
Benefits: Managed by MCO: MCOs do not manage outpatient MH/SUD benefits for PROMISE members Managed by DSAMH • Same as 2B – Outpatient – PROMISE • Alcohol and/or drug abuse service; detoxification (residential addiction program outpatient) • Alcohol and/or drug services, intensive outpatient	**Benefits:** Managed by MCO: • Same as 2B – Outpatient – Adult
Processes: DSAMH Processes: Benefits listed above require the application of the NQTL prior to the delivery of the service after the initial authorization period has ended or, for SUD outpatient benefits, per the concurrent review requirements of SB109. A concurrent review is scheduled, prior to the end of the initial authorization period. The provider assesses continued need according to DE ASAM for medical necessity. The provider will submit SUD-DE ASAM and EEU packet for the concurrent review. The EEU receives and reviews continued stay requests and will approve or deny authorization for services as required by the processes and timelines noted in the DSAMH billing	**Processes:** MCO Processes: Concurrent reviews follow the same process as a standard prior authorization request. Concurrent reviews are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period. The request is reviewed by the MCO's clinical staff (independently licensed medical clinicians i.e., RN) and usually begins the first business day following admission to a program. Clinical information is solicited from facilities and providers as required and peer-to-peer consultations are also utilized. The review is conducted by telephone or on-site and may include a review of Electronic Medical Records (EMR)

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manual. EEU staffing allows for different positions such as RN and Psychiatric Social Workers, but all staff members may not necessarily be licensed. EEU applies clinical discretion for authorization determinations. Clinical discretion is based on alternate information if it appears there is underreporting of symptomology such as prior treatment history; third party feedback; other lab tests, etc. The SUD provider counselor, Clinical Supervisors, and EEU staff are empowered to use their clinical discretion as it applies to medical necessity. Validation practices are done through a tiered process via the staff named above. There are no exception processes. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy. Per SB109, concurrent review does not occur for SUD outpatient benefits until after the first 30 days of an intensive outpatient program. The treating agency/facility is required to notify DSAMH of the admission and the initial treatment plan within 48 hours of a member's admission. Each treating facility is required to use ASAM criteria for SUD benefits to establish the appropriate level of care for a member.	as needed. Should a reviewer believe that an admission or continued stay is not an appropriate use of benefit coverage; the attending physician/facility may be required to furnish more information concerning the treatment and case management plan. The reviewer may also refer the case to the Plan's Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. The attending physician/facility has sole authority and responsibility for the medical care of patients and the MCO never directs providers to discharge patients following a medical necessity review. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy.
Strategies: Authorization is used to apply the least-restricted environment. Individualized treatment settings provide better outcomes as individuals can apply skills in their own environment. Concurrent review also acts as cost-containment by avoiding unnecessary higher levels of care. The frequency of the application of medical necessity and appropriateness reviews are based on the need to ensure that clients receive individualized treatment services in the least-restricted environment. This criteria is updated as often as evidence based practices are updated (i.e., fidelity scales) or feedback is provided from a federal sponsor (SAMHSA). In addition, DSAMH complies with the concurrent review requirements in SB109 for SUD benefits.	**Strategies:** Concurrent review is part of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. Medical necessity determinations are based on the MCO's generally accepted standards of medical practice. The number of visits or length of authorization is determined based on medical necessity criteria and the plan's clinical guidelines. Hospitalizations are also reviewed to identify and better manage over- and under-utilization and to determine whether ongoing treatment is consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines.
Evidentiary Standards:	**Evidentiary Standards:**

MH/SUD	M/S
SUD/MH services apply Delaware ASAM for SUD and Mental Health Services for level of care services. PROMISE Services are specifically designed for individuals diagnosed with SPMI with history of multiple hospitalizations. PROMISE and SUD services use Delaware ASAM for SUD and MH for level of care determination. Dr. Mee Lee (https://www.changecompanies.net/bios/david_mee_lee.php) specifically adapted Delaware ASAM to add elements that would determine the need for mental health services as well as services for SUDs. Individualized treatment settings provide better outcomes as individuals can apply skills in their own environment. Medical necessity is determined via DE ASAM. SUD providers including clinical Supervisors and EEU staff oversee the application of medical necessity to ensure consistency. For more information on PROMISE please see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/de/de-dshp-fs.pdf Success is measured by frequency of relapse, frequency of treatment episodes, and length of stay.	On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, the MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com.

MH/SUD	M/S
Compliance Determination DSAMH MH/SUD to MCO M/S: DSAMH applies concurrent reviews to MH/SUD benefits to ensure members are being served in the least restrictive environment (meeting medical necessity) and to contain costs. The MCO's concurrent review for M/S benefits is a component of the plan's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period. Concurrent reviews are also applied to gather/review information needed for quality improvement and referrals to case management. DSAMH use the DE ASAM for MH/SUD benefits, and the MCO relies on nationally recognized clinical guidelines (e.g., MCG) for M/S benefits. Concurrent reviews follow the same process as prior authorizations and are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period, or for SUD benefits that cannot be prior authorized per SB109. The processes employed by the MCO and DSAMH when conducting concurrent review is similar. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
3B – Concurrent Review – Outpatient – Children*	
Benefits: Managed by MCO: • Same as 2B – Outpatient – Children • SA Intensive OP Managed by DSCYF: • Same as 2B – Outpatient – Children • Outpatient, Substance Use	**Benefits:** Managed by MCO: • Same as 2B – Outpatient – Children
Processes: MCO Processes: Concurrent reviews follow the same process as a standard prior authorization request. Concurrent reviews are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period or, for SUD outpatient, per the concurrent review requirements of SB109. The request is reviewed by the MCO's clinical staff (independently licensed mental health clinician i.e., RN, LPCC, LISW, etc.) and usually begins the first business day following admission to a program. Clinical information is solicited from facilities and providers as required and peer-to-peer consultations are also utilized. The review is conducted by telephone or on-site and may include a review of Electronic Medical Records (EMR) as needed. Should a reviewer believe that an	**Processes:** MCO Processes: Concurrent reviews follow the same process as a standard prior authorization request. Concurrent reviews are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period. The request is reviewed by the MCO's clinical staff (independently licensed medical clinicians i.e., RN) and usually begins the first business day following admission to a program. Clinical information is solicited from facilities and providers as required and peer-to-peer consultations are also utilized. The review is conducted by telephone or on-site and may include a review of Electronic Medical Records (EMR) as needed. Should a reviewer believe that an admission or continued stay is not an appropriate use of benefit coverage; the attending physician/facility

MH/SUD	M/S
admission or continued stay is not an appropriate use of benefit coverage; the attending physician/facility may be required to furnish more information concerning the treatment and case management plan. The reviewer may also refer the case to the MCO's Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. The attending physician/facility has sole authority and responsibility for the medical care of patients and the MCO never directs providers to discharge patients following a medical necessity review. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy. Per SB109, concurrent review for SUD outpatient benefits does not occur until the first 30 days of an intensive outpatient program. The treating agency/facility is required to notify the MCO of the admission and the initial treatment plan within 48 hours of a member's admission. Each treating facility is required to use ASAM criteria for SUD benefits to establish the appropriate level of care for a member. DSCYF Processes: All services in the inpatient classification (see list above) are subject to concurrent review. A concurrent review is required before service authorization expires or, for SUD outpatient, per the concurrent review requirements of SB109. DSCYF uses concurrent review to confirm services provided are still medically necessary and to ensure there is enough information for the reauthorization of services. This includes an overview of current services, client clinical status, discharge criteria and plans, client engagement and participation and progress. DSCYF has a team of individuals including an adolescent treatment care coordinator, psychiatric social worker, and oversight by licensed behavioral health practitioners. If the NQTL is not met reimbursement for the services is in jeopardy. Professional discretion and clinical judgement of licensed behavioral health	may be required to furnish more information concerning the treatment and case management plan. The reviewer may also refer the case to the Plan's Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. The attending physician/facility has sole authority and responsibility for the medical care of patients and the MCO never directs providers to discharge patients following a medical necessity review. Failure to obtain authorization in combination with an absence of medical necessity results in a coverage denial and reimbursement is in jeopardy.

MH/SUD	M/S
practitioners is used and enhances service planning by assisting in determining the most appropriate level of care and locating services. There are exceptions to the criteria such as court-ordered services [note: community based services are not co-funded]. In addition, the length of authorization varies by benefit, for example bed-based and day hospital benefits are shorter in duration than OP benefits. Variation also reflects whether there is a definite discharge date involved (e.g., family is moving to Texas in 20 days), and whether there are concerns about the provider, the treatment quality, or client deterioration. Per SB109, concurrent review for SUD outpatient benefits does not occur until the first 30 days of an intensive outpatient program. The treating agency/facility is required to notify DSCYF of the admission and the initial treatment plan within 48 hours of a member's admission. Each treating facility is required to use ASAM criteria for SUD benefits to establish the appropriate level of care for a member.	
Strategies: MCO Strategies: Concurrent review is part of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period or, for outpatient SUD benefits, per the concurrent review requirements in SB109. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. Medical necessity determinations are based on clinical guidelines developed by the MCO. The number of visits or length of authorization is determined based on medical necessity criteria and the plan's clinical guidelines. Hospitalizations are also reviewed to identify and better manage over- and under-utilization and to determine whether ongoing treatment is consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. DSCYF Strategies:	**Strategies:** MCO Strategies: Concurrent review is part of the MCO's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period. Concurrent reviews are also applied to gather/review information needed for discharge planning, quality improvement and referrals to case management. Medical necessity determinations are based on the MCO's generally accepted standards of medical practice. The number of visits or length of authorization is determined based on medical necessity criteria and the plan's clinical guidelines. Hospitalizations are also reviewed to identify and better manage over- and under-utilization and to determine whether ongoing treatment is consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines.

MH/SUD	M/S
The NQTL confirms medical necessity and ensures appropriate modality of services is available for the individual client in the least restrictive environment. The NQTL safeguards against unnecessary use of services, assures appropriate and quality treatment, manages risk, promotes coordinated case management and supports cost management. Concurrent reviews provide an opportunity for individualized treatment planning, which provides better outcomes for individuals. DSCYF does not have a schedule for reviewing it concurrent review process; however, if research, best practices, or industry standards reflect a change is needed, DSCYF will use an identified group to review and revise its practices. DSCYF complies with the concurrent review requirements in SB109 for SUD benefits.	
Evidentiary Standards: MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. The MCO's clinical criteria can be requested from the Case Reviewer and are available online at www.providerexpress.com/html/guidelines/index.html Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the MCO's Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. As new information becomes available this is reviewed annually in the level of care guidelines and will therefore be revised accordingly. DSCYF Evidentiary Standards: DSCYF identified a group of qualified professionals, including licensed behavioral health practitioners and a psychiatrist, to develop medical	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, The MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources

MH/SUD	M/S
necessity criteria using documents from professional associations such as the American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), and American Society of Addiction Medicine (ASAM), peer-reviewed and research-based literature, and practice standards. Specifically, DSCYF uses CASII and ASAM, evidence-based tools, to assist in the decision making process for concurrent review. DSCYF supervisors and managers are responsible for monitoring the use of concurrent reviews and the consistency and outcomes. DSCYF' database system tracks this information and can report this data, if requested.	and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 3B – Outpatient – Adult **Compliance Determination DSCYF MH/SUD to MCO M/S:** DSCYF applies concurrent reviews to MH benefits to confirm services provided are still medically necessary, obtain information regarding the reauthorization of services, promote coordinated case management, and to assure appropriate and quality treatment. The MCO's concurrent review for M/S benefits is a component of the plan's overall utilization management program and is applied to ensure medical necessity and coverage determinations for benefits extending beyond the initial authorization period. Concurrent reviews are also applied to gather/review information needed for quality improvement and referrals to case management. DSCYF developed their own evidentiary standards to monitor concurrent review criteria for MH child benefits based on national information from professional associations, peer-reviewed, and research-based literature, and practice standards. The MCO relies on nationally recognized clinical guidelines (e.g., MCG) for M/S benefits. Concurrent reviews follow the same process as prior authorizations and are applied when a certain benefit is requested by a provider, facility and or member to extend beyond the initial authorization period, or for SUD benefits that cannot be prior authorized per SB109. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
3C – Concurrent Review – Emergency Care – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: Emergency care benefits	**Benefits:** Managed by MCO: Emergency care benefits
Processes: MCO Processes: Emergency admissions follow the guidelines for standard IP concurrent review once contact has occurred.	**Processes:** MCO Processes: Emergency admissions follow the guidelines for standard IP concurrent review once contact has occurred.
Strategies:	**Strategies:**

MH/SUD	M/S
MCO Strategies: Same as 3A – Inpatient - Adult.	MCO Strategies: Same as 3A – Inpatient - Adult.
Evidentiary Standards: MCO Evidentiary Standards: Same as 3A – Inpatient - Adult.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 3A – Inpatient - Adult.
Compliance Determination MH/SUD MCO to M/S MCO: Same as 3A – Inpatient - Adult.	
4A – Retrospective Review – Inpatient – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: Same as 2A – Inpatient – Adult, PROMISE, Children Managed by DSAMH/DSCYF: The State does not conduct retrospective reviews of inpatient MH/SUD FFS benefits. Please see prior authorization and concurrent review NQTLs above.	**Benefits:** Managed by MCO: Same as 2A – Inpatient – Adult, PROMISE, Children
Processes: MCO Processes: Retrospective reviews follow the same process as a standard prior authorization request. Retrospective reviews are conducted: 1. In the event an initial request for the clinical review occurs after the member is discharged over a weekend/holiday and clinical review is requested. 2. To document the actual discharge date, when logging the case in the plan's medical management system and clinical information is required. 3. A claim for services by an OON facility/provider under a benefit plan that does not require PA, but does require clinical determination. 4. A claim for services by an OON facility/provider where OON benefits are not covered. 5. A post-service request for coverage if a non-coverage determination has been made (appeal/dispute review). 6. When an initial review was never obtained.	**Processes:** MCO Processes: Retrospective reviews follow the same process as a standard prior authorization request. Retrospective reviews are conducted: 1. In the event an initial request for the clinical review occurs after the member is discharged over a weekend/holiday and clinical review is requested, 2. To document the actual discharge date, when logging the case in the plan's medical management system and clinical information is required. 3. A claim for services by an OON facility/provider under a benefit plan that does not require PA, but does require clinical determination. 4. A claim for services by an OON facility/provider where OON benefits are not covered. 5. A post-service request for coverage if a non-coverage determination has been made (appeal/dispute review). 6. When an initial review was never obtained.

MH/SUD	M/S
Strategies: MCO Strategies: The purpose of retrospective review is to support utilization management and to allow providers who did not obtain authorization due to mitigating circumstances to obtain medical necessity review required for claims payment or to appeal/dispute a coverage denial.	**Strategies:** MCO Strategies: The purpose of retrospective review is to support utilization management and to allow providers who did not obtain authorization due to mitigating circumstances to obtain medical necessity review required for claims payment or to appeal/dispute a coverage denial.
Evidentiary Standards: MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO develops their own guidelines based on a thorough review of professional/scientific journals and research, as well as input from the provider community. This includes acute and sub-acute behavioral treatment. The MCO's clinical criteria can be requested from the Case Reviewer and are available online at www.providerexpress.com/html/guidelines/index.html Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the MCO's Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. As new information becomes available this is reviewed annually in the level of care guidelines and will therefore be revised accordingly.	**Evidentiary Standards:** MCO Evidentiary Standards: On an annual basis, the MCO develops and maintains clinical policies. The MCO's generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. The MCO uses a graded hierarchy in the development/review of their technology assessments and medical/drug policies, including but not limited to: statistically robust, well-designed randomized controlled trials; statistically robust, well-designed cohort studies; multi-site observational studies; and single-site observational studies. In addition, the MCO uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com.

MH/SUD	M/S
Compliance Determination MCO MH/SUD to MCO M/S: The MCO's purpose for retrospective review is to support utilization management and to allow providers who did not obtain authorization due to mitigating circumstances to obtain medical necessity review required for claims payment or to appeal/dispute a coverage denial. Reviews for both MH/SUD and M/S benefits are completed based upon accepted and established criteria. Standards are based on the MCO's medical policy, payment policy, and provider manual. Retrospective reviews follow the same process as a standard prior authorization request and concurrent review requirements. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
4B – Retrospective Review – Outpatient – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: Same as 2B. Managed by DSAMH/DSCYF: The State does not conduct retrospective reviews on outpatient MH/SUD FFS benefits. Please see prior authorization and concurrent review NQTLs above.	**Benefits:** Managed by MCO: Same as 2B.
Processes: MCO Processes: Same as 4A.	**Processes:** MCO Processes: Same as 4A.
Strategies: MCO Strategies: Same as 4A.	**Strategies:** MCO Strategies: Same as 4A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 4A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 4A.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 4A.	
4C – Retrospective Review – Emergency Care – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: • Emergency care benefits	**Benefits:** Managed by MCO: • Emergency care benefits

MH/SUD	M/S
Processes: MCO Processes: Emergency admissions follow the guidelines for standard IP retrospective review once contact has occurred. See 4A.	**Processes:** MCO Processes: Emergency admissions follow the guidelines for standard IP retrospective review once contact has occurred. See 4A.
Strategies: MCO Strategies: Same as 4A.	**Strategies:** MCO Strategies: Same as 4A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 4A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 4A.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 4A.	
5D – Requiring Use of Preferred Drugs before Approving Non-preferred Agents (Step Therapy) – Prescription Drugs – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: Certain MH/SUD prescription drugs	**Benefits:** Managed by MCO: Certain M/S prescription drugs
Processes: MCO Processes: Specific medications on the Preferred Drug List (PDL) require step therapy (use of precursor agent(s)) prior to the drug being authorized. A step therapy agent can be allowed at point of sale due to paid claim(s) of the first-line agent(s) in the pharmacy adjudication system. When designated first-line drugs are not found within RxClaims, a prior authorization request can be submitted by the provider. To obtain prior authorization for a drug, the prescriber may either call the request in to the MCO's prior authorization phone line or fax a completed request form to the MCO. The MCO also allows for pharmacy prior authorization requests to be submitted via the web. The prior authorization request is received by the pharmacy prior authorization unit and a clinical review for medical necessity is conducted.	**Processes:** MCO Processes: Specific medications on the Preferred Drug List (PDL) require step therapy (use of precursor agent(s)) prior to the drug being authorized. A step therapy agent can be allowed at point of sale due to paid claim(s) of the first-line agent(s) in the pharmacy adjudication system. When designated first-line drugs are not found within RxClaims, a prior authorization request can be submitted by the provider. To obtain prior authorization for a drug, the prescriber may either call the request in to the MCO's prior authorization phone line or fax a completed request form to the MCO. The MCO also allows for pharmacy prior authorization requests to be submitted via the web. The prior authorization request is received by the pharmacy prior authorization unit and a clinical review for medical necessity is conducted.

MH/SUD	M/S
The request is reviewed against the applicable clinical policy and must be completed in the amount of time allotted based upon the urgency of the request. Requests for prior authorization will be evaluated within 24 hours by pharmacy staff. If required, a 72-hour emergency supply can be dispensed if a request is submitted after business hours and the delay in therapy will result in loss of life, limb or organ functions. Prior to a denial, an outbound telephone call is performed to the provider to obtain all clinical information required to support approval of the request. Once the review is complete notice of action is sent to both the member and provider. If the notice of action is a denial then the member and provider are advised of their options and Appeals Rights.	The request is reviewed against the applicable clinical policy and must be completed in the amount of time allotted based upon the urgency of the request. Requests for prior authorization will be evaluated within 24 hours by pharmacy staff. If required, a 72-hour emergency supply can be dispensed if a request is submitted after business hours and the delay in therapy will result in loss of life, limb or organ functions. Prior to a denial, an outbound telephone call is performed to the provider to obtain all clinical information required to support approval of the request. Once the review is complete notice of action is sent to both the member and provider. If the notice of action is a denial then the member and provider are advised of their options and Appeals Rights.
Strategies: MCO Strategies: Members are required to try and fail first-line agents prior to receiving a second-line agent to ensure rational, clinically appropriate, safe, and cost-effective drug therapy.	**Strategies:** MCO Strategies: Members are required to try and fail first-line agents prior to receiving a second-line agent to ensure rational, clinically appropriate, safe, and cost-effective drug therapy.
Evidentiary Standards: MCO Evidentiary Standards: Preferred agents are more cost-effective than non-preferred agents. Preferred agents typically account for nearly 80% of a program's total prescription fills, but only 20%-30% of the cost. A recent Blue Cross/Blue Shield study using pharmacy data from 2010-2016 reinforced this general split between preferred drugs (primarily generics) and non-preferred; the study can be accessed here https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/BCBS.HealthOfAmericaReport.RisingCostsPatentedDrugs_1.pdf	**Evidentiary Standards**: MCO Evidentiary Standards: Preferred agents are more cost-effective than non-preferred agents. Preferred agents typically account for nearly 80% of a program's total prescription fills, but only 20%-30% of the cost. A recent Blue Cross/Blue Shield study using pharmacy data from 2010-2016 reinforced this general split between preferred drugs (primarily generics) and non-preferred; the study can be accessed here https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/BCBS.HealthOfAmericaReport.RisingCostsPatentedDrugs_1.pdf

MH/SUD	M/S
Compliance Determination MCO MH/SUD TO MCO M/S: Specific medications on the Preferred Drug List (PDL) require step therapy (precursor agent(s)) prior to the drug being authorized. Members are required to try and fail first-line agents prior to receiving a second-line agent to ensure rational, clinically appropriate, safe, and cost-effective drug therapy. Preferred agents are more cost-effective than non-preferred agents and account for nearly 80% of a program's total prescription fills, but only 20%-30% of the cost. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
6A – Experimental/Investigational Determinations – Inpatient – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: All inpatient MH/SUD benefits	**Benefits:** All inpatient M/S benefits
Processes: MCO Processes: Unproven or experimental services are defined in clinical policy. They will be denied administratively as not covered by the benefit plan.	**Processes:** MCO Processes: Unproven or experimental services are defined in clinical policy. They will be denied administratively as not covered by the benefit plan.
Strategies: MCO Strategies: Unproven/experimental services are services, including medications, which are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. The strategies applied to these types of services are applied uniformly for both MH/SUD and M/S conditions. Any experimental or investigational or unproven service, treatment, device or pharmacological regimen is not available to members if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition.	**Strategies:** MCO Strategies: Unproven/experimental services are services, including medications, which are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. The strategies applied to these types of services are applied uniformly for both MH/SUD and M/S conditions. Any experimental or investigational or unproven service, treatment, device or pharmacological regimen is not available to members if the procedure is considered to be experimental or investigational or unproven in the treatment of that particular condition.

MH/SUD	M/S
Evidentiary Standards: MCO Evidentiary Standards: Experimental or investigational services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination regarding coverage in a particular case is made, are determined to be any of the following: • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use. • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.) • The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.	**Evidentiary Standards**: MCO Evidentiary Standards: Experimental or investigational services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination regarding coverage in a particular case is made, are determined to be any of the following: • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use. • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.) • The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
Compliance determination MCO MH/SUD to MCO M/S: The MCO has clinical policies defined for unproven or experimental services for both MH/SUD and M/S benefits. These services are denied administratively as not covered benefits to MCO members. All benefits related to experimental or investigational and unproven services are excluded regardless of whether or not the treatment, device or pharmacological regimen is the only available treatment for a particular condition. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
6B – Experimental/Investigational Determinations – Outpatient – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: All outpatient MH/SUD benefits	**Benefits:** All outpatient M/S benefits
Processes: MCO Processes: Same as 6A.	**Processes:** MCO Processes: Same as 6A.
Strategies:	**Strategies:**

MH/SUD	M/S
MCO Strategies: Same as 6A.	MCO Strategies: Same as 6A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 6A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 6A.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 6A.	
6C – Experimental/Investigational Determinations – Emergency Care – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: All emergency care benefits	**Benefits:** All emergency care benefits
Processes: MCO Processes: Same as 6A.	**Processes:** MCO Processes: Same as 6A.
Strategies: MCO Strategies: Same as 6A.	**Strategies:** MCO Strategies: Same as 6A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 6A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 6A.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 6A.	
6D – Experimental/Investigational Determinations – Prescription Drugs – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Certain MH/SUD prescription drugs	**Benefits:** Certain M/S prescription drugs
Processes: MCO Processes: Same as 6A.	**Processes:** MCO Processes: Same as 6A.
Strategies: MCO Strategies: Same as 6A.	**Strategies:** MCO Strategies: Same as 6A.

MH/SUD	M/S
Evidentiary Standards: MCO Evidentiary Standards: Same as 6A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 6A.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 6A.	
7A – Provider Reimbursement (in-network) – Inpatient – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: • All inpatient INN (in-network) treatment providers	**Benefits:** Managed by MCO: • All inpatient INN treatment providers
Processes: MCO Processes: The MCO uses the current Medicaid fee schedules and payment methodology as the basis for setting rates and contracting inpatient MH/SUD providers. In addition, the MCO uses a variety of information (e.g., UCR, Medicare, competitor information) to support developing rate parameters for negotiating contracts. The MCO's goal is to negotiate rates consistent for providers with similar organizational types and specialty services. The MCO also offers performance-based contracts that incentivize providers to accomplish various clinical objectives and efficiencies.	**Processes:** MCO Processes: The majority of the acute hospital facilities for inpatient reimbursement are reimbursed at either 100% of the published DMAP inpatient discharge rate or a multiple of the DMAP discharge rate. The contractual rates are a matter of negotiations between the MCO and the hospital facility, and are a balance of attempting to obtain a reimbursement level as close to 100% of the state FFS rates versus providing members sufficient access to inpatient hospital care in their county. The MCO always begins negotiations attempting to pay no higher than 100% of the state FFS rates. However, some hospitals find that level unacceptable to cover their costs for treating these members, requiring the MCO to pay an incentive. Thus the two parties find a compromise rate position. In the few instances where some aspect of inpatient reimbursement is not based upon DMAP rates, that reimbursement is based upon a percentage of charges.
Strategies: MCO Strategies: The MCO develops rate in order to reduce provider abrasion and improve contracting consistency. The final methodology applied to each provider will depend on the details of any negotiated contract. Contracts and fee schedules may be adjusted to	**Strategies:** MCO Strategies: The MCO uses the current DMAP fee schedules and payment methodologies in order to reduce provider abrasion and improve contracting consistency. The final methodology applied to each provider will depend on the details of

MH/SUD	M/S
establish appropriate provider networks and to address issues such as service type, geographic market, demand for services, supply, practice size, provider qualifications, etc.	any negotiated contract. Contracts and fee schedules may be adjusted to establish appropriate provider networks and to address issues such as service type, geographic market, demand for services, supply, practice size, provider qualifications, etc.
Evidentiary Standards: MCO Evidentiary Standards: The MCO uses a variety of information such as current Medicaid fee schedule, usual and customary rates, Medicare rates and competitor information to develop rate parameters for negotiating contracts.	**Evidentiary Standards**: MCO Evidentiary Standards: The MCO uses the DMAP Medicaid fee schedule as the basis for provider contracts in order to most closely mimic the current DMAP methodology for establishing medical cost expectations. The MCO also evaluates rate levels in comparison to what CMS would pay for those services and the cost of those services by accessing the hospitals CMS HCFA #2552 cost report. The MCO tries to avoid paying hospital rates that are in excess of their actual costs or what CMS would pay for Medicare patients.
Compliance Determination MCO MH/SUD to MCO M/S: The MCO develops rates for MH/SUD providers and use the DMAP fees schedule for M/S providers. For both MH/SUD and M/S benefits, the MCO develops rates in order to reduce provider abrasion and improve contracting consistency. To develop MH/SUD rates, the MCO relies on the current DMAP fee schedules, UCR, Medicare, and competitor information payment methodology as the basis for inpatient contracting. The MCO contracts with each MH/SUD provider to establish the rates for covered benefits. The final methodology applied to each provider (MH/SUD and M/S) depends on the details of any negotiated contract. Contracts and fees for both MH/SUD and M/S benefits may be adjusted to establish appropriate provider networks and to address issues such as service type, geographic market, and demand for services, supply, practice size, and provider qualifications. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
7B – Provider Reimbursement (in-network) – Outpatient – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: • All outpatient INN (in-network) treatment providers State FFS Benefits: • All outpatient MH/SUD providers	**Benefits:** Managed by MCO: • OP Hospital providers
Processes: MCO Processes: The MCO uses the current Medicaid fee schedules and payment methodology as the basis for setting rates and contracting outpatient	**Processes:** MCO Processes: The majority of the acute hospital facilities for outpatient reimbursement are reimbursed at either 100% of the published DMAP inpatient discharge rate

MH/SUD	M/S
MH/SUD providers. In addition, the MCO uses a variety of information (e.g., UCR, Medicare, competitor information) to support developing rate parameters for negotiating contracts. The MCO's goal is to negotiate rates consistent for providers with similar organizational types and specialty services. The MCO also offers performance-based contracts that incentivize providers to accomplish various clinical objectives and efficiencies. State FFS Processes: Reimbursements for services are based upon a Medicaid fee schedule established by the State of Delaware. If a Medicare fee exists for a defined covered procedure code, then Delaware will base its rate on the Medicare fee schedule. Where Medicare fees do not exist for a covered code, Delaware developed a fee considering components of provider costs, including staffing assumptions and staff wages, employee-related expenses, program-related expenses, provider overhead expenses, and the reimbursement units.	or a multiple of the DMAP published reimbursement rates. The contractual rates are a matter of negotiations between the MCO and the hospital facility, and are a balance of attempting to obtain a reimbursement level as close to 100% of the State FFS rates versus providing members sufficient access to outpatient hospital care in their county. The MCO always begins negotiations attempting to pay no higher than 100% of the state fee for service rates. However, some hospitals find that level unacceptable to cover their outpatient costs for treating these members, requiring the MCO to pay an incentive. Thus the two parties find a compromise rate position. In the few instances where some aspect of outpatient reimbursement is not based upon DMAP rates, that reimbursement is based upon a percentage of charges.
Strategies: MCO Strategies: The MCO develops rates in order to reduce provider abrasion and improve contracting consistency. The final methodology applied to each provider will depend on the details of any negotiated contract. Contracts and fee schedules may be adjusted to establish appropriate provider networks and to address issues such as service type, geographic market, demand for services, supply, practice size, provider qualifications, etc. State FFS Strategies: The purpose of establishing provider reimbursement rates is to produce rates that comply with federal law, including being sufficient to enlist enough providers so that covered services are available to members at least to the	**Strategies:** MCO Strategies: The MCO uses the current DMAP fee schedules and payment methodologies in order to reduce provider abrasion and improve contracting consistency. The final methodology applied to each provider will depend on the details of any negotiated contract. Contracts and fee schedules may be adjusted to establish appropriate provider networks and to address issues such as service type, geographic market, demand for services, supply, practice size, provider qualifications, etc.

MH/SUD	M/S
extent that these services are available to the general population and that are consistent with economy, efficiency, and quality of care. Provider enrollment and retention are reviewed periodically to ensure that access to care and adequacy of payments are maintained.	
Evidentiary Standards: MCO Evidentiary Standards: The MCO uses a variety of information such as current Medicaid fee schedule, usual and customary rates, Medicare rates and competitor information to develop rate parameters for negotiating contracts. State FFS Evidentiary Standards: For rates based on the Medicare fee schedule, the evidentiary standard is the Medicare fee schedule. For rates developed by the State, the evidence includes provider compensation studies, cost data, and fees from similar state Medicaid programs	**Evidentiary Standards**: MCO Evidentiary Standards: The MCO uses the DMAP Medicaid fee schedules as the basis for provider contracts in order to most closely mimic the current DMAP methodology for establishing medical cost expectations. The MCO also evaluates what CMS would pay for those services and the cost of those services by accessing the hospitals CMS HCFA #2552 cost report. The MCO tries to avoid paying hospital rates that are in excess of actual costs or what CMS would pay for Medicare patients.

MH/SUD	M/S
Compliance Determination MCO MH/SUD to MCO M/S: The MCO develops rates for MH/SUD providers and use the DMAP fees schedule for M/S providers. For both MH/SUD and M/S benefits, the MCO develop rates in order to reduce provider abrasion and improve contracting consistency. To develop MH/SUD rates, the MCO relies on the current DMAP fee schedules, UCR, Medicare, and competitor information payment methodology as the basis for inpatient contracting. The MCO contracts with each MH/SUD provider to establish the rates for covered benefits. The final methodology applied to each provider (MH/SUD and M/S) depends on the details of any negotiated contract. Contracts and fees for both MH/SUD and M/S benefits may be adjusted to establish appropriate provider networks and to address issues such as service type, geographic market, and demand for services, supply, practice size, and provider qualifications. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification. **Compliance Determination State FFS MH/SUD to MCO M/S:** The State establishes FFS MH/SUD rates that comply with federal law, to ensure enough providers are available for covered benefits that are consistent with economy, efficiency and quality of care. The FFS MH/SUD rates are based on the Medicare fee schedule if a Medicare fee exists for a defined covered procedure code; if Medicare fee does not exist, Delaware develops a fee. For M/S benefits, the MCO uses Medicaid current fee schedules and payment methodologies (which are developed using the same processes, strategies, and evidentiary standards as fees for MH/SUD benefits) in order to reduce provider abrasion and improve contracting consistency. The MCO also employs UCR and Medicare rates to develop rate parameters for negotiating contracts. The final methodology applied to each M/S provider depends on the details of any negotiated contract. Contracts and fees may be adjusted to establish appropriate provider networks and to address issues such service type, geographic market, demand for services, supply, practice size, and provider qualifications. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
7D – Provider Reimbursement (in-network) – Prescription Drugs – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: Certain MH/SUD prescription Drugs	**Benefits:** Managed by MCO: Certain M/S prescription Drugs
Processes: MCO Processes: In network pharmacy providers are reimbursed as follows: Brand drugs: AWP – XX%. Generic – AWP – XX%. Specialty brands: AWP – XX%. Specialty generics: AWP – XX%	**Processes:** MCO Processes: In network pharmacy providers are reimbursed as follows: Brand drugs: AWP – XX%. Generic – AWP – XX%. Specialty brands: AWP – XX%. Specialty generics: AWP – XX%
Strategies: MCO Strategies: Reimbursement logic is designed to fairly compensate providers for	**Strategies:** MCO Strategies: Reimbursement logic is designed to fairly compensate providers for

MH/SUD	M/S
providing prescription drugs.	providing prescription drugs.
Evidentiary Standards: MCO Evidentiary Standards: Average Wholesale Price (AWP) and Wholesale Acquisition Cost (WAC) are regularly updated pharmacy industry pricing benchmarks. Both AWP and WAC are based on manufacturer-reported prices. Government program payers generally pay at WAC or less for brand drugs, with further discounts on generic drugs achieved through the use of Maximum Allowable Cost (MAC) or Actual Acquisition Cost (AAC) prices. The National Average Drug Acquisition Cost (NADAC) is a national benchmark maintained by CMS and is also a regularly updated pricing benchmark used by many state Medicaid pharmacy programs for pricing retail community pharmacy (non-specialty) drugs. These pricing benchmarks help responsible use a program's funds while also providing adequate reimbursement to pharmacies to ensure member access. If a pharmacy is unable to dispense a medication at the MAC or AAC price and still cover its costs, the pharmacy can appeal to the MCO for a pricing review and provide evidence of their actual purchase price.	**Evidentiary Standards**: MCO Evidentiary Standards: Average Wholesale Price (AWP) and Wholesale Acquisition Cost (WAC) are regularly updated pharmacy industry pricing benchmarks. Both AWP and WAC are based on manufacturer-reported prices. Government program payers generally pay at WAC or less for brand drugs, with further discounts on generic drugs achieved through the use of Maximum Allowable Cost (MAC) or Actual Acquisition Cost (AAC) prices. The National Average Drug Acquisition Cost (NADAC) is a national benchmark maintained by CMS and is also a regularly updated pricing benchmark used by many state Medicaid pharmacy programs for pricing retail community pharmacy (non-specialty) drugs. These pricing benchmarks help responsible use a program's funds while also providing adequate reimbursement to pharmacies to ensure member access. If a pharmacy is unable to dispense a medication at the MAC or AAC price and still cover its costs, the pharmacy can appeal to the MCO for a pricing review and provide evidence of their actual purchase price.
Compliance Determination MCO MH/SUD to MCO M/S: The MCO develops its own ingredient cost reimbursement and professional dispensing fee rates for MH/SUD and M/S prescription drugs and over-the-counter products dispensed by pharmacy providers. To develop pharmacy reimbursement rates, the MCO relies on national drug pricing benchmarks available in drug pricing compendia such as the Average Wholesale Price (AWP), Wholesale Acquisition Cost (WAC) and the National Average Drug Acquisition Cost (NADAC). The final reimbursement rates must be adequate to ensure member access. If the established reimbursement rate for a drug does not cover the cost of a drug, the pharmacy can appeal to the MCO for a pricing review and provide evidence of their actual purchase price. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
8A – Usual, Customary and Reasonable (UCR) Determinations – Inpatient – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: All inpatient OON (out of network) MH/SUD treatment providers	**Benefits:** Managed by MCO: All inpatient OON (out of network) M/S treatment providers

MH/SUD	M/S
Processes: MCO Processes: The MCO establishes UCR for certain providers when there is gap in coverage. Typically the MCO will establish UCR when there are no in-network providers to maintain State access requirements or if a certain clinical specialty is unavailable. For in-state accommodations, the MCO relies on the Medicaid fee schedule for establishing UCR. Providers are contracted using single-case agreements; UCR serves as the basis for a rate, but each rate is negotiated between the provider and the MCO on a case by case basis.	**Processes:** MCO Processes: The MCO establishes UCR for certain providers when there is gap in coverage. Typically the MCO will establish UCR when there are no in-network providers to maintain State access requirements or if a certain clinical specialty is unavailable. For in-state accommodations, the MCO relies on the Medicaid fee schedule for establishing UCR. Providers are contracted using single-case agreements; UCR serves as the basis for a rate, but each rate is negotiated between the provider and the MCO on a case by case basis.
Strategies: MCO Strategies: Fees are established using Medicaid fee schedule for in-network state accommodation requests. Out of Network/Out of State reimbursement is negotiated on a case by case basis when there is no network provider who can provide the service and is within a reasonable travel distance from the member. UCR rates are updated as state fee schedules are revised.	**Strategies:** MCO Strategies: Fees are established using Medicaid fee schedule for in-network state accommodation requests. Out of Network/Out of State reimbursement is negotiated on a case by case basis when there is no network provider who can provide the service and is within a reasonable travel distance from the member. UCR rates are updated as state fee schedules are revised.
Evidentiary Standards: MCO Evidentiary Standards: The MCO relies on the State's Medicaid fee schedule. In the event the State's fees schedule does not have rates available for certain benefits, the MCO utilizes CMS reimbursement rates (Medicare).	**Evidentiary Standards:** MCO Evidentiary Standards: The MCO relies on the State's Medicaid fee schedule. In the event the State's fees schedule does not have rates available for certain benefits, the MCO utilizes CMS reimbursement rates (Medicare).
Compliance Determination MCO MH/SUD TO MCO M/S: The MCO establishes UCR for certain MH/SUD and M/S providers when there is gap in coverage (no network provider) in order to maintain State access requirements or clinical specialties within the MCO provider network. UCR serves as the basis for a rate, but each rate is negotiated between the MH/SUD and M/S provider and the MCO on a case by case basis. The MCO primarily relies on the State's Medicaid fee schedule, but will refer to CMS reimbursement rates (Medicare) when rates for certain benefits are unavailable/not provided on the State's fee schedule. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
8B – Usual, Customary and Reasonable (UCR) Determinations – Outpatient – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO:	**Benefits:** Managed by MCO:

MH/SUD	M/S
All outpatient OON (out of network) MH/SUD treatment providers	All outpatient OON (out of network) M/S treatment providers
Processes: MCO Processes: Same as 8A.	**Processes:** MCO Processes: Same as 8A.
Strategies: MCO Strategies: Same as 8A.	**Strategies:** MCO Strategies: Same as 8A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 8A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 8A.
Compliance Determination MCO MH/SUD TO MCO M/S: Same as 8A.	
8C – Usual, Customary and Reasonable (UCR) Determinations – Emergency Care – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: Emergency care providers	**Benefits:** Managed by MCO: Emergency care providers
Processes: MCO Processes: Same as 8A.	**Processes:** MCO Processes: Same as 8A.
Strategies: MCO Strategies: Same as 8A.	**Strategies:** MCO Strategies: Same as 8A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 8A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 8A.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 8A.	
9A – Provider Enrollment and Credentialing Requirements – Inpatient – All Benefit Packages (Adult, PROMISE, Children)*	
Providers: All contracted MH/SUD inpatient providers.	**Providers:** All contracted M/S inpatient providers.
Processes:	**Processes:**

MH/SUD	M/S
State Processes: The State sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, disclosures, and licensure/certification, In addition, the MCO credentials all network providers in accordance with its credentialing criteria. MCO Processes: Providers must meet all credentialing criteria outlined in the MCO's Credentialing Policies to remain eligible for network participation. The Credentialing Plan is available online at https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf . Participating providers/facilities are required to re-credential every 36 months. The MCO' s credentialing/re-credentialing criteria includes: • Education requirements • Licensing requirements • Admitting privileges • Current and unrestricted DEA or Controlled Substance Certificate(s) – unless practitioners practice does not require it • Medicare/Medicaid Program Participation Eligibility • Work history (five year employment history) • Insurance or state approved alternative • Site visit • Network participation (without termination within 24-month period) Credentialing policies are applicable to all network providers across all levels of care.	State Processes: The State sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, disclosures, and licensure/certification, In addition, the MCO credentials all network providers in accordance with its credentialing criteria. MCO Processes: Providers must meet all credentialing criteria outlined in the MCO's Credentialing Plan to remain eligible for network participation. The Credentialing Plan is available online at www.unitedhealthcareonline.com. Participating providers/facilities are required to re-credential every 36 months. The MCO's credentialing/re-credentialing includes: • Education requirements • Post-graduate education/training verifications (e.g., fellowships) • Licensing/Certification requirements • Admitting privileges • Current and unrestricted DEA or Controlled Substance Certificate(s) – unless practitioners practice does not require it • Medicare/Medicaid Program Participation Eligibility • Work history (five year employment history) • Insurance or state approved alternative • Insurance or state approved alternative • Malpractice history (five year history) • Passing site visit score • Review of NPDB/FSMB and state licensing boards • No denials or terminations of network participation (24-month review) • Review of application of disclosure questions Credentialing policies are applicable to all network providers across all levels of care.
Strategies:	**Strategies:**

MH/SUD	M/S
MCO Strategies: To ensure properly qualified providers are delivering services to members. Providers must meet certain levels of clinical competency and practice performance in order to maintain the quality and integrity of the MCO network.	MCO Strategies: To ensure properly qualified providers are delivering services to members. Providers must meet certain levels of clinical competency and practice performance in order to maintain the quality and integrity of the MCO network.
Evidentiary Standards: MCO Evidentiary Standards: The MCO adheres to national accreditation and provider/facility certification standards as required by NCQA, CMS and respective state laws.	**Evidentiary Standards:** MCO Evidentiary Standards: The MCO adheres to national accreditation and provider/facility certification standards as required by NCQA, CMS and respective state laws.
Compliance Determination MH/SUD to M/S: The State sets the provider enrollment requirements for all provider types enrolled as Medicaid providers. This includes requirements such as; NPI, tax ID, disclosures, and licensure/certification, In addition, the MCO credentials all network providers in accordance with its credentialing criteria. The MCO maintains credentialing requirements to ensure qualified providers are delivering services to members and that providers meet certain levels of clinical competencies and practice performance to maintain quality and integrity of the MCO's network. The MCO adheres to national accreditation and provider/facility certification standards as required by NCQA, CMS and State law. The MCO maintains maintain specific credentialing criteria and credentialing/re-credentialing policies applicable to all network providers across all levels of care for both MH/SUD and M/S. All providers/facilities are required to be re-credentialed every three years based on the criteria noted above. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
9B – Provider Enrollment and Credentialing Requirements – Outpatient – All Benefit Packages (Adult, PROMISE, Children)*	
Providers: All contracted MH/SUD outpatient providers.	**Providers:** All contracted M/S outpatient providers.
Processes: MCO Processes: Same as 9A.	**Processes:** MCO Processes: Same as 9A.
Strategies: MCO Strategies: Same as 9A.	**Strategies:** MCO Strategies: Same as 9A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 9A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 9A.

MH/SUD	M/S
Compliance Determination MCO MH/SUD to MCO M/S: Same as 9A.	
9C – Provider Enrollment and Credentialing Requirements – Emergency Care – All Benefit Packages (Adult, PROMISE, Children)*	
Providers: Emergency care providers	**Providers:** Emergency care providers
Processes: MCO Processes: Same as 9A.	**Processes:** MCO Processes: Same as 9A.
Strategies: MCO Strategies: Same as 9A.	**Strategies:** MCO Strategies: Same as 9A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 9A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 9A.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 9A.	
10A – Geographic Restrictions – Inpatient – All Benefit Packages (Adult, PROMISE, Children)	
Providers: All contracted MH/SUD inpatient providers.	**Providers:** All contracted M/S inpatient providers.
Processes: MCO Processes: Members accessing benefits are expected to seek treatment from network professionals and facilities within the State. When a service is clearly not available from a network provider, arrangements may be made for an out of network provider this includes within bordering states as needed who otherwise meets United's standards of care, including having or being willing to obtain a Medicaid provider ID. Services not meeting the criteria of emergent/acute are not covered out of network. Emergent and unplanned admissions are reimbursed based on the state fee schedule when appropriate or through a single case agreement.	**Processes:** MCO Processes: Members accessing benefits are expected to seek treatment from network professionals and facilities within the state. When a service is clearly not available from a network provider, arrangements may be made for an out of network provider this includes within bordering States as needed who otherwise meets United's standards of care, including having or being willing to obtain a Medicaid provider ID. Services not meeting the criteria of emergent/acute are not covered out of network. Emergent and unplanned admissions are reimbursed based on the state fee schedule when appropriate or through a single case agreement.

MH/SUD	M/S
Strategies: MCO Strategies:: The MCO contract with all providers as designated in the State Provider Agreement and is applicable to all benefits. The MCO allows for access to emergent care outside of the State including unplanned IP admissions and emergent Outpatient care. All non-emergent/planned admissions must be provided in state.	**Strategies:** MCO Strategies:: The MCO contract with all providers as designated in the State Provider Agreement and is applicable to all benefits. The MCO allows for access to emergent care outside of the State including unplanned IP admissions and emergent Outpatient care. All non-emergent/planned admissions must be provided in state.
Evidentiary Standards: MCO Evidentiary Standards: The MCO follows State plan requirements, the State's Provider Agreement and the MCO's Behavioral Health standards for geo-access to providers and facilities in urban and rural areas. The MCO specific standards are established by the MCO's quality committees.	**Evidentiary Standards:** MCO Evidentiary Standards: The MCO follows State plan requirements, the State's Provider Agreement and the MCO's standards for geo-access to providers and facilities in urban and rural areas. The MCO specific standards are established by the MCO's quality committees.
Compliance Determination MCO MH/SUD to MCO M/S: The MCO maintains geographic access requirements based on the Delaware State Plan, the State's provider agreement and MCO-specific standards for providers/facilities in urban/rural areas. The MCO requires that members seek treatment from the MCO's network of providers/facilities within the State for both MH/SUD and M/S benefits. When emergent/acute service(s) are unavailable from network providers, the MCO will allow a member to access services through an out of network provider if the provider meets all MCO/State requirements to practice. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
10B – Geographic Restrictions – Outpatient – All Benefit Packages (Adult, PROMISE, Children)	
Providers: All contracted MH/SUD outpatient providers.	**Providers:** All contracted M/S outpatient providers.
Processes: MCO Processes: Same as 10A.	**Processes:** MCO Processes: Same as 10A.
Strategies: MCO Strategies: Same as 10A.	**Strategies:** MCO Strategies: Same as 10A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 10A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 10A.

MH/SUD	M/S
Compliance Determination MCO MH/SUD to MCO M/S: Same as 10A.	
10C – Geographic Restrictions – Emergency Care – All Benefit Packages (Adult, PROMISE, Children)	
Providers: Emergency care providers	**Providers:** Emergency care providers
Processes: MCO Processes: Same as 10A.	**Processes:** MCO Processes: Same as 10A.
Strategies: MCO Strategies: Same as 10A.	**Strategies:** MCO Strategies: Same as 10A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 10A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 10A.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 10A.	
11A – Standards for Out-Of-Network Coverage – Inpatient – All Benefit Packages (Adult, PROMISE, Children)	
Providers: All MH/SUD out of network inpatient providers.	**Providers:** All M/S out of network inpatient providers.
Processes: MCO Processes: Used when in-network care is not available within geo access or clinical specialty not available in network. Individuals accessing benefits are expected to seek treatment from network professionals and facilities contracted with the MCO. When a service is clearly not available from a network provider, arrangements may be made for an out of network provider who otherwise meets the MCO's standards of care, including having or being willing to obtain a Medicaid provider ID or other appropriate credentials. Once a request is received, it is reviewed in the same process as for an in network provider as listed above. The MCO will then determine if the provider requires a single-case agreement.	**Processes:** MCO Processes: Used when in-network care is not available within geo access or clinical specialty not available in network. Individuals accessing benefits are expected to seek treatment from network professionals and facilities contracted with the MCO. When a service is clearly not available from a network provider, arrangements may be made for an out of network provider who otherwise meets the MCO's standards of care, including having or being willing to obtain a Medicaid provider ID or other appropriate credentials. Once a request is received, it is reviewed in the same process as for an in network provider as listed above. The MCO will then determine the need for a single case agreement.

MH/SUD	M/S
All emergency department and post-stabilization services are covered without authorization. However, at the point of inpatient admission the facility must notify the MCO in order to coordinate care. In general, the MCO does not require transfer to a Network facility until the member is discharged to another level of care or until the needed services are more than the out of network facility is licensed to provide.	All emergency department and post-stabilization services are covered without authorization. However, at the point of inpatient admission the facility must notify the MCO in order to coordinate care. In general, the MCO does not require transfer to a Network facility until the member is discharged to another level of care or until the needed services are more than the out of network facility is licensed to provide.
Strategies: MCO Strategies: Applies to all care when accommodation is necessary (no qualified network provider within a specific access standard) or emergency/unplanned admissions out of area. If there is no network provider who can provide the service and is within a reasonable travel distance from the member. Current provider network would be reviewed for specialty and access standard as well as availability prior to a single case agreement. Single case agreement information is reviewed to identify network needs and frequently used providers for contracting purposes.	**Strategies:** MCO Strategies: Applies to all care when accommodation is necessary (no qualified network provider within a specific access standard) or emergency/unplanned admissions out of area. If there is no network provider who can provide the service and is within a reasonable travel distance from the member. Single Case Agreement information is reviewed monthly for trends and to identify frequently used providers for contracting purposes. Providers who were initially unwilling to contract with the MCO may change their mind when they require frequent single case agreements.
Evidentiary Standards: MCO Evidentiary Standards: The MCO follows State requirements, including the MCO contract.	**Evidentiary Standards:** MCO Evidentiary Standards: The MCO follows State requirements, including the MCO contract.
Compliance Determination MCO MH/SUD to MCO M/S: For both MH/SUD and M/S benefits, the MCO provides out of network coverage when in-network care is not available. The MCO expects members to seek treatment from network professionals and facilities contracted with the MCO. However, when a qualified in-network provider is not available, arrangements are made with a qualified out of network provider, generally using a single case agreement. This NQTL is based on state requirements. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
11B – Standards for Out-Of-Network Coverage – Outpatient – All Benefit Packages (Adult, PROMISE, Children)	
Providers: All MH/SUD out of network outpatient providers.	**Providers:** All M/S out of network outpatient providers.
Processes: MCO Processes:	**Processes:** MCO Processes:

MH/SUD	M/S
Same as 11A.	Same as 11A.
Strategies: MCO Strategies: Same as 11A.	**Strategies:** MCO Strategies: Same as 11A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 11A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 11A.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 11A	
11C – Standards for Out-Of-Network Coverage – Emergency Care – All Benefit Packages (Adult, PROMISE, Children)	
Providers: Out of network emergency care providers.	**Providers:** Out of network emergency care providers.
Processes: MCO Processes: Same as 11A.	**Processes:** MCO Processes: Same as 11A.
Strategies: MCO Strategies: Same as 11A.	**Strategies:** MCO Strategies: Same as 11A.
Evidentiary Standards: MCO Evidentiary Standards: Same as 11A.	**Evidentiary Standards:** MCO Evidentiary Standards: Same as 11A.
Compliance Determination MCO MH/SUD to MCO M/S: Same as 11A.	
12D – Drugs Not Covered Pursuant to Section 1927(d)(2) – Prescription Drugs – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: Certain MH/SUD prescription drugs	**Benefits:** Managed by MCO: Certain M/S prescription drugs
Processes: MCO Processes: While the MCO does not cover drugs or classes of drugs specified in Section 1927(d)(2) of the Social Security Act (Act), coverage for these	**Processes:** MCO Processes: While the MCO does not cover drugs or classes of drugs specified in Section 1927(d)(2) of the Act, coverage for these drugs is provided if

MH/SUD	M/S
drugs is provided if medically necessary through prior authorization (see PA NQTL).	medically necessary through prior authorization (see PA NQTL).
Strategies: MCO Strategies: The MCO does not cover these drugs unless medically necessary due to their primary indications as quality of life drugs.	**Strategies:** MCO Strategies: The MCO does not cover these drugs unless medically necessary due to their primary indications as quality of life drugs.
Evidentiary Standards: MCO Evidentiary Standards: The Act allows the exclusion of certain drugs that may not always be medically necessary. The Act allows the exclusion of certain drugs generally considered “lifestyle drugs” (used to improve quality of life rather than for alleviating pain or managing or curing an illness). These include agents for weight loss, to promote fertility, and cosmetic purposes. Examples are: (A) Agents when used for anorexia, weight loss, or weight gain. (B) Agents when used to promote fertility. (C) Agents when used for cosmetic purposes or hair growth.	**Evidentiary Standards**: MCO Evidentiary Standards: The Act allows the exclusion of certain drugs that may not always be medically necessary. The Act allows the exclusion of certain drugs generally considered “lifestyle drugs” (used to improve quality of life rather than for alleviating pain or managing or curing an illness). These include agents for weight loss, to promote fertility, and cosmetic purposes. Examples are: (A) Agents when used for anorexia, weight loss, or weight gain. (B) Agents when used to promote fertility. (C) Agents when used for cosmetic purposes or hair growth.
<u>Compliance Determination MCO MH/SUD to MCO M/S:</u> The MCO does not cover drugs or classes of drugs specified in Section 1927(d)(2) of the Social Security Act unless medically necessary, due to their primary indications as quality of life drugs. This section of the Social Security Act allows for exclusion of agents that are not always medically necessary such as drugs used for weight loss or weight gain, drugs used to promote fertility and drugs used for cosmetic purposes or hair growth. Coverage exclusion is determined based on the drug being in one of these drug classes listed in federal law. Coverage may be considered through medical necessity determination through the prior authorization process. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
13D – Early Refills – Prescription Drugs – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: All MH/SUD prescription drugs	**Benefits:** Managed by MCO: All M/S prescription drugs
Processes: MCO Processes: Refills are not allowed until XX% of the previous fill has been used. If the prescriber has changed the directions for a member’s medication requiring	**Processes:** MCO Processes: Refills are not allowed until XX% of the previous fill has been used. If the prescriber has changed the directions for a member’s medication requiring

MH/SUD	M/S
an early refill, the pharmacy may call the MCO's Pharmacy Help Desk with the new dosing details to gain an approval.	an early refill, the pharmacy may call the MCO's Pharmacy Help Desk with the new dosing details to gain an approval.
Strategies: MCO Strategies: Early refill edits help to prevent stockpiling and abuse. Exceptions to the early refill restriction can be handled through the prior authorization process when necessary. Early refills for controlled substances are prohibited.	**Strategies:** MCO Strategies: Early refill edits help to prevent stockpiling and abuse. Exceptions to the early refill restriction can be handled through the prior authorization process when necessary. Early refills for controlled substances are prohibited.
Evidentiary Standards: MCO Evidentiary Standards: State Medicaid pharmacy programs include early refill requirements as part of their Drug Utilization Review (DUR) programs. Section 1927(g) of the Social Security Act, Drug Use Review, allows for prospective drug review to ensure that states provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits, typically at the point-of-sale or point of distribution and that the review include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.	**Evidentiary Standards**: MCO Evidentiary Standards: State Medicaid pharmacy programs include early refill requirements as part of their Drug Utilization Review (DUR) programs. Section 1927(d) of the Social Security Act, Drug Use Review, allows for prospective drug review to ensure that states provide for a review of drug therapy before each prescription is filled or delivered to an individual receiving benefits, typically at the point-of-sale or point of distribution and that the review include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse.
Compliance Determination MCO MH/SUD to MCO M/S: The MCO does not allow prescription drug refills until a certain percentage of a prescription has been used to prevent overutilization. Exceptions to the early refill restriction can be handled through the prior authorization process for clinically appropriate reasons such as if the prescriber has changed the directions for use of the drug such that an early refill of the drug is needed in order to fill the prescription in compliance with the prescriber's directions. Section 1927(g) of the Social Security Act allows for prospective drug review under the DUR program to ensure states can provide a review of drug therapy prior to prescriptions being dispensed by a pharmacy provider. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
14D – Copay Tiers – Prescription Drugs – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: All MH/SUD prescription drugs	**Benefits:** Managed by MCO: All M/S prescription drugs
Processes:	**Processes:**

MH/SUD	M/S
MCO Processes: Copays are imposed on drugs as directed by the State in accordance with 42 CFR 447.50 through 42 CFR 447.60. Copays are assessed by the payer system when the claim is submitted by the pharmacy. The pharmacist is responsible for assessing the copay at point of sale when dispensing the medication to the member. The maximum out-of-pocket cost a member may incur will not exceed $15.00 for every 30 calendar days.	MCO Processes: Copays are imposed on drugs as directed by the State in accordance with 42 CFR 447.50 through 42 CFR 447.60. Copays are assessed by the payer system when the claim is submitted by the pharmacy. The pharmacist is responsible for assessing the copay at point of sale when dispensing the medication to the member. The maximum out-of-pocket cost a member may incur will not exceed $15.00 for every 30 calendar days.
Strategies: MCO Strategies: Copays are assessed to share health care costs between payers and members, and to avoid members seeking unneeded services. In order to share the cost proportionately, copays are set by tier to charge lower copays for less-expensive drugs and higher copays for more-expensive drugs.	**Strategies:** MCO Strategies: Copays are assessed to share health care costs between payers and members, and to avoid members seeking unneeded services. In order to share the cost proportionately, copays are set by tier to charge lower copays for less-expensive drugs and higher copays for more-expensive drugs.
Evidentiary Standards: MCO Evidentiary Standards: Below is a reference providing evidence that copays share the cost between plan and beneficiary. http://kff.org/report-section/modern-era-medicaid-premiums-and-cost-sharing/	**Evidentiary Standards**: MCO Evidentiary Standards: Below is a reference providing evidence that copays share the cost between plan and beneficiary. http://kff.org/report-section/modern-era-medicaid-premiums-and-cost-sharing/
Compliance Determination MCO MH/SUD to MCO M/S: The MCO assesses copays so that the member shares the cost of prescription drugs and to prevent members from seeking unneeded services. In order to share the cost proportionately, copays are set by tier to charge lower copays for less-expensive drugs and higher copays for more-expensive drugs. Copays are imposed on drugs as directed by the State in accordance with 42 CFR 447.50 through 42 CFR 447.60. Copays are assessed by the payer system when the claim is submitted by the pharmacy. The maximum out-of-pocket cost a member may incur will not exceed $15.00 for every 30 calendar days. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	
15D – Pharmacy Lock-in – Prescription Drugs – All Benefit Packages (Adult, PROMISE, Children)	
Benefits: Managed by MCO: Certain MH/SUD prescription drugs	**Benefits:** Managed by MCO: Certain M/S prescription drugs

MH/SUD	M/S
Processes: MCO Processes: The MCO has a provider restriction program that reviews the utilization data and then decides next steps. The MCO can require that a member see a certain provider while ensuring reasonable access to quality services when: a. Utilized services have been identified as unnecessary, or b. A member's behavior is detrimental to that member's health or well-being, or c. A need is indicated to provide case continuity. The MCO can require that a member obtain all prescriptions, or only certain prescriptions such as narcotics, from a designated pharmacy provider(s) when poor compliance or drug seeking behavior is suspected. The Plan will use multiple sources to identify members for whom poor compliance or drug seeking behavior is suspected. Possible sources would include referrals from the Care Coordinators, High Risk Case Management, Pharmacy reviews, community providers, MAD, and the Quality Department. The MCO's Community & State's Business Intelligence Team (BIT), using pharmacy and medical claims data, identifies on a quarterly basis members with potentially inappropriate patterns of utilization as defined below: 1. Identification criteria parameters within a specified time frame include one of the following: • Number of targeted pharmacy claims (nine or more per quarter) and number of prescribers (three or more per quarter) and number of pharmacies (three or more per quarter) in 90 days. • History of drug, alcohol, and/or substance abuse, dependence, and/or poisoning in 180 days. 2. Exclusion criteria parameters include members identified for inclusion that have a cancer diagnosis on file within the previous 12 months. 3. Medical claims are then pulled for the identified members by the MCO's Community & State's BIT. The medical claims report includes: • Number of Emergency Room, Clinic and/or Hospital visits (six	**Processes**: MCO Processes: The MCO has a provider restriction program that reviews the utilization data and then decides next steps. The MCO can require that a member see a certain provider while ensuring reasonable access to quality services when: a. Utilized services have been identified as unnecessary, or b. A member's behavior is detrimental to that member's health or well-being, or c. A need is indicated to provide case continuity. The MCO can require that a member obtain all prescriptions, or only certain prescriptions such as narcotics, from a designated pharmacy provider(s) when poor compliance or drug seeking behavior is suspected. The Plan will use multiple sources to identify members for whom poor compliance or drug seeking behavior is suspected. Possible sources would include referrals from the Care Coordinators, High Risk Case Management, Pharmacy reviews, community providers, MAD, and the Quality Department. The MCO's Community & State's Business Intelligence Team (BIT), using pharmacy and medical claims data, identifies on a quarterly basis members with potentially inappropriate patterns of utilization as defined below: 1. Identification criteria parameters within a specified time frame include one of the following: • Number of targeted pharmacy claims (nine or more per quarter) and number of prescribers (three or more per quarter) and number of pharmacies (three or more per quarter) in 90 days. • History of drug, alcohol, and/or substance abuse, dependence, and/or poisoning in 180 days. 2. Exclusion criteria parameters include members identified for inclusion that have a cancer diagnosis on file within the previous 12 months. 3. Medical claims are then pulled for the identified members by the BIT. The medical claims report includes: • Number of Emergency Room, Clinic and/or Hospital visits (six or more visits with a diagnosis of pain, migraine, or sinusitis in

MH/SUD	M/S
or more visits with a diagnosis of pain, migraine, or sinusitis in 180 days) • History of drug, alcohol, and/or substance abuse The Clinical Pharmacy Team reviews the pharmacy and medical claims history for the members identified to determine if they should be considered for the restriction program. The Clinical Pharmacy Team creates a case report with a recommendation for approval for inclusion in the restriction program, and presents the recommendations to the MCO multidisciplinary team, on a quarterly basis. The MCO's multidisciplinary team makes the final determination as to which members recommended for the restriction program will be selected for inclusion within 14 days of receipt of the recommendations. Once the final determination is made, the approved list of members is provided to the Clinical Pharmacy Team. If a recommended member is not chosen for lock-in, the plan multidisciplinary team is responsible for providing rationale for not recommending enrollment into the program. Prior to placing the member on restriction/lock-in, the MCO shall inform the member and/or the member's representative(s) of the intent. The Plan will inform the member in writing of the designated pharmacy(s) to give the member an opportunity to choose their pharmacy of choice. The lock-in will begin 30 days after the mailing of the letter. The MCO's Grievance procedure shall be made available to the Member. The restriction shall be reviewed and documented by the MCO every quarter. The review will be conducted by the multidisciplinary team. Additionally, there will be a review of current behaviors with the PCP and CC. All members on a pharmacy lock-in shall be reviewed quarterly. It is anticipated that members will be kept on the lock-in for 12 months. Reviews will be documented in the member's electronic record. The member shall be removed from restrictions when the Plan has determined that the compliance issue, drug seeking behavior, utilization problems, or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable.	180 days) • History of drug, alcohol, and/or substance abuse The Clinical Pharmacy Team reviews the pharmacy and medical claims history for the members identified to determine if they should be considered for the restriction program. The Clinical Pharmacy Team creates a case report with a recommendation for approval for inclusion in the restriction program, and presents the recommendations to the MCO multidisciplinary team, on a quarterly basis. The MCO's multidisciplinary team makes the final determination as to which members recommended for the restriction program will be selected for inclusion within 14 days of receipt of the recommendations. Once the final determination is made, the approved list of members is provided to the Clinical Pharmacy Team. If a recommended member is not chosen for lock-in, the plan multidisciplinary team is responsible for providing rationale for not recommending enrollment into the program. Prior to placing the member on restriction/lock-in, the MCO shall inform the member and/or the member's representative(s) of the intent. The Plan will inform the member in writing of the designated pharmacy(s) to give the member an opportunity to choose their pharmacy of choice. The lock-in will begin 30 days after the mailing of the letter. The MCO's Grievance procedure shall be made available to the Member. The restriction shall be reviewed and documented by the MCO every quarter. The review will be conducted by the multidisciplinary team. Additionally, there will be a review of current behaviors with the PCP and CC. All members on a pharmacy lock-in shall be reviewed quarterly. It is anticipated that members will be kept on the lock-in for 12 months. Reviews will be documented in the member's electronic record. The member shall be removed from restrictions when the Plan has determined that the compliance issue, drug seeking behavior, utilization problems, or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable.

MH/SUD	M/S
Members of the Plan multidisciplinary team are made up of the following: a. Licensed physicians b. Licensed pharmacists c. Licensed Nurses d. Clinical Social Workers	Members of the Plan multidisciplinary team are made up of the following: a. Licensed physicians b. Licensed pharmacists c. Licensed Nurses d. Clinical Social Workers
Strategies: MCO Strategies: The purpose of the Lock-In Program is to identify and manage members that meet criteria indicative of potential misuse or abuse of prescription medications or there are concerns with utilization of unnecessary services. The pharmacy benefit, like the medical benefit, is subject to Lock-In review to ensure quality of care and to reduce fraud, waste, and abuse.	**Strategies**: MCO Strategies: The purpose of the Lock-In Program is to identify and manage members that meet criteria indicative of potential misuse or abuse of prescription medications or there are concerns with utilization of unnecessary services. The pharmacy benefit, like the medical benefit, is subject to Lock-In review to ensure quality of care and to reduce fraud, waste, and abuse.
Evidentiary Standards: MCO Evidentiary Standards: The Lock-In Program is required by the State of Delaware and the final outcome is reported to the State monthly and quarterly as required (3.21.9.2 of the contract). Overutilization of the review process could be inferred if there were a large number of grievances filed by members selected for pharmacy/provider restriction. An underutilization of the review process would result in increased overutilization of services and potential adverse health outcomes for members abusing prescription medications.	**Evidentiary Standards**: MCO Evidentiary Standards: The Lock-In Program is required by the State of Delaware and the final outcome is reported to the State monthly and quarterly as required (3.21.9.2 of the contract). Overutilization of the review process could be inferred if there were a large number of grievances filed by members selected for pharmacy/provider restriction. An underutilization of the review process would result in increased overutilization of services and potential adverse health outcomes for members abusing prescription medications.
Compliance Determination MCO MH/SUD to MCO M/S: The MCO uses a Lock-In Program to manage members that meet criteria indicative of potential misuse or abuse of prescription medications or if there are concerns with utilization of unnecessary services. Members can be required to receive all of their prescriptions or only certain prescriptions from a designated pharmacy and/or prescriber. The Lock-Program is required by DMMA, and the MCO provides DMMA monthly and quarterly reports of program activities. The MCO uses pharmacy and medical claims data quarterly to identify members with potentially inappropriate patterns of utilization according to identification criteria parameters within a specific time period. The processes, strategies, evidentiary standards, or other factors used in applying this NQTL to MH/SUD benefits in this classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in this classification.	