Department of
HUMAN SERVICES

DEPARTMENT OF HUMAN SERVICES
IOWA MEDICAID ENTERPRISE

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) COMPLIANCE SUMMARY

DECEMBER 2018

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EXECUTIVE SUMMARY

A summary of Iowa's analysis of compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), conducted by the Iowa Medicaid Enterprise in cooperation with Amerigroup and United Healthcare is presented below. The analysis was conducted by gathering benefit information from the state's MCOs, Children's Health Insurance Program (CHIP) as well as an analysis of the Alternative Benefit Plan (ABP). The state of Iowa determined that the robust mental health and substance use disorder benefits offered by the state's Medicaid program and CHIP satisfy the requirements of MHPAEA as detailed in the final rule issued by the Centers for Medicare & Medicaid Services in 42 CFR Parts 438, 440, 456, and 457.

INTRODUCTON

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that IA Medicaid members are offered behavioral health benefits equal to their medical/surgical benefits. Mental Health Parity applies to the IA Health Link managed care program, and the Iowa Medicaid Fee-for-Service (FFS) program. Compliance for the Children's Health Insurance Program (CHIP), known in Iowa as Healthy and Well Kids in Iowa or ***hawk-i***, will be addressed in the CHIP State Plan Amendment (SPA). The Managed Care Organizations (MCOs) are responsible for the parity analysis, and the State is responsible for ensuring and monitoring compliance for the IA Health Link managed care program. The State is responsible for the parity analysis and for ensuring and monitoring compliance for FFS program.

The final rule requires the state to ensure compliance with three general areas: aggregate lifetime and annual dollar limits (AL/ADLs), financial requirements (FRs) and quantitative treatment limitations (QTLs), and non-quantitative treatment limitations

(NQTLs). States were asked to look at their benefit and utilization management practices and policies to ensure compliance with the following general requirements:

• AL/ADLs are not applied to mental health and substance use disorder (MH/SUD) benefits unless a limit is applied to at least one-third of medical/surgical benefits.

• FRs and QTLs applied to a classification of MH/SUD benefits may not be more restrictive than the financial requirements and quantitative treatment limits applied to medical/surgical benefits in the same classification.

• Any processes, strategies, evidentiary standards, or other factors used to apply NQTLs to MH/SUD benefits in a classification are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply NQTLs to medical/surgical benefits.

A summary of Iowa's analysis, conducted by the Iowa Department of Human Services, Iowa Medicaid Enterprise, is found below. The analysis was conducted by gathering benefit information from the state's MCOs, and CHIP. The state of Iowa determined that the robust mental health and substance use disorder benefits offered by the state's Medicaid program and CHIP satisfy the requirements of MHPAEA as detailed in the final rule issued by the Centers for Medicare & Medicaid Services in 42 CFR Parts 438, 440, 456, and 457.

METHODOLOGY

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

1) Identifying all benefit packages to which parity applies.
2) Determining whether the State or MCO is responsible for the parity analysis (by benefit package).

3) Defining mental health (MH), substance use disorder (SUD), and medical/surgical services and determining which covered services are MH, SUD, and/or medical/surgical services.
4) Defining the four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care) and mapping MH/SUD and medical/surgical services to these classifications.
5) Determining whether any aggregate lifetime or annual dollar limits (AL/ADLs) apply to MH/SUD services.
6) Determining whether any financial requirements (FRs) or quantitative treatment limitations (QTLs) apply to MH/SUD services in a benefit package and testing the applicable financial requirement for compliance with parity.
7) Identifying and analyzing non-quantitative treatment limitations (NQTLs) that apply to MH/SUD services in a benefit package.

MEDICAID AND CHIP DELIVERY SYSTEM AND BENEFIT PACKAGES

Medical Assistance (Medicaid—Title XIX) provides medically necessary health care coverage for financially needy adults, children, parents with children, people with disabilities, elderly people and pregnant women. The goal is for members to live healthy, stable and self-sufficient lives. IA Health Link is a major initiative in which the Iowa Department of Human Services (DHS) has enrolled the majority of Medicaid and Children's Health Insurance Program (CHIP) members in managed care organizations (MCOs). DHS has contracted with MCOs to provide comprehensive health care services including dental care, physical health, pharmacy, behavioral health, and long term supports and services. This single system of care promotes the delivery of efficient, coordinated and high quality health care and establishes accountability in health care coordination.

DHS provides Home and Community Based Services through seven waiver programs and one state plan HCBS program:

1. 1915(c) Acquired Immunodeficiency Syndrome/ Human Immunodeficiency Virus (AIDS/HIV) Waiver provides service funding provides service funding and individualized services/supports to maintain eligible members in their own homes that are not available through the state plan benefit
2. 1915(c) Brain Injury (BI) Waiver provides service funding provides service funding and individualized services/supports to maintain eligible members in their own homes that are not available through the state plan benefit.
3. 1915(c) Children's Mental Health (CMH) Waiver provides service funding and individualized services/supports for children with serious emotional disturbance that are not available through that are not available through the state plan benefit
4. 1915 (c) Elderly Waiver - provides service funding and individualized services/supports to maintain eligible members age 65 and older in their own homes that are not available through the state plan benefit
5. Health and Disability (HD) Waiver provides service funding and individualized services and supports to maintain eligible members in their own homes that are not available through the state plan benefit
6. 1915 (c) Intellectual Disability (ID) Waiver provides service funding and individualized services and supports to maintain eligible members in their own homes that are not available through the state plan benefit
7. 1915(c) Physical Disability (PD) Waiver provides service funding and individualized services and supports to maintain eligible members in their own homes that are not available through the state plan benefit
8. 1915(i) State Plan HCBS Habilitation provides service funding and individualized services and supports to maintain eligible members with serious and persistent mental illness in their own homes that are not available through the state plan benefit

BENEFIT PACKAGES

DHS identifies three benefit plans for Medicaid and CHIP applicants:

IA Health Link - Most Iowa Medicaid members are enrolled in the IA Health Link managed care program. This program gives members health coverage through Managed Care Organizations.

Dental Wellness Plan- Adults age 19 and over receive their dental benefits through the Dental Wellness 1115(a) State Plan Amendment (SPA) The goal of this dental benefits program is to focus on improving, restoring basic functionality for the enrollees; improving the oral health of Enrollees over time; habilitating enrollees through education, care facilitation and community support; ensuring adequate, quality access to dental providers across the state; and establishing a meaningful and sustainable adults dental program for Iowa.

IA Medicaid Fee-For-Service (FFS) Some Iowa Medicaid members are served through a Fee-for-Service (FFS) system where their health care providers are paid separately for each service (like an office visit, test, or procedure) this includes dental services for children under 18 years of age. Members who qualify for or receive services from the following FFS programs:

- Health Insurance Premium Payment Program (HIPP)
- Iowa Health and Wellness Plan - The Iowa Health and Wellness Plan refers to one plan that includes two separate eligibility groups. All Iowa Health and Wellness Plan members are covered for the same types of health benefits. Eligibility is based on household income.
- Medicare Savings Program (MSP)
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Three Day Emergency
- Medically Needy (also known as the spenddown program)
- Presumptive Eligibility (subject to change once ongoing eligibility is determined)
- American Indian or Alaskan Native program
    - American Indians and Alaskan Natives may choose to enroll in the Managed Care program.

- Program of All-Inclusive Care for the Elderly (PACE) program
- Family Planning Program (FPP)

The Children's Health Insurance Program (CHIP) called ***hawk-i*** – Provides health care coverage for uninsured children of working families. The amount members pay is based on the family's income. A child who qualifies for hawk-i health insurance will get all of his or her health care services through a health plan that has agreed to participate in the program.

DEFINTION OF MENTAL HEALTH AND SUBSTANCE USE DISORDER (MH/SUD) BENEFITS

For the purposes of the parity analysis, DHS adopted the most recent version of the International Classification of Diseases (ICD), the ICD-10-CM, as its standard for defining MH/SUD Services and Medical and Surgical services. ICD-10-CM is the current version of the ICD, which is identified in the final Medicaid/CHIP parity rule as an example of a "generally recognized independent standard of current medical practice" for defining MH/SUD and Medical and Surgical conditions.

DHS defines behavioral health benefits as a benefit specifically designed to treat a mental health or substance use disorder condition. Behavioral Health conditions as those conditions listed in ICD-10-CM, Chapter 5, "Mental, Behavioral Health and Neurodevelopmental Disorders. The conditions listed in Chapter 5: subchapter 1, "Mental Disorders due to known physiological conditions" and subchapter 8, "Pervasive and Specific Developmental Disorders" were excluded because the etiology of these conditions is a medical condition, and treatment would address medical concerns first.

BENEFIT CLASSIFICATIONS

DHS defined each of the four benefit classifications identified in the Medicaid/CHIP parity rule as described below:

Inpatient (IP): Any non-emergency service that involves the individual staying overnight at a facility. This includes inpatient MH and SUD treatment and crisis stabilization services occurring in a facility

Outpatient (OP): Routine services that occur in an outpatient setting and are not included in the emergency category.

Emergency Care (EC): Emergency: Services or items delivered in an emergency department (ED) setting or emergency/crisis stabilization services, not requiring an overnight stay, which are not delivered in an inpatient setting.

Prescription Drugs (PD): Covered medications, drugs and associated supplies requiring a prescription.

AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS (AL/ ADLs)

No aggregate lifetime or annual dollar limits in any classification, apply to Medicaid/CHIP MH/SUD services in any benefit package.

FINANACIAL REQUIREMETNS (FR) AND QUATITATIVE TREATMENT LIMITATIONS (QTL)

Financial Requirements

No financial requirements are applied to MH/SUD services in the inpatient, or emergency care classifications of any benefit package.

For outpatient visits for both medical/surgical and MH/SUD, the MCOs apply copayments to CHIP and Medicaid for members age 21 and over ($2 / visit) benefit packages.

For the prescription drugs classification, the MCOs apply copayments to Medicaid for members age 21 and over ($1 / prescription) benefit packages. Copayments are applied

without regard to whether the drug is generally prescribed for medical/surgical services or for MH/SUD. Consistent with federal Medicaid requirements, certain drugs (e.g., prenatal and family planning drugs) are exempt from copayment requirements. Aside from these exclusions, pharmacy copayments are applied to 100% of medical/surgical prescription drugs, and copayment levels are applied consistently within each benefit package. Given the limited number of medical/surgical drugs exempt from copayments, the State determined that no cost-based analysis was necessary, and the prescription drug copayments are compliant with the Medicaid/CHIP parity rule.

Quantitative Treatment Limitations

DHS does not apply any QTLs in any classification to Medical/Surgical or MH/SUD services that cannot be exceeded when medically necessary. Given that any QTL applied to MH/SUD benefits are no more stringent than the QTLs for Medical/Surgical services and given that QTLs in any classification of Medical/Surgical or MH/SUD services may be exceed when medically necessary, the state determined that no cost-based analysis was not necessary, and that the MH/SUD benefit QTLs are compliant with the Medicaid/CHIP parity rule.

NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTLS)

A requirement of this analysis per 42 CFR 438.910(d) requires a review of Non-Quantitative Treatment Limitations (NQTLs) to ensure the processes, strategies, and evidentiary standards used for applying NQTLs to MH/SUD benefits are no more stringent than the processes, strategies, and evidentiary standards used to apply NQTLs for medical/surgical benefits.

Through the final MHPAEA rule, CMS guidance, and technical assistance provided to the states, the Department identified and analyzed five NQTLs across the MH/SUD and medical/surgical benefits:

- Prior Authorization,
- Retrospective Review,

- Network Provider Admission,
- Establishing Charges, and
- Concurrent Review.

Each of these areas was broken down by each of the four benefit categories (inpatient, outpatient, emergency, pharmacy) and questions were asked regarding the processes, strategies, and evidentiary standards used for each benefit category.

The Department's analysis concludes that NQTLs applied to the behavioral health benefit are comparable and applied no more stringently than NQTLs applied to the medical/surgical benefit; thus, the Department is compliant with MHPAEA requirements put forth in 42 CFR 438 Subpart K. Please refer to Appendix A of this document for the analysis of each NQTL.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) COMPLIANCE DOCUMENTATION

Iowa's CHIP plan is fully comprehensive, offering both MH/SUD and medical/surgical benefits. As the plan is fully comprehensive, the plans were responsible for conducting their own parity analysis of their MH/SUD and medical/surgical benefits. Through the Department's review of the plans' analyses, the Department concurs that Iowa's CHIP MCO plans are compliant with MHPAEA requirements put forth in 42 CFR 457 Subpart D.

CONCLUSION

DHS confirms its compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) for its Medicaid and CHIP programs. DHS will continue to strive to maintain full parity compliance and to address any parity issues that arise in the future.

APPENDICES

APPENDIX A. MEDICAID NQTL ANALYSIS

APPENDIX B. REVIEW OF CHIP NQTL ANALYSIS

Appendix A
MEDICAID NQTL ANALYSIS

PRIOR AUTHORIZATION

Prior Authorization is a requirement that a provider must submit a request before performing a service and may only render it after receiving approval.

Inpatient

The Prior Authorization NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Inpatient benefit category. All benefits are subject to some form of guidelines to determine whether to prior authorize MH/SUD and medical/surgical services, either through internal guidelines or a clinical decision support product.

Outpatient

The Prior Authorization NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Outpatient benefit category. For example, not all outpatient MH/SUD and medical/surgical benefits are required to be prior authorized, and there are exceptions to prior authorization requirements in both benefit categories. MH/SUD and medical/surgical benefits are all prior authorized by the direct treatment provider with 14 days allowed for a prior authorization request to be determined unless

the request is expedited in which a determination must be rendered within 72 hours. All MH/SUD and medical surgical benefits that are prior authorized are done so under the same rationale: monitor overutilization, manage high-cost services, and to determine the appropriate level of care.

Emergency

Emergency MH/SUD and medical/surgical services are not prior authorized; therefore, the stringency test does not apply to this section.

Pharmacy

Pharmacy prior authorization (PA) involves obtaining approval for dispensing a drug before providing it to a member as a condition for provider reimbursement. Prior Authorization (PA) is requested at the prescriber level. The Prior Authorization NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Pharmacy benefit category.

RETROSPECTIVE REVIEW

Retrospective Review is a protocol for approving a service after it has been delivered.

Inpatient

The Retrospective Review NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Inpatient benefit category. For example, MH/SUD benefits have a shorter timeframe for when a retrospective review can be performed on inpatient services compared to medical/surgical benefits. Exceptions to retrospective reviews are applied to both benefit categories, and the rationale for performing retrospective reviews is substantially similar for both benefit categories, including medical necessity. Retrospective review policies are the same for in-network and out-of-network providers for both benefit categories. MH/SUD and medical/surgical benefits are subject to some form of clinical guidelines to determine whether to

retrospectively review services, either through internal guidelines or a clinical decision support product.

Outpatient

The Retrospective Review NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Outpatient benefit category. For example, MH/SUD benefits have a shorter timeframe for when a retrospective review can be performed on outpatient services compared to medical/surgical benefits. All services are subject to retrospective reviews due to medical necessity and providing the providers the opportunity to obtain authorizations.

Emergency

The Retrospective Review NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Emergency benefit category. Occasionally, retrospective reviews are performed on MH/SUD and medical/surgical emergency services to determine a member's eligibility, as managed care entities are not contractually required to pay for services for a member that is not in their network. This is an expected business practice and has no impact on the service rendered.

Pharmacy

The Drug Utilization Review Commission performs retrospective drug utilization review (retro-DUR) on both MH/SUD and medical/surgical medications. The retro-DUR program provides ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and members, or associated with specific drugs. The Retrospective Review NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Pharmacy benefit category.

NETWORK PROVIDER ADMISSION

Network Provider Admission is the process of accepting treatment providers into a health plan's network of care professionals.

Inpatient

The Network Provider Admission NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Inpatient benefit category. MH/SUD providers are not limited in participating in provider networks compared to their medical/surgical counterparts. For example, all plans have an internal credentialing committee that makes decisions on admitting providers into the network, and there are no exceptions to the process. All plans have an appeals process for providers who are denied admission into the network, either internally or through the Department. All providers are subject to National Committee for Quality Assurance (NCQA) guidelines for being admitted into networks, and all providers have their primary source data (licensure, certifications, liability insurance, etc.) subject to review for admission.

Outpatient

The Network Provider Admission NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Outpatient benefit category. All plans have an internal credentialing committee that makes decisions on admitting providers into the network. Some MH/SUD providers are exempted from credentialing committees to ensure behavioral health network adequacy. All providers can partake in an appeals process if admission into a network, either internally or with the Department. All providers are subject to National Committee for Quality Assurance (NCQA) guidelines for being admitted into networks, and all providers have their primary source data (licensure, certifications, liability insurance, etc.) subject to review for admission.

Emergency

The Network Provider Admission NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Emergency benefit category.

Pharmacy

The Network Provider Admission NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Pharmacy benefit category.

ESTABLISHING CHARGES

Establishing Charges are the methods used for determining usual, customary, and reasonable charges for services.

Inpatient

The Establishing Charges NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Inpatient benefit category. For example, all plans have an internal process for establishing charges for all MH/SUD and medical/surgical services, and charges are updated as needed. Market values and the Department's fee schedule are taken into account when establishing charges for all MH/SUD and medical/surgical services, along with the need to attract an adequate network of providers. All plans use Iowa's Medicaid FFS rate schedule when establishing charges for all MH/SUD and medical/surgical services.

Outpatient

The Establishing Charges NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Outpatient benefit category. For example, all plans have an internal process for establishing charges for all MH/SUD and medical/surgical services, and charges are updated as needed. Market values and the Department's fee schedule are taken into account when establishing charges for all MH/SUD and medical/surgical services, along with the need to attract an adequate network of providers.

Emergency

The Establishing Charges NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Emergency benefit category. For example, all plans have an internal process for establishing charges for all MH/SUD and medical/surgical services, and charges are updated as needed. Market values and the

Department's fee schedule are taken into account when establishing charges for all MH/SUD and medical/surgical services.

Pharmacy

The Establishing Charges NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Pharmacy benefit category. Reimbursement for covered ingredient drug cost is one the following:

- 340B actual acquisition cost (340B AAC) is defined as the net cost of a drug paid by a pharmacy for drugs purchased through the 340B drug pricing program. A drug's 340B AAC includes discounts, rebates, chargebacks, and other adjustments to the price of the drug, but excludes dispensing fees.
- Average actual acquisition cost (average AAC) is defined as retail pharmacies' average prices paid to acquire drug products.
  - Average AAC is determined by the Department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies.
  - Surveys are conducted at least once every six months, or more often at the Department's discretion.
  - The average AAC is calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the Department is published on the Iowa Medicaid Enterprise website.
  - If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span is used.
- Federal upper limit (FUL) is defined as the upper limit for multiple-source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services, as described in 42 CFR 447.514.
- Federal Supply Schedule actual acquisition cost (FSS AAC) is defined as the net cost of a drug paid by a pharmacy for drugs purchased through the FSS drug pricing program.
- Nominal Price actual acquisition cost (NP AAC) is defined as the net cost of a drug paid by a pharmacy for drugs purchased through the NP drug pricing program.

- Total submitted charge represented by gross amount due and ingredient cost plus the professional dispensing fee.
- Usual and customary (U&C) charge is defined as the fee that the provider typically charges the general public for the product or service.

CONCURRENT REVIEW

Concurrent Review is a requirement that services be periodically reviewed as they are being provided in order to continue the authorization for the service.

Inpatient

The Concurrent Review NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Inpatient benefit category. For example, MH/SUD and medical/surgical services have similar frequencies for when concurrent reviews are performed. Concurrent reviews performed on MH/SUD services do not require a secondary assessment, which is required for certain medical/surgical services. MH/SUD and medical/surgical services are subject to concurrent reviews for similar rationale: to ensure the member is receiving the appropriate level of care and for fiscal management. MH/SUD and medical/surgical benefits are subject to some form of clinical guidelines to determine whether to concurrently review services, either through internal guidelines or a clinical decision support product.

Outpatient

The Concurrent Review NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Outpatient benefit category. For examples, not all MH/SUD and medical/surgical benefits are subjected to concurrent reviews. MH/SUD and medical/surgical benefits have similar varying frequencies for when concurrent reviews are performed and determined. Concurrent reviews performed on MH/SUD services do not require a secondary assessment, which is required for certain medical/surgical services. MH/SUD and medical/surgical services are subject to

concurrent reviews for similar rationale: to ensure the member is receiving the appropriate level of care and for fiscal management. MH/SUD and medical/surgical benefits are subject to some form of clinical guidelines to determine whether to concurrently review services, either through internal guidelines or a clinical decision support product.

Emergency

MH/SUD and medical/surgical emergency services are not concurrently reviewed. Therefore, this section is not applicable to this analysis.

Pharmacy

Concurrent Review NQTL is not applicable to the pharmacy benefits

Step Therapy Protocols

These protocols do not apply to inpatient, outpatient, or emergency services. CHIP plans use step therapy to meet fail-first criteria for both MH/SUD and medical/surgical pharmacy services.

Conditioning Benefits on Completion of a Course of Treatment

While recommendations to begin with a conservative course of treatment may be recommended, inpatient, outpatient, and emergency service exclusions are not based on the failure to complete a certain course of treatment.

Restrictions Based on Geographic Location, Facility Type, or Provider Specialty

There are no restrictions that limit the scope or duration of a service placed on MH/SUD and medical/surgical inpatient, outpatient, emergency, or pharmacy benefits based on geographic location, facility type, or provider specialty.

Out-of-network Provider Access Standards

Prior authorization is required for MH/SUD and medical-surgical benefits for out-of-network providers. Inpatient, outpatient, and pharmacy services all require prior authorization. If a service rendered by an out-of-network provider is approved, the Financial Requirements are the same as services rendered by an in-network provider.

APPENDIX B
REVIEW OF CHIP NQTL ANALYSIS

The Department's review of the CHIP (hawk-i) plans' analyses confirms NQTLs applied to the behavioral health benefit are comparable and applied no more stringently than NQTLs applied to the medical/surgical MCO benefit; thus, the Department is compliant with MHPAEA requirements put forth in 42 CFR 457 Subpart D. Please refer to Appendix B of this document for the analysis of each CHIP NQTL.

PRIOR AUTHORIZATION

Prior Authorization is a requirement that a provider must submit a request before performing a service and may only render it after receiving approval.

Inpatient

The Prior Authorization NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Inpatient benefit category. All benefits are subject to some form of guidelines to determine whether to prior authorize MH/SUD and medical/surgical services, either through internal guidelines or a clinical decision support product.

Outpatient

The Prior Authorization NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Outpatient benefit category. For example, not all outpatient MH/SUD and medical/surgical benefits are required to be prior authorized, and there are exceptions to prior authorization requirements in both benefit categories. MH/SUD and medical/surgical benefits are all prior authorized by the direct treatment provider with 14 days allowed for a prior authorization request to be determined unless the request is expedited in which a determination must be rendered within 72 hours. All MH/SUD and medical surgical benefits that are prior authorized are done so under the same rationale: monitor overutilization, manage high-cost services, and to determine the appropriate level of care.

Emergency

Emergency MH/SUD and medical/surgical services are not prior authorized; therefore, the stringency test does not apply to this section.

Pharmacy

Pharmacy prior authorization (PA) involves obtaining approval for dispensing a drug before providing it to a member as a condition for provider reimbursement. Prior Authorization (PA) is requested at the prescriber level. The Prior Authorization NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Pharmacy benefit category.

RETROSPECTIVE REVIEW

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program provides ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and members, or associated with specific drugs. The Retrospective Review NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Pharmacy benefit category**.**

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guidelines for being admitted into networks, and all providers have their primary source data (licensure, certifications, liability insurance, etc.) subject to review for admission.

Emergency

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Pharmacy

The Network Provider Admission NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Pharmacy benefit category.

ESTABLISHING CHARGES

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Department's fee schedule are taken into account when establishing charges for all MH/SUD and medical/surgical services, along with the need to attract an adequate network of providers.

Emergency

The Establishing Charges NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Emergency benefit category. For example, all plans have an internal process for establishing charges for all MH/SUD and medical/surgical services, and charges are updated as needed. Market values and the Department's fee schedule are taken into account when establishing charges for all MH/SUD and medical/surgical services.

Pharmacy

The Establishing Charges NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Pharmacy benefit category. Reimbursement for covered ingredient drug cost is one the following:

- 340B actual acquisition cost (340B AAC) is defined as the net cost of a drug paid by a pharmacy for drugs purchased through the 340B drug pricing program. A drug's 340B AAC includes discounts, rebates, chargebacks, and other adjustments to the price of the drug, but excludes dispensing fees.
- Average actual acquisition cost (average AAC) is defined as retail pharmacies' average prices paid to acquire drug products.
  - Average AAC is determined by the Department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies.
  - Surveys are conducted at least once every six months, or more often at the Department's discretion.
  - The average AAC is calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the Department is published on the Iowa Medicaid Enterprise website.
  - If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span is used.

- Federal upper limit (FUL) is defined as the upper limit for multiple-source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services, as described in 42 CFR 447.514.
- Federal Supply Schedule actual acquisition cost (FSS AAC) is defined as the net cost of a drug paid by a pharmacy for drugs purchased through the FSS drug pricing program.
- Nominal Price actual acquisition cost (NP AAC) is defined as the net cost of a drug paid by a pharmacy for drugs purchased through the NP drug pricing program.
- Total submitted charge represented by gross amount due and ingredient cost plus the professional dispensing fee.
- Usual and customary (U&C) charge is defined as the fee that the provider typically charges the general public for the product or service.

CONCURRENT REVIEW

Concurrent Review is a requirement that services be periodically reviewed as they are being provided in order to continue the authorization for the service.

Inpatient

The Concurrent Review NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Inpatient benefit category. For example, MH/SUD and medical/surgical services have similar frequencies for when concurrent reviews are performed. Concurrent reviews performed on MH/SUD services do not require a secondary assessment, which is required for certain medical/surgical services. MH/SUD and medical/surgical services are subject to concurrent reviews for similar rationale: to ensure the member is receiving the appropriate level of care and for fiscal management. MH/SUD and medical/surgical benefits are subject to some form of clinical guidelines to determine whether to concurrently review services, either through internal guidelines or a clinical decision support product.

Outpatient

The Concurrent Review NQTL is applied no more stringently to MH/SUD benefits than it is to medical/surgical benefits in the Outpatient benefit category. For examples, not all MH/SUD and medical/surgical benefits are subjected to concurrent reviews. MH/SUD and medical/surgical benefits have similar varying frequencies for when concurrent reviews are performed and determined. Concurrent reviews performed on MH/SUD services do not require a secondary assessment, which is required for certain medical/surgical services. MH/SUD and medical/surgical services are subject to concurrent reviews for similar rationale: to ensure the member is receiving the appropriate level of care and for fiscal management. MH/SUD and medical/surgical benefits are subject to some form of clinical guidelines to determine whether to concurrently review services, either through internal guidelines or a clinical decision support product.

Emergency

MH/SUD and medical/surgical emergency services are not concurrently reviewed. Therefore, this section is not applicable to this analysis.

Pharmacy

Concurrent Review NQTL is not applicable to the pharmacy benefits

Step Therapy Protocols

These protocols do not apply to inpatient, outpatient, or emergency services. CHIP plans use step therapy to meet fail-first criteria for both MH/SUD and medical/surgical pharmacy services.

Conditioning Benefits on Completion of a Course of Treatment

While recommendations to begin with a conservative course of treatment may be recommended, inpatient, outpatient, and emergency service exclusions are not based on the failure to complete a certain course of treatment.

Restrictions Based on Geographic Location, Facility Type, or Provider Specialty

There are no restrictions that limit the scope or duration of a service placed on MH/SUD and medical/surgical inpatient, outpatient, emergency, or pharmacy benefits based on geographic location, facility type, or provider specialty.

Out-of-network Provider Access Standards

Prior authorization is required for MH/SUD and medical-surgical benefits for out-of-network providers. Inpatient, outpatient, and pharmacy services all require prior authorization. If a service rendered by an out-of-network provider is approved, the Financial Requirements are the same as services rendered by an in-network provider.