Mental Health Parity and Addiction Equity Act Report

Administración de Seguros de Salud de Puerto Rico

April 1, 2022

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Section 1
Introduction

The Centers for Medicare & Medicaid Services (CMS) issued a Final Rule that applies requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid Managed Care Organization (MCO) members' benefits, Medicaid Alternative Benefit Plans, and the Children's Health Insurance Program (CHIP).

The Puerto Rico Department of Health (PRDOH) is the Single State Agency for administering the State Medicaid and CHIP Program and includes two supporting entities, Puerto Rico Medicaid and the Puerto Rico Health Insurance Administration (PRHIA). Puerto Rico Medicaid manages the Medicaid and CHIP State Plans, eligibility, beneficiary enrollment and is responsible for the operation of the Medicaid Management Information System (MMIS). The PRHIA (commonly referred to as Administración de Seguros de Salud (ASES)) was created in 1993 to oversee, monitor and evaluate benefits offered by MCOs under contract with ASES. ASES is the entity responsible for administration and oversight of the Government Health Plan (GHP), also referred to as "Plan Vital." As of October 2021, 1.4 million Medicaid/CHIP enrollees, including over 90,000 children covered under a recent CHIP expansion, received their benefits through an MCO contracted with ASES.

Managed Care Overview

The Plan Vital program is an island-wide, fully capitated, risk-based, managed care program for Medicaid and CHIP enrollees. ASES contracts with four MCOs to provide island-wide mental health (MH), substance use disorder (SUD), and medical/surgical (M/S) benefits to Plan Vital enrollees. At the time of this report, no benefits were carved out of the MCO benefit package, with exception to certain HIV and Hepatitis C drugs covered through Puerto Rico's fee-for-service program. Specific to pharmacy benefits, Plan Vital MCOs are at risk for the pharmacy benefit and conduct utilization management and formulary management. The Puerto Rico Pharmacy Benefit Manager and Rebate Aggregator are responsible for claims payment, adjudication, and administration of rebates. All four MCOs are contracted to provide the full array of state plan benefits. Three of the four MCOs subcontract with "APS Health" to provide and manage MH and SUD benefits.

Section 2

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, ASES' 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*"[1] and included the following steps:

1. Identifying all benefit packages to which parity applies.
2. Determining whether ASES or MCO is responsible for the parity analysis.
3. Defining MH/SUD and M/S and determining which covered benefits are MH, SUD and/or M/S benefits.
4. Defining the four benefit classifications (inpatient (IP), outpatient (OP), prescription drugs (PDs), and emergency care (EC)) and mapping MH, SUD and M/S benefits to these classifications.
5. Determining whether any aggregate lifetime or annual dollar limits (AL/ADLs) apply to MH/SUD benefits.
6. Determining whether any financial requirements (FRs) or quantitative treatment limitations (QTLs) apply to MH/SUD benefits in a benefit package and testing the applicable FRs and QTLs for compliance with parity.
7. Identifying and analyzing non-quantitative treatment limitations (NQTLs) that apply to MH/SUD benefits in a benefit package.

[1] Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs. Retrieved from https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf

Section 3

Service Delivery System and Benefit Packages

ASES identified four benefit packages (listed in the Table 1 below) subject to the requirements in the Medicaid/CHIP parity rule. Each of these benefit packages includes MH and SUD benefits in each classification in which there is an M/S benefit (all four-benefit classifications).

See Appendix A for detailed information on the benefit packages, including a mapping of MH, SUD, and M/S benefits, by classification, for each benefit package.

Table 1. Benefit Packages for Plan Vital Parity Analysis

Benefit Packages for the Plan Vital Parity Analysis	
Federal Adults (age 21 and older)	Benefits provided to Medicaid enrollees age 21 and older who are not eligible for Platino, including enrollees covered by the alternative benefit plan.
Federal Children (age 0 to 20)	Benefits provided to Medicaid and CHIP enrollees under age 21 who are not eligible for Platino, including enrollees covered by the alternative benefit plan.
Medicare Platino Adults (age 21 and older)	Medicaid benefits provided to enrollees age 21 and older who are in a Medicare Platino plan. For the purposes of the parity analysis, the benefit package includes Medicaid benefits and does not include Medicare benefits provided to this population.
Medicare Platino Children (age 0 to 20)	Medicaid benefits provided to enrollees under age 21 who are in a Medicare Platino plan. For the purposes of the parity analysis, the benefit package includes Medicaid benefits and does not include Medicare benefits provided to this population.

Section 4

Definition of Mental Health/Substance Use Disorder Benefits

The Medicaid/CHIP parity rule defines MH, SUD, and M/S benefits in reference to the condition being treated. MH benefits are items or services for MH conditions, SUD benefits are items or services for SUD conditions, and medical/surgical benefits are items or services for medical/surgical conditions. The Medicaid/CHIP parity rule requires the definition of MH, SUD, and medical/surgical conditions be in accordance with federal and state law, and consistent with generally recognized independent standards of current medical practice and references, including, for example, the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).

ASES adopted the most recent version of the ICD, the ICD-10-CM, as its standard for defining MH, SUD, and medical/surgical conditions for purposes of the parity analysis.

ASES defined MH/SUD benefits as services for the conditions listed in ICD-10-CM, chapter 5 "Mental, Behavioral, and Neurodevelopmental Disorders" with the exception of:

- The conditions listed in subchapter 1, "Mental disorders due to known physiological conditions" (F01 to F09)
- The conditions listed in subchapter 8, "Intellectual disabilities" (F70 to F79)
- The conditions listed in subchapter 9, "Pervasive and specific developmental disorders" (F80 to F89)

Thus, MH/SUD benefits are services for the conditions listed in the following subchapters of chapter 5:

- Subchapter 2, "Mental and behavioral disorders due to psychoactive substance use" (F10 to F19)
- Subchapter 3, "Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders" (F20 to F29)
- Subchapter 4, "Mood [affective] disorders" (F30 to F39)
- Subchapter 5, "Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders" (F40 to F48)
- Subchapter 6, "Behavioral syndromes associated with physiological disturbances and physical factors" (F50 to F59)
- Subchapter 7, "Disorders of adult personality and behavior" (F60 to F69)

- Subchapter 10, “Behavioral and emotional disorders with onset usually occurring in childhood and adolescence” (F90 to F98)
- Subchapter 11, “Unspecified mental disorder” (F99)

ASES defined M/S benefits as services for the conditions listed in ICD-10-CM Chapters 1 through 4, subchapters 1, 8 and 9 of Chapter 5, and Chapters 6 through 20.

For the purposes of the parity analysis, benefits to treat intellectual, and/or developmental disabilities, including autism spectrum disorder, are defined as medical/surgical benefits.

Section 5

Benefit Classifications

For the analysis, ASES defined each benefit classifications as follows:

Inpatient

All covered services or items (including medications) provided to an enrollee when the enrollee is admitted to a facility that provides overnight care.

Outpatient

All covered services or items (including medications not dispensed by a pharmacy) provided to an enrollee that do not otherwise meet the definition of inpatient, emergency care, or prescription drugs.

Emergency Care

All covered services or items (including medications) provided in an emergency room (ER) setting, including a freestanding ER, or an emergency or stabilization unit. Services or items provided in another setting, such as an urgent care or walk-in clinic, which are not specifically an ER setting or an emergency or stabilization unit are considered outpatient.

Prescription Drugs

Covered medications, drugs, and associated supplies requiring a prescription and dispensed by a pharmacy.

Section 6

Aggregate Lifetime and Annual Dollar Limits

No AL/ADLs apply to Medicaid/CHIP MH/SUD benefits in any benefit package.

Section 7

Financial Requirements and Quantitative Treatment Limitations

Financial Requirements

ASES reviewed available Medicaid service documentation including the Plan Vital contract, State Plans for Medicaid and CHIP, associated documents, regulations and legislative requirements to evaluate the application of cost sharing to benefits.

Under Plan Vital, copayments apply to both MH/SUD and M/S benefits for enrollees in the Federal Adult and Medicare Platino Adult benefit packages. Since copayments do not apply to CHIP or to Medicaid children under age 21, no analysis was needed for enrollees in the Federal Children or Medicare Platino Children benefit packages.

Because the prescription drug copayment varies depending on whether the drug is preferred or non-preferred, this copayment meets the special MHPAEA rule for multi-tiered prescription drug benefits, and no further FR analysis is required.

Thus, only the non-pharmacy copayments that apply to adults in Medicaid and Medicare Platino benefit packages were subject to compliance with the FR test. High-level analyses indicated the proportion of M/S claims with an associated copayment provided a strong indication that the Medicaid and Medicare Platino benefit packages would not pass the “Substantially All” test if quantitative claims based testing was performed.

In order to ensure compliance with the FR requirement without conducting a quantitative “substantially all” analysis, ASES will remove all non-pharmacy copayment requirements from M/S and MH/SUD benefits. This change will be reflected in a forthcoming Medicaid state plan amendment with a proposed effective date of January 1, 2023.

Quantitative Treatment Limitations

ASES reviewed available Medicaid service documentation including the Plan Vital contract, State Plans for Medicaid, associated documents, regulations and legislative requirements to identify QTLs. ASES identified a numerical limit on Physical Therapy benefits, but additional benefit may be approved based on medical necessity, therefore this limit was analyzed as an NQTL, not a QTL for purposes of the analysis.

No QTLs apply to any Medicaid/CHIP MH/SUD benefits in any benefit package.

Section 8

Non-Quantitative Treatment Limitations

Identifying NQTLs and Information Collection

Based on the illustrative list of NQTLs in the Medicaid/CHIP parity rule, the parity toolkit, information from Puerto Rico's consultant, and discussion during the parity workgroup meetings, ASES prioritized the analysis of three NQTLs applied by the MCOs to MH/SUD benefits. This list included NQTLs related to utilization management (UM), including Prior Authorization for Prescription Drugs (PAPD), and Medical Necessity Criteria (MNC).

Each MCO completed a standardized online survey for each NQTL that addressed applicable processes (UM, PAPD, MNC), strategies (UM, MNC), evidentiary standards (UM, MNC), and other factors used in applying the NQTL to MH/SUD and M/S benefits. The surveys collected information by applicable classification (IP, OP, and/or PD) and benefit package (see Appendix A). In the case of EC, that was either not chosen as an applicable classification or through review with ASES it was determined not applicable to the NQTL. Each survey included questions to help identify the type of information relevant to the parity analysis, including questions regarding processes, strategies, and evidentiary standards for each component of the NQTL analysis (comparability and stringency). The information provided was reviewed by the ASES parity workgroup, and two follow-up interviews and additional emailed requests for information were completed to obtain an accurate description of the application of NQTLs by each MCO. In addition, since ASES establishes the prior authorization criteria for prescription drugs, ASES provided information regarding strategies and evidentiary standards for PAPD.

Defining NQTLs

To support the NQTL analysis, ASES developed the following definitions for each of the NQTLs analyzed.

Table 2. NQTL Definitions

NQTL	Definition
Utilization Management (UM)	UM is inclusive of referral, prior authorization (PA), concurrent review (CR), and retrospective review (RR). Defined below is each type of review. **Referral**: Review by a primary medical group (PMG) provider to authorize an enrollee to receive services from a provider outside the preferred provider network (PPN). **Prior Authorization (PA)**: Review by the MCO to determine if benefit coverage will be authorized. May include review of eligibility, coverage, medical necessity, medical appropriateness, and/or level of care (LOC). May occur prior to service delivery, after a designated number

NQTL	Definition
	of services or amount of time, or between emergency room and inpatient LOC such as hospital or residential. **Concurrent Review (CR)**: Review by the MCO to determine if benefit coverage will be authorized beyond the initial authorization (see Prior Authorization above) within the same benefit year or treatment episode. May include review of eligibility, coverage, medical necessity, medical appropriateness, and/or LOC. **Retrospective Review (RR)**: Review by the MCO to determine if benefits will be covered after services have been delivered. May include review of eligibility, coverage, medical necessity, medical appropriateness, and/or LOC.
Prior Authorization of Prescription Drugs (PAPD)	Review to determine if coverage of a particular drug will be authorized, including the exceptions process. May include review of eligibility, coverage, medical necessity, and/or medical appropriateness, including the approval or disapproval of the drug by the FDA for specific conditions.
Medical Necessity Criteria (MNC)	The selection, modification, or development of the medical necessity criteria (MNC) used to conduct UM and determine benefit coverage. MNC includes national third-party MNC (e.g., InterQual and MCG®) or level of care guidelines (e.g., ASAM) and clinical guidelines or policy developed by the MCO or ASES in accordance with federal and state laws and regulations.

Conducting the NQTL Analysis

Using the information received, the parity workgroup conducted side-by-side comparisons and analyses of the processes, strategies, evidentiary standards and other factors used to apply each NQTL to MH/SUD and M/S benefits, by classification for each benefit package. These factors were reviewed for comparability and stringency in written policy and in operation.

The NQTL analysis consisted of the following steps:

- Consolidation of the NQTL information collected from the MCOs and ASES (for PAPD) into a side-by-side structure by benefit package group and classification. The information included the MH/SUD and M/S benefits to which the NQTL applied and a summary of the NQTL's processes, strategies and evidentiary standards. Analysis of the side-by-side information to develop a preliminary determination for each MH/SUD NQTL, by benefit package group and classification.

- Review and revision of the side-by-side summary information and preliminary determinations.

- MCO review of the side-by-side summary information and preliminary determinations.

- Workgroup review of the side-by-side summary information and preliminary determinations and final compliance determination.

List of Analyzed MH/SUD NQTLs

The table below summarizes the NQTLs that were analyzed as part of the parity analysis. A "✓" indicates the NQTL applies to all benefit packages outlined in Table 1. The grayed out sections indicate that the NQTL does not apply to a certain benefit package or classification.

Table 3. NQTLS — Applicability of NQTLs reviewed to each classification

	NQTL	Applicable Classifications		
	IP	OP	EC	PD
Utilization Management (includes PA/CR/RR for non-pharmacy benefits)	✓	✓	N/A	N/A
Prior Authorization for Prescription Drugs	N/A	N/A	N/A	✓
Medical Necessity Criteria/Guidelines	✓	✓	N/A	✓

IP=Inpatient, OP=Outpatient, EC=Emergency Care, PD=Prescription Drug

NQTL Findings

As noted below and based on the NQTL analysis, ASES determined the MCOs are compliant in their application of the UM, PAPD and MNC NQTLs. The information supporting these compliance determinations is noted below.

Utilization Management

The MCOs all require prior authorization (PA) and retrospective review (RR) for inpatient and outpatient electroconvulsive therapy and outpatient neuropsych testing, and CR and RR for inpatient MH/SUD hospital, IP SUD detox and OP MH/SUD partial hospitalization. The MCOs also require PA, CR and RR for various M/S benefits including OT/PT and speech therapy, durable medical equipment, IP hospitalizations, and surgical benefits. Referral is not required for MH/SUD IP or OP benefits, but is required in certain circumstances for M/S benefits.

The MCOs indicated they apply UM to the identified MH/SUD and M/S IP and OP benefits 1) to comply with the Plan Vital contract standards, 2) because these benefits have the potential for overutilization, 3) to ensure medical necessity of high-cost benefits, 4) to ensure patient safety, 5) to manage recent medical cost escalation and 6) to manage high levels of variation in length of stay. While some evidence to support these strategies was provided, not all of the referenced ASES documentation (i.e., contract language, normative letters) supported the survey responses provided by the MCOs. Therefore, ASES will develop and implement additional information and guidance on UM requirements for both MH/SUD and M/S benefits

to ensure that evidentiary standards are comparable and not more stringently applied to MH/SUD benefits than to M/S benefits.

For MH/SUD benefits requiring PA the MCOs require providers to submit the request one to two business days or sooner dependent on the clinical needs of the person, while most MCOs do not have a specific timeline for M/S PA requests. The MCOs' timeframes for making PA decisions are the same for both MH/SUD and M/S and are 72 hours for standard requests and 24 hours for expedited requests. The prescriptiveness of the timeframes for requesting PA for MH/SUD benefits appears to be more stringent than the timeframes for requesting PA for M/S benefits.

For MH/SUD IP hospital, the MCOs require providers to submit CR requests one business day after the hospitalization and one business day after the expiration of the previously approved benefits. For OP MH/SUD partial hospitalization, CR must be requested one business day before the expiration of PA. M/S providers (facility) must request CR within 24 hours of all admissions and once notification of admission occurs, the MCOs complete CR daily onsite at the facility. CR decisions for MH/SUD are made within 24 hours and for M/S, decisions are typically made as soon as the MCO is notified of the admission and daily thereafter.

The analysis revealed some discrepancies in the application of the ASES policy among MCOs and between MH/SUD and M/S related to timeframes to request RR and make decisions. Although no parity concern was noted here, ASES plans to follow-up with all MCOs through their standard contract compliance activities to ensure adherence to the policy.

Both MH/SUD and M/S providers can submit UM requests in a variety of ways including fax, in person, via portal, and by mail. UM request forms are provided but not required so long as the necessary clinical information is submitted. CR for M/S is largely conducted onsite with the nurse reviewing the EHR while MH/SUD requires submission of medical necessity documentation.

As detailed in the MNC section, for most IP and OP MH/SUD and M/S benefits subject to UM, the MCOs use Milliman Care Guidelines, InterQual Level of Care Criteria and CMS clinical guidelines, nationally recognized criteria and guidelines to support MNC. In rare cases for M/S, the MCOs have developed criteria when MCG® or InterQual does not have available criteria (i.e., durable medical equipment).

The analysis revealed some variations in the frequency at which PA and CR is performed and the evidence to support the frequency of review. Most but not all MCOs cite evidence-based MNC criteria as supporting the frequency at which PA and CR is applied.

The stringency and consistency with which UM is conducted was analyzed by reviewing IRR standards and appeal overturn rates. For all MCOs, the IRR standard for MH/SUD was the same as or higher than the IRR standard for M/S. In most MCOs, the appeal overturn rate is higher for M/S benefits, however due to the small MH/SUD denominators caution should be considered when making comparisons.

Ongoing collection, review and monitoring and oversight of appeal and overturn rates is important to ensure the stringency of strategy and evidentiary standards are comparable and no more stringently applied to MH/SUD compared to M/S.

Prior Authorization for Prescription Drugs

ASES requires prior authorization for selected MH/SUD and M/S drugs to obtain additional information from the prescriber for the purpose of ensuring eligibility, benefit coverage, medical necessity, and/or medical appropriateness. ASES uses prior authorization to promote appropriate, safe, and cost effective prescription drug utilization. The ASES Pharmacy and Therapeutics (P&T) Committee recommends prior authorization based on clinical evidence and professional judgment. 12.4% of MH/SUD drugs and 14.9% of M/S drugs on the formulary of medications covered (FMC) are subject to prior authorization requirements, which indicates that prior authorization is not applied more stringently to MH/SUD.

In accordance with Contract requirements, the MCOs apply ASES's prior authorization criteria to promote the appropriate and cost-effective use of prescription drugs. The MCOs provide prescription drugs in accordance with the FMC and the Local Management Entities (LME) and do not impose restrictions on prescription drugs beyond those stated in the FMC or LME. The MCOs use the same prior authorization process for MH/SUD and M/S drugs, including required information, methods for submission, timeframes for review, the qualifications of review staff, the consequences for failure to obtain prior authorization, and the method for monitoring consistent application of prior authorization criteria. The processes, strategies, and evidentiary standards for prior authorization are comparable to and no more stringently applied to MH/SUD drugs than to M/S drugs.

Medical Necessity Criteria

For most IP and OP MH/SUD and M/S benefits subject to UM, the MCOs use Milliman Care Guidelines, InterQual Level of Care Criteria, CMS coverage determinations, and/or other nationally recognized criteria or guidelines to support their utilization management decisions. For certain pharmacy benefits (e.g., insulin pumps and certain physician administered drugs), the MCOs are required to follow MNC prescribed by ASES. ASES established these MNC due to concerns with access, utilization and/or high costs.

MCOs generally apply similar approaches to develop, review and update MNC. MCOs generally review their MNC on an annual basis. However, if Milliman Care Guidelines MCG or InterQual Level of Care Criteria release changes or updates more frequently, the MCOs will conduct reviews in an ad hoc manner at that time. The MCOs use the following to inform their reviews and subsequent decisions about MNC: existing national MNC; changes to MNC specified by ASES; literature reviews; and emerging evidence-based practices.

As a result, the processes, strategies and evidentiary standards for MNC, in writing and in operation, are comparable and no more stringently applied to MH/SUD benefits than to M/S benefits.

Compliance Determination and Next Steps

Using information received, the parity workgroup conducted side-by-side comparisons and analyses of the processes, strategies, evidentiary standards and other factors used to apply each NQTL to MH/SUD and M/S benefits, by classification for each benefit package. These factors were reviewed for comparability and stringency in written policy and in operation.

ASES has identified targeted follow-up, monitoring and oversight activities in the area of utilization management to mitigate any parity risks and demonstrate compliance. A high-level plan with timelines for this subsequent analysis is outlined below in Section 9 — Compliance Plan.

Section 9

Compliance Plan

To ensure ongoing compliance with the final Medicaid/CHIP parity rule, ASES has identified a compliance review team that will be responsible for implementing the compliance tasks identified in Table 4 below. ASES and the MCOs as directed by ASES, will also be responsible for overseeing ongoing compliance through routine compliance reviews, reporting, and will ensure compliance as system changes, updates or transformation activities occur. Implementation of the following plan will mitigate any identified parity risks and demonstrate compliance.

Table 4. Medicaid/CHIP Parity Rule Compliance Plan

Task	Timeframe
ASES will incorporate mental health parity requirements into its routine compliance reviews of all MCOs.	Immediately (Mercer/ASES Compliance Team)
Submit a State Plan Amendment to remove all non-pharmacy copayments in Plan Vital.	October 1, 2022 (Medicaid/ASES)
ASES will provide written communication to all MCOs summarizing actions taken to date to comply with the Medicaid/CHIP parity rule, including: • Amending the Plan Vital contract to require ongoing MCO oversight activities and annual compliance reviews. • Issuing normative letters to address the prescriptiveness of the timeframes for requesting PA for MH/SUD and application of RR in accordance with the current policy.	October 1, 2022
ASES will formulate and implement a plan to monitor denial, appeal, and appeal overturn rates in an ongoing manner. This includes: • Requiring the MCOs to separately identify authorization and appeal information for MH/SUD benefits and M/S benefits. • Requiring MCOs to provide information on all authorization requests (not just prior authorization requests). • Working with ASES' quality and compliance departments to formulate a plan to monitor information from the MCOs to ensure there are no ongoing parity concerns. • According to the 2016: Politicas y Procedimientos para-Revision, Determinación y Apelación Estadias de Hospitales) Page 11 A.1.b of the document, it also says MCOs should report to ASES on a quarterly basis their CR rate, approved and denied days and cost impact of denied days. ASES will utilize the MCO report as part of monitoring and oversight.	June 1, 2022 – June 1, 2023

Task	Timeframe
As a follow-up to the findings of a recent External Quality Review audit, ASES will standardize UM requirements for PA, CR and RR, for both MH/SUD and M/S benefits including: • Issuing associated guidance to the MCOs to comply with new requirements. • Developing and implementing a monitoring plan in order to ensure consistency in applying UM between MH/ SUD and M/S.	June 1, 2022 – June 1, 2023

Section 10
Conclusion

Following the comprehensive review of the ASES's Medicaid/CHIP delivery system and with the implementation of the Compliance Plan (Section 9), ASES has determined that Plan Vital MCOs are in compliance with the parity requirements in 42 CFR Part 438 for the current delivery system of the Plan Vital program for Calendar Year 2021.

ASES will post a public report online documenting compliance with the Medicaid/CHIP parity rule. ASES will continue to monitor compliance with the Medicaid/CHIP parity rule on an ongoing basis and will update associated documentation (i.e., contracts, normative letters, etc.) to reflect the additional activities on an ongoing basis to reflect changes to program delivery/program requirements as they evolve.

Appendix A

Benefit Package and Services Grid

Appendix A
Benefit Package and Services Grid

Plan Vital Benefit Mapping Grid				**Key** ✓ Covered by MCO for the specified benefit package NA Not covered by MCO for the specified benefit package				
#	**Benefits**	**MH, SUD, M/S**	**Classification (IP, OP, EC, PD)**	**Benefit Package 1 Federal Adults (age 21 and older)**	**Benefit Package 2 Federal Children (age 0-20)**	**Benefit Package 3 Medicare Platino Adults (age 21 and older)**	**Benefit Package 4 Medicare Platino Children (age 0-20)**	**Notes**
				Benefits provided to Medicaid enrollees age 21 and older who are not eligible for Platino, including enrollees covered by the alternative benefit plan.	Benefits provided to Medicaid and CHIP enrollees under age 21 who are not eligible for Platino, including enrollees covered by the alternative benefit plan.	Medicaid benefits provided to enrollees age 21 and older who are in a Medicare Platino plan. For the purposes of the parity analysis, the benefit package includes Medicaid benefits and does not include Medicare benefits provided to this population.	Medicaid benefits provided to enrollees under age 21 who are in a Medicare Platino plan. For the purposes of the parity analysis, the benefit package includes Medicaid benefits and does not include Medicare benefits provided to this population.	
Classifications: **Inpatient (IP):** All covered services or items (including medications) provided to an enrollee when the enrollee is admitted to a facility that provides overnight care. **Outpatient (OP)**: All covered services or items (including medications not dispensed by a pharmacy) provided to an enrollee that do not otherwise meet the definition of inpatient, emergency care, or prescription drugs. **Emergency Care (EC)**: All covered services or items (including medications) provided in an emergency room (ER) setting, including a free standing ER, or an emergency or stabilization unit. Services or items provided in another setting, such as an urgent care or walk-in clinic, that are not specifically an ER setting or an emergency or stabilization unit are considered OP. **Prescription Drugs (PD):** Covered medications, drugs and associated supplies requiring a prescription and dispensed by a pharmacy.								
A	**Basic Coverage Structured as Section 7.5 of Plan Vital Contract**							
A.1	**Preventive Services**							
A.1.1	Well baby care	MH, SUD, M/S	OP	✓	✓	✓	✓	
A.1.2	Immunizations	M/S	OP	✓	✓	✓	✓	
A.1.3	Hearing exams	M/S	OP	✓	✓	✓	✓	
A.1.4	Evaluation and nutritional screening	M/S	OP	✓	✓	✓	✓	
A.1.5	Laboratory and diagnostic tests	MH, SUD, M/S	OP	✓	✓	✓	✓	
A.1.6	Nutritional, oral, and physical health education	M/S	OP	✓	✓	✓	✓	
A.1.7	Reproductive health/family planning	M/S	OP	✓	✓	✓	✓	
A.1.8	Annual physical exams for diabetics	M/S	OP	✓	✓	✓	✓	
A.1.9	Health certificates	M/S	OP	✓	✓	✓	✓	
A.2	**Diagnostic Test Services**	MH, SUD, M/S	OP	✓	✓	✓	✓	Prior authorization required for radiation therapy.
A.3	**Outpatient Rehabilitation Services**							
A.3.1	Physical therapy	M/S	OP	✓	✓	✓	✓	Adults limited to 15 treatments unless PA for an additional 15 treatments.
A.3.2	Occupational therapy	M/S	OP	✓	✓	✓	✓	

Appendix A
Benefit Package and Services Grid

#	Benefits	MH, SUD, M/S	Classification (IP, OP, EC, PD)	Benefit Package 1 Federal Adults (age 21 and older)	Benefit Package 2 Federal Children (age 0-20)	Benefit Package 3 Medicare Platino Adults (age 21 and older)	Benefit Package 4 Medicare Platino Children (age 0-20)	Notes
A.3.3	Speech therapy	M/S	OP	✓	✓	✓	✓	
A.4	**Medical and Surgical Services**			✓	✓	✓	✓	
A.4.1	EPSDT	MH, SUD, M/S	IP, OP	NA	✓	NA	✓	
A.4.2	Primary care physician visits, including nursing services	MH, SUD, M/S	OP	✓	✓	✓	✓	
A.4.3	Specialist treatment	M/S	OP	✓	✓	✓	✓	PCP referral required if outside the enrollee's PPN BH specialist services captured in section A.9 below.
A.4.4	Sub-specialist treatment	M/S	OP	✓	✓	✓	✓	PCP referral required if outside the enrollee's PPN. BH sub-specialist services captured in section A.9 below.
A.4.5	Physician home visits	M/S	OP	✓	✓	✓	✓	BH physician home visits captured in section A.9 below.
A.4.6	Respiratory therapy	M/S	OP	✓	✓	✓	✓	
A.4.7	Anesthesia services (except for epidural)	M/S	OP	✓	✓	✓	✓	
A.4.8	Radiology services	M/S	OP	✓	✓	✓	✓	
A.4.9	Pathology services	M/S	OP	✓	✓	✓	✓	
A.4.10	Surgery	M/S	IP, OP	✓	✓	✓	✓	
A.4.11	Outpatient surgery facility services	M/S	OP	✓	✓	✓	✓	
A.4.12	Nursing services	M/S	OP	✓	✓	✓	✓	BH nursing services captured in section A.9 below.
A.4.13	Sterilization	M/S	OP	✓	✓	✓	✓	
A.4.14	Prosthetics	M/S	OP	✓	✓	✓	✓	
A.4.15	Ostomy equipment	M/S	OP	✓	✓	✓	✓	
A.4.16	Blood transfusion and blood plasma services	M/S	OP	✓	✓	✓	✓	
A.4.17	Services to patients with Level 1 or Level 2 chronic renal disease	M/S	OP	✓	✓	✓	✓	Levels 3 to 5 are included in Special Coverage.
A.4.18	Skin, bone and corneal transplants	M/S	OP	✓	✓	✓	✓	
A.4.19	Veklruy (remedesivir) for COVID-19	M/S	OP	✓	✓	✓	✓	
A.4.20	Breast reconstruction after mastectomy	M/S	OP	✓	✓	✓	✓	
A.4.21	Surgical procedures to treat morbid obesity	M/S	OP	✓	✓	✓	✓	
A.4.22	Mechanical respirators and ventilators	M/S	OP	NA	✓	NA	✓	
A.4.23	Durable Medical Equipment	M/S	OP	✓	✓	✓	✓	Covered on a case-by-case basis under an exceptions process.
A.5	**Emergency Transportation Services**	MH, SUD, M/S	EC	✓	✓	✓	✓	No prior authorization required.
A.6	**Maternity and Pre-Natal Services**	MH, SUD, M/S	IP, OP	✓	✓	✓	✓	
A.7	**Emergency Services**	MH, SUD, M/S	EC	✓	✓	✓	✓	No prior authorization required.
A.8	**Hospitalization Services**	M/S	IP	✓	✓	✓	✓	Hospitalization for MH or SUD included in section A.9 below.
A.9	**Behavioral Health Services**			✓	✓	✓	✓	Prior authorization/referral for benefits listed below.

Appendix A
Benefit Package and Services Grid

#	Benefits	MH, SUD, M/S	Classification (IP, OP, EC, PD)	Benefit Package 1 Federal Adults (age 21 and older)	Benefit Package 2 Federal Children (age 0-20)	Benefit Package 3 Medicare Platino Adults (age 21 and older)	Benefit Package 4 Medicare Platino Children (age 0-20)	Notes
A.9.1	Evaluation, screening, and treatment of individuals, couples, families, and groups	MH, SUD	OP	✓	✓	✓	✓	
A.9.2	Outpatient services with psychiatrists, psychologists, and social workers	MH, SUD	OP	✓	✓	✓	✓	
A.9.3	Hospital services for substance and alcohol abuse disorders	SUD	IP	✓	✓	✓	✓	
A.9.4	Outpatient services for substance and alcohol abuse disorders	SUD	OP	✓	✓	✓	✓	
A.9.5	Behavioral health hospitalizations	MH	IP	✓	✓	✓	✓	
A.9.6	Intensive outpatient services	MH, SUD	OP	✓	✓	✓	✓	
A.9.7	Emergency or crisis intervention services	MH, SUD	EC	✓	✓	✓	✓	
A.9.8	Detoxification services	SUD	IP	✓	✓	✓	✓	Prior authorization required for this benefit.
A.9.9	Long-lasting injected medicine clinics	MH, SUD	OP	✓	✓	✓	✓	
A.9.10	Escort/professional assistance and ambulance services	MH, SUD	OP, EC	✓	✓	✓	✓	
A.9.11	Prevention and secondary-education services	MH, SUD	OP	✓	✓	✓	✓	
A.9.14	Treatment of attention deficit disorder	MH	OP	✓	✓	✓	✓	
A.9.15	Substance abuse treatment	SUD	OP	✓	✓	✓	✓	
A.9.16	Opiate addiction treatment	MH, SUD	OP and PD	✓	✓	✓	✓	
A.9.17	Inpatient behavioral health services in an Institution for Mental Disease (IMD)	MH, SUD	IP	✓	✓	✓	✓	
A.9.18	Partial hospitalization	MH	OP	✓	✓	✓	✓	Prior authorization required for this benefit.
A.9.19	Electroconvulsive therapy (ECT)	MH	IP, OP	✓	✓	✓	✓	Prior authorization required for this benefit.
A.9.20	Psychological / Neuropsychological testing	MH	IP, OP	✓	✓	✓	✓	Prior authorization required for this benefit.
A.10	**Pharmacy Services**	MH, SUD, M/S	PD	✓	✓	✓	✓	
A.11	**Dental Services**	M/S	OP	✓	✓	✓	✓	Prior authorization/referral cannot be required for dental services except for maxiofacial surgery, which requires prior authorization from a PCP.