MERCER

Mental Health Parity and Addiction Equity Act (MHPAEA)
Final Report

Non-Quantitative Treatment Limitations (NQTL) Addendum

Commonwealth of Virginia
Department of Medical Assistance Services
December 18, 2020

Contents

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 Department of Medical Assistance Services (DMAS) is the single state agency in the Commonwealth of Virginia (Commonwealth) that administers the Medicaid program and CHIP, which is referred to as Family Access to Medical Insurance Security (FAMIS) in Virginia. These programs are delivered to individuals through two delivery models: managed care and fee-for-service (FFS).

On January 10, 2020, DMAS submitted its initial MHPAEA parity analysis to CMS. The analysis included findings on four Non-Quantitative Treatment Limitations (NQTLs): utilization management (UM); prescription drug prior authorization; out-of-network coverage; and, provider network admission. Based on the analysis, DMAS decided to follow-up with the managed care organizations (MCOs) to better understand how they develop, modify and update Medical Necessity Criteria (MNC) used as part of UM. Based on the literature and recommendations from DMAS' contractor, the agency also decided to analyze Provider Reimbursement (PR) as an NQTL. The MNC and PR NQTL reviews were not conducted as a result of any specific concerns uncovered during DMAS' initial review. Therefore, this report addendum, which summarizes the methodology and findings from the supplemental MNC and PR NQTLs analyses, should be viewed as a supplement to DMAS' initial parity analysis and a part of Virginia's on-going efforts to ensure parity compliance.

2

Analysis decisions

Benefit packages

In total, DMAS identified 12 benefit packages (listed in Table 1 below) subject to the requirements in the final Medicaid/CHIP Parity rule. In these benefit packages, Virginia covers mental health/substance use disorder (MH/SUD) services in each classification in which there is a medical/surgical (M/S) service (across all four benefit classifications). Benefit packages 13 and 14 apply only to waiver benefits for individuals with a primary medical/surgical (M/S) condition. See Appendix A for detailed information on the benefit packages, including a mapping of MH/SUD and M/S services, by classification, for each benefit package.

For the purposes of the NQTL analysis, Virginia structured benefit packages based on how MH/SUD services are delivered across the Commonwealth's delivery systems. The Commonwealth conducted a detailed review of service delivery variations and reviewed the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) contracts, the State plan and regulatory requirements, as noted in Appendix A. For MH/SUD services, much of the Commonwealth's service delivery expectations are prescribed in contracts and are closely aligned across programs (Medallion 4.0 and CCC Plus). As part of the NQTL request for information (see Section 3 of this report), both the State agency and the MCOs were asked to identify any differences in the application of the NQTLs across benefit packages. Service delivery variations that are applicable by benefit package or classification are noted as part of the NQTL analyses. Where services delivery did not vary by benefit package, all applicable benefit packages were identified.

Table 1: MCO member benefit packages

Benefit packages
1. Medallion 4.0 Adults (19–64 years)
2. Medallion 4.0 Adults Expansion (19–64 years)
3. Medallion 4.0 Pregnant women (including pregnant youth)
4. Medallion 4.0 Children (0–18 years)
5. FAMIS Children (0–18 years)
6. FAMIS MOMS (0–18 years and 19–64 years)

Benefit packages
7. CCC Plus Adults (21+ years Non-Long-Term Services and Supports [LTSS])
8. CCC Plus Adults (21+ years LTSS)
9. CCC Plus – Medicaid Works (16–64 years)
10. CCC Plus – Medicaid Expansion (19–64 years)
11. CCC Plus Children (0–21 years Non-LTSS)
12. CCC Plus Children (0–21 years LTSS)
13. CCC Plus Waiver
14. DD Waiver

Definition of MH/SUD services

For the purposes of the Parity analysis, DMAS adopted the most recent version of the International Classification of Diseases (ICD), the ICD-10-CM, as its standard for defining MH/SUD and M/S 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 M/S and MH/SUD conditions.

DMAS defined[1] MH/SUD services 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).

DMAS defined M/S services as services for the conditions listed in ICD-10-CM Chapters 1–4, subchapters 1, 8 and 9 of Chapter 5 and Chapters 6–20. Given these definitions, DMAS determined

[1] Note: The definition of MH/SUD was for purposes of the Parity analysis and ensuring that MH/SUD services are provided in Parity with M/S services. The exclusion of certain conditions from the Parity analysis will not impact eligibility or treatment for conditions excluded from the Parity definition of MH/SUD.

that, because members must meet Intellectual Disability (ID)/DD level of care (LOC) criteria to participate in a §1915(c) waiver program, and an MH/SUD diagnosis is not a qualifying criterion for waiver participation, all §1915(c) waiver services are considered M/S services.

DMAS excluded subchapter 1 from the definition of MH/SUD because these mental disorders are due to known physiological conditions (e.g., vascular dementia and delirium due to known physiological condition) and all, except one, require that the physiological condition is coded first, indicating that the physiological (rather than the MH) condition is the focus of services. DMAS based this exclusion on the structure of the ICD-10-CM.

DMAS excluded subchapters 8 (IDs) and 9 (DDs) from the definition of MH/SUD consistent with the structure and content of the ICD-10-CM. Chapter 5 of the ICD-10-CM is entitled Mental, Behavioral and Neurodevelopmental Disorders and is divided into three subsets of disorders; only two of which are Mental and Behavioral. In addition, not including these disorders as MH/SUD disorders is consistent with CMS' definition of "mental disease," in the State Medicaid Manual Section 4390.D, which provides as follows: "…the term 'mental disease' includes diseases listed as mental disorders in the [ICD-9-CM], with the exception of mental retardation, senility, and organic brain syndrome." [2] Also, this definition is consistent with the definition of "Persons with related conditions" in 42 CFR 435.1010: "Persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: (a) It is attributable to (1) Cerebral palsy or epilepsy; or (2) Any other condition, other than mental illness, found to be closely related to ID because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons…" (Sections (b) through (d) omitted; emphasis supplied). [3]

Benefit classifications

DMAS defined each of the four benefit classifications identified in the final Medicaid/CHIP Parity rule as described below:

- **Inpatient (IP):** All covered services or items (including medications) provided to a member when a physician (or other qualified provider as applicable) has written an order/certification for a >24-hour admission to a facility.

- **Outpatient (OP):** All covered services or items (including medications) provided to a member in a setting that does not require a physician (or other qualified provider as applicable)

[2] State Medicaid Manual – Part 4 Services. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R74SMM.pdf

[3] 42 CFR § 435.1010 – Definitions relating to institutional status. Retrieved from https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol4/xml/CFR-2015-title42-vol4-sec435-1010.xml

order/certification for a >24-hour admission, and does not meet the definition of emergency care (EM). This includes observation bed services for up to 23-hours.

- **EM:** All covered services or items (including medications) provided in an emergency department (ED) setting or to stabilize an emergency/crisis, when provided in a setting other than in an IP setting.

- **Prescription Drugs (PD)**: Covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a freestanding pharmacy.

3

Non-Quantitative Treatment Limitations

Conducting the NQTL analysis

As outlined in Section 1, the supplemental NQTL analysis focused on MNC/Clinical Guidelines and PR. For the purposes of the analysis, the NQTLs were defined as follows:

- **MNC/Clinical Guidelines:** The process of determining how MNC/Clinical Guidelines are selected and monitored for each level of care (LOC) to which they are assigned. This includes an analysis of how the criteria/guideline was chosen, developed or modified to meet the needs of the plan. The *application* of MNC/Clinical Guidelines, which occurs as part of prior authorization and concurrent review processes, was included in the previously reviewed Utilization Management NQTL.

- **Provider Reimbursement:** The process by which PR rates are established for in-network and out-of-network practitioners, group practices, agencies and facilities. It includes the use of Diagnosis Related Groups (DRGs), development or adoption of fee schedules for specific Current Procedural Terminology® (CPT®) codes, contract terms based on a percent of a national fee schedule (e.g., Medicare), rate negotiations, etc.

Each MCO completed a standardized online survey that addressed processes, strategies, evidentiary standards, and other factors used in selecting, developing, and modifying MNC/Clinical Guidelines and applying PR to MH/SUD and M/S services. The information request was broken down by classification (IP, OP, PD and EM) and benefit package group (see Appendix A). The information request included prompts to help identify the type of information relevant to the Parity analysis. Separate sets of prompts were provided for processes, strategies, and evidentiary standards for each component of the NQTL analysis (comparability and stringency). The information provided was reviewed by DMAS, and a follow-up interview and additional emailed requests for information were completed to obtain an accurate description of the application of NQTLs by each MCO.

Using information received, DMAS conducted side-by-side comparisons and analyses of the processes, strategies, evidentiary standards and other factors associated with each NQTL for MH/SUD and M/S services, 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 into a side-by-side structure by benefit package group and classification. The information included the MH/SUD and M/S

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

List of analyzed MH/SUD NQTLs

Table 2 below summarizes the NQTLs that were analyzed as part of the parity analysis. An "X" indicates the NQTL applies to all benefit packages outlined previously in Table 1. The grayed out sections indicate that the NQTL does not apply to a certain benefit package or classification. Pursuant to the final Medicaid/CHIP Parity rule, Appendix B lists the MH/SUD services to which the NQTL applies.

Table 2: NQTLS — applicability of NQTLs reviewed to each classification

MCOs: Aetna, Anthem, Magellan, Optima, United and Virginia Premier	Applicable classifications			
	IP	OP	EM	PD
Medical Necessity Criteria	X	X	N/A	N/A
Provider Reimbursement	X	X	X	N/A

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

NQTL findings

As noted below and based on the NQTL analysis, DMAS determined the MCOs are compliant in their application of MNC and PR NQTLs. The information supporting these compliance determinations is summarized below and detailed by MCO in Appendix B.

NQTL: MNC (IP and OP classifications)

For most IP and OP MH/SUD and M/S services, the MCOs use a variety of recognized criteria and guidelines to support MNC (e.g., Milliman Care Guidelines® [MCG®], American Society of Addiction Medicine [ASAM], InterQual Level of Care Criteria [InterQual], Level of Care Utilization System [LOCUS], Early Childhood Service Intensity Instrument [ECSII] and Child and Adolescent Service Intensity Instrument [CASII]).

For certain DMAS programs, MNC/Clinical Guidelines requirements are prescribed in regulations, contracts, and DMAS provider manuals, such as the Community Mental Health and Rehabilitation Services (CMHRS) manual and the Addiction and Recovery Treatment Services (ARTS) manual.

DMAS established these program-specific standards due to concerns with overutilization and high costs, based cost and utilization reports.[4]

MCOs vary in the approaches used to develop, review and revise the MNC/Clinical Guidelines. MNC reviews are typically conducted by the MCOs on an annual basis. The following inform these reviews and subsequent decisions about MNC: existing national criteria; changes to DMAS contract standards; literature reviews; double blind studies; developing best practices; and, emerging evidence-based practices. The MCOs also review over/under utilization data, cost reports, and member appeals and grievances. As necessary, the MCOs may also conduct ad hoc reviews.

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

NQTL: PR (IP, OP and EM classifications)

The MCOs are consistent in their establishment of reimbursement rates for MH/SUD and M/S services. All providers of IP, OP and EM services are subject to PR requirements. The MCOs' goals for PR are achieving cost savings, predicting costs through contracted rates, and ensuring access to care via market competitive rates that allow for adequate network participation.

For most IP, OP and EM MH/SUD and M/S services, the MCOs rely on the Commonwealth's fee schedule to establish rates. In certain cases, MCOs may establish rates using All Patients Refined Diagnosis Related Groups (APR-DRGs) or the Medicare fee schedule for services not included in the Commonwealth's fee schedule. This varies across MCOs. For example, one MCO bases PR for all classifications either at 75% of Medicare and 100% of the Commonwealth fee schedules, while several other MCOs leverage APR-DRGs with the Commonwealth fee schedule. In addition, several MCOs noted supplementing rates Per Diems, Unit Cost Fee Schedule, Case Rate, Bundled Rate, percent of billed charges and cost-based reimbursements typically established on a case-by-case basis. While there is variation in the application of PR across the MCOs, the analyses did not uncover any parity concerns regarding the establishment of rates across MH/SUD and M/S services in the IP, OP or EC classifications.

The MCOs indicated that rate negotiations are triggered by provider requests, changes to the Commonwealth's fee schedule or other industry changes that impact provider reimbursement. Some MCOs adjust rates (increase) based on the geographic area of the state. For example in Northern Virginia, certain MCOs offer a rate differential due to cost of living differences. Required documentation and processes to negotiate rates are comparable for MH/SUD and M/S services. When rate negotiations fail, providers can withdraw from the MCO's provider network. The same

[4] Evidence to support these strategies include the Virginia Administrative Code (VAC) and the Medallion 4.0 and CCC Plus contracts.

process is implemented across MH/SUD and M/S services; therefore, no parity concerns were identified with how the MCOs support rate negotiations.

DMAS excluded the PD classification from the PR NQTL due to the nature of pharmacy reimbursement. Pharmacy reimbursement is based on readily-available, industry-standard price metrics and most MCOs incorporate one or more of these metrics into their reimbursement methodology. Once determined, the pricing methodology applies to all drugs regardless of the condition the drug is intended to treat and it does not distinguish between MH/SUD or M/S conditions.

As a result of the review, DMAS determined the processes, strategies and evidentiary standards for PR, in writing and in operation, are comparable and no more stringently applied to MH/SUD services than to M/S services.

4

Conclusion

Following this supplemental review, DMAS determined the MCOs are compliant in their application of the MNC and PR NQTLs and with the requirements in the final Medicaid/CHIP Parity rule. DMAS will post a public report addendum online documenting compliance. DMAS will continue to monitor MCO compliance and will update this documentation as needed to reflect any changes in program delivery/program requirements that may impact either the MNC or PR NQTL.

Appendix A

Benefit package and services grid

Appendix A - Benefit Package and Services Grid

MCO Managed Services

Key

✓	Covered service by MCO for the specified benefit package
NA	Not covered service by MCO for the specified benefit package
<21	Covered service with age limitation for specified benefit package
EPSDT	Covered service under EPSDT benefit only
EC	Covered service when member meets additional criteria for specified benefit package

	Benefits	MH/SUD or M/S	Classification (IP, OP, PD, EC)	1 Medallion 4.0 Adults (19–64 yrs.)	2 Medallion 4.0 Adults Expansion (19–64 yrs.)	3 Medallion 4.0 Pregnant Women (incl. preg. youth)	4 Medallion 4.0 Children (0–18 yrs.)	5 FAMIS Children (0–18 yrs.)	6 FAMIS Moms (0–18 yrs. & 19–64 yrs.)	7 CCC Plus Adults (21+ yrs. Non-LTSS)	8 CCC Plus Adults 21+ yrs. LTSS	9 CCC Plus - Medicaid Works (16-64 yrs.)	10 CCC Plus – Medicaid Expansion (19–64 yrs.)	11 CCC Plus Children (0 -21 yrs. Non-LTSS)	12 CCC Plus Children (0 -21 yrs. LTSS)	13 CCC Plus Waiver	14 DD Waiver
Classifications:																	
IP: All covered services or items (including medications) provided to a member when a physician (or other qualified provider as applicable) has written an order/certification for a >24-hour admission to a facility.																	
OP: All covered services or items (including medications) provided to a member in a setting that does not require a physician (or other qualified provider as applicable) order/certification for a >24 hour admission, and does not meet the definition of EM.(* *This includes observation bed services.)																	
PD: Covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a freestanding pharmacy.																	
EM: All covered services or items (including medications) provided in an ED setting or to stabilize an emergency/crisis, when provided in a setting other than in an IP setting.																	
A	**General Covered Services**																
A.1	Abortions - Induced	M/S	IP,OP, EM	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC
A.2	Chiropractic Services	M/S	OP	< 21 (EPSDT)	< 21 (EPSDT)	< 21 (EPSDT)	< 21 (EPSDT)	✓	NA	NA	NA	NA	< 21 (EPSDT)	< 21 (EPSDT)	< 21 (EPSDT)	< 21 (EPSDT)	< 21 (EPSDT)
A.3	Christian Science Sanatoria Facilities	M/S	OP	✓	✓	✓	✓	✓	✓	NA	NA	NA	NA	NA	NA	NA	NA
A.4	Clinic Services (preventive, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits)	Both	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.5	Colorectal Cancer Screening	M/S	OP	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.6	Court Ordered Services	Both	OP	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Benefits	MH/SUD or M/S	Classification (IP, OP, PD, EC)	1 Medallion 4.0 Adults (19–64 yrs.)	2 Medallion 4.0 Adults Expansion (19–64 yrs.)	3 Medallion 4.0 Pregnant Women (incl. preg. youth)	4 Medallion 4.0 Children (0–18 yrs.)	5 FAMIS Children (0–18 yrs.)	6 FAMIS Moms (0–18 yrs. & 19–64 yrs.)	7 CCC Plus Adults (21+ yrs. Non-LTSS)	8 CCC Plus Adults 21+ yrs. LTSS	9 CCC Plus - Medicaid Works (16-64 yrs.)	10 CCC Plus – Medicaid Expansion (19–64 yrs.)	11 CCC Plus Children (0 -21 yrs. Non-LTSS)	12 CCC Plus Children (0 -21 yrs. LTSS)	13 CCC Plus Waiver	14 DD Waiver
A.7	Dental Services	M/S	IP,OP	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC
A.8	Early Intervention Services	Both	OP	NA	NA	NA	<3	<3	NA	NA	NA	NA	NA	<3	<3	NA	NA
A.9	Emergency Services	Both	IP,OP,EM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.10	Emergency Services - Post Stabilization Care	Both	IP,OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.11	Enhanced Services	Both	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.12	Experimental and Investigational Procedures	Both	IP,OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
A.13	Family Planning Services	M/S	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.14	Hearing Aids	M/S	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	EPSDT	✓	✓	NA	NA	NA	NA	EPSDT	EPSDT	NA	NA
A.15	HIV Testing and Treatment Counseling	M/S	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.16	Home Health Services	M/S	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.17	Hospice Services	M/S	IP,OP	NA	NA	NA	NA	✓	NA	✓	✓	✓	✓	✓	✓	✓	✓
A.18	Immunizations	M/S	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.19	Inpatient Hospital Services	Both	IP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.20	Laboratory, Radiology and Anesthesia Services	M/S	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.21	Lead Testing	M/S	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	EPSDT	✓	✓	NA	NA	NA	NA	EPSDT	EPSDT	NA	NA
A.22	Mammograms	M/S	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.23	Medical Supplies and Equipment	M/S	IP,OP,EM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.24	Certified Nurse-Midwife Services	M/S	IP,OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.25	Organ Transplantation	M/S	IP,OP	✓	✓	✓	EPSDT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.26	Outpatient Hospital Services	Both	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.27	Pap Smears	M/S	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.28	Personal Care	M/S	OP	< 21 (EPSDT)	< 21 (EPSDT)	< 21 (EPSDT)	< 21 (EPSDT)	✓	✓	< 21 (EPSDT)	< 21 (EPSDT)	✓	< 21 (EPSDT)	< 21 (EPSDT)	< 21 (EPSDT)	NA	NA
A.29	Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	M/S	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.30	Physician Services and Audiology Services	Both	IP,OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.31	Podiatry	M/S	IP,OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.32	Pregnancy-Related Services	M/S	IP,OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Benefits	MH/SUD or M/S	Classification (IP, OP, PD, EC)	1 Medallion 4.0 Adults (19–64 yrs.)	2 Medallion 4.0 Adults Expansion (19–64 yrs.)	3 Medallion 4.0 Pregnant Women (incl. preg. youth)	4 Medallion 4.0 Children (0–18 yrs.)	5 FAMIS Children (0–18 yrs.)	6 FAMIS Moms (0–18 yrs. & 19–64 yrs.)	7 CCC Plus Adults (21+ yrs. Non-LTSS)	8 CCC Plus Adults 21+ yrs. LTSS	9 CCC Plus - Medicaid Works (16-64 yrs.)	10 CCC Plus – Medicaid Expansion (19–64 yrs.)	11 CCC Plus Children (0 -21 yrs. Non-LTSS)	12 CCC Plus Children (0 -21 yrs. LTSS)	13 CCC Plus Waiver	14 DD Waiver
A.33	Prescription Drugs	Both	PD	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.34	Private Duty Nursing (PDN)	M/S	OP	< 21 (EPSDT)	< 21 (EPSDT)	< 21 (EPSDT)	< 21 (EPSDT)	✓	<21 (EPSDT)	<21 (EPSDT)	<21 (EPSDT)	<21 (EPSDT)	<21 (EPSDT)	<21 (EPSDT)	EPSDT	EC	EC
A.35	Prostate Specific Antigen (PSA) and Digital Rectal Exams	M/S	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.36	Prosthetics/Orthotics	M/S	OP,EM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.37	Prostheses, Breast	M/S	IP,OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.38	Reconstructive Breast Surgery	M/S	IP,OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.39	School Health Services	Both	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
A.40	Skilled Nursing Facility Care	Both	IP,OP	NA	NA	NA	NA	EC	NA	NA	✓	NA	NA	NA	✓	NA	NA
A.41	Telemedicine Services	Both	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.42	Transportation	Both	IP,OP,EM	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓	✓	✓
A.43	Vision Services	M/S	IP,OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
B: Inpatient Mental Health Treatment Services																	
B.1	Inpatient Psychiatric Hospitalization in Freestanding Psychiatric Hospital	MH/SUD	IP	<21, EC	<21, EC	<21, EC	EC	EC	NA	EC	EC	<21, EC	<21, EC	✓	✓	<21, EC	<21, EC
B.2	Inpatient Psychiatric Hospitalization in General Hospital	MH/SUD	IP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
B.3	Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	MH/SUD	IP	NA	NA	NA	NA	NA	NA	EC	EC	<21, EC	<21, EC	✓	✓	<21, EC	<21, EC
B.4	Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECO)	MH/SUD	IP	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC	EC
C: Outpatient Mental Health Treatment Services																	
C.1	Electroconvulsive Therapy	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
C.2	Pharmacological Management, Including Prescription and Review of Medication, when Performed with Psychotherapy Services	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
C.3	Psychiatric Diagnostic Evaluation	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
C.4	Psychological-Neuropsychological Testing	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
C.5	Psychotherapy (Individual, Family, and Group)	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Benefits	MH/SUD or M/S	Classification (IP, OP, PD, EC)	1 Medallion 4.0 Adults (19–64 yrs.)	2 Medallion 4.0 Adults Expansion (19–64 yrs.)	3 Medallion 4.0 Pregnant Women (incl. preg. youth)	4 Medallion 4.0 Children (0–18 yrs.)	5 FAMIS Children (0–18 yrs.)	6 FAMIS Moms (0–18 yrs. & 19–64 yrs.)	7 CCC Plus Adults (21+ yrs. Non-LTSS)	8 CCC Plus Adults 21+ yrs. LTSS	9 CCC Plus - Medicaid Works (16-64 yrs.)	10 CCC Plus – Medicaid Expansion (19–64 yrs.)	11 CCC Plus Children (0 -21 yrs. Non-LTSS)	12 CCC Plus Children (0 -21 yrs. LTSS)	13 CCC Plus Waiver	14 DD Waiver
D: CMHRS																	
D.1	Behavioral Therapy Services	M/S	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
D.2	Crisis Intervention Services	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
D.3	Crisis Stabilization Services	MH/SUD	OP	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓	✓	✓
D.4	Day Treatment/Partial Hospitalization	MH/SUD	OP	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓	✓	✓
D.5	Intensive Community Treatment Assessment and Treatment Services	MH/SUD	OP	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓	✓	✓
D.6	Intensive In-Home Assessment and Treatment Services	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
D.7	Mental Health Case Management	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
D.8	Mental Health Skill-building Assessment and Treatment Services	MH/SUD	OP	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓	✓	✓
D.9	Psychosocial Rehabilitation Assessment and Treatment Services	MH/SUD	OP	✓	✓	✓	✓	NA	✓	✓	✓	✓	✓	✓	✓	✓	✓
D.10	Therapeutic Day Treatment (TDT) for Children and Adolescents	MH/SUD	OP	<21	<21	<21	✓	✓	<21	✓	✓	<21	<21	✓	✓	<21	<21
D.11	Treatment Foster Care (TFC) Case Management (CM) for Children Under Age 21 Years	MH/SUD	OP	<21	<21	<21	✓	NA	<21	NA	NA	<21	<21	✓	✓	<21	<21
D.12	Peer Support Services Group/Individual	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
E: Residential Treatment Services (Psychiatric Only)																	
E.1	Psychiatric Residential Treatment Facility Services (PRTF)	MH/SUD	IP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
E.2	Therapeutic Group Home Services (TGH)	MH/SUD	IP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
F: Addiction and Recovery Treatment Services (ARTS)																	
F.1	Medically Managed Intensive Inpatient	MH/SUD	IP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
F.2	Medically Monitored Intensive Inpatient Services	MH/SUD	IP	✓	✓	✓	✓	NA	NA	✓	✓	✓	✓	✓	✓	✓	✓
F.3	Clinically Managed High Intensity Residential Services	MH/SUD	IP	✓	✓	✓	✓	NA	NA	✓	✓	✓	✓	✓	✓	✓	✓
F.4	Clinically Managed Population-Specific High Intensity	MH/SUD	IP	✓	✓	✓	✓	NA	NA	✓	✓	✓	✓	✓	✓	✓	✓

	Benefits	MH/SUD or M/S	Classification (IP, OP, PD, EC)	1 Medallion 4.0 Adults (19–64 yrs.)	2 Medallion 4.0 Adults Expansion (19–64 yrs.)	3 Medallion 4.0 Pregnant Women (incl. preg. youth)	4 Medallion 4.0 Children (0–18 yrs.)	5 FAMIS Children (0–18 yrs.)	6 FAMIS Moms (0–18 yrs. & 19–64 yrs.)	7 CCC Plus Adults (21+ yrs. Non-LTSS)	8 CCC Plus Adults 21+ yrs. LTSS	9 CCC Plus - Medicaid Works (16-64 yrs.)	10 CCC Plus – Medicaid Expansion (19–64 yrs.)	11 CCC Plus Children (0 -21 yrs. Non-LTSS)	12 CCC Plus Children (0 -21 yrs. LTSS)	13 CCC Plus Waiver	14 DD Waiver
F.5	Clinically Managed Low Intensity Residential Services Residential Services	MH/SUD	IP	✓	✓	✓	✓	NA	NA	✓	✓	✓	✓	✓	✓	✓	✓
F.6	ARTS Partial Hospitalization	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
F.7	ARTS Intensive Outpatient	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
F.8	(MAT) Methadone in Opioid Treatment Program (DBHDS-Licensed CSBs and Private Practitioner Clinics)	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
F.9	(MAT) Buprenorphine/Naloxone in Opioid Treatment Program (DBHDS-Licensed CSB and Private Practitioner Clinics)	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
F.10	(MAT) Buprenorphine/Naloxone in Office-Based Opioid Treatment (Primary Care and other Physician Offices, FQHCs, etc.)	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
F.11	Substance Abuse Case Management Treatment	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
F.12	Outpatient ARTS Individual, Family, and Group Counseling Services	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
F.13	Peer Recovery Supports Services	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
F.14	Screening, Brief Intervention and Referral to Treatment (SBIRT)	MH/SUD	OP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
G: (EPSDT Services)																	
G.1	EPSDT Case Management for High Risk Infants (up to age 2)	M/S	IP,OP	NA	NA	NA	<3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
G.2	EPSDT Clinical Trials	Both	IP,OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.3	EPSDT Dental Screenings	M/S	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.4	EPSDT Hearing Services	M/S	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.5	EPSDT Immunizations	M/S	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.6	EPSDT Laboratory Tests	Both	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.7	EPSDT Lead Investigations	M/S	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	✓	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.8	EPSDT Other MN Services	Both	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.9	EPSDT Personal Care	M/S	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT

	Benefits	MH/SUD or M/S	Classification (IP, OP, PD, EC)	1 Medallion 4.0 Adults (19–64 yrs.)	2 Medallion 4.0 Adults Expansion (19–64 yrs.)	3 Medallion 4.0 Pregnant Women (incl. preg. youth)	4 Medallion 4.0 Children (0–18 yrs.)	5 FAMIS Children (0–18 yrs.)	6 FAMIS Moms (0–18 yrs. & 19–64 yrs.)	7 CCC Plus Adults (21+ yrs. Non-LTSS)	8 CCC Plus Adults 21+ yrs. LTSS	9 CCC Plus - Medicaid Works (16-64 yrs.)	10 CCC Plus – Medicaid Expansion (19–64 yrs.)	11 CCC Plus Children (0 -21 yrs. Non-LTSS)	12 CCC Plus Children (0 -21 yrs. LTSS)	13 CCC Plus Waiver	14 DD Waiver
G.10	EPSDT Private Duty Nursing	M/S	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.11	EPSDT Program Global Coverage Guidelines	Both	IP,OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.12	EPSDT Screenings	M/S	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.13	EPSDT Tobacco Cessation	Both	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
G.14	EPSDT Vision Services	M/S	OP	<21 EPSDT	<21 EPSDT	<21 EPSDT	✓	NA	NA	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT	<21 EPSDT
H: Medicaid Expansion Population Services																	
H.1	ACIP Recommended Adult Vaccines	M/S	OP	NA	✓	NA	NA	NA	NA	NA	NA	NA	✓	NA	NA	NA	NA
H.2	Annual Adult Wellness Exams	M/S	OP	NA	✓	NA	NA	NA	NA	NA	NA	NA	✓	NA	NA	NA	NA
H.3	Nutritional Counseling for Individuals with Obesity or Chronic Disease	M/S	OP	NA	✓	NA	NA	NA	NA	NA	NA	NA	✓	NA	NA	NA	NA
H.4	Smoking Cessation Counseling, Individual and Group	M/S	OP	NA	✓	NA	NA	NA	NA	NA	NA	NA	✓	NA	NA	NA	NA
J: Long-Term Services and Supports Services																	
J.1	Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)	M/S	IP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
J.2	Long Stay Hospital - State Plan Only Service	M/S	IP	NA	NA	NA	NA	NA	NA	NA	EC	NA	EC	NA	EC	EC	EC
J.3	Nursing Facility	M/S	IP	NA	NA	NA	NA	NA	NA	NA	EC	NA	EC	NA	EC	EC	EC
J.4	Specialized Care - State Plan Only Service	M/S	IP	NA	NA	NA	NA	NA	NA	NA	EC	NA	EC	NA	EC	EC	EC
J.5	CCC Plus Waiver - Adult Day Health Care	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	NA
J.6	CCC Plus Waiver - Assistive Technology and Assistive Technology Maintenance	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	NA
J.7	CCC Plus Waiver - Environmental Modifications and Environmental Modification Maintenance	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	NA
J.8	CCC Plus Waiver - Personal Care	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	NA
J.9	CCC Plus Waiver - Personal Emergency Response System (PERS)	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	NA
J.10	CCC Plus Waiver - Respite Care	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	NA
J.11	CCC Plus Waiver - Services Facilitation	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	NA
J.12	CCC Plus Waiver - Skilled Private Duty Nursing	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	NA

	Benefits	MH/SUD or M/S	Classification (IP, OP, PD, EC)	1 Medallion 4.0 Adults (19–64 yrs.)	2 Medallion 4.0 Adults Expansion (19–64 yrs.)	3 Medallion 4.0 Pregnant Women (incl. preg. youth)	4 Medallion 4.0 Children (0–18 yrs.)	5 FAMIS Children (0–18 yrs.)	6 FAMIS Moms (0–18 yrs. & 19–64 yrs.)	7 CCC Plus Adults (21+ yrs. Non-LTSS)	8 CCC Plus Adults 21+ yrs. LTSS	9 CCC Plus - Medicaid Works (16-64 yrs.)	10 CCC Plus – Medicaid Expansion (19–64 yrs.)	11 CCC Plus Children (0 -21 yrs. Non-LTSS)	12 CCC Plus Children (0 -21 yrs. LTSS)	13 CCC Plus Waiver	14 DD Waiver
J.13	CCC Plus Waiver - Transition Services	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓	NA
K: DD Waiver Services																	
K.1	Assistive Technology (AT)	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.2	Benefits Planning	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.3	Center-Based Crisis Supports	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.4	Community Coaching	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.5	Community Engagement	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.6	Community Guide	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.7	Community-Based Crisis Supports	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.8	Companion Services	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.9	Crisis Support Services	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.10	Electronic-Based Home Supports	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.11	Employment and Community Transportation	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.12	Environmental Modifications	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.13	Group Day Services	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.14	Group Home Residential	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.15	Group Supported Employment	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.16	Independent Living	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.17	Individual & Family Caregiver Training	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.18	Individual Supported Employment	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.19	In-Home Supports	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.20	Peer Monitoring	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.21	Personal Assistance	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.22	Personal Emergency Response System (PERS)	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.23	Private Duty Nursing	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.24	Respite Services	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.25	Services Facilitation (SF)	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.26	Shared Living	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓

	Benefits	MH/SUD or M/S	Classification (IP, OP, PD, EC)	1 Medallion 4.0 Adults (19–64 yrs.)	2 Medallion 4.0 Adults Expansion (19–64 yrs.)	3 Medallion 4.0 Pregnant Women (incl. preg. youth)	4 Medallion 4.0 Children (0–18 yrs.)	5 FAMIS Children (0–18 yrs.)	6 FAMIS Moms (0–18 yrs. & 19–64 yrs.)	7 CCC Plus Adults (21+ yrs. Non-LTSS)	8 CCC Plus Adults 21+ yrs. LTSS	9 CCC Plus - Medicaid Works (16-64 yrs.)	10 CCC Plus – Medicaid Expansion (19–64 yrs.)	11 CCC Plus Children (0 -21 yrs. Non-LTSS)	12 CCC Plus Children (0 -21 yrs. LTSS)	13 CCC Plus Waiver	14 DD Waiver
K.27	Skilled Nursing	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.28	Sponsored Residential	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.29	Supported Living Residential	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.30	Therapeutic Consultation - Other Professionals	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.31	Therapeutic Consultation - Psychologist/Psychiatrist	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.32	Therapeutic Consultation - Therapists/Behavior	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.33	Transition Services Analysts/Rehab Engineer	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓
K.34	Workplace Assistance Services	M/S	OP	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	✓

Appendix B

Summary of NQTL findings by MCO

Aetna Better Health of Virginia

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
MNC/Clinical Guidelines	**IP classification (All Benefit Packages)** • Criteria developed utilizing the MCG, ASAM (adult and child), DMAS Provider Manual, the CMHRS manual, Aetna Clinical Policy Bulletins and Aetna Clinical policy council review. • Applied to all covered services following annual review of the existing national criteria, literature reviews and double blind studies and emerging and evidence-based practices. • A senior-level multi-disciplinary Steering Committee reviews national criteria and sets the procedures for applying them against current clinical and medical evidence annually. • Discretion may be exercised in urgent situations, but only at the authority of the Medical Director or designee, DMAS or the health plan committee.
	OP classification (All Benefit Packages) • Criteria developed utilizing the MCG, ASAM (adult and child), DMAS Provider Manual, the CMHRS manual, Aetna Clinical Policy Bulletins and Aetna Clinical policy council review. • Applied to all covered services following annual review of the existing national criteria, literature reviews and double blind studies and emerging and evidence-based practices. • A senior-level multi-disciplinary Steering Committee reviews national criteria and sets the procedures for applying them against current clinical and medical evidence annually. • Discretion may be exercised in urgent situations, but only at the authority of the Medical Director or designee, DMAS or the health plan committee.
Provider Reimbursement	**IP classification (All Benefit Packages)** • All providers are subject to requirements. • Uses the Commonwealth fee schedule to establish all rates.

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
	• Rate negotiations are triggered by provider requests or industry changes. • Rates are reviewed and updated quarterly and at contract renewal through comparison to reference databases, market analysis and internal data.
	OP classification (All Benefit Packages) • All providers are subject to requirements. • Uses the Commonwealth fee schedule to establish all rates. • Rate negotiations are triggered by provider requests or industry changes. • Rates are reviewed and updated quarterly and at contract renewal through comparison to reference databases, market analysis and internal data.
	EM classification (All Benefit Packages) • All providers are subject to requirements. • Uses the Commonwealth fee schedule to establish all rates. • Rate negotiations are triggered by provider requests or industry changes. • Rates are reviewed and updated quarterly and at contract renewal through comparison to reference databases, market analysis and internal data.

Anthem Healthkeepers Plus of Virginia

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
MNC/Clinical Guidelines	**IP classification (All Benefit Packages)** • Criteria developed utilizing the MCG, ASAM (adult and child), and the CMHRS manual. • Applied to all covered services following annual review of the existing national criteria, literature reviews and double blind studies and emerging and evidence-based practices. • Criteria are reviewed at least annually against changes to Commonwealth standards, emerging gest practices and fidelity standards and changes to LOC guidelines.

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
	OP classification (All Benefit Packages) • Criteria developed utilizing the MCG, ASAM (adult and child), and the CMHRS manual. • Applied to all covered services following annual review of the existing national criteria, literature reviews and double blind studies and emerging and evidence-based practices. • Criteria are reviewed at least annually against changes to Commonwealth standards, emerging gest practices and fidelity standards and changes to LOC guidelines.
Provider Reimbursement	**IP classification (All Benefit Packages)** • All providers are subject to requirements. • Uses the Commonwealth fee schedule to establish all rates. • Rate negotiations are triggered by provider requests, industry changes, or market analysis. • Network access, appointment access, provider complaints and volume of non-participating/Single Case Agreements are all used to monitor the adequacy of established rates.
	OP classification (All Benefit Packages) • All providers are subject to requirements. • EAPG software is used for Ambulatory Surgical Services only, and all others use Unit Cost Fee Schedule to establish rates. • Rate negotiations are triggered by provider requests, industry changes or market analysis. • Network access, appointment access, provider complaints and volume of non-participating/Single Case Agreements are all used to monitor the adequacy of established rates.
	EM classification (All Benefit Packages) • All providers are subject to requirements. • Uses the Commonwealth fee schedule to establish all rates. • Rate negotiations are triggered by provider requests, industry changes or market analysis. • Network access, appointment access, provider complaints and volume of non-participating/Single Case Agreements are all used to monitor the adequacy of established rates.

Magellan Complete Care of Virginia

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
MNC/Clinical Guidelines	**IP classification (All Benefit Packages)** • Criteria developed utilizing the MCG, ASAM (adult and child), DMAS psychiatric manual, DMAS provider manual and the CMHRS manual. • Applied to IP psychiatric hospitalization, TGH, PRTF and ARTS 3.5, 3.7 and 4.0 and TGH. • Criteria sets are selected after review of fitness with existing national criteria against the Commonwealth's requirements; otherwise, MNC and LOC guidelines are developed. • MNC are reviewed against changes to the Commonwealth's contract standards, emerging best practices and EBP fidelity standards, changes to national LOC guidelines, service gaps and needs, data metrics such as utilization reports, grievance and appeal numbers, and member and provider feedback annually.
	OP classification (All Benefit Packages) • Criteria developed utilizing the MCG, ASAM (adult and child), DMAS psychiatric manual, DMAS provider manual and the CMHRS manual. • Applied to CMHRS services, crisis services, intensive community treatment, intensive in-home services, MH skill building services, therapeutic day treatment, therapeutic foster care and ARTS Partial Hospitalization Program, Intensive OP and peer recovery services. • Criteria sets are selected after review of fitness with existing national criteria against the Commonwealth's requirements; otherwise, MNC and LOC guidelines are developed. • MNC are reviewed against changes to the Commonwealth's contract standards, emerging best practices and EBP fidelity standards, changes to national LOC guidelines, service gaps and needs, data metrics such as utilization reports, grievance and appeal numbers, and member and provider feedback annually.
Provider Reimbursement	**IP classification (All Benefit Packages)** • All providers are subject to requirements. • Uses APR-DRGs and the Commonwealth fee schedule to establish all rates.

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
	• Rate negotiations are triggered by provider requests or industry changes and evaluated against normative data using internal claims databases, as well as publicly available databases. • Monthly monitoring of network access, appointment access, provider or member complaints, volume of negotiation requests, volume of reimbursement related provider terminations or refusals to join the network and volume of non-participating /single case agreements are used to determine the adequacy of established rates.
	OP classification (All Benefit Packages) • All providers are subject to requirements. • Uses APR-DRGs and the Commonwealth fee schedule to establish all rates. • Rate negotiations are triggered by provider requests or industry changes and evaluated against normative data using internal claims databases, as well as publicly available databases. • Monthly monitoring of network access, appointment access, provider or member complaints, volume of negotiation requests, volume of reimbursement related provider terminations or refusals to join the network and volume of non-participating /single case agreements are used to determine the adequacy of established rates.
	EM classification (All Benefit Packages) • All providers are subject to requirements. • Uses APR-DRGs and the Commonwealth fee schedule to establish all rates. • Rate negotiations are triggered by provider requests or industry changes and evaluated against normative data using internal claims databases, as well as publicly available databases. • Monthly monitoring of network access, appointment access, provider or member complaints, volume of negotiation requests, volume of reimbursement related provider terminations or refusals to join the network and volume of non-participating /single case agreements are used to determine the adequacy of established rates.

Optima Health of Virginia

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
MNC/Clinical Guidelines	**IP classification (All Benefit Packages)** • Criteria developed utilizing the MCG, ASAM (adult and child), DMAS provider manual and the CMHRS manual. • Applied to IP psychiatric hospitalization, ARTS IP and residential treatment. • Applied to all covered services following annual review of the existing national criteria, literature reviews and double blind studies and emerging and evidence-based practices. • Discretion may be exercised in urgent situations, but only at the authority of the Medical Director or designee, DMAS or the health plan committee.
	OP classification (All Benefit Packages) • Criteria developed utilizing the MCG, ASAM (adult and child), DMAS provider manual and the CMHRS manual. • Applied to ARTS partial hospitalization and intensive OP services, SUD peer recovery services, SUD case management, ECT, psych and neuropsych testing, CMHRS, investigative and experimental, behavioral therapy and some EPSDT services. • Applied to all covered services following annual review of the existing national criteria, literature reviews and double blind studies and emerging and evidence-based practices. • Discretion may be exercised in urgent situations, but only at the authority of the Medical Director or designee, DMAS or the health plan committee.
Provider Reimbursement	**IP classification (All Benefit Packages)** • All providers are subject to requirements. • Certain non-MD MH/SUD providers must maintain specialty training(s) or certification(s). • Uses the Commonwealth fee schedule to establish all rates. • Rate negotiations are triggered by provider requests or industry changes and evaluated against normative data using internal claims databases, as well as publicly available databases. • If a provider does not accept a rate, they may withdraw from the network or continue negotiations.
	OP classification (All Benefit Packages) • All providers are subject to requirements. • Certain non-MD MH/SUD providers must maintain specialty training(s) or certification(s).

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
	• Uses the Commonwealth fee schedule to establish all rates. • Rate negotiations are triggered by provider requests or industry changes and evaluated against normative data using internal claims databases, as well as publicly available databases. • If a provider does not accept a rate, they may withdraw from the network or continue negotiations.
	EM classification (All Benefit Packages) • All providers are subject to requirements. • Certain non-MD MH/SUD providers must maintain specialty training(s) or certification(s). • Uses the Commonwealth fee schedule to establish all rates. • Rate negotiations are triggered by provider requests or industry changes and evaluated against normative data using internal claims databases, as well as publicly available databases. • If a provider does not accept a rate, they may withdraw from the network or continue negotiations.

UnitedHealthcare Community Plan

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
MNC/Clinical Guidelines	**IP classification (All Benefit Packages)** • Criteria developed utilizing the ASAM (adult and child), DMAS provider manual and the CMHRS manual, the LOCUS and ECSII and CASII, which includes LOC placement and service intensity. • Applied to IP psychiatric hospitalization, ARTS IP and residential services. • Criteria sets selected after review of existing national criteria, the Commonwealth's requirements, literature reviews and double blind studies and emerging and evidence-based practices. • Discretion may be exercised in urgent situations, or if a supplemental service needs to be added, or to address a non-duplicative service need, but only at the authority of the Medical Director or designee, DMAS or the authoring health plan committee.

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
	OP classification (All Benefit Packages) • Criteria developed utilizing the ASAM (adult and child), DMAS provider manual and the CMHRS manual, the LOCUS and ECSII and CASII, which includes LOC placement and service intensity. • Applied to ARTS PHP and IOP services, and SUD peer recovery services, ECT and CMHRS services. • Criteria sets selected after review of existing national criteria, the Commonwealth's requirements, literature reviews and double blind studies and emerging and evidence-based practices. • Discretion may be exercised in urgent situations, or if a supplemental service needs to be added or to address a non-duplicative service need, but only at the authority of the Medical Director or designee, DMAS or the authoring health plan committee.
Provider Reimbursement	**IP classification (All Benefit Packages)** • All providers are subject to requirements. • Either uses the Commonwealth fee schedule to establish rates where a Commonwealth fees exist, otherwise the Medicare fee schedule or APR-DRG is used. • Rate negotiations are triggered by provider requests, industry changes, or where a market analysis suggest a higher or lower rate. • Rates are reviewed and updated annually and at contract renewal through comparison to reference databases, market analysis and internal data.
	OP classification (All Benefit Packages) • All providers are subject to requirements. • Either uses the Commonwealth fee schedule to establish rates where a Commonwealth fees exist, otherwise the Medicare fee schedule or APR-DRG is used. • Rate negotiations are triggered by provider requests, industry changes, or where a market analysis suggest a higher or lower rate. • Rates are reviewed and updated annually and at contract renewal through comparison to reference databases, market analysis and internal data.

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
	EM classification (All Benefit Packages) • All providers are subject to requirements. • Either uses the Commonwealth fee schedule to establish rates where a Commonwealth fees exist, otherwise the Medicare fee schedule or APR-DRG is used. • Rate negotiations are triggered by provider requests, industry changes, or where a market analysis suggest a higher or lower rate. • Rates are reviewed and updated annually and at contract renewal through comparison to reference databases, market analysis and internal data.

Virginia Premier

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
MNC/Clinical Guidelines	**IP classification (All Benefit Packages)** • Criteria developed utilizing the Intermural, ASAM (adult and child), DMAS provider manual and the CMHRS manual. • Applied to all covered services following annual review of the existing national criteria, literature reviews and double blind studies and emerging and evidence-based practices. • Criteria sets selected after review of existing national criteria, the Commonwealth's requirements, literature reviews and double blind studies and emerging and evidence-based practices. • Discretion may be exercised in urgent situations, or if a supplemental service needs to be added or to address a non-duplicative service need, but only at the authority of the Medical Director or designee, DMAS or the authoring health plan committee.
	OP classification (All Benefit Packages) • Criteria developed utilizing the Intermural, ASAM (adult and child), DMAS provider manual and the CMHRS manual. • Applied to all covered services following annual review of the existing national criteria, literature reviews and double blind studies, and emerging and evidence based practices • Criteria sets selected after review of existing national criteria, the Commonwealth's requirements, literature reviews and

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
	double blind studies and emerging and evidence-based practices. • Discretion may be exercised in urgent situations, or if a supplemental service needs to be added or to address a non-duplicative service need, but only at the authority of the Medical Director or designee, DMAS or the authoring health plan committee.
Provider Reimbursement	**IP classification (All Benefit Packages)** • All providers are subject to requirements. • 75% of the Medicare fee and 100% of the Commonwealth fee schedule is used to establish rates. • Rate negotiations are triggered by provider requests or industry changes and evaluated against normative data using internal claims databases. • Out-of-Network rates are calculated as a percentage of the Medicare Advantage (MA) FFS rates. • Monthly monitoring of network access, appointment access, provider or member complaints and volume of non-participating/Single Case Agreements are used to determine the adequacy of established rates.
	OP classification (All Benefit Packages) • All providers are subject to requirements. • 75% of the Medicare fee and 100% of the Commonwealth fee schedule is used to establish rates. • Rate negotiations are triggered by provider requests or industry changes and evaluated against normative data using internal claims databases. • Out-of-Network rates are calculated as a percentage of the MA FFS. • Monthly monitoring of network access, appointment access, provider or member complaints and volume of non-participating/Single Case Agreements are used to determine the adequacy of established rates.

NQTL	MH/SUD services (A full list by classification and benefit package can be found in Appendix A)
	EM classification (All Benefit Packages) • All providers are subject to requirements. • 75% of the Medicare fee and 100% of the Commonwealth fee schedule is used to establish rates. • Rate negotiations are triggered by provider requests or industry changes and evaluated against normative data using internal claims databases. • Out-of-Network rates are calculated as a percentage of the MA FFS. • Monthly monitoring of network access, appointment access, provider or member complaints and volume of non-participating/Single Case Agreements are used to determine the adequacy of established rates.

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