WellCare Parity Submission Template

State: Kentucky

Plan(s): Kentucky Medicaid

Date: 08/03/2017

INTRODUCTORY STATEMENT

The following document is WellCare's submission and assessment of mental health parity in accordance with the Mental Health Parity and Addiction Equity Act. The responses were developed collaboratively across internal teams within WellCare, using the CMS Parity Compliance Toolkit published in January 2017 as the guide. The document is organized into four sections and each section within this document responds to a specific topic found in toolkit to help meet our parity assessment.

I. Benefit Classification Grid

II. Analysis of Financial Requirements, Quantitative Treatment Limitations, and Aggregate Lifetime and Annual Dollar Limits and

III. NQTL Response

IV. Compliance Monitoring Plan

I. BENEFIT CLASSIFICATION GRID

The following grid displays our determination on the bucketing of services and benefits in accordance with the State's plan. Responses meet requirements found in section 4 of the toolkit.

Definitions

Inpatient: All covered services or items provided to a beneficiary when a physician has written an order for admission to a facility.

Outpatient: All covered services or items that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care.

Emergency Care: All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting.

Pharmacy: Covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy.

Benefit Type	Inpatient	Outpatient	Prescription Drugs	Emergency Care
M/S	Hospice Hospital Services Maternity Services Nursing Home Care Physician Services Surgical Services Transplant Services	Ambulatory Surgery Center Abortion Allergy Services Chiropractic Care Dental Services Diagnostic Screening Durable Medical Equipment Family Planning Hearing Services Home Health Care Home Health Care - Nursing Services Hospital Services Laboratory Services Maternity Services Non-Emergency Transportation Nutritional Counseling Oral and Maxillofacial Surgery (OMS) Physician Services Podiatry Care Services Preventive Services Primary Care Visits Private Duty Nursing Prosthetic & Orthotic Devices Radiology Services Rehabilitative Services Renal Dialysis Respite Smoking Cessation Sterilization Telehealth Urgent Care Facility Vision Services	Clinic Administered Injections DME Outpatient Hospital Services Inpatient Hospital	Anesthesia Emergency Room Services Emergency Transportation/Ambulance Laboratory Services Outpatient Hospital Services Physician Services Radiology Services

Benefit Type	Inpatient	Outpatient	Prescription Drugs	Emergency Care
MH	Mental Health Hospital Inpatient Community Mental Health Center Services Level I & II Psychiatric Residential Treatment Facilities (PRTFs) Children Age 6 to 21 Substance Abuse Crisis -Stabilization Service	Crisis - Stabilization Service Intensive in home services Intensive outpatient behavioral health services (less than age 21) Mental Health Hospital Outpatient Mental Health Rehabilitation Community Centers Partial Hospitalization at a hospital or CMHC Psychotherapy Substance Abuse Therapeutic Child Support Services (less than age 21) Therapeutic Rehabilitation Services (CMHC)	Generic Brand Non-Preferred Brand OTC Preferred Brand Prescription OTC	Emergency Room Services Emergency Transportation/Ambulance Crisis - Stabilization Service

II. ANALYSIS OF FINANCIAL REQUIREMENTS, QUANTITATIVE TREATMENT LIMITATIONS, AND AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS

The following response is our assessment in analyzing the financial requirements, quantitative treatment limitations, and aggregate lifetime and annual dollar limits. Responses meet requirements found in section 5 of the toolkit.

1. Financial Requirements Testing (FR)

Classification	Medical/Surgical Cost Share	Mental Health/SUD Cost Share	Substantially All Test	Outcome
Inpatient	0	0	NA- Classification meets parity on its face, test not required.	The Medical Surgical and Behavioral/SUD inpatient benefits have the same copay and therefore are compliant with the parity requirement.
Outpatient	Various	0	NA- Classification meets parity on its face, test not required.	The Behavioral/SUD outpatient benefits have no copay and are therefore compliant with the parity requirements.
Emergency	0	0	NA- Classification meets parity on its face, test not required.	Emergency services for both Medical Surgical and Behavioral/SUD have no copays and therefore are complaint with the parity requirement.

2. Quantitative Treatment Limitations (QTL)

Classification	Medical/Surgical limits	Mental Health/SUD limits	Substantially All Test	Outcome
Inpatient	-No limits	-No limits	NA- Classification meets parity on its face, test not required.	Both the Medical Surgical and Behavioral benefits do not have limits and are compliant with the parity requirements.
Outpatient	-Majority of benefits - no limits -DME - limits based on service type -PT/OT/ST - 20 visits -Chiropractic - 26 visits per year -Hearing - limits based on procedure -Preventative Care - limits based on procedure -OB/Maternity - limits based on procedure -Physical Exam - 1 per year -Preventative Screening - limits based on age & procedure -Home Health - limits based on procedure	-3 hours of treatment per day for group and individual therapy.	Fail	Approximately 80% of the Medical Surgical benefits in the Outpatient classification have no benefit limits. Therefore, the limits imposed on the Behavioral benefits are not compliant with Mental Health Parity regulations.
Emergency	- No limits	-No limits	NA- Classification meets parity on its face, test not required.	Emergency services both for Medical Surgical & Behavioral/SUD have no limits and therefore are compliant with the parity requirement.

3. Aggregate Lifetime and Annual Dollar Limits (AL/ADL)

Classification	Medical/Surgical limits	Mental Health/SUD AL & ADL	Substantially All Test	Outcome
Inpatient	None	None	NA- Classification meets parity on its face, test not required.	There are no aggregate or annual dollar limits for Inpatient classification, therefore, the parity requirements are met.
Outpatient	None	None	NA- Classification meets parity on its face, test not required.	There are no aggregate or annual dollar limits for Outpatient classification, therefore, the parity requirements are met.
Emergency	None	None	NA- Classification meets parity on its face, test not required.	There are no aggregate or annual dollar limits for Emergency classification, therefore, is complaint with the parity requirements are met.

As stated in the above chart, WellCare identified a potential issue of non-compliance with the MHPAEA regarding the State's outpatient benefits design and quantitative treatment limitations ("QTL"). In accordance with current Kentucky Medicaid requirements, outpatient mental health/SUD benefits currently have hourly and daily limitations in place. The MHPAEA provides that no QTLs may apply to MH/SUD benefits in a classification if the QTL of that type does not also apply to substantially all (two-thirds) M/S benefits in the same classification. Without similar daily & hourly limitations on at least two thirds of the medical and surgical benefits in the outpatient classification, the hourly/daily QTL cannot be applied to the MH/SUD under this new rule.

III. NQTL RESPONSE

The following response is our assessment in analyzing the non-quantitative treatment limits. Responses meet requirements found in section 6 of the toolkit.

NQTL	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
Inpatient			
Medical Necessity and Appropriateness Criteria and Application - Inpatient	Depending on the pre-service procedure, Industry accepted Medical Criteria and approved WellCare Clinical Coverage Guidelines are utilized to assess medical necessity and appropriateness. If none is available based on service requested, or criteria is not met, a request is sent for a secondary Medical Director review Industry accepted medical necessity criteria in this classification and authorization rules include but are not limited to: • Clinical complexity, • Place of service appropriateness, • Financial and utilization data, and • Benefit restrictions, such as cosmetic procedures. • Diagnosis and clinical must be supplied by the facility. • Number of days approved are based on diagnosis and member co-morbidities. • Concurrent reviews are every 3 days • Discharge planning begins on admission Authorization is nearly always required for inpatient settings, with some exceptions on the claims side for newborn deliveries. Inpatient hospital services are considered and treated as an emergency service. We request the provider to notify us within 24 hours of admission. If there is a concern that an authorization does not meet MN, we offer a peer-to-peer review and we will send for a secondary review.	Industry accepted Medical Necessity Criteria (in addition to WellCare's Clinical Coverage Guidelines are utilized to assess medical necessity (MN) and appropriateness. Authorizations are given based on MN. If there is a concern that an authorization does not meet MN, we offer a peer-to-peer review. Industry accepted medical necessity criteria in this classification routinely include: • Level of clinical need that cannot be met in an outpatient environment. • Safety of the patient regarding danger to self or others, • current mental status, • compliance with medication and • duration of the current psychiatric event. Inpatient Psychiatric hospital services are considered and treated as an emergency service. As such, we request the provider to notify us within 24 hours of admission and while an authorization is required, prior authorization is not required.	C7UM MD-3.4; C7UM-3.4-PR-001

NQTL	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
Outpatient			
Medical Necessity and Appropriateness Criteria and Application - Outpatient:	Outpatient services are reviewed by the services requested, dependent on codes and place of service. Medical necessity is reviewed using clinical criteria, including industry accepted medical criteria and WellCare Clinical Coverage guidelines, to make a determination. The industry accepted and WellCare criteria reviewed in this classification for services ranging from Speech, Physical and Occupational therapy services to pre-planned surgeries routinely include but are not limited to the following: • Imaging results • Members age • Past medical history or co-morbidities • Symptoms and diagnosis • Prior level of function Providers submit outpatient service requests. Outpatient services are requested via fax, web portal, phone or/and state portals from the provider. If there is a concern that an authorization does not meet medical necessity, we offer a peer-to-peer review and we will send for a secondary review by a Medical Director.	In reviewing medical necessity and appropriateness, industry accepted Medical criteria are utilized which routinely include: • Risk of Harm, • Functional Status, • Co-Morbidity, • Recovery Environment, Acceptance, • Engagement in treatment, and • Level of Support. These criteria are utilized for Psych testing, ECT, Substance Abuse services, Day Rehabilitation, Community Support, and Psychiatric Residential Rehabilitation. Providers submit an Outpatient Services request form via web portal or fax to Utilization review and any clinical information that they feel is appropriate for initial and recurrent review. Utilization Management sends a fax regarding authorization or calls the provider to request further information. For substance abuse outpatient services, WellCare uses the American Society of Addiction Medicine, (ASAM) for criteria review. Examples of applied criteria include: • Acute Intoxication and Withdrawal • Potential, Biochemical complications, • Emotional, Behavioral and Cognitive Conditions. • Readiness to Change, • Relapse and Continued Problem Potential and Living and Recovery. Authorizations are given based on MN. If there is a concern that an authorization does not meet medical necessity, we offer a peer to peer	C7UM MD-3.4; C7UM-3.4-PR-001

NQTL	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
Pharmacy			
Fail first requirements or step-therapies	WellCare uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. WellCare also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. WellCare uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication. An example of ST criteria would be for Denivar cream 1%. The patient would have had to complete a trial of a preferred oral acyclovir or valacyclovir within the past 100 days before Denivar cream 1% would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - WellCare uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial, and failure of alternative drug(s), allergic reaction to preferred product, etc.).	WellCare uses quantity limits ("QL") to minimize inappropriate utilization, waste, and stockpiling of drugs, ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. WellCare also utilizes QL to help prevent billing errors. Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for approval. WellCare uses Step Therapy (ST) when there are several different drugs available on the PDL for treating a particular medical condition. A ST is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy) before "stepping up" to more expensive alternatives. 1. ST protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period. 2. At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the DER process and will receive the ST medication. An example of ST criteria would be for Saphris tablet. The patient would have had to complete a trial and failure of a preferred alternative within the last 100 days or have a contraindication before the Saphris tablet would be approved. 3. Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval. PA (DER) - WellCare uses this Utilization Management tool for drugs that have a high potential for misuse or inappropriate use. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial, and failure of alternative drug(s), allergic reaction to preferred product, etc.).	Policy C20RX-136 Policy C20RX-150 Preferred Drug List

NQTL	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
Outpatient			
Prior authorization:	Prior authorization is required for certain outpatient services. Medical necessity and appropriateness are required for prior authorization. Medical necessity is determined using Industry accepted Medical criteria. Outpatient services are requested via fax, web portal, phone, or state portals from the provider. Services are reviewed dependent on code, place of service and clinical information received from the provider. Industry accepted medical criteria, WellCare Clinical Coverage Guidelines and Benefit limits that are applied in this classification routinely include but are not necessarily limited to the following: • Determination of prior level of function • Members age and previous services • Clinical information which must include assessments, tools and non-standardized testing • Plan of Care • Review of benefit limits using the Benefit Master list. If there is a concern that an authorization does not meet medical necessity, we offer a peer-to-peer review and we will send for a secondary review by a Medical Director.	Outpatient therapies such as individual, family and group do not have to have prior authorization for the first 20 sessions. After 20 sessions, the provider can submit a request for additional services through web portal or fax. UM then determines the number of additional sessions and sends a fax informing the provider. There is substantial research in the area of outcomes and treatment effectiveness for outpatient psychotherapy. Psychotherapy has been demonstrated to be an effective treatment intervention. However, there is data that suggests that the effectiveness of treatment occurs early in care and better outcomes are not produced by long-term treatment. A 2001 study published in the Journal of Counseling Psychology found that patients improved most dramatically between their seventh and tenth sessions. Another study, published in 2006 in the Journal of Consulting and Clinical Psychology, looked at nearly 2,000 people who underwent counseling for 1 to 12 sessions and found that while 88 percent improved after one session, the rate fell to 62 percent after 12. Yet, according to research conducted at the University of Pennsylvania, therapists who practice more traditional psychotherapy treat patients for an average of 22 sessions before concluding that progress is not being made. Only 12 percent of those therapists choose to refer their stagnant patients to another therapist. Even though extended therapy is not always beneficial, many therapists persist in leading patients on an open-ended, potentially endless, therapeutic course. The review starting at session 21 is to help identify providers who have become “stuck” with members or where care is not progressing as expected to help facilitate a care plan review with the provider.	C7UM 4.12; C7UM-4.12 PR-001

		Industry accepted Medical Criteria are utilized to determine the appropriate medical necessity (“MN”) per member. The aforementioned criteria provide assessment tools used to support accurate level of care recommendations. The assessment determines clinical need based on multiple levels, including: • Mental, • Social, • Physical, and • Current functioning levels. Based on the results obtained from these assessment tools, the appropriate amount of units based on medical necessity and services are authorized for 20 sessions. The session limit is to ensure that members are getting their needs met, treatment plans are being followed, and that community resources are being connected to the member. If there is a concern that an authorization does not meet MN, we offer a peer-to-peer review and we will send for a secondary review by a Medical Director.	

NQTL	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
Emergency Care			
Authorization	Preauthorization is not required for emergency services Industry accepted Medical criteria are reviewed for all Medical Inpatient stays from the Emergency care setting. The industry accepted medical criteria utilized routinely in this classification are typically based on symptoms such as: • Specific injuries, • Labor pains, • Chest pain, • Altered mental status, • Positive testing, and dehydration Authorizations are given based on medical necessity. If there is a concern that an authorization does not meet medical necessity, we send for secondary review, a peer to peer is offered and then a final determination is made Authorization is required for all Inpatient stays. Inpatient hospital services are considered an emergency service. As such, we request the provider to notify us within 24 hours of admission and while an authorization is required, prior authorization is not required.	Preauthorization is not required for emergency services Authorization is required for all inpatient settings. Inpatient Psychiatric hospital services are considered and treated as an emergency service. As such, we request the provider to notify us within 24 hours of admission and while an authorization is required, prior authorization is not required. We utilize Industry accepted Medical Criteria to assess MN. The industry accepted medical criteria reviewed to establish MN for authorization in this classification routinely includes the identification of: • Suicidal ideation or attempts, • Homicidal or violent (due to mental state) toward others. • Inability to be treated as outpatient in the current mental state. • Lack of supports that will prevent hospitalization. Authorizations are given based on MN. If there is a concern that an authorization does not meet MN, we offer a peer to peer review KY has a Crisis stabilization service (facility based) for adults and children. Criteria for admit is the person is a danger to their self and others, is delusional or psychotic and unable to care for themselves due the mental condition to the point of harm to themselves or others. Programming is designed to stabilize, assess, and refer the patient for services. The service is considered a short-term intervention to establish community supports. If the patient requires more intensive help, they would be referred to IP.	C7UM MD-6.1; C7UM MR-6.1

NQTL	M/S	MH/SUD	Documentation and/or Confirmation of Information
Inpatient			
Prior Authorization	Pre-service, planned Inpatient surgeries, require prior authorization. Services are requested via fax, web portal, phone, or state portals from the provider. Inpatient services are reviewed for medical necessity dependent on code. WellCare utilizes the following criteria to conduct a medical necessity review: For Inpatient Prior Authorization review we use the industry standard criteria or WellCare Clinical coverage guidelines to review diagnosis and symptoms depending on the services requested. All Inpatient pre-planned surgeries require an authorization. The industry standard criteria or WellCare Clinical coverage guidelines applied in this classification routinely include: • Injuries in need of repair, • progression of diseases which require surgical intervention such as mastectomy and breast reconstruction, • possibly arthritis in joints, which may require a repair. • Hernia repairs Specific clinical information must meet the standards and guidelines presented in the criteria review. Criteria points are reviewed according to the diagnosis presented and services requested. Nurse will outreach to the provider three times, to obtain any additional clinical information required to make a determination or send the review to the Medical Director if the medical necessity does not meet criteria and outreach has been unsuccessful. The prior authorization nurse will review the System for Award Management (SAM) website and Office of Inspector general website for provider and facility sanctions. If there is a concern that an authorization does not meet medical necessity, we offer a peer-to-peer review and we will send for a secondary review by a Medical Director. Once the member is admitted to the hospital a concurrent review will be conducted by the Inpatient nurse every 3 – 5 days depending on diagnosis, co-morbidities, and treatment plan.	Residential substance abuse is an example of non-acute inpatient level of care that requires prior authorization. Psychiatric Residential Treatment Facilities for youth is another example of non-acute inpatient level of care. Prior authorization is required in order for a member to be admitted into a program. Authorizations are based on Industry Accepted Medical Criteria to assess medical necessity, which can include: • The presenting problems, • How long they have been having difficulties, • Interventions previously attempted, • Social support, • Physical health, and • School performance Specific clinical information must meet the standards and guidelines presented in the criteria review. Criteria points are reviewed according to the diagnosis presented and services requested. Nurse will outreach to the provider three times, to obtain any additional clinical information required to make a determination or send the review to the Medical Director if the medical necessity does not meet criteria and outreach has been unsuccessful.	C7UM 4.12; C7UM-4.12 PR-001

NQTL	M/S	MH/SUD	Documentation and/or Confirmation of Information
Inpatient			
Concurrent Review:	Concurrent review is not done selectively; it is performed for all inpatient stays to determine medical necessity of continued length of stay in addition to prepare for discharge planning. Continued stays are reviewed every 3 – 5 days using Industry accepted Medical criteria and based on clinical complexity for the services requested. Each service requires clinical information to review for medical necessity for the continued stay. Examples include: • Inpatient Hospital stay: What is the treatment plan currently for the Inpatient stay? • Skilled Nursing Facility: What was the Prior level of function prior to the Inpatient hospital stay? • Inpatient Rehabilitation: Is the Member capable of tolerating 3 hours of skilled therapy, at least 5 days a week? • Long Acute Care: Member requires 6.5 hours/24 hours of skilled nursing services and medical practitioner assessment daily. Additional days are approved based on medical necessity. Discharge planning begins on admission for all Inpatient stays. Discharge planning is reviewed as an individual plan for each member by reviewing the following for the next level of care: member age, diagnosis, co-morbidities, prior level of function, home environment. The nurse reviewer will arrange discharge planning for the member prior to discharge. Setting up services such as Skilled nursing facility, home health, durable equipment needs, care management referrals and follow-ups with their primary care provider or Specialist will assist a safe discharge and to prevent re-admissions.	For facility contracts on a per diem (contracted by the day for all diagnoses), concurrent reviews are not done selectively. They are performed for BH Inpatient admissions to determine the medical necessity of continued stay, in addition to ensuring safe transitions upon completion of treatment for our member. Due to the per diem nature of these contracts, concurrent reviews for BH Inpatient admissions are completed, *on average*, every 2-3 days and are based on medical necessity. Additional days are approved based on medical necessity. Many of medical necessity criteria points reflect symptomatology and treatment within the last 24 to 72 hours. The criteria in this classification is used to assess • Presenting problems, • How long the patient has been having difficulties, • Interventions previously attempted, • Social support • Physical health, and • School performance Discharge planning includes follow up appointments to the member's primary care physician (PCP) and therapist(s), as well as community resources needed. This information is also discussed at concurrent reviews to ensure safe transitions upon completion of treatment.	C7UM-5.4; C7UM-5.4-PR-001; C7UM-5.4- PR-002

NQTL	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
Pharmacy			
Formulary Design/Construction:	The selection of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	The selections of which drugs are covered use the same criteria for both medical and behavioral. The following is a summary of that process: Preferred Drug List (PDL) design including the Rx utilization (UM) criteria are based on the following guiding principles and considerations for all therapeutic classes and is governed by the same standard Pharmacy and Therapeutic (P&T) committee. a. Verify clinical appropriateness b. Ensure drug safety c. Prevent fraud and diversion d. Detect members receiving duplicate or unnecessary medication therapies from multiple prescribers e. Detect and prevent substance abuse f. Allow coverage for medications not listed on the PDL	Policy C20RX-136 Preferred Drug List; Policy C20RX-134 Corporate Pharmacy committee.

Pharmacy Network Access	WellCare's Rx network construction and management approaches for all therapeutic classes complies with all state and federal regulations regarding Pharmacy Networks and Access for all Medicare and Medicaid enrollees, including the following: WellCare contracts with CVScaremark to provide PBM Services and meet all contractual pharmacy network and pharmacy access requirements. CVScaremark maintains a comprehensive network of pharmacies to ensure that pharmacy services are available and accessible to all WellCare members 24 hours a day, 7 days a week. CVScaremark manages the pharmacy networks by recruiting and credentialing pharmacies, negotiating discounts from pharmacies for drug ingredients and dispensing services, monitoring pharmacies for quality and customer service, auditing pharmacy records, and providing technical support to pharmacies and pharmacists.	WellCare's Rx network construction and management approaches for all therapeutic classes complies with all state and federal regulations regarding Pharmacy Networks and Access for all Medicare and Medicaid enrollees, including the following: WellCare contracts with CVScaremark to provide PBM Services and meet all contractual pharmacy network and pharmacy access requirements. CVScaremark maintains a comprehensive network of pharmacies to ensure that pharmacy services are available and accessible to all WellCare members 24 hours a day, 7 days a week. CVScaremark manages the pharmacy networks by recruiting and credentialing pharmacies, negotiating discounts from pharmacies for drug ingredients and dispensing services, monitoring pharmacies for quality and customer service, auditing pharmacy records, and providing technical support to pharmacies and pharmacists.	C20RX-146 Pharmacy Network Contracting and Pharmacy Access
Prior Authorization	Members or providers may request consideration for coverage of a drug not on the PDL, or coverage of a drug on the PDL that is subject to limitations, by calling or writing to WellCare and explaining the medical justification. WellCare treats all requests the same. Such requests, regardless of therapeutic class, are subject to the same considerations and review process as outlined below.	Members or providers may request consideration for coverage of a drug not on the PDL, or coverage of a drug on the PDL that is subject to limitations, by calling or writing to WellCare and explaining the medical justification. WellCare treats all requests the same. Such requests, regardless of therapeutic class, are subject to the same considerations and review process as outlined below.	

NQTL	M/S	MH/SUD	Documentation and/or Confirmation of Information Included in the Tool
Network			
Network Access Requirements: A.	WellCare provides contracted networks of qualified organizational health care providers, and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. WellCare performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	WellCare provides contracted networks of qualified organizational health care providers, and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. WellCare performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation.	C7CR-009, C7CR-001, C7CR-004, C7CR-009-PR-001
B.	Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above.	Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they meet the criteria outlined in the assessment policies noted above	C7CR-009, C7CR-001 C7CR-004, C7CR-009-PR-001
C.	The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is).	The only geographic limitations on provider inclusion are the service area of the plan (i.e., the provider must practice within the state where the Medicaid plan is).	C7CR-009
D.	The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services. The State's benefit plan design dictates how members can access out of network benefits.	The Medicaid plan is an HMO product, thus the member is restricted to their network providers for non-emergent, routine care. Out-of-Network coverage is available for emergency services. The State's benefit plan design dictates how members can access out of network benefits.	State benefit plan documentation

E.	WellCare utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	WellCare utilizes the outpatient fee schedule prescribed by the State for reimbursing outpatient providers. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	State Medicaid Fee Schedule
F.	None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Geographic Market • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *WellCare utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	None of the following factors affect how professional provider reimbursement rates are determined: • Service Type • Geographic Market • Service demand • Provider Supply • Practice Size • Medicare reimbursement rates • Licensure *WellCare utilizes the fee schedule prescribed by the State for reimbursing outpatient providers as noted above. All providers are reimbursed at 100% of the State's fee schedule unless there is a geographic or provider availability issue that requires a higher percentage of the State's fee schedule.	State Medicaid Fee Schedule

WellCare identified the NQTL's applicable to the MH/SUD benefits in each classification. Once the NQTLs were identified, information was collected from the business about the processes, strategies, evidentiary standards, and other factors used in applying the NQTL (in writing and in operation) to assess the comparability and stringency to which the NQTL is applied between Med/Surg. and the MH/SUD benefits in all of the four classifications. The NQTL analysis was conducted for each type of classification. Pursuant to CMS' guidance in Section 6 of the Toolkit, each type of NQTL was tested only once in a classification, regardless of the types or number of services it limits. WellCare then analyzed the results to determine if parity was met.

It is WellCare's opinion that the non-quantitative treatment limitations are substantially consistent with parity standards.

IV. COMPLIANCE MONITORING PLAN

WellCare will implement and maintain monitoring procedures to ensure continued compliance with state requirements and the Mental Health Parity and Addiction Equity Act ("MHPAEA").

In collaboration with WellCare's Product department, Compliance will review potential benefit changes, require an updated parity analysis to be submitted, and approve changes if compliance requirements are met. In addition, Compliance will collaborate with business operational units on identifying key processes and procedures that could affect compliance with the MHPAEA, and require updated parity analysis be submitted prior to implementing any operational changes.

After parity has been assessed as complete within a state market, Compliance will monitor the trending patterns of medical/surgical and behavioral health data to identify potential anomalies from baseline statistics established with the successful implementation of MHPAEA practices. If detected, such deviations will be reviewed and analyzed to ensure parity is maintained in accordance with state and federal requirements. Should monitoring efforts identify potential non-compliance, Compliance will request formal corrective action from the applicable business unit and perform follow-up procedures to validate action has been taken to remediate the potential non-compliance.

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