New Hampshire Department of Health and Human Services Parity Compliance Report
For
Well Sense/Beacon Health Plan for Calendar Year 2016
(December 31, 2018)

A. Overview:

Background. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health insurance carriers to achieve coverage parity for mental health/substance use disorders (MH/SUD) and medical/surgical benefits, especially with regard to financial requirements and treatment limitations. On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule ("Parity Rule") to strengthen access to mental health (MH) and substance use disorder (SUD) services for services provided through Medicaid Managed Care Plans, Children's Health Insurance Plans, and Alternative Benefit Plans, thus aligning such public coverage with the protections already required of private health plans. (Hereinafter MHPAEA and the Parity Rule shall be collectively referred to as the "Parity Law.") To insure that inappropriate limitations were not being placed on MH/SUD services, the Parity Law required the New Hampshire Department of Health and Human Services ("DHHS" or "Department") to conduct a parity analysis for Calendar Year 2016 ("CY 2016") and submit the results of the analysis to CMS not later than October 2, 2017.

As part of the process to ensure its compliance with the October 2, 2017 CMS reporting obligation, on July 3, 2017, DHHS requested the Well Sense/Beacon Health Plan ("Plan") to conduct an analysis of parity compliance as required by the relevant provisions of the Plan's Managed Care Contract with DHHS ("Contract"). The July 3, 2017 document, titled "New Hampshire Department of Health and Human Services MCO Mental Health and Substance Use Disorder Parity Analysis" provided guidance about the conduct of the required analysis: "The Plan must conduct an analysis by completing the Excel document entitled "NH DHHS Parity Analysis Tool, July 3, 2017" and by providing narrative responses to questions in the aforementioned July 3, 2017 document." The Plan was required to provide an analysis of the limitations imposed by the Plan for each Medicaid mental health, substance use disorder, and medical/surgical service provided in the four specified classification categories (Inpatient, Outpatient, Emergency, and Pharmacy) in which the Plan provided services in CY 2016. The required narrative inquiries were designed to elicit information and assurances that the Plan had processes and procedures in place to ensure parity between MH/SUD and Med/Surg services. On September 15, 2017, the Plan submitted the required parity analysis and certification to DHHS, attesting that the comprehensive review of its administrative, clinical, and utilization practices for CY 2016 was complete and that the Plan was in compliance with the relevant provisions of the Parity Law.

Following the DHHS review of the Plan's September 15, 2017 parity analysis and certification of parity compliance, DHHS submitted its parity compliance report to CMS on October 2, 2017. The October 2, 2017 Compliance Report included a description of the approach and activities undertaken by the Department as part of its parity analysis and concluded that "[T]he NH Medicaid Program, as determined through its Parity Analysis, is in compliance with the Mental Health and Addiction Equity Act."

In the conclusion section of the October 2, 2017 Compliance Report, DHHS stated that although the DHHS parity analysis had determined that New Hampshire was in compliance with the Parity Law, "its work on ensuring parity between mental health/substance use disorder services and medical/surgical services is far from over" and referenced the NH DHHS Compliance Monitoring Plan included as Appendix D to the October 2, 2017 Compliance Report. Following the submission of the October 2, 2017 Report, DHHS began the implementation of the Compliance Monitoring Plan by requesting additional information and further analysis from the Plan as required by the parity provisions in the Contract between DHHS and the Plan. The Contract requires the Plan to demonstrate how all administrative, clinical, and utilization practices are in compliance with the relevant provisions of the Parity Law. The Plan was also required to provide an analysis of any Quantitative Treatment Limitations and Non-Quantitative Limitations in place for CY 2016 for MH or SUD services in order to demonstrate that any such limitations imposed by the Plan were in compliance with parity requirements using the methodologies outlined in the Parity Rules and relevant CMS guidance documents.

To assist the Plan in meeting its ongoing responsibility to insure parity compliance and accurate reporting, DHHS arranged for support from a national parity expert on October 18, 2017. Following the technical assistance consultation, DHHS requested that the Plan provide additional information on non-quantitative treatment limitations in each classification (inpatient, outpatient, emergency, and pharmacy) using guidance documents provided by DHHS for each classification. During the period from December 1, 2017 to April 15, 2018, the Plan submitted the completed guidance documents in a timely manner to DHHS. DHHS reviewed the completed guidance documents and sent follow-up questions to the Plan, to which the Plan responded.

Purpose of Report. The purpose of this report is twofold. The first purpose is to fulfill the Department's responsibility to conduct an independent analysis of the material submitted by the Plan in order to validate both the parity analysis conducted by the Plan and the Plan's conclusion that it was compliant with the requirements of the Parity Law for CY 2016. Based on the Department's independent review of the materials provided by the Plan, the Department finds that the Plan was compliant with the requirements of the Parity Law for CY 2016.

The second purpose of this report is to identify any areas of concern with regard to ongoing parity implementation and compliance and to make recommendations to the Plan for improvements. DHHS will use its findings to make recommendations for future managed care contract amendments and reprocurement.

Structure of Report. As described above, pursuant to its contractual obligation to demonstrate parity compliance, the Plan provided information and responded to questions from DHHS regarding the Plan's parity compliance activities/analysis. The information provided by the Plan was organized by the four service categories: Inpatient, Outpatient, Emergency, and Pharmacy.

The iterative process utilized by DHHS and the Plan resulted in the resolution of a significant number of the Department's parity questions, leaving only a limited number of outstanding issues for discussion and resolution. This report includes only those questions, responses, and recommendations that remain outstanding. Finally, it is noted that the requests for further

information/analysis and the recommendations for future action in this report relate only to the Inpatient and Outpatient Service Classifications. This is because the Plan's parity analysis in the Emergency and Pharmacy Classifications did not give rise to further DHHS inquiries or recommendations to improve parity compliance.

B. Availability and Accessibility of Information
a. Inpatient

1. DHHS Inquiry: During the parity compliance review process, the Plan explained that there are no inpatient authorization requirements for the first five (5) days. DHHS requests that the Plan provide information about where such information is located and explained to consumers and providers.

Well Sense/Beacon Response: The link in the original response explains the inpatient prior authorization requirements and processes. However, there is not documentation that references that the first five (5) days do not require prior authorization.

To clarify, the documentation explains that inpatient services require prior authorization within the first 24 hours of admission. Inpatient facilities in New Hampshire are aware that they are able to give Beacon a notification of admission (NOA) through the e-services portal on the Beacon website. This process would generate an authorization number for five days without requiring the provider to submit clinical information. Most facilities, however, use the telephonic pre-authorization review process. They call the Well Sense/ Beacon Health Options 24/7 line (855-834-5655) to obtain an authorization. Beacon would authorize five days upon review of the clinical information. The Member handbook directs members to call Beacon Health Strategies Member Service Line 24 hour/7 days a week at: 1-855-834-5655, or 1-866-727-9441 for hearing impaired members for any questions.

Beacon and Well Sense will provide clearer information on the WSHP website for the member to access.

DHHS Response/Recommendation: DHHS recommends that the Plan update its website and member materials in order to make information regarding the inpatient prior authorization and notification process more accessible to its members.

2. DHHS Inquiry: Where/how can members find information about experimental/investigative inpatient treatment?

Well Sense/Beacon Response: This information is contained within the WSHP member handbook, page 93.

DHHS Response/Recommendation: The Plan's response is sufficient.

b. Outpatient:

3. DHHS Inquiry: Where can the member find a clear explanation of the Plan's prior authorization process for psychotherapy/counseling?

Well Sense/Beacon Response: Well Sense reviewed all of its outpatient medical/surgical treatments in order to find the right comparators for psychotherapy and counseling for its parity analysis. Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) are the closest match to outpatient behavioral health office visits.

In general, the Initial Encounter (IE) authorization requirement for outpatient behavioral therapies is less restrictive than it is for similar medical therapies with the exception of the PCP office visit, which has no utilization management requirements. Beacon's IE model meets the standards for permissibility as set forth in The Mental Health Parity and Addiction Equity Act (MHPAEA), e.g., the model is comparable to, and applied no more stringently than, the authorization requirements for medical/surgical therapies like ST/OT/PT in the outpatient classifications.

Psychotherapy/counseling uses 18 initial encounters (IEs) for members 18 years and older and 24 initial encounters for members under 18 per benefit year. Once the IEs have been utilized, providers then request authorization through the online portal, Provider Connect. If the electronic method is not available, providers/participating providers should submit a written Beacon Outpatient Review (available on the Beacon website) or use the toll-free number for a telephonic review. In instances where a review does not meet medical necessity criteria and/or where questions arise as to elements of a treatment plan, the case file may be forwarded to a Peer Advisor for review.

The Plan covers outpatient physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services which are limited to eighty 15-minute units per benefit year in any combination of PT, OT, and ST services. Prior authorization from the Plan, by the requesting provider, is required for initial units.

The process is explained in the WSHP Member Handbook, page 39, and in the Beacon Provider Handbook, page 51.

https://s21151.pcdn.co/wp-content/uploads/2016/11/Beacon-Health-Options-Provider-Handbook.pdf

https://www.wellsense.org/members/-/media/0bd616da208b4929b4cc50a57f13b817.ashx

DHHS Response/Recommendation: The Plan's response is sufficient.

4. DHHS Inquiry: Where/how can members find information about experimental/investigative treatment?

Well Sense/Beacon Response: This information is contained within the WSHP member handbook, page 93.

DHHS Response/Recommendation: The Plan's response is sufficient.

C. Out of Network Referrals for Inpatient Mental Health:

5. DHHS Inquiry: If a member is unable to access in-network inpatient mental health treatment, does the Plan help facilitate access to an out of network provider? If so, please describe that process.

Well Sense/Beacon Response:
Yes.

- The crisis team or emergency department staff that assess the member can alert Beacon that there are no in-network beds available.
- In the event there are no in-network options available, Beacon supports a single case agreement (SCA) to allow members to access out of network inpatient mental health treatment.
- Beacon Prior Authorization team staff is available to assist with providing out of network options. If requested, Beacon Prior Authorization Team staff is available to call out of network facilities admission department to inquire about availability.
- Beacon Prior Authorization team staff is available to help coordinate with crisis team staff ensuring the out of network provider obtained the referral.
- Beacon Prior Authorization team staff completes a single case agreement form which is then submitted to Beacon's network department.

DHHS Response/Recommendation: DHHS recommends that the Plan work to ensure that inpatient facilities and treating providers are aware of both the out-of-network placement options and the processes outlined above in the Well Sense/Beacon Response for individuals seeking inpatient mental health treatment.

6. DHHS Inquiry: Does the Plan track out of network referrals for inpatient mental health?

Well Sense/Beacon Response: Yes—Beacon delivers a Semi-annual Out of Network Utilization report for inpatient and outpatient mental health services, inclusive of SUD services to WSHP. The report includes, but is not limited to the reason for out of network care:

- Continuity of Care
- Emergency
- Geographic Access
- Out of State
- Clinical Specialty

- Plan Request
- Transitional Care

DHHS Response/Recommendation: The Plan's Response is sufficient.

D. PA Denials for Inpatient Mental Health:

7. DHHS Inquiry: DHHS believes that the Plan does not provide adequate support to the member when the Plan denies a PA request for inpatient mental health because: the burden is placed on the clinician to provide/identify alternative levels of care; and because DHHS believes that a referral to a Peer Advisor is not sufficient. In addition, although some members have access to case management through the Plan, many do not. Of those enrollees denied inpatient mental health treatment, how many are enrolled in case management?

Well Sense/Beacon Response:

- There are no denials upon pre-authorization review or notice of admission. Therefore, of the 46 inpatient denials in 2016, the member was already inpatient.
- At the time of an adverse determination, a lower level of care is recommended to the requesting provider. During the communication of the adverse determination, the Beacon clinician communicates what the lower level of care is and in network options that are appropriate to the member's geographic location.
- Discharge planning would primarily be the role of a facility social worker; however, if assistance in a step-down is requested, the Beacon clinician can coordinate with Beacon's Aftercare team to assist the inpatient provider in discharge planning. The aftercare team can contact providers for the recommended level of care to ensure there is availability.
- If a member indicates a need for additional support or resources, Beacon would facilitate a connection to the member's Case Manager at the Community Mental Health Center (CMHC) to provide additional support around discharge planning. If the member is not affiliated with a CMHC, Beacon would then outreach the member or provider to assist with care coordination prior to discharge if requested.
- The Aftercare team can help coordination in the step-down referral request ensure the referring providers submits all necessary clinical information to the accepting provider.
- The Aftercare team outreaches every member who is discharged from an Inpatient unit to ensure follow up appointments have been made, and assist members with resolving any barriers to keeping those appointments.
- If a lower level of care is not a viable option, Beacon then authorizes the next appropriate higher level of care.
- Denial of inpatient M/S or BH/SUD services does not automatically trigger a case management referral. For your review, we have included the Beacon Case Management Policy that explains the Case Management referral process and criteria.

DHHS Response/Recommendation: DHHS recommends that the Plan work toward ensuring that the member and the treating provider are made aware of opportunities for available service access and case management opportunities when a denial for level of care is made.

E. Criteria for Reviewers:

a. Inpatient:

8. DHHS Inquiry: Please provide a list of the licenses and credentials held by the providers who sit on Beacon's Scientific Review Committee.

Well Sense/Beacon Response: DHHS notes that the names of the individuals serving on the Plan's Scientific Review Committee have been redacted and the list below includes only the license(s) held by these individuals.

Scientific Review Committee Members 2018
Member Names
MBA – Co-Chair
MD
MD
MD
MD
MS, M.Ed.
RN, MA
RN, CNS
MD
MD
LMHC
LCSWR ACSW
MPH
RN

MD
MD – Co-Chair
MPH
MD
PhD
MD
Administrative

DHHS Response/Recommendation: While the behavioral health licenses listed above are eligible to provide SUD services and expertise, DHHS recommends that the Plan make an effort to recruit a member for the Committee that specifically holds an SUD related license or specialty (i.e. LADC/MLADC/FASAM).

9. DHHS Inquiry: DHHS notes that the Plan's Credentialing, Licensure and Certification of Clinical Staff policy does not specifically state what competencies or licenses mental health/substance use disorder staff must hold in order to be authorized to review PA and concurrent review requests.

Well Sense/Beacon Response: Beacon's policy currently states that Initial Clinical Review Staff, which is staff reviewing Prior Auth Reviews, must be health professionals who possess an active professional license in behavioral health disciplines to diagnose and treat mental illnesses, thus allowing them to approve admissions, procedures, and services that meet clinical review criteria. The licensures include Licensed Mental Health Counselors (LMHC), Licensed Independent Clinical Social Worker (LICSW), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapists (LMFT), and Registered Nurse (RN).

If DHHS would prefer the additional detail, Beacon will update Beacon Credentialing Licensure and Certification of Clinical Staff policy to reflect the types of licensure and credentials MH/SUD staff performing PA must have.

DHHS Response/Recommendation: DHHS recommends that the Plan update their Credentialing, Licensure, and Certification of Clinical Staff policy to set minimum recommended or required licenses and direct service experiences for MH/SUD staff responsible for prior authorizations and concurrent reviews. This policy should also explicitly outline SUD related requirements in addition to those for mental health.

10. DHHS Inquiry: In an earlier exchange of information, the Plan did not adequately respond to the question: "List all qualifications (licenses, certifications, and registrations) of those who are reviewing PA requests for SUD treatment."

Well Sense/Beacon Response: Policies that were submitted with the February 15, 2018 Inpatient Submission (Well Sense Appropriate Professionals Policy and Beacon Credentialing Licensure and Certification of Clinical Staff) contain the language noted in the grid below which demonstrates that licensure and certification for BH/SUD staff are comparable to licensure and certification of M/S staff.

Well Sense Health Plan	**Beacon Health Strategies**
Case managers/case review staff are: Licensed clinicians such as nurses or pharmacists, with current unrestricted valid state licensure	Case Managers/case review staff are: health professionals who possess an active professional license in behavioral health disciplines, such as registered nurses, Masters or Doctoral level prepared behavioral health clinicians with active state license
The Plan's medical directors/physician reviewers have current unrestricted licenses as M.D.s or D.O.s and board certification in their areas of clinical practice. The pharmacists have unrestricted licenses.	Beacon's Peer Advisors/ Physician Reviewers are psychiatrists or doctoral level psychologists in a state or territory of the United States with an active, unrestricted license to practice medicine and are (b) Board-certified OR are a (c) Licensed doctoral-level psychologist
The CMO, medical directors/physician reviewers and the licensed pharmacists may use board certified consultants as needed and appropriate. The Plan has contracted with a vendor for external peer reviews. The vendor utilizes a nationwide network of board certified physician specialists.	Peer Reviews are in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate

As noted in the response to question #9, if DHHS would like the specific mental health licensures listed out, (Licensed Mental Health Counselors (LMHC), Licensed Independent Clinical Social Worker (LICSW), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapists (LMFT)), we can update the policies.

DHHS Response/Recommendation: DHHS recommends that the Plan update their Credentialing, Licensure, and Certification of Clinical Staff policy to set minimum recommended or required licenses and direct service experience for MH/SUD staff responsible for prior authorization and concurrent reviews. This policy should also explicitly outline SUD related requirements in addition to those for mental health.

b. Outpatient:

11. DHHS Inquiry: Does the Plan think that Beacon's Physical (Peer) Advisors would benefit from having SUD expertise?

Well Sense/Beacon Response: The PA's have a diverse range of expertise, including SUD expertise.

DHHS Response/Recommendation: The Plan's Response is sufficient.

12. DHHS Inquiry: Please provide additional explanation as to how the qualifications/training for staff implementing the coverage determinations are comparable between MH/SUD and M/S.

Well Sense/Beacon Response: Policies that were submitted with February 15, 2018 Outpatient Submission (Well Sense Appropriate Professionals Policy and Beacon Credentialing Licensure and Certification of Clinical Staff) contain language, which demonstrate that licensure and certification for BH/SUD staff are comparable to licensure and certification of M/S staff. Please see grid noted above in number 10 to compare.

DHHS Response/Recommendation: DHHS recommends that the Plan update its Credentialing, Licensure, and Certification of Clinical Staff policy to set minimum recommended or required licenses and direct service experience for MH/SUD staff responsible for prior authorization and concurrent reviews. This policy should also explicitly outline SUD related requirements in addition to those for mental health.

F. Prior Authorization Counseling:

13. DHHS Inquiry: The Department is concerned that the Plan requires PA for psychotherapy/counseling for SUD or mental health beyond the initial encounters. Please explain the bases for this prior authorization requirement.

Well Sense/Beacon Response:

- Initial Encounters (IE) for BH psychotherapy/counseling are comparable to outpatient physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services which are limited to eighty 15-minute units per benefit year in any combination of PT, OT, and ST services. Prior authorization from the Plan, by the requesting provider, is required for PT, OT, ST. Beacon often uses physical therapy (PT), occupational therapy (OT), and speech therapy (ST) as comparators for outpatient behavioral health office treatments.

- Under MHPAEA, a plan or issuer can divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits, and (2) all other outpatient items and

services. Outpatient psychotherapy is often subject to plan review after a certain number of visits because of a variety of reasons that do not exist with Primary Care visits, e.g., there exists a high degree of uncertainty about the nature of the problem (diagnosis), about what treatment will work, about what type of provider is required, and high variability in quality and duration of treatment.

- Beacon's goal is to promote effective clinical outcomes and the quality of care for outpatient, non-emergent treatment. In general, the IE authorization requirement for outpatient behavioral therapies is less restrictive than it is for similar medical therapies with the exception of the PCP office visit, which has no utilization management requirements. The IE model is designed to improve the quality of care for outpatient, non-emergent treatment and encourage recovery.

DHHS Response/Recommendation: The Plan's response is sufficient.

G. InterQual:

14. DHHS Inquiry: Please explain why the Plan has determined that InterQual is not sufficient in determining medical necessity for behavioral health, but is for medical/surgical? What evidence did the Plan use to make the determination that InterQual is insufficient for behavioral health? What evidence did the Plan rely on in developing its own criteria?

Well Sense/Beacon Response: Beacon Health Options reviewed InterQual BH criteria in the past for other business considerations, and found at the time that:

- the criteria was not as well developed as other national (MCG) and proprietary national criteria (competitors/peers) sets,
- did not cover the same breadth of BH levels of care
- reflected more of a 'medical model bias's / thought process, i.e., not taking into account broader biopsychosocial factors impacting placement decisions
- presented in a format that was not as intuitive for providers to decipher to understand how the criteria actually worked

The process and other evidence based resources used to develop the Beacon criteria are found on pages 8-10 of the Introduction to Beacon Clinical Criteria document submitted 02/15/2018 and attached.

This document can also be found on the Beacon website:
https://www.beaconhealthoptions.com/pdf/clinical/1-INTRO.pdf

DHHS Response/Recommendation: The Plan's response is sufficient.

H. DRG:

15. DHHS Inquiry: The Department is concerned that the Plan accepts DRG payment methodology for medical/surgical, but not for mental health/SUD and requests additional clarification as to why DRG payment is not suitable for inpatient mental health/SUD stays.

Well Sense/Beacon Response: Beacon does accept DRG in New Hampshire for Inpatient Behavioral Health. Pricing points are set forth by the State and the State gives guidance on how to calculate the facilities payments. The price points for DRG reimbursement from DHHS are sent to Beacon annually. The PA process is followed for DRG facilities to ensure medical necessity criteria is met.

Concurrent reviews are completed for inpatient mental health facilities, though this differs from medical (no concurrent reviews required for DRG facilities except for NICU). The additional management of services has not led to higher denial rates in comparison to medical services. The purpose and intent of concurrent review is to support treatment and discharge planning for the best quality of care for the member, and to try to support coordination of aftercare within 7 days of discharge.

In efforts to align with Well Sense, Beacon has will be removing concurrent review for inpatient mental health services at DRG facilities, while continuing to offer support services through our utilization management team to help with treatment planning throughout the admission, as well as discharge and aftercare planning. Additionally, Beacon will only be performing prior authorization for inpatient admissions at non-DRG facilities, and only requiring NOA from DRG facilities.

DHHS Response/Recommendation: DHHS requests that the Plan submit a plan and timeline associated with removing the concurrent review for inpatient mental health services at DRG facilities. The Plan should outline the process whereby the Plan will ensure that support services and care coordination remain intact for the member to ensure that quality of care is not compromised.

I. Miscellaneous Questions:

a. Inpatient:

16. DHHS Inquiry: Can the Plan confirm that residential SUD treatment was included in the answers supplied for inpatient responses?

Well Sense/Beacon Response: Yes.

DHHS Response/Recommendation: The Plan's response is sufficient.

17. DHHS Inquiry: The Plan explains that there are no inpatient prior authorization requirements for the first five (5) days. What happens if the Plan does not agree with the

inpatient placement? If the PA is denied for days after the 5th day, how is this resolved without disrupting a member's care?

Well Sense/Beacon Response: To clarify, the provider obtains an authorization for inpatient services within 24 hours of the admission. It is considered "authorization free" because the provider is only required to submit a notice of admission (NOA) without providing clinical information. The provider receives 5 days of authorization upon the NOA, and an authorization number is provided. Although, this is an option for all providers, currently only two providers submit NOAs. Most providers prefer to call and obtain authorization through the telephonic UM review process. In this case, the Provider will give all clinical information to the Beacon clinician, and five days of authorization is provided. A concurrent review is conducted on day five and Beacon will follow the typical UM process. As stated in previous responses (Question 1, & 15), once operationalized, Beacon will no longer conduct concurrent reviews for behavioral health inpatient services at DRG facilities to align with the Well Sense DRG facility authorization process.

- The first five days of inpatient hospitalization do not require prior authorization. If Beacon is in disagreement with the admission, the admission continues to be approved.
- Following the initial five day authorization, if a Physician Advisor does not feel a Member is meeting medical necessity criteria and an adverse determination is issued the Provider is offered an appeal. Beacon covers inpatient coverage during the expedited appeal process if the facility is in disagreement with Beacon's decision. Beacon covers through the date of decision on the expedited appeal.
- If the member is discharged following the denial, at the time of an adverse determination, a lower level of care is recommended to the requesting Provider. During the communication of the adverse determination, the Beacon clinician communicates the lower level of care recommendation and gives in network options that are appropriate to the Member's geographic location.
- If assistance in a step-down is requested, the Beacon clinician is available coordination with Beacon's Aftercare team to assist the inpatient Provider in discharge planning. The Aftercare team is available to contact providers for the recommended level of care to ensure there is availability.

DHHS Response/Recommendation: DHHS requests that the Plan submit a plan and timeline associated with removing concurrent review for inpatient mental health services at DRG facilities. The plan should outline the process whereby the Plan will ensure that support services and care coordination remain intact for the member to ensure that quality of care is not compromised. DHHS also requests that, to the best of the Plan's ability, whenever a lower level of care is recommended to the requesting provider following a denial, a specific provider and direct referral to the available in or out of network option is provided to the requesting provider.

18. DHHS Inquiry: How does the Plan determine when it must conduct concurrent reviews for inpatient mental health and SUD treatment?

Well Sense/Beacon Response: As referenced in our response to question #15, Beacon is will be discontinuing concurrent reviews for DRG facilities to align with the medical authorization process for DRG facilities. For non-DRG facilities, and SUD treatment reviews, Beacon will continue to follow the same concurrent review process that has been used since implementation.

Beacon maintains contracts and agreements with its participating hospitals/facilities that hold the network facility responsible to contact Beacon for continued stay review for all acute inpatient behavioral health services. For concurrent review requests, the Beacon UR Clinician gathers the necessary clinical information from reliable clinical sources (i.e., the attending physician/designee/facility or medical record) that will assist in the determination process and then applies the UM LOC criteria to authorize the most appropriate medically necessary treatment for the member. Authorizations are based on all clinical information gathered and available at the time of the review.

Concurrent reviews are based on the severity and complexity of the member's condition. A clinical evaluation for medical necessity is conducted at each concurrent review to determine when the next review will be due. Concurrent reviews are not routinely conducted on a daily basis.

When evaluating the need for continued care, the Clinical Reviewer/Peer Advisor and primary behavioral health provider confirm that the treatment plan:

1) remains individualized, clinically appropriate and potentially effective or has been realistically and appropriately updated based on the Member's desire and response to treatment, and
2) reflects any psychosocial, occupational, cultural or linguistic factors that affect the level of care determination.

Benefits of conducting concurrent review include but are not limited to: timely intervention to reduce risk of adverse outcomes, identification of potential patient safety issues, to ensure that active treatment planning is occurring and to assist in aftercare planning.

The following factors should be considered for continuation of a treatment plan:

- Timely coordination with other relevant providers;
- Level of treatment plan individualization;
- Individual is actively participating in the plan of care and treatment to the extent possible as consistent with the individual's condition;
- Progress in relation to specific symptoms or impairments is clearly evident and measurable (or treatment plan has been changed to allow for progress); or stability at the maximum level of function has been obtained and can be sustained only by this level of care; or additional time is needed at this level of care to reach recovery goals;
- Level of treatment plan individualization;
- Individual is actively participating in the plan of care and treatment to the extent possible as consistent with the individual's condition;
- Progress in relation to specific symptoms or impairments is clearly evident and measurable (or treatment plan has been changed to allow for progress); or stability at the

maximum level of function has been obtained and can be sustained only by this level of care; or additional time is needed at this level of care to reach recovery goals;

- Active evaluation, identification of barriers and treatment appropriate for the individual's condition are occurring with involvement of the individual and his/her family or other support system, with timely relief of symptoms either evident or reasonably expected;
- Treatment plan includes documented expected benefit from all relevant modalities and each intervention identifies a target symptom;
- Treatment or rehabilitation goals are realistic and established within an appropriate time frame for this level of treatment;
- Psychosocial, occupational, and cultural or linguistic issues are being addressed through timely referral to and coordination with workplace, school, community, natural supports and psychosocial rehabilitation resources (e.g., EAP, culturally specific treatment modalities, social service agencies, peer support, recovery/self-help groups, legal aid, credit counseling, assertive community treatment, warm lines, clubhouse programs, homeless shelters);
- Discharge planning is evident from the time of admission and updates are evident throughout the course of treatment;
- All service and treatment modalities are carefully structured to achieve maximum results with the greatest efficiency in the use of resources so that the individual is treated at the least intensive level of care appropriate to the conditions and achieves the results desired (e.g., less intensive level of care, reunification of the family) and is cost effective.

DHHS Response/Recommendation: DHHS requests that the Plan submit a plan and timeline associated with removing the concurrent review for inpatient mental health services at DRG facilities. The plan should outline the process whereby the Plan will ensure that support services and care coordination remain intact for the member to ensure that quality of care is not compromised.

b. Outpatient:

19. DHHS Inquiry: Can the Department have access to the meeting minutes of the Medical Management Committee of Beacon and Well Sense?

Well Sense/Beacon Response: We can provide minutes if needed.

DHHS Response/Recommendation: DHHS recommends making meeting minutes and key Committee decisions publicly available.

20. **DHHS Inquiry:** Has the Plan had any MH/SUD providers interested in the Plan's network but denied based on GeoAccess? If so, what is the justification for denying these providers?

Well Sense/Beacon Response: No, we have open access.

DHHS Response/Recommendation: The Plan's response is sufficient.