Washington State Health Care Authority

Washington State Parity Analysis

As required by Mental Health Parity and Addiction Act (MHPAEA) regulations

March 2023

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Acknowledgements

Thank you to the managed care organizations for their timely submissions and the Health Care Authority Parity team.

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Introduction

Overview and purpose

On March 30, 2016, the Center for Medicare and Medicaid Services (CMS) issued the Mental Health Parity and Addiction Equity Act (MHPAEA). The act requires states to analyze financial requirements (FR), Quantitative Treatment Limitations (QTL) and Non-Quantitative Treatment Limitations (NQTL) applied to behavioral health services (mental health and substance use disorder treatment services), to ensure that those limitations are no more restrictive than those under medical/surgical benefits. States must also ensure that certain availability of information requirements are met. Washington's original parity report was completed in October 2017 and updated December 2019. This report demonstrates continued compliance with the analysis and reporting requirements of MHPAEA.

Medicaid covers and finances care for people with behavioral health conditions more than any other form of health insurance within the United States (**Guth, et al**, 2023).

> Nearly **40%** of the nonelderly adult Medicaid population (13.9 million enrollees) had a mental health or substance use disorder (SUD) in 2020.

Medicaid is a critical step towards addressing the United States' behavioral health crisis (Sullivan, Pearsall, & Bailey, 2021) and the only way to increase access to behavioral health services for adults is through Medicaid expansion. Access is not uniform throughout the country, even within Medicaid expansion states, due to lower provider reimbursement rates (HealthDay, 2023) and the historic restrictions on behavioral health care that led to the parity legislation (Pestaina, 2022).

> Medicaid is the single largest payer for mental health services in the United States and is increasingly playing a larger role in the reimbursement of substance use disorder services.

Medicaid is the primary payor for behavioral health services within the United States (CMS, 2023), partly because Medicaid is required to offer inpatient hospital services, outpatient hospital services, rural health clinic services, nursing facility services, home health services and physician services (MACPAC, 2023). States are also allowed to include optional services such as prescription medications, targeted case management, rehabilitation services, rehabilitative therapies, and peer supports (MACPAC, 2023) which are not typically available through private insurance or plans available through the health benefit exchange. A parity analysis of non-Medicaid health insurance programs to Medicaid would demonstrate a large difference in benefit options within behavioral health coverage. This report focuses on parity requirements within managed care for Medicaid, it does not cover Medicare, private insurance, or plans purchased on a health exchange.

Previous parity analysis reports focused on Washington's efforts to integrate physical and behavioral health benefits within Apple Health (Medicaid) programs and describe the Health Care Authority's (HCA) oversight of this transition. This is the first parity analysis since full integration of Apple Health, which occurred in 2020. While Apple Health has a fee-for-service option, most Apple Health clients are enrolled in a managed care organization (MCO) and routine behavioral health services are provided through managed care. This parity report focuses only on Washington's Apple Health MCOs.

Washington State currently has contracts with five MCOs to deliver and administer physical and behavioral health services to Washingtonians who are enrolled in Apple Health. These MCOs are required to follow MHPAEA requirements and provide HCA with documentation describing their adherence at least every three years.

Figure 1. Apple Health managed care plans

Plan name	Plan abbreviation
Amerigroup Washington, Inc.	AMG
Community Health Plan of Washington	CHPW
Coordinated Care of Washington, Inc.	CCW
Molina Healthcare of Washington	MHW
UnitedHealthcare Community Plan	UHC

MCOs are required to provide the following information to HCA regarding their parity adherence:

1. A copy of their behavioral health parity analysis applicable to the year under review. Including a narrative summary of:
    a. Data;
    b. Actions taken or planned in response to any differences discovered between behavioral health and comparable medical/surgical services; and
    c. An explanation of any differences.
2. A description of the processes, tools, or models used to complete the behavioral health parity analysis. Including the mechanism(s) that would trigger a review.
3. A description of the following:
    a. The findings from the NQTL comparative analysis;
    b. Any actions taken or planned to bring the program into compliance; and
    c. A copy of the comparative NQTL analysis.
4. A description of any differences identified in the behavioral health and medical/surgical standards comparative analysis for fail first or failure to complete/initiate.
5. A description of the steps taken to ensure access to out-of-network providers for behavioral health and medical/surgical benefits are comparable to access to out-of-network providers for other benefits.
6. A list of any differences in prior authorization and concurrent review requirements between behavioral health and medical/surgical benefits. Provide an explanation of any difference(s) that may be acceptable.

The information provided by the MCOs was used to generate the data and analysis within this report. This report outlines future efforts and opportunities to monitor and ensure Apple Health MCOs compliance.

Approach to Parity Analysis

Identifying behavioral health and medical surgical benefits

The parity analysis process requires states to define which benefits fall under the medical/surgical and behavioral health categories (Appendix A). Benefits are categorized based on the diagnoses they are meant to treat. States choose a method for assigning benefits to categories based on generally recognized independent standards of current medical practice. Following guidance provided by the CMS Parity Compliance Toolkit and subsequent technical assistance, Washington State used the ICD-10-CM as a guide to determine diagnostic benefit categories.

For the purpose of the parity review, the state defines behavioral health conditions as those conditions listed in ICD-10-CM, Chapter 5, Mental, Behavioral Health and Neurodevelopmental Disorders. The conditions listed in Chapter 5: Subchapter 1, Mental Disorders due to Known Physiological Conditions, and subchapter 8, Pervasive and Specific Developmental Disorders, were excluded because the etiology of these conditions is a medical condition, and treatment would address medical concerns first. Definitions of medical/surgical conditions are consistent with the medical/surgical conditions listed in ICD-10-CM, Chapters 1-4, Chapter 5-subchapter 1, and Chapters 6-20.

Placement of services in benefit categories

MHPAEA requires states to conduct a comparison of behavioral health and medical/surgical benefits within the defined categories below, keeping in line with the Parity Compliance Toolkit shared by CMS. To ensure MHPAEA compliance, every benefit in the plan needs to be placed into one of six classifications: in-patient in-network; in-patient out-of-network; outpatient in-network; outpatient out-of-network; emergency services; and pharmacy. For example, behavioral health inpatient benefits are analyzed for parity against medical/surgical inpatient benefits. For the purposes of the parity analysis, the four benefit categories are: outpatient, inpatient, emergency, and pharmacy.

Federal parity regulations allow states some latitude in placement of benefits within each of these categories. Washington State developed a preliminary list of benefits in each category based on current state plan services (Appendix A). For previous parity reports, the state consulted with MCOs to ensure the list was accurate and complete. This ensured consistency among MCOs when answering questions about each benefit category.

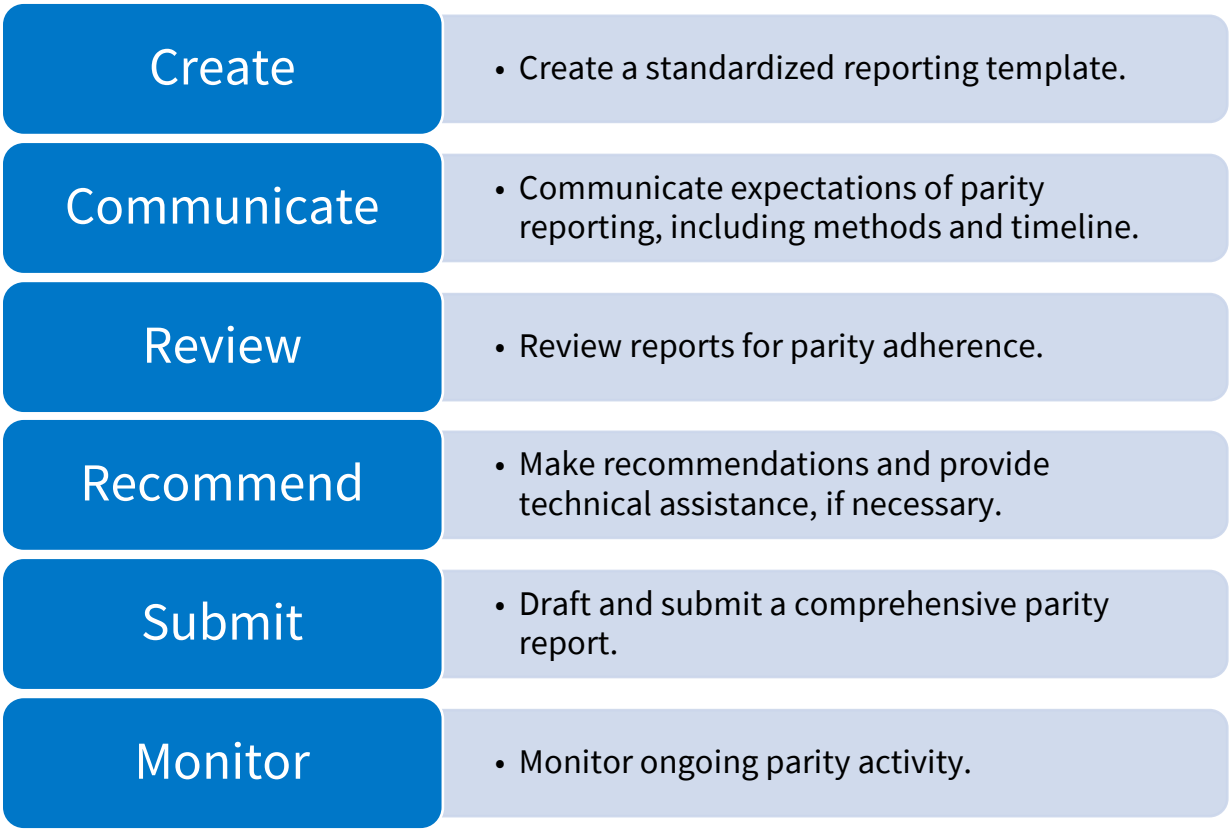
Category definitions

- **Outpatient**: Routine services that occur in an outpatient setting and are not included in the emergency category.
- **Inpatient**: Any non-emergency service that involves the individual staying overnight at a facility. This includes inpatient mental health (MH) and substance use disorder (SUD) treatment and crisis stabilization services occurring in a facility.
- **Emergency**: Services or items delivered in an emergency department (ED) setting or emergency/crisis stabilization services, not requiring an overnight stay, which are not delivered in an inpatient setting.
- **Pharmacy**: Covered medications and associated supplies requiring a prescription.

Information gathering and monitoring process

HCA employed the following steps to gather information from all five MCOs regarding their internal parity processes and adherence to NQTL standards. The materials were due on November 1, 2022 and were analyzed by a team of HCA parity experts.

Figure 2. Steps taken to assess and monitor the Parity Report



Parity compliance

MCOs performed an analysis of limits on their medical/surgical and behavioral health benefits within the following categories: Inpatient: in-network, Inpatient: out of network, Outpatient: in network, Outpatient: out-of-network, emergency care, and prescription medications. These categories are within the following domains as stipulated through the Parity Compliance Toolkit:

- **Financial requirements:** Payment by beneficiaries for services received that are in addition to payments made by the state or MCO for those services. This includes copayments, coinsurance, and deductibles.
- **Quantitative treatment limitations:** Limits on the scope or duration of a benefit that are expressed numerically. This includes day or visit limits.
- **Aggregate lifetime or annual dollar limits:** Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.

Figure 3: Parity compliance chart

Key: ✓ = Compliant

Categories	AMG	CHPW	CCW	MHC	UHC
Inpatient, in-network	✓	✓	✓	✓	✓
Inpatient, out-of-network	✓	✓	✓	✓	✓
Outpatient, in-network	✓	✓	✓	✓	✓
Emergency care	✓	✓	✓	✓	✓
Prescription drugs	✓	✓	✓	✓	✓

Summary of Parity Analysis

The state is pleased to find that in all areas addressed by this analysis, there was little disparity between the behavioral health and medical/surgical benefits. There are no Quantitative Treatment Limitations (QTL) or other financial restrictions on any behavioral health benefits. No disparity exists between the medical/surgical and behavioral health emergency and inpatient benefits.

Ongoing and future monitoring activities

HCA continues to review and ensure parity compliance on a regular basis to determine whether behavioral health benefits meet parity requirements. Any changes to the state plan or waivers that affect behavioral health services will be reviewed for compliance. A high volume of specific complaints about parity issues may trigger a parity analysis.

HCA has an on-going workgroup that evaluates our current parity review practices. This workgroup meets quarterly and utilizes identified best practices and makes modifications and changes as needed to ensure compliance with federal parity requirements. The workgroup, based on the outcome of the 2022/2023 parity analysis, will revise and update monitoring practices as needed.

The HCA parity workgroup's next scheduled parity analysis will be conducted in 2025. Barring any substantial changes in parity regulations and expectations, the workgroup will solicit updated responses.

Individual MCO responses

Each MCO responded to HCA's request with their complete parity analysis. The following is a summary of their responses (Appendix B). All MCOs reported they are in full compliance of meeting mental health parity. In addition to following the Parity Compliance Toolkit, HCA based the questions and monitoring items off of "The Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation Requirements (Kennedy Forum Issue Brief, 2017).

Figure 4. Amerigroup Washington, Inc.'s response

Topic	Self-report
Process, tool or model used to complete parity analysis.	Amerigroup utilized the Elevance Health standardized template to complete the parity analysis.
Findings from NQTL Comparative analysis.	Parity between medical/surgical and behavioral health was found.
Actions taken or planned to ensure compliance.	No actions needed at this time
Use of fail first or failure to complete/initiate.	Services are authorized based on medical necessity, not "fail first".
Process to ensure out-of-network providers.	Amerigroup accepts out-of-network providers to service members. A prior authorization is required; they are reimbursed at 100% of the Medicaid Fee-for-Service rate.
Process differences for prior authorization and concurrent review requirements.	No differences were noted between medical/surgical and behavioral health.

Figure 5. Coordinated Care or Washington, Inc.'s response

Topic	Self-report
Process, tool or model used to complete parity analysis.	Quantitative data review, comparison of policies and procedures governing NQTLs (Qualitative data review) and interviews with key business owners.
Findings from NQTL Comparative analysis.	There were no findings from the NQTL analysis. All standards for behavioral health NQTLs are at parity with medical and in many cases NQTLs for BH were less stringent than medical.
Actions taken or planned to ensure compliance.	No actions needed at this time.
Use of fail first or failure to complete/initiate.	Coordinated Care does not require that an individual "fail first" in a service to get a higher cost service, or any service. The service must be medically necessary regardless of tried therapies or treatments received prior to the request.
Process to ensure out-of-network providers.	Coordinated Care assesses for medical necessity and whether care cannot be met within network, if out-of-network provider continues to be needed, a single-case agreement and mutually agreeable rates for non-contracted provider(s) are established.
Process differences for prior authorization and concurrent review requirements.	Prior authorization and concurrent review requirements are no more stringent for behavioral health services than medical, and oftentimes are less stringent.

Figure 6. Community Health Plan of Washington's response

Topic	Self-report
Process, tool or model used to complete parity analysis.	Analyzed policies and procedures, criteria, authorization list, procedure code, look up tool and provider manual.
Findings from NQTL Comparative analysis.	No findings where there is a more restrictive requirement for behavioral health services than there is for medical/surgical services.
Actions taken or planned to ensure compliance.	No action needed at this time.
Use of fail first or failure to complete/initiate.	Does not have fail first limitations on either behavioral health or medical/surgical. All criteria used are listed on the website to make medical necessity decisions.
Process to ensure out-of-network providers.	No restrictions or differences in access to out-of-network providers for behavioral health and medical/surgical benefits. It is noted that services

	outside of Washington State are limited to emergency services only.
Process differences for prior authorization and concurrent review requirements.	A complete analysis of all services that require prior authorization and concurrent review found there is no more restrictive requirement for behavioral health services than exists for medical/surgical services.

Figure 7. Molina Healthcare of Washington's response

Topic	Self-report
Process, tool or model used to complete parity analysis.	Uses a standardized approach that includes enterprise-wide policy and procedure, annual internal review, benefit crosswalk, address potential parity concerns, behavioral health benefits review for new plans, cost trend analysis, parity review of approval decisions, multi-disciplinary team rounds, internal gap analysis, use evidence-based national criteria sets, and review based on medical necessity.
Findings from NQTL Comparative analysis.	One potential concern with parity regarding provider network: medical/surgical is open but behavioral health varies by region. This concern was further investigated and no issues with parity were found. Molina Healthcare submitted a written confirmation to HCA. The concern was a result of BHSO members authorization denials for medical services which would be covered under a different benefit program (fee-for-service).
Actions taken or planned to ensure compliance.	Need to evaluate data more closely to understand categorization. Approval rates for SUD services apart from Urine Drug Screening tend to run higher due to the legislation-mandated initial approvals of all SUD intensive programs (withdrawal management and residential treatment facilities). Administrative Denials – Further evaluation concluded that parity was met and the issue was a result of small population that skewed the data.
Use of fail first or failure to complete/initiate.	There are no differences between behavioral health and medical/surgical standards with regards to fail first or failure to complete/ initiate requirements.
Process to ensure out-of-network providers.	This is same for all types of services: Molina reviews out of network requests for medical necessity and if approved to ensure payment so member will be held harmless. If there is no participating provider that can provide a non-emergency covered service, it will be covered by a non-participating provider, if prior authorization occurs before initiation of service.

Process differences for prior authorization and concurrent review requirements.	Planned admissions such as: Mental Health Residential Treatment Admissions require prior authorization and Planned Substance Use Disorder (SUD) Residential Treatment Facility Admissions are optional for prior authorization per ESHB 2642 as members can also be admitted by such facilities without prior authorization under this law, effective 1/1/2021. These services were chosen to ensure they are medically necessary, including appropriateness of services for an individual member at a specific time.

Figure 8. UnitedHealthcare Community Plan's response

Topic	Self-report
Process, tool or model used to complete parity analysis, including ad hoc review.	UHC implemented the following policies Mental Health Parity Non-Quantitative Treatment Limitations Process and a Mental Health Parity Program Practices Monitoring to adhere to parity requirements.
Findings from NQTL Comparative analysis.	There were no findings from the NQTL analysis.
Actions taken or planned to ensure compliance.	No actions needed at this time.
Use of fail first or failure to complete/initiate.	There is no "fail first" or "failure to complete/initiate" within its behavioral health benefits and/or services.
Process to ensure out-of-network providers.	If UHC determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by contract and/or state or federal requirements, UHC will actively seek to add providers to the network in that specialty or provider type unless there is a known supply gap in provider type in the area. If there is a supply gap, the plan language allows members to seek an exception and receive services from an out-of-network provider at the in-network benefit level, for both behavioral health and medical/surgical services.
Process differences for prior authorization and concurrent review requirements.	UHC concluded the methodology used to determine which behavioral health services are subject to Concurrent Review and Prior Authorization and how UHC conducts Concurrent Review and Prior Authorization "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which medical/surgical services are subject to Concurrent Review or Prior Authorization "in operation."

Appendices

Appendix A. Washington State benefits

Figure 1: Medicaid State Plan Benefit Packages (WAC 182-501-0060)

1. The letter "Y" means a service category is included for that program.
2. The letter "N" means a service category is not included for that program.
3. Refer to WAC 182-501-0065 for a description of each service category and for the specific program rules containing the limitations and restrictions to services*.

Service categories	ABP 20-	ABP 21+	CN1 20-	CN 21+	MN20-	MN 21+
Ambulance (ground and air)	Y	Y	Y	Y	Y	Y
Applied behavior analysis (ABA)	Y	N	Y	N	Y	N
Behavioral health services	Y	Y	Y	Y	Y	Y
Blood/blood products/related services	Y	Y	Y	Y	Y	Y
Dental services	Y	Y	Y	Y	Y	Y
Diagnostic services (lab and X-ray)	Y	Y	Y	Y	Y	Y
Early and periodic screening, diagnosis, and treatment (EPSDT) services	Y	N	Y	N	Y	N
Enteral nutrition program	Y	Y	Y	Y	Y	Y
Habilitative services	Y	Y	N	N	N	N
Health care professional services	Y	Y	Y	Y	Y	Y
Health homes	Y	Y	Y	N	N	N
Hearing evaluations	Y	Y	Y	Y	Y	Y
Hearing aids	Y	Y	Y	Y	Y	Y
Home health services	Y	Y	Y	Y	Y	Y
Home infusion therapy/parenteral nutrition program	Y	Y	Y	Y	Y	Y
Hospice services	Y	Y	Y	Y	Y	Y
Hospital services Inpatient/outpatient	Y	Y	Y	Y	Y	Y
Intermediate care facility/services for persons with intellectual disabilities	Y	Y	Y	Y	Y	Y
Maternity care and delivery services	Y	Y	Y	Y	Y	Y
Medical equipment, supplies, and appliances	Y	Y	Y	Y	Y	Y
Medical nutrition therapy	Y	N	Y	N	Y	N
Nursing facility services	Y	Y	Y	Y	Y	Y
Organ transplants	Y	Y	Y	Y	Y	Y

Orthodontic services	Y	N	Y	N	Y	N
Out-of-state services	Y	Y	Y	Y	Y	Y
Outpatient rehabilitation services (OT, PT, ST)	Y	Y	Y	Y	Y	N
Personal care services	Y	Y	Y	Y	N	N
Prescription drugs	Y	Y	Y	Y	Y	Y
Private duty nursing	Y	Y	Y	Y	Y	Y
Prosthetic/orthotic devices	Y	Y	Y	Y	Y	Y
Reproductive health services	Y	Y	Y	Y	Y	Y
Respiratory care (oxygen)	Y	Y	Y	Y	Y	Y
School-based medical services	Y	N	Y	N	Y	N
Vision care Exams, refractions, and fittings	Y	Y	Y	Y	Y	Y
Vision hardware Frames and lenses	Y	N	Y	N	Y	N

***ABBREVIATIONS:**

ABP - Alternative Benefit Plan

CN - Categorically Needy Program

MCS - Medical Care Services

MN - Medically Needy Program

Figure 2: SUD Services

Service	Service category
Level 1 WM Ambulatory withdrawal management without extended onsite monitoring.	Outpatient
Level 2 WM Ambulatory withdrawal management with extended onsite monitoring.	Outpatient
Level 3.1 Clinically Managed, Low Intensity Residential Services	Inpatient
Level 3.2 WM Clinically managed Residential Withdrawal Management.	Inpatient
Level 3.3 Clinically Managed, Population Specific, High Intensity, Residential Services.	Inpatient
Level 3.5 Clinically Managed, Medium Intensity Residential Services	Inpatient
Level 3.7 WM Medically monitored inpatient withdrawal management.	Inpatient
Alcohol/Drug Screening and Brief Intervention	Outpatient
Case Management Services	Outpatient
Laboratory Services	Outpatient
Level 1 Outpatient Services	Outpatient
Level 2.1 Intensive Outpatient Services	Outpatient

Figure 3: Mental health services

Service	Service category
Crisis services	Emergency
Freestanding Evaluation and Treatment	Inpatient
Psychiatric Inpatient Services	Inpatient
Brief Intervention Treatment.	Outpatient
Day Support	Outpatient
Family Treatment	Outpatient
Group Treatment Services	Outpatient
High Intensity Treatment	Outpatient
Individual Treatment Services	Outpatient
Intake Evaluation	Outpatient
Medication Management	Outpatient
Medication Monitoring	Outpatient
Mental Health Services provided in Residential Settings	Outpatient
Peer Support	Outpatient
Psychological Assessment	Outpatient
Rehabilitation Case Management	Outpatient
Special Population Evaluation	Outpatient
Stabilization Services	Outpatient
Therapeutic Psychoeducation	Outpatient
Crisis Triage	Inpatient
Crisis Stabilization (Inpatient)	Inpatient
Crisis Stabilization (Outpatient)	Outpatient

Figure 4: Service categories for mental health benefits

Behavioral health services codes

CPT® Code	Short description	IP/OP/PH/C*	HCA	HCA limits/EPA/PA
90785	Psytx complex inter-active	IP/OP	HCA	
90791	Psych diagnostic evaluation	IP/OP	HCA	One per client, per provider, per calendar year
90792	Psych diag eval w/med srvcs	IP/OP	HCA	One per client, per provider, per calendar year
90832	Psytx pt&/family 30 minutes	IP/OP	HCA	
90833	Psytx pt&/fam w/e&m 30 min	IP/OP	HCA	
90834	Psytx pt&/family 45 minutes	IP/OP	HCA	
90836	Psytx pt&/fam w/e&m 45 min	IP/OP	HCA	
90837	Psytx pt&/family 60 minutes	IP/OP	HCA	
90838	Psytx pt&/fam w/e&m 60 min	IP/OP	HCA	
90845	Psychoanalysis	IP/OP	HCA	
90846	Family psytx w/o patient	IP/OP	HCA	
90847	Family psytx w/patient	IP/OP	HCA	
90849	Multiple family group psytx	IP/OP	HCA	
90853	Group psychotherapy	IP/OP	HCA	
90867	Tcranial magn stim tx plan	OP	HCA	One per client, per year; outpatient only
90868	Tcranial magn stim tx deli	IP/OP	HCA	30 visits in 7-week period followed by 6 taper treatments: outpatient only
90869	Tcran magn stim redetermine	IP/OP	HCA	Limit 1 per client per year
90870	Electroconvulsive therapy	OP	HCA	
96110	Developmental screen	OP	HCA	
96112	Devel tst phys/qhp 1st hr	OP	HCA	
96113	Devel tsxt phys/qhp ea add	Op	HCA	
96116	Neurobehavioral status exam	OP	HCA	PA
96121	Nubhvl xm phy/qhp ea addl hr			
96130	Psycl tst eval phys/qhp 1st	OP	HCA	
96131	Psycl tst eval phys/qhp ea	OP	HCA	Lifetime limit of 12 units for any combination of 96130, 96131, 96136, 96137, 96138, 96139 and 9614
96132	Neuropsych test by psych/phys	OP	HCA	EPA, PA if EPA does not apply

96133	Nrpsyc tst eval phys/qhp ea	OP	HCA	Lifetime limit of 12 units for any combination of 96130, 96131, 96136, 96137, 96138, 96139 and 9614
96136	Psycl/nrpsyc tst phy/qhp 1st	OP	HCA	PA for Neuropsych age 20 and older
96137	Psycl/nrpsyc tst phy/qhp ea	OP	HCA	PA for Neuropsych age 20 and older
96138	Neuropsych testing by tech	OP	HCA	EPA, PA if EPA does not apply
96139	Psycl/nrpsyc tst tech ea	OP	HCA	PA for Neuropsych age 20 and older
96146	Psycl/nrpsyc tst auto result	OP	HCA	PA for Neuropsych age 20 and older
99202	Office o/p new sf 15-29 min	OP	HCA	
99203	Office o/p new low 30-44 min	OP	HCA	
99204	Office o/p new mod 45-59 min	OP	HCA	
99205	Office o/p new hi 60-74 min	OP	HCA	
99211	Office o/p est minimal prob	OP	HCA	
99212	Office o/p est sf 10-19 min	OP	HCA	
99213	Office o/p est low 20-29 min	OP	HCA	
99214	Office o/p est mod 30-39 min	OP	HCA	
99215	Office o/p est hi 40-54 min	OP	HCA	
99218	Initial observation care	IP	HCA	
99219	Initial observation care	IP	HCA	
99220	Initial observation care	IP	HCA	
99304	Nursing facility care init	OP	HCA	
99305	Nursing facility care init	OP	HCA	
99306	E&M, nursing facility, new patient, level 3	OP	HCA	
99307	E&M, established patient, nursing facility, level 1	OP	HCA	
99308	E&M, established patient, nursing facility, level 2	OP	HCA	
99309	E&M, established patient, nursing facility, level 3	OP	HCA	
99310	E&M, established patient, nursing facility, level 4	OP	HCA	
99315	Nursing fac discharge day	OP	HCA	
99316	Nursing fac discharge day	OP	HCA	
99341	Home visit, new patient	OP	HCA	
99344	Home visit, new patient	OP	HCA	

99345	Home visit, new patient	OP	HCA
99347	Home visit, ext. patient	OP	HCA
99348	Home visit, ext. patient	OP	HCA
99349	Home visit, ext. patient	OP	HCA
99350	Home visit, ext. patient	OP	HCA
+ G0317	Prolong nursing fac eval 15M	OP	HCA
+ G0318	Prolong home eval add 15Ml	OP	HCA
+ G2212	Prolong outpt/office vis	OP	HCA

Appendix B. MCO response table

Figure 1. MCO Response Table

Key: Yes = Standard met; No = Standard not met

Questions	AMG	CHPW	CCW	MHC	UHC
Provide a copy of your behavioral health parity analysis applicable to the year under review. Include a narrative summary of the following: *a)* your data, *b)* actions taken or planned in response to any differences discovered between behavioral health (mental health and substance use disorder) and comparable medical/surgical (MEDICAL/SURGICAL) services; and *c)* an explanation of any differences.	Yes	Yes	Yes	Yes	Yes
Provide a description of the processes, tools, or models used to complete your behavioral health parity analysis. Include the mechanism(s) you have that would trigger an ad hoc review.	Yes	Yes	Yes	Yes	Yes
Describe the following: a) the findings from your Non-Quantitative Treatment Limits (NQTL) comparative analysis. b) any actions taken or planned to bring your program into compliance; and C) a copy of your comparative NQTL analysis.	Yes	Yes	Yes	Yes	Yes
If there were any differences identified in the comparative analysis for 'fail first' or 'failure to complete/initiate' within behavioral health and medical/surgical standards, describe why they differ.	Yes	Yes	Yes	Yes	Yes
Describe the steps taken to ensure access to out-of-network providers for behavioral health and medical/surgical benefits are comparable to access to out-of-network providers for other benefits.	Yes	Yes	Yes	Yes	Yes