**State**: Arizona

**Plan(s)**: Arizona Complete Health–Complete Care Plan (AzCH-CCP)

**Date**: August 14, 2026

## INTRODUCTORY STATEMENT

The following document is the AzCH-CCP 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 AzCH-CCP, using the CMS Parity Compliance Toolkit published in January 2017 and the Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) published in April 2018 as guides. This document is organized into four sections and each section within this document responds to a specific topic found in toolkit for parity assessment. The populations assessed for this parity analysis included all AzCH-CCP (RBHA and ACC) members as described in ACOM Policy 110-Attachment A.

**I. Benefit Classification Grid**

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

**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 network pharmacy.

| Benefit Type | Inpatient | Outpatient | Prescription Drugs | Emergency Care |
|---|---|---|---|---|
| **M/S** | Assisted Living<br>Hospice<br>Hospital – Inpatient<br>Hospital – Observation<br>Hysterectomy<br>Intermediate Care Facility<br>Maternity Services<br>Non-Experimental Transplants<br>Nursing Facilities<br>Nursing Home Care<br>Physician Services<br>Skilled Nursing Facility<br>Surgical Services (including transplant)<br>Inpatient Acute Rehab<br>Rehabilitative Services (PT, OT, ST, RT) Inpatient | Audiology<br>Breast Reconstruction<br>Chiropractic Services<br>Cochlear Implants<br>Diagnostic Services<br>Dialysis Services<br>Direct Care Services<br>Durable Medical Equipment<br>EPSDT<br>Family Planning Services<br>Hearing Services<br>Home Health Services<br>Hospital – Outpatient<br>Immunization<br>Laboratory Services<br>Maternity Services<br>Personal Care Services<br>Podiatry Care Services<br>Preventive Services<br>Primary Care Services<br>Private Duty Nursing<br>Prosthetic & Orthotic Devices<br>Radiology Services<br>Rehabilitative Services (PT, OT, ST, RT) Outpatient<br>Respite<br>Smoking Cessation<br>Therapy Services<br>Urgent Care Facility<br>Vision Services<br>Non-Emergent Transportation | Generic<br>Non-Preferred Brand<br>Preferred Brand<br>Prescription OTC<br>Mail Order Pharmacy<br>Transplant Related Immunosuppressant Drugs | Emergency Room Services<br>Emergency Room Services-Emergency Air Ambulance<br>Emergency Eye Exam<br>Transportation/Ambulance<br>Triage |

| Benefit Type | Inpatient | Outpatient | Prescription Drugs | Emergency Care |
|---|---|---|---|---|
| **Mental Health** | Inpatient Hospital<br>Inpatient Psychiatric Facilities/IMD<br>Medical Detoxification<br>Behavioral Health Residential Facility Treatment<br>Therapeutic Foster Care (children)<br>Behavioral Health Therapeutic Homes (adults)<br>Respite | Behavioral Analysis<br>Community Psychiatric Intensive Outpatient Programs and Behavioral Health Day Programs (including Partial Care)<br>Laboratory and Radiology<br>Medical Services* and Medication Management<br>Non-emergency Rehabilitation Services Transportation<br>Support Services<br>Supportive Treatment*<br>Treatment Services: Individual, Group, Family | Generic<br>Mail Order Pharmacy Medications<br>Methadone/LAAM<br>Non-Preferred Brand<br>Preferred Brand<br>Prescription OTC | Crisis Intervention Evaluation<br>Emergency Behavioral Health Care<br>Emergency Transportation |

## II. ANALYSIS OF AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS

The following response is our assessment of aggregate lifetime and annual dollar limits: AzCH-CCP would follow guidance from the AHCCCS Reference files, however, changes to aggregate lifetime, annual dollar limits, copayments, deductibles, and co-insurance would not be from the health plan's authority, but rather, by AHCCCS's direction. As of August 2026, AzCH-CCP reflects *no* coinsurance/deductibles for *any* Medicaid members/services. https://www.azahcccs.gov/PlansProviders/RatesAndBilling/copayments.html

### 1. Aggregate Lifetime and Annual Dollar Limit (AL/ADL)

| | | Behavioral/SUD AL & ADL | | |
|---|---|---|---|---|
| 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, the parity requirements are met. |
| Pharmacy | None | None | NA- Classification meets parity on its face, test not required. | There are no aggregate or annual dollar limits for Pharmacy classification, therefore, the parity requirements are met. |

## III. NQTL RESPONSE

The following response is our assessment in analyzing the non-quantitative treatment limits. No MHP conflicts found – meets parity requirements.

| NQTL | M/S | MH/SUD | Documentation and/or Confirmation of Information Included in the Tool |
|---|---|---|---|
| **Inpatient** | | | |
| **UM/Medical Necessity and Appropriateness Criteria and Application including documentation requirements - Inpatient** | Depending on the pre-service procedure, industry accepted medical criteria. InterQual, Clinical Care Guidelines are utilized to assess medical necessity (MN) and appropriateness.<br><br>If none is available based on service requested, or criteria is not met, the request is reviewed by a Medical Director.<br><br>Industry accepted medical necessity criteria in this classification and authorization rules may include:<br><br>• Level of clinical need that cannot be met in an outpatient environment.<br>• Clinical complexity,<br>• Place of service appropriateness,<br>• Financial and utilization data, and<br>• Benefit restrictions, such as cosmetic procedures.<br>• Diagnosis and clinical including discharge plan must be supplied by the facility.<br>• Reviews are based on diagnosis and member co-morbidities.<br>• Depending on the type of admission and level of care (example, hospital vs. SNF) Concurrent review timelines vary, but occur no later than 7 days<br>• Discharge planning begins on admission<br><br>Authorization required for inpatient settings, with some exceptions on the claims side for newborn deliveries.<br><br>Inpatient hospital services are considered and treated as a medically necessary 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 Medical Director review as applicable. | Industry accepted medical criteria such as InterQual, ASAM (including ASAM Continuum), and Clinical Care Guidelines are utilized to assess medical necessity (MN) and appropriateness. These tools may include assessment by the LOCUS (adults) or CALOCUS (children).<br><br>Authorization is based on MN. If MN criteria are not met, we offer a peer-to-peer review, and the request is reviewed by a Medical Director.<br><br>Industry accepted medical necessity criteria in this classification and authorization rules include but are not limited to:<br><br>• Level of clinical need that cannot be met in an outpatient environment.<br>• Clinical complexity<br>• Place of service appropriateness<br>• Diagnosis and clinical including discharge plan must be supplied by the facility.<br>• Safety of the patient regarding danger to self or others,<br>• Current mental status,<br>• Compliance with medication<br>• Duration of the current psychiatric event<br>• Concurrent Reviews (specified in AZ.MM.13 Concurrent Review)<br><br>Inpatient Psychiatric hospital services are considered and treated as an emergency service. We request the provider to notify us within 24 hours of admission and while an authorization is required, prior authorization is not required. | • AZ.MM.13 Concurrent Review<br>• AZ.MM.91 AZ Interrater Reliability<br>• CC.UM.02<br>• AMPM 310-B<br>• AMPM Ex. 300-2A<br>• AZ.MM.115 Emergent Care and Post-Stabilization<br>• AZ.MM.112 Discharge Planning<br><br>• AHCCCS Covered Behavioral Health Services Guide (CBHSG) |

| NQTL | M/S | MH/SUD | Documentation and/or Confirmation of Information Included in the Tool |
|---|---|---|---|
| **Outpatient** | | | |
| **UM/Medical Necessity and Appropriateness Criteria and Application including documentation requirements - Outpatient:** | Outpatient services are reviewed by the services requested, dependent on codes and place of service. Medical necessity is reviewed and based on nationally recognized, evidence-based criteria such as InterQual, CMS, AHCCCS, American College of Obstetrics and Gynecology, The American Academy of Pediatrics, and Centene National Clinical Criteria for making determinations.<br><br>The industry accepted and AzCH-CCP criteria reviewed in this classification for services ranging from Advance Radiology Imaging, Speech, Physical and Occupational therapy services to pre-planned surgeries routinely include but are not limited to the following:<br><br>• Diagnostic testing results<br>• Member's age<br>• Past medical history or co-morbidities<br>• Progress of treatment<br>• Symptoms and diagnosis (including ICD10 code(s)<br>• Prior level of function<br>• CPT Code(s) and Procedure description<br>• A clinical exam<br><br>Providers submit outpatient service requests. Outpatient services are requested from the provider via fax or provider. Utilization Management sends a fax regarding authorization or calls the provider to request further information as needed.<br><br>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 as applicable. | Outpatient services are reviewed for medical necessity and appropriateness using industry accepted medical necessity criteria (e.g., InterQual, ASAM, and Clinical Care Guidelines). These criteria routinely include:<br><br>• Danger to self or others,<br>• Functional Status,<br>• Co-Morbidity and/or Past history<br>• Substance Use history,<br>• Recovery Environment,<br>• Acceptance<br>• Recovery environment,<br>• Level of Support<br>• Coding: CPT codes and description<br><br>These criteria are utilized for Psychological and Neuropsychological testing, ECT, Residential Levels of Care, Day Rehabilitation, and Community Support,<br><br>Providers submit a Treatment Authorization Request form via fax or online provider portal. Clinical information supporting the request is either faxed with the request or obtained telephonically.<br><br>Authorizations are given based on medical necessity. If there is a concern that an authorization does not meet medical necessity, we offer a peer-to-peer review by a Medical Director or psychologist, and we will send for a secondary review as applicable. | • CC.UM.02<br>• AMPM 310-B<br>• AMPM 320-S<br>• AMPM Ex. 300-2A<br>• AHCCCS Coding resources, including AHCCCS Covered Behavioral Health Services Guide (CBHSG)<br>• Clinical Practice Guidelines<br>• Centene Clinical Policy TMS CP.BH.200<br>• Centene Clinical Policy ABA CP.BH.104 |

| NQTL | M/S | MH/SUD | Documentation and/or Confirmation of Information Included in the Tool |
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| **Pharmacy** | | | |
| **Prescription Drugs- Medical Necessity Criteria, Fail first requirements or step-therapies** | 1) AzCH-CCP uses quantity limits ("QL") to minimize inappropriate utilization and promote drug safety by ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. AzCH-CCP also utilizes QL to help prevent billing errors.<br>a) Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for medical necessity prior to approval.<br>b) All Utilization Management (UM) for the State PDL are determined by AHCCCS and AzCH-CCP implements it as directed.<br>2) AzCH-CCP 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.<br>a) 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.<br>b) If the member has met the ST criteria, they will not be subject to the Prior authorization process and will receive the ST medication. An example of a medication that requires ST would be Januvia tablets. The patient has to complete a trial and failure of metformin at a minimum dose of 1500 mg daily for at least 90 days before Januvia may be approved.<br>c) Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for medical necessity prior to approval.<br>3) Prior Authorization (PA) process –AzCH-CCP uses this Utilization Management tool to ensure prescribed drugs are safe, efficacious, and cost effective. PA protocols are developed and reviewed at least annually. They indicate the criteria that must be met 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.).<br>4) Preferred Antipsychotic medications do not require a PA when prescribed by a Behavior Health (BH) provider on the AzCH-CCP BH roster list. QL and/or Age edits still require review.<br>5) Medical necessity is reviewed using AHCCCS approved clinical criteria, industry accepted medical criteria and trial and failure of preferred formulary alternatives to make a determination.<br>. | 1) AzCH-CCP uses quantity limits ("QL") to minimize inappropriate utilization and promote drug safety by ensuring that quantities supplied are consistent with Federal Drug Administration (FDA) approved clinical dosing guidelines. AzCH-CCP also utilizes QL to help prevent billing errors.<br>a) Requests for exceptions to the quantity limits listed on the Preferred Drug List (PDL) shall be reviewed for medical necessity prior to approval.<br>b) All Utilization Management (UM) for the State PDL are determined by AHCCCS and AzCH-CCP implements it as directed.<br>2) AzCH-CCP 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.<br>a) 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.<br>b) If the member has met the ST criteria, they will not be subject to the Prior authorization process and will receive the ST medication. An example of a medication that requires ST would be Rozerem tablets. The patient has to complete a trial and failure of two preferred alternatives within the last 100 days or have a contraindication to the preferred alternatives before Rozerem may be approved.<br>c) Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for medical necessity prior to approval.<br>3) Prior Authorization (PA) process - AzCH-CCP uses this Utilization Management tool to ensure prescribed drugs are safe, efficacious, and cost-effective 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.).<br>4) Preferred Antipsychotic medications do not require a PA when prescribed by a Behavior Health (BH) provider on the AzCH-CCP BH roster list. QL and/or Age edits still require review.<br>5) Medical necessity is reviewed using AHCCCS approved clinical criteria, industry accepted medical criteria, trial, and failure of preferred formulary alternatives to make a determination. | • CC.PHAR. 10 Preferred Drug List<br>• CC.PHAR.10 Arizona Addendum<br>• CC.PHARM.03A Medicaid Prior Authorization Review Process<br>• CC.PHARM.03A Arizona Addendum<br>• Preferred Drug List: https://www.azcompletehealth.com/members/medicaid/benefits-services/pharmacy.html |

| NQTL | M/S | MH/SUD | Documentation and/or Confirmation of Information Included in the Tool |
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| **Outpatient** | | | |
| **UM/Prior authorization (including documentation): Outpatient** | 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.<br><br>Outpatient services are requested from the Provider via fax or provider portal. Services are reviewed dependent on code, place of service and clinical information received from the provider.<br><br>AzCH-CCP utilizes InterQual, AHCCCS, CMS, and Centene National Clinical Care Guidelines and benefit limits that are applied in this classification routinely include but are not necessarily limited to the following:<br><br>• Determination of prior level of function<br>• Member's age and previous services<br>• Clinical information which must include assessments, tools, reports, and non-standardized testing<br>• Plan of Care<br>• Past medical history or co-morbidities<br>• Symptoms and diagnosis (including ICD10 code(s)<br>• CPT Code(s) and Procedure description<br><br>If there is a concern that an authorization does not meet medical necessity, we offer a peer-to-peer review and we will send to a medical director as applicable. | 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 (e.g., InterQual, ASAM, relevant AHCCCS policies (such as AMPM 320-V,Clinical Care Guidelines and the AHCCCS Covered Services Guide).<br><br>Outpatient services are requested via fax or online provider portal from the provider. Services are reviewed dependent on code, place of service and clinical information received from the provider.<br><br>Industry accepted medical criteria are utilized to determine the appropriate MN per member. The criteria provide assessment tools used to support accurate level of care recommendations. The assessment determines clinical need based on multiple levels, including:<br><br>• Mental,<br>• Social,<br>• Physical, and<br>• Current functioning levels.<br><br>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 review by a medical director as applicable. | • CC.UM.02<br>• CC.UM.05<br>• AMPM 320-V<br>• AMPM 310-B<br>• AMPM 320-S<br>• AMPM 320-W<br>• AMPM 320-X<br>• AZ.MM.75 Prior Authorization Process<br>• AMPM Ex. 300-2A<br>• AHCCCS Covered Behavioral Health Services Guide (CBHSG)Centene Clinical Policy TMS CP.BH.200<br>• Centene Clinical Policy ABA CP.BH.104 |

| NQTL | M/S | MH/SUD | Documentation and/or Confirmation of Information Included in the Tool |
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| **Emergency Care** | | | |
| **UM-Authorization and Medical Necessity-Emergency Care** | Preauthorization is not required for emergency services<br><br>Industry accepted medical criteria are reviewed for all medical inpatient stays from the Emergency care setting.<br><br>The industry accepted medical criteria utilized routinely in this classification are typically based on symptoms such as:<br>• Specific injuries,<br>• Labor pains,<br>• Chest pain,<br>• Altered mental status,<br>• Positive testing, and dehydration<br><br>Authorizations are given based on medical necessity. If there is a concern that an authorization does not meet medical necessity, we send for a Medical Director review, a peer to peer is offered and then a final determination is made.<br><br>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. | Prior authorization is not required for emergency services; however, when authorization is required (such as a concurrent stay and review), we request a facility notify us within 24 hours of an admission to an inpatient MH/SUD setting, for continued stay/concurrent review.<br><br>The industry accepted medical necessity criteria used in this classification (such as InterQual and ASAM) routinely include the identification of:<br>• Suicidal ideation or attempts,<br>• Homicidal or violent (due to mental state) toward others.<br>• Inability to be treated in an outpatient setting due to current mental state.<br>• Lack of support that will prevent hospitalization.<br>• Life threatening detoxification from abused substances.<br><br>Authorization is given based on medical necessity criteria. If the clinical does not appear to meet medical necessity, we send for a Medical Director review as applicable. A peer to peer is offered and then a final determination is made.<br><br>AZ (RBHA system) crisis intervention services include intervention activities during the first twenty-four (24) hour duration designed to stabilize a member in a psychiatric emergency then the MCO is responsible. | • CC.UM.41 Covered Benefits and Services<br>• AZ.MM.75 Prior Authorization Process<br>• AZ.MM.115 Emergency and Post Stabilization |

| NQTL | M/S | MH/SUD | Documentation and/or Confirmation of Information |
|---|---|---|---|
| **Inpatient** | | | |
| **UM/Prior Authorization (including documentation)- Inpatient** | Pre-service and planned inpatient surgeries require prior authorization.<br><br>Services are requested via fax, or phone from the provider. Inpatient services are reviewed for medical necessity dependent on code. AzCH-CCP utilizes the following criteria to conduct a medical necessity review:<br><br>For Inpatient Prior Authorization review we use InterQual, ASAM, and Centene National Clinical Care Guidelines to review diagnosis and symptoms depending on the services requested.<br><br>The industry standard criteria or AzCH-CCP Clinical Care Guidelines applied in this classification routinely include:<br>• Injuries in need of repair,<br>• progression of diseases which require surgical intervention,<br><br>All inpatient pre-planned surgeries require an authorization.<br><br>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. In accordance with NCQA standards, outreach occurs to the provider no less than one time to obtain any additional clinical information required for a determination.<br><br>If there is a concern that an authorization does not meet medical necessity, we offer a peer-to-peer review and we will send to a medical director as applicable.<br><br>Once the member is admitted to the hospital a concurrent review will be conducted by the Inpatient nurse every no later than 7 days depending on diagnosis, co-morbidities and treatment plan. | Residential substance use is an example of non-acute inpatient level of care that requires prior authorization. Psychiatric Residential Treatment Facilities is another example of non-acute inpatient level of care.<br><br>Prior authorization is required for a member to be admitted into a residential program. Authorization is based on industry accepted medical necessity criteria such as InterQual, ASAM and Centene Clinical Care Guidelines to assess medical necessity, which can include:<br>• The presenting problems,<br>• How long they have been having difficulties,<br>• Interventions previously attempted,<br>• Social support,<br>• Physical health, and<br>• School performance<br><br>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.<br><br>In accordance with NCQA standards, outreach occurs to the provider no less than one time to obtain any additional clinical information required for a determination. 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 Medical Director review as applicable.<br><br>Once the member is admitted to the hospital a concurrent review will be conducted at a frequency appropriate to the level of care and documented in authorization parameters. | • AZ.MM.75 Prior Authorization Process<br>• CC.UM.02<br>• CC.UM.05<br>• AMPM 320V<br>• AMPM 320-W<br>• AMPM 320-X<br>• AZ.MM.13 Concurrent Review |

| NQTL | M/S | MH/SUD | Documentation and/or Confirmation of Information |
|---|---|---|---|
| **Inpatient** | | | |
| **UM/Concurrent Review (including documentation):** | All the inpatient medical facility admissions (IP and IP Acute Rehab (INR) contracts are Diagnosis Related Group (DRG) and paid a flat rate based on the diagnosis code.<br><br>Skilled Nursing Facilities (SNF) and Long-Term Acute Care (LTAC) facilities and paid as fee for service days (FFS).<br><br>Concurrent review nurse (CRN) performs initial reviews on all admissions to facilities utilizing InterQual criteria to determine medical necessity. Discharge planning starts at the time of the initial review and is identified on all continued-stay reviews to determine appropriate discharge needs.<br><br>CRN performs continued-stay reviews on all IP/SNF/INR/LTAC every 3 to 5 days, and no later than 7 days utilizing InterQual criteria and based on clinical complexity for the services requested.<br><br>CRN requires sufficient clinical records for identify medical necessity, discharge planning, and continued-stay reviews for the following:<br><br>• Inpatient Hospital stay: ALOS and treatment plan for inpatient admission.<br>• Skilled Nursing Facility: Identify prior level of functions and specific discharge needs.<br>• Inpatient Rehabilitation: Patient must be able to tolerate a minimum of three (3)—five (5) hours of skilled therapy, at least 5 days per week.<br>• Long Term Acute Care: Member requires 6.5 hours/24 hours of skilled nursing services and medical practitioner assessment daily.<br><br>FFS days are approved based on medical necessity.<br><br>Discharge planning reviews start at the time of the initial review, and with all continued-stay reviews to determine appropriate discharge needs. The CRN will assist facility case manager (CM) and social worker (SW) with discharge planning for the member prior to discharge or assist with transitional level of care by providing prior authorization for those patients who meet skilled criteria. | Some facility contracts are Diagnosis Related Group (DRG) contracts in that the facility is paid a flat rate based on the diagnosis code; however, most behavioral health facilities contract on a per diem (contracted by the day for all diagnoses).<br><br>Concurrent review is performed for all inpatient admissions to determine medical necessity in addition to preparing for discharge planning, and to ensure safe transitions upon completion of treatment for our member.<br><br>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.<br><br>Many of medical necessity criteria points reflect symptomatology and treatment within the last 24 to 72 hours. The criterion in this classification is used to assess<br><br>• Presenting problems,<br>• How long the patient has been having difficulties,<br>• Interventions previously attempted,<br>• Social support<br>• Physical health, and<br>• School performance<br><br>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.<br><br>Discharge planning includes follow up appointments to the member's primary care physician (PCP) and therapist(s), community resources needed is discussed at concurrent reviews to ensure safe transitions upon completion of treatment. | • AZ.MM.13 Concurrent Review<br>• AZ.MM.91 AZ Interrater Reliability<br>• CC.UM.02 Clinical Decision Criteria and Application (AZ Addendum)<br>• AZ.MM.112 Discharge Planning |

| NQTL | M/S | MH/SUD | Documentation and/or Confirmation of Information Included in the Tool |
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| **Pharmacy** | | | |
| **Pharmacy Network Access** | AzCH-CCP Rx network construction and management approaches for all therapeutic classes complies with all state and federal regulations regarding Pharmacy Networks and Access for all Medicaid enrollees, including the following:<br><br>AzCH-CCP contracts with a Pharmacy Benefit Manager (PBM) to provide PBM services and meet all contractual pharmacy network and pharmacy access requirements. The PBM maintains a comprehensive network of pharmacies to ensure pharmacy services are available and accessible to all AzCH-CCP members 24 hours a day, 7 days a week.<br><br>The PBM 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 | AzCH-CCP Rx network construction and management approaches for all therapeutic classes complies with all state and federal regulations regarding Pharmacy Networks and Access for all Medicaid enrollees, including the following:<br><br>AzCH-CCP contracts with a Pharmacy Benefit Manager (PBM) to provide PBM services and meet all contractual pharmacy network and pharmacy access requirements. The PBM maintains a comprehensive network of pharmacies to ensure pharmacy services are available and accessible to all AzCH-CCP members 24 hours a day, 7 days a week.<br><br>The PBM 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 | AZ.ND.305 Monitoring Network Access and Availability<br><br>CC.PHARM.PM.01.67 Pharmacy Benefit Manager Oversight |

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|---|---|---|---|
| **Prior Authorization RX (including documentation)** | 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 (including Prior Authorization (PA), Age or QL limits), by faxing, calling, or submitting an electronic request to AzCH-CCP. Medical justification and supporting documentation are required. AzCH-CCP considers all requests the same. Such requests, regardless of therapeutic class, are subject to the same considerations and review process. The PDL is primarily managed by the AHCCCS P&T committee.<br><br>AzCH-CCP follows AHCCCS prior authorization guidelines and therefore specific clinical information must be submitted that meets the standards set forth per the establish guideline before coverage of requested drug is approved. Prior authorization drug requests are reviewed for medical necessity using approved guidelines that also take into consideration the patients' drug history and tried and failed therapies. | 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 (including Prior Authorization (PA), Age or QL limits), by faxing calling or submitting an electronic request to AzCH-CCP. Medical justification and supporting documentation is required. AzCH-CCP considers all requests the same. Such requests, regardless of therapeutic class, are subject to the same considerations and review process. The PDL is primarily managed by the AHCCCS P&T committee.<br><br>AzCH-CCP follows AHCCCS prior authorization guidelines and therefore specific clinical information must submitted that meets the standards set forth per the establish guideline before coverage of requested drug is approved. Prior authorization drug requests are reviewed for medical necessity using approved guidelines that also take into consideration the patients' drug history and tried and failed therapies.<br><br>. | • CC.PHAR. 10 Preferred Drug List<br>• CC.PHAR.10 Arizona Addendum<br>• CC.PHARM.03A Medicaid Prior Authorization Review Process<br>• CC.PHARM.03A Arizona Addendum<br>• Preferred Drug List: https://www.azcompletehealth.com/members/medicaid/benefits-services/pharmacy.html |
| **Out of Network Coverage – Inpatient** | The Medicaid plan is an HMO product; thus, the member is restricted to their network providers for non-emergent, routine care. The only exception is when there is no in network provider available for the member's specific needs. In that instance, a benefit exception will be made to ensure the member gets the care they need. | The Medicaid plan is an HMO product; thus, the member is restricted to their network providers for non-emergent, routine care. The only exception is when there is no in network provider available for the member's specific needs. In that instance, a benefit exception will be made to ensure the member gets the care they need. | • AZ.MM.UM.59 Out of Network Services |
| **Out of Network Coverage – Outpatient** | The Medicaid plan is an HMO product; thus, the member is restricted to their network providers for non-emergent, routine care. The only exception is when there is no in network provider available for the member's specific needs. In that instance, a benefit exception will be made to ensure the member gets the care they need. | The Medicaid plan is an HMO product; thus, the member is restricted to their network providers for non-emergent, routine care. The only exception is when there is no in network provider available for the member's specific needs. In that instance, a benefit exception will be made to ensure the member gets the care they need. | • AZ.MM.UM.59 Out of Network Services |
| **Out of Network Coverage – Emergency** | Out of network, services are available for emergency services. The member is advised to go to the nearest facility (in network or out) when faced with a life-threatening medical situation. | Out of network, services are available for emergency services. The member is advised to go to the nearest facility (in network or out) when faced with a life-threatening medical situation. | • AZ.MM.UM.59 Out of Network Services<br>• AZ.MM.115 Emergency and Post Stabilization |

AzCH-CCP 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 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. AzCH-CCP then analyzed the results to determine if parity was met.

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

## IV. COMPLIANCE MONITORING PLAN

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

AzCH-CCP's impacted product departments will review potential benefit changes and produce an updated parity analysis. In addition, the team 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. These changes are reviewed ongoing and filtered up at least quarterly through the Medical Management Committee for review and approval.

After parity has been assessed as complete within a state market, the team 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, results will be forwarded to Compliance for 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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