Mental Health Parity and Addiction Equity Audit

VCHCP Non-Quantitative Treatment Limitations

September 4, 2020

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
A. Definition of Medical Necessity What is the definition of medical necessity?	"Medically Necessary" means services or supplies which are determined by VCHCP to be (a) provided for the diagnosis or care and treatment of a medical condition; (b) appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition, considering potential benefits and harm to the Member; (c) consistent with professionally recognized standards of care prevailing in the community at the time; and (d) not primarily for the convenience of a Member, his or her family, Physician, or other Provider. **(VCHCP EOC page 91)**	**Medical Necessity**[1] - An intervention, if, as recommended by the treating clinician and determined by an OHBS-CA medical director to be all of the following: a) A health intervention for the purpose of treating a mental disorder or substance use disorder; b) The most appropriate level of service or item, considering potential benefits and harms to the Enrollee; c) Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions,	**USBHPC:** The definition of medical necessity is comparable between the medical/surgical benefits provided by Ventura County Health Care Plan (VCHCP) and the MH/SUD benefits provided by LifeStrategies, offered by U.S. Behavioral Health Plan, California ("USBHPC"). Non-quantitative treatment limits of medical necessity are applied using a variety of processes and strategies such as prior authorization, concurrent review, etc. that are described elsewhere in this Table 5. See USBHPC P&P, *Definitions*

[1] USBHPC adheres to this definition of medical necessity. For some full-service plan customers, this definition may vary. In such situations, USBHPC will support the customers' definition. For a current list of these health plan customers, USBHPC's regulatory affairs department may be consulted.

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		effectiveness is determined by scientific evidence; and d) If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Enrollee. "Cost-effective" does not necessarily mean lowest price. A service or item will be covered under OHBS-CA if it is an intervention that is an otherwise covered category of service or item, not specifically excluded and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.	
B. Prior-authorization Review Process Include all services for which prior-authorization is required. Describe any step-therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. **Inpatient, In-Network:**	**Authorization Required for all inpatient hospital care (Prior Authorization Guide pg. 1 of the document)** Admission Authorization must contain the following details regarding the admission: • *Member Name* • *Member's Benefit Plan.* • *Other Insurance* • *Member ID #* • *Requesting Provider*	**Authorization Required for all inpatient, residential, and detox**: Admission Authorization must contain the following details regarding the admission: ›› Customer name and Customer ID number ›› Facility name and TIN or NPI ›› Admitting/attending physician name and TIN or NPI ›› Description for admitting diagnosis or ICD-9-CM (or its successor) diagnosis code ›› Actual admission date Additional behavioral specific information must also be included, and is a variation allowed due to	**USBHPC:** For MH/SUD services, basic clinical information – i.e. only the critical information needed to make a clinical determination - is collected by the USBHPC clinical care advocate. No fail-first protocols are applied and there are no step-therapy requirements. The member or his/her provider must call USBHPC before behavioral health expenses are incurred. See USBHPC P&P, *Initial Authorization for Behavioral Health Services*.

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	• *Referral Provider* • *Services that are required as a result of an accident are specified as such and the location of the accident is noted such as work, home, auto, other* • *Diagnosis (ICD-10 Code), Procedure (CPT Code)* ***(Policy: Treatment Authorization Request (TAR) Authorization Process and Timeline Standards pg. 5 of the document).*** *Additional medical/surgical specific information must also be included to determine medical necessity as Plan practice guidelines, Plan policies and procedures, and other accepted criteria are applied by qualified personnel in making authorization determinations. This process includes the application of the guidelines and criteria based on the needs of individual patients and characteristics of the local delivery system.* ***(Medical Policy Development and Application of***	recognized clinically appropriate standards of care permitting such a difference. This additional information may include: • Precipitant • Suicidal Ideation Information • Homicidal Ideation Information • Eating Disorder Information • Substance Information • Geriatric Information • Mental Status Information • Biopsychosocial Information • Psychiatric Medications • Coordination of Care Information • Treatment Goals Information • For emergency admissions when a Customer is unstable and not capable of providing coverage information, the facility should notify USBHPC as soon as the information is known and communicate the extenuating circumstances. We will not apply any notification-related reimbursement deductions. There are no fail first or step-therapy requirements.	

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	Medical Criteria; pgs 2 & 3 of the document) • *The additional information may include:* • *Clinical History/Findings which justify the requested procedure* • *Attempted treatment, other consults* • *Hospital records, if indicated* • *Diagnostic testing if indicated or applicable* • *Operative and pathological reports when applicable* • *Medications* • *Requested care, procedure, or test (CPT and/or HCPCS code)* • *Description of service (inpatient, outpatient, office)* *Estimated length of stay (for inpatient requests)* ***(Policy: Treatment Authorization Request (TAR) Authorization Process and Timeline Standards pg. 5 of the document).*** *The facility must contact the Plan for Prior Authorization if additional*		

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	care is needed after member's emergency condition is stabilized ***(VCHCP EOC page 19)*** *For emergency admissions, the Plan requires that prior authorization be obtained for medical care that follow stabilization of an emergency medical condition. The provider of care should request authorization from the Plan to provide post-stabilization of medical care (Policy: TAR Emergency Care Services pg. 5)* Primary care physician (PCP) must request, arrange for and obtain Plan's prior approval for referrals to certain specialists, and for hospitalizations and certain other benefits **(VCHCP EOC page 20)** There are no fail first or step-therapy requirements.		

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Outpatient, In-Network: Office Visits:	No authorization required for the following: • Primary care physicians (PCP) office visits (**VCHCP's Referrals and Prior Authorization Process page 1**) • Obstetrics and Gynecologic services (Direct Access OB/GYN services) **(VCHCP EOC page 14)** • Certain specialties office visits and procedures that are covered under the Direct Specialty Referral process **(Policy: Direct Specialty Referral pgs 1 &2)** • Common/routine diagnostic/radiological imaging studies **(List of Diagnostic Studies that May or May Not Require Prior Authorization; page 1)** • Routine outpatient services There are no fail first or step-therapy requirements	**No authorization required for routine outpatient services** There are no fail first or step-therapy requirements.	**USBHPC:** **All outpatient services other than Routine In-Network Outpatient treatment** is subject to a Preauthorization Requirement. If treatment is not preauthorized, it will not be covered by the Plan. See USBHPC P&P, *Initial Authorization for Behavioral Health Services*.
Outpatient, In-Network: Other Outpatient Items and Services:	Outpatient services that require authorization are:	Non-routine outpatient services are: Partial Hospitalization, Intensive Outpatient Program Treatment; Outpatient Electro-Convulsive Treatment; Outpatient Treatment extended beyond 50 minutes; and Psychological Testing. Such	**USBHPC:** In-network providers are required to obtain prior authorization for non-routine services based on the following strategies, processes, evidentiary standards and other factors:

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	•Certain Specialist physicians **(VCHCP EOC page 20)** • Primary care physician (PCP) must request, arrange for and obtain Plan's prior approval for referrals to certain specialists, and for hospitalizations and certain other benefits **(VCHCP EOC page 20)** • Other Outpatient Services: Participating hospital and supplies authorized by the Plan and performed by hospital or outpatient facility such as outpatient surgery, radiology, pathology, cardiology, hemodialysis and other diagnostic services **(VCHCP EOC page 38)** • Outpatient surgery, clinical trials, dialysis, DME, genetic and infertility services, home health & hospice services, orthotics & prosthetics, pain management program, orthotics & prosthetics, non-routine radiological imaging and diagnostic studies such as MRI/MRA/MRV, Bone Scan, CT Angiograpy, Dexa Scan, Myelogram, Pet Scan Nuclear Medicine	services must be provided at the office of the Participating Practitioner or at a participating Outpatient Treatment Center. Authorization must contain the following details: ›› Customer name and Customer ID number ›› Facility name and TIN or NPI (for Partial and IOP) ›› Admitting/attending physician or treating providers name and TIN or NPI ›› Diagnosis ›› Actual admission date or DOS requested. Additional behavioral specific information must also be included, and is a variation allowed due to recognized clinically appropriate standards of care permitting such a difference. This additional information may include: • Precipitant • Suicidal Ideation Information • Homicidal Ideation Information • Eating Disorder Information • Substance Information • Geriatric Information • Mental Status Information • Biopsychosocial Information • Psychiatric Medications • Coordination of Care Information • Treatment Goals Information	1) Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a) Preference driven b) Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost analysis Upon request, even when prior authorization is not required, the provider can request that the medical plan provide a medical necessity review of a proposed service prior to the provision of such service. This enables the provider to avoid retrospective medical necessity or other coverage review, which can result in full or partial denial of claims. See USBHPC P&P, *Initial Authorization for Behavioral Health Services*.

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	(VCHCP's Referrals and Prior Authorization Process List-whole document; Prior Authorization Guide – whole document, List of Diagnostic Studies that May or May Not Require Prior Authorization –whole document) Authorization Required for all inpatient hospital care **(Prior Authorization Guide pg. 2 of the document)** Admission Authorization must contain the following details regarding the admission: • Member Name • Member's Benefit Plan. • Other Insurance • Member ID # • Requesting Provider	There are no fail first or step-therapy requirements.	

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	• Referral Provider • Services that are required as a result of an accident are specified as such and the location of the accident is noted such as work, home, auto, other • Diagnosis (ICD-10 Code), Procedure (CPT Code) (Policy: Treatment Authorization Request (TAR) Authorization Process and Timeline Standards pg. 5 of the document). Additional medical/surgical specific information must also be included to determine medical necessity as Plan practice guidelines, Plan policies and procedures, and other accepted criteria are applied by qualified personnel in making authorization determinations. This process includes the application of the guidelines and criteria based on the needs of individual patients and characteristics of the local delivery system. **(Medical Policy Development and Application of Medical Criteria; pgs 2 & 3 of the document)**		

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	• The additional information may include: • Clinical History/Findings which justify the requested procedure • Attempted treatment, other consults • Hospital records, if indicated • Diagnostic testing if indicated or applicable • Operative and pathological reports when applicable • Medications • Requested care, procedure, or test (CPT and/or HCPCS code) • Description of service (inpatient, outpatient, office) Estimated length of stay (for inpatient requests) **(Policy: Treatment Authorization Request (TAR)**		

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	Authorization Process and Timeline Standards pg. 5 of the document). The facility must contact the Plan for Prior Authorization if additional care is needed after member's emergency condition is stabilized **(VCHCP EOC page 19)** For emergency admissions, the Plan requires that prior authorization be obtained for medical care that follow stabilization of an emergency medical condition. The provider of care should request authorization from the Plan to provide post-stabilization of medical care (**Policy: TAR Emergency Care Services pg. 5)** Primary care physician (PCP) must request, arrange for and obtain Plan's prior approval for referrals to certain specialists, and for hospitalizations and certain other benefits **(VCHCP EOC page 20)** There are no fail first or step-therapy requirements.		
Inpatient, Out-of-Network:	Members must receive covered services from Plan providers inside the Plan's Service Area, except for Emergency care, urgent care, and post-stabilization care	Members must receive covered services from USBHPC-contracted providers except for Emergency care. Post-stabilization care and other	See USBHPC P&Ps, *Provision of Crisis & Emergency Services* and *Participating and Non-Participating Clinician and Facility Referrals*.

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	received from non-Plan Providers when authorized by the Plan. **(VCHCP EOC page 10)** Non-emergency services with non – participating provider are covered only when such services have been pre-authorized by the Plan **(VCHCP EOC page 21)** If member is admitted to an out of network facility as a result of an emergency medical condition, once member's condition is stabilized VCHCP has an option to transfer the member to an in-network facility, otherwise, member will be financially responsible for services rendered **(VCHCP EOC page 17)** The case manager manages and tracks out-of-network hospitalizations for members and arranges for transfer to an in-Plan hospital or provider as soon as the member is stable for transfer. The Medical Director has responsibility for ensuring the process and the Medical Director or his designee will have substantial involvement in the implementation of the case management. Physicians from appropriate specialty areas	behavioral health services received from non-Plan Providers when authorized by the Plan.	

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	assist in making determinations of medical appropriateness. The staff facilitates continuity and coordination of the member's care. **(Policy: Case Management (CM) Out of Network and Out of Area Services pgs 1 &2)**		
Outpatient, Out-of-Network: Office Visits:	Members must receive covered services from Plan providers inside the Plan's Service Area, except for Emergency care, urgent care, and post-stabilization care received from non-Plan Providers when authorized by the Plan. **(VCHCP EOC page 10)** Non-emergency services with non – participating provider are covered only when such services have been pre-authorized by the Plan **(VCHCP EOC page 10)** If member is admitted to an out of network facility as a result of an emergency medical condition, once member's condition is stabilized VCHCP has an option to transfer the member to an in-network facility, otherwise, member will be financially responsible for services rendered **(VCHCP EOC page 10)**	Members must receive covered services from USBHPC-contracted providers except for Emergency care. Post-stabilization care and other behavioral health services received from non-Plan Providers when authorized by the Plan.	See USBHPC P&Ps, *Provision of Crisis & Emergency Services* and *Participating and Non-Participating Clinician and Facility Referrals*.

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	Elective follow-up care and /or services, (that is, elective care needs arising out of the emergency condition which was being treated), to be furnished when the patient is not in the Plan's service area, (that is, not in Ventura County), require Plan pre-authorization **(Policy: Treatment Authorization Request (TAR) Emergency Care Services – page 4**)		
Outpatient, Out-of-Network: Other Items and Services:	Non-emergency services with non – participating provider are covered only when such services have been pre-authorized by the Plan (**VCHCP EOC page 16)** Elective follow-up care and /or services, (that is, elective care needs arising out of the emergency condition which was being treated), to be furnished when the patient is not in the Plan's service area, (that is, not in Ventura County), require Plan pre-authorization **(Policy: Treatment Authorization Request (TAR) Emergency Care Services – page 4**)	Members must receive covered services from USBHPC-contracted providers except for Emergency care. Post-stabilization care and other behavioral health services received from non-Plan Providers when authorized by the Plan.	See USBHPC P&Ps, *Provision of Crisis & Emergency Services* and *Participating and Non-Participating Clinician and Facility Referrals*.

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C. Concurrent Review Process, including frequency and penalties for all services. Describe any step-therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. **Inpatient, In-Network:**	All inpatient care is subject to concurrent review as long as continued authorization is required. Facilities must provide clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information via access to Electronic Medical Records (EMR). Continued stay review for each member's hospitalization is based on the application of current literature and community standards. Additional hospital days are justified and authorized based on the UM review information. (**Policy: Treatment Authorization Request (TAR) Concurrent Review –page 2**). This process includes the application of the guidelines and criteria based on the needs of individual patients and characteristics of the local delivery system. (**Medical Policy Development and Application of Medical Criteria; page 2)**	All inpatient care is subject to concurrent review as long as continued authorization is required. Facilities must provide clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information via access to Electronic Medical Records (EMR). Frequency of concurrent review may occur more frequently if factors are present that require a case to be escalated to staffing or clinical rounds Concurrent review can result in an adverse benefit determination if medical necessity is not met on a go forward basis only. There are no penalties on this plan if medical necessity is established on appeal. There are no fail first or step-therapy requirements.	**USBHPC:** The services provided to members in an inpatient psychiatric or substance use disorder unit are reviewed initially and may be reviewed concurrently by licensed USBHPC clinicians. These reviews provide information regarding the patient's status and need for continued inpatient care. USBHPC reserves the right to require a direct conversation with the attending psychiatrist before authorizing benefits for any inpatient stay. For potential adverse determinations based on relevant USBHPC guidelines, USBHPC makes a peer reviewer available before the decision is made so that additional information about the case can be provided. If the provider does not contact USBHPC prior to the expiration of the decision time frame, the peer reviewer will still be available to discuss the basis of an adverse determination. If the provider has received an authorization letter or an adverse determination letter and wishes to discuss any aspect of the decision with the Care Advocate or peer reviewer who made the decision, there is a toll-free number in the letter to call. Effective 1/30/2020, USBHPC uses guidelines (LOCUS/CASII/ECSII for Mental Health; ASAM for Substance Use Disorder), based on nationally recognized clinical guidelines, to assist clinicians in making informed decisions. This includes acute and sub-acute behavioral treatment. Prior to 1/30/2020, USBHPC utilized Level of Care Guidelines which were

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	Additional hospital days are justified and authorized based on the UM review information. Similarly, plans for discharge and restriction of certain services are identified (**Policy: Treatment Authorization Request (TAR) Concurrent Review – page 2)** Concurrent review can result in an adverse benefit determination if medical necessity is not met on a go forward basis only. The continued stay then is either approved or denied. It is appropriate number of days are assigned. If it is denied, the expedited appeals process may be initiated and denial letters are sent the same day **(Policy: Treatment Authorization Request (TAR) Concurrent Review- page 2)** There are no penalties on this plan if medical necessity is established on appeal. There are no fail first or step-therapy requirements.		based on nationally recognized clinical guidelines. All of USBHPC's clinical criteria can be requested from the Case Reviewer and are available online at https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the USBHPC Regional Medical Director considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay. Information about the concurrent review process is described on **page 48-49** of the **Network Manual**. This information may also be found online at the provider website: https://providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/ohbscaNetworkManual.html . USBHPC P&P, *Concurrent Review Decisions*

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Outpatient, In-Network: For services not requiring Prior Authorization:	VCHCP has an established process for review of Treatment Authorization Requests (TARs) during the delivery of service, such as hospital inpatient care, rehabilitation and physical therapy and extended care. **(Treatment Authorization Request (TAR) Concurrent Review Policy –whole document)** Milliman Care Guidelines/Plan's Medical Policies are used to determine medical necessity and frequency of review. Other guidelines used include UpToDate, other peer-reviewed medical and scientific literature, National Guideline Clearinghouse and additional state Federal and state publications. This process includes the application of the guidelines and criteria based on the needs of individual patients and characteristics of the local delivery system. (**Medical Policy Development and Application of Medical Criteria – page 1)**	Routine Outpatient services are not selected for Concurrent Review. There are no fail first or step-therapy requirements.	

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	There are no fail first or step-therapy requirements		
Outpatient, In-Network: Other Outpatient Items and Services:	VCHCP has an established process for review of Treatment Authorization Requests (TARs) during the delivery of service, such as hospital inpatient care, rehabilitation and physical therapy and extended care. **(Treatment Authorization Request (TAR) Concurrent Review Policy-whole document)** As part of the direct specialty referral, there is no prior authorization required for physical therapy and occupational therapy for the initial eight (8) visits. Prior authorization is required after the twenty four (24) visits. The providers are required to submit the request and documentation of the treatment plan (**Policy: Direct Specialty Referral-page 4**). Milliman Care Guidelines/Plan's Medical Policies are used to determine medical necessity and frequency of review. This process includes the	For Concurrent review of Non- Routine Services (Partial Hospitalization, Intensive Outpatient Program Treatment; Outpatient Electro-Convulsive Treatment; Outpatient Treatment extended beyond 50 minutes; and Psychological Testing), provider's request for additional sessions are granted, if medically necessary. For Partial Hospitalization and Intensive Outpatient Treatment, facilities must provide clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information via access to Electronic Medical Records (EMR). Frequency of concurrent review is determined by the member's level of acuity and may occur more frequently if factors are present that require a case to be escalated to staffing or clinical rounds. Concurrent review can result in an adverse benefit determination if medical necessity is not met on a go forward basis only. There are no penalties on this plan if medical necessity is established.	**USBHPC:** Non-routine outpatient services are covered only when they are pre-authorized by Life Strategies/USBHPC as required, except in the event of an Emergency. The Utilization Review process begins with the member/provider's call to USBHPC requesting services; the Intake Counselor will assist the Covered Person in identifying his/her needs and refer to a Care Advocate as appropriate. The frequency of concurrent review is determined by the member's clinical condition/level of acuity.

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	application of the guidelines and criteria based on the needs of individual patients and characteristics of the local delivery system. **Medical Policy Development and Application of Medical Criteria – page 1).** Home Health care services require prior authorization. Milliman Care Guidelines is used as criteria to determine medical necessity and frequency of review **(Prior Authorization Guide – page 3)**. This process includes the application of the guidelines and criteria based on the needs of individual patients and characteristics of the local delivery system. (**Medical Policy Development and Application of Medical Criteria- page 1).** There are no fail first or step-therapy requirements	There are no fail first or step-therapy requirements.	

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Inpatient, Out-of-Network:	Members must receive covered services from Plan providers inside the Plan's Service Area, except for Emergency care, urgent care, and post-stabilization care received from non-Plan Providers when authorized by the Plan. (**VCHCP EOC page 20)** The utilization management staff must be notified of the out-of-plan hospitalization as soon as is reasonably possible by the hospital staff, so that the transfer to an in-Plan facility can be accomplished. The activities and information are documented **(Policy: Case Management (CM) Out of Network and Out of Area Services – page 2)** A continued stay review for each member's hospitalization is based on the application of criteria and community standards. Additional hospital days are justified and authorized based on the UM review information. Similarly, plans for discharge and restriction of certain services are identified **(Policy:**	Members must receive covered services from USBHPC contracted providers except for Emergency care. Post-stabilization care and other behavioral health services received from non-Plan Providers when authorized by the Plan.	See USBHPC P&Ps, *Provision of Crisis & Emergency Services* and *Participating and Non-Participating Clinician and Facility Referrals*.

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	Treatment Authorization Request (TAR) Concurrent Review- page 2)		
Outpatient, Out-of-Network: Office Visits:	Members must receive covered services from Plan providers inside the Plan's Service Area, except for Emergency care, urgent care, and post-stabilization care received from non-Plan Providers when authorized by the Plan. (**VCHCP EOC page 20)** Elective follow-up care and /or services, (that is, elective care needs arising out of the emergency condition which was being treated), to be furnished when the patient is not in the Plan's service area, (that is, not in Ventura County), require Plan pre-authorization **(Policy: Treatment Authorization Request (TAR) Emergency Care Services- page 4)**	Members must receive covered services from USBHPC contracted providers except for Emergency care. Post-stabilization care and other behavioral health services received from non-Plan Providers when authorized by the Plan.	See USBHPC P&Ps, *Provision of Crisis & Emergency Services* and *Participating and Non-Participating Clinician and Facility Referrals*.
Outpatient, Out-of-Network: Other Items and Services:	Members must receive covered services from Plan providers inside the Plan's Service Area, except for Emergency care, urgent care, and post-stabilization care received from non-Plan Providers when	Members must receive covered services from USBHPC contracted providers except for Emergency care. Post-stabilization care and other behavioral health services received from non-Plan Providers when authorized by the Plan.	See USBHPC P&Ps, *Provision of Crisis & Emergency Services* and *Participating and Non-Participating Clinician and Facility Referrals*.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	authorized by the Plan. (**VCHCP EOC page 20)** Elective follow-up care and /or services, (that is, elective care needs arising out of the emergency condition which was being treated), to be furnished when the patient is not in the Plan's service area, (that is, not in Ventura County), require Plan pre-authorization **(Policy: Treatment Authorization Request (TAR) Emergency Care Services- page 4)**		
D. Retrospective Review Process, including timeline and penalties. **Inpatient, In-Network:**	**Retrospective or post- service review** decisions are those decisions which are made by the Plan after the time the Plan member is hospitalized and/or receiving specific care which must be authorized **(Policy: Treatment Authorization Request (TAR) Authorization Process and Timeline Standards- page 9)** Retrospective review authorization is required for services that require prior authorization (see pre-auth and concurrent	Retrospective review is provided for services without authorization, where authorization was required. No penalty is applied if medical necessity is established.	**USBHPC:** Post-service, pre-claim reviews are conducted on inpatient services. Network providers should follow the same process as is applied for a standard Prior Authorization request. A clinical coverage review will be done to determine whether the service is medically necessary, and payment may be withheld if the services are determined not to have been medically necessary. Urgent services rendered without a required Prior Authorization number will also be subject to retrospective review for medical necessity, and payment may be withheld if the services are determined not to have been medically necessary.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	section) (**Prior Authorization Guide – whole document**) A decision regarding Medical Necessity is made within 30 calendar days of receipt of the request. The practitioner and member are notified in writing within 30 calendar days of receipt of the request. (**Policy: Treatment Authorization Request (TAR) Authorization Process and Timeline Standard – pages 9 &10)** The Plan may extend the decision making time frame once if it is unable to make a decision due to matters beyond its control or the lack of necessary information. The Plan must notify the member or the member's authorized representative of the specific information required within 30 calendar days of receipt of request and also notifies the member or the member's authorized representative that they are allowed at least 45 calendar days to provide the requested information.		Network providers/facilities may not balance bill the member for any denied charges under these circumstances. USBHPC P&P, *Retrospective Review*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	Once the specific information is received, complete or not, the decision to approve or deny must be made with the information available within 15 calendar days of receipt of the information. If the requested information is not received within 45 calendar days, the decision to approve or deny must be made with the information available not to exceed an additional 15 business days. The practitioner and the member are notified within 15 calendar days of the decision. **(Treatment Authorization Request (TAR) Authorization Process and Timeline Standards – page 11)** So-called "balance billing", where claims are sent to members for the "balance" of the account after the Plan has paid the claim pursuant to the above, is not permitted. Plan members are to be reassured that they are not to be billed by providers for any remainder, and that it is against contractual requirements for a Plan network provider to present such bills		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	for the balance of the account. (**Retrospective Review Process Emergency Care and/or Urgently Needed Services – page 5**) In the event that VCHCP fails to pay a participating provider for covered services, the member shall not be liable to the participating provider for any sums owed by VCHCP. Participating providers are contractually required to accept VCHCP's payments on behalf of the member for covered services and will not assert against the member statutory or other lien rights that may exist (**VCHCP EOC page 20**)		
Outpatient, In-Network: Office Visits:	No authorization required for the following: • Primary care physicians (PCP) office visits (**VCHCP's Referrals and Prior Authorization Process page 1**) • Obstetrics and Gynecologic services (Direct Access OB/GYN services) **(VCHCP EOC page 11)** • Certain specialties office visits and procedures that are covered under the	No authorization is required for routine Outpatient Visits.	See USBHPC P&P, *Initial Authorization for Behavioral Health Services*.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	Direct Specialty Referral process **(Policy: Direct Specialty Referral pgs 1 &2)** • Common/routine diagnostic/radiological imaging studies **(List of Diagnostic Studies that May or May Not Require Prior Authorization; page 1)** • Routine outpatient services There are no fail first or step-therapy requirements		
Outpatient, In-Network: Other Outpatient Items and Services:	Outpatient services that require authorization are: •Certain Specialist physicians **(VCHCP EOC page 20)** • Primary care physician (PCP) must request, arrange for and obtain Plan's prior approval for referrals to certain specialists, and for hospitalizations and certain other benefits **(VCHCP EOC page 20)** • Other Outpatient Services: Participating hospital and supplies authorized by the Plan and performed by hospital or outpatient facility such as outpatient surgery, radiology, pathology, cardiology, hemodialysis and other	Retrospective review is provided for services without authorization, where authorization was required. No penalty is applied if medical necessity is established.	USBHPC P&P, *Retrospective Review*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	diagnostic services **(VCHCP EOC page 38)** • Outpatient surgery, clinical trials, dialysis, DME, genetic and infertility services, home health & hospice services, orthotics & prosthetics, pain management program, orthotics & prosthetics, non-routine radiological imaging and diagnostic studies such as MRI/MRA/MRV, Bone Scan, CT Angiograpy, Dexa Scan, Myelogram, Pet Scan Nuclear Medicine **(VCHCP's Referrals and Prior Authorization Process List-whole document; Prior Authorization Guide – whole document, List of Diagnostic Studies that May or May Not Require Prior Authorization –whole document)** Authorization Required for all inpatient hospital care **(Prior Authorization Guide pg. 2 of the document)** Admission Authorization must contain the following details regarding the admission: • Member Name		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	• Member's Benefit Plan. • Other Insurance • Member ID # • Requesting Provider • Referral Provider • Services that are required as a result of an accident are specified as such and the location of the accident is noted such as work, home, auto, other • Diagnosis (ICD-10 Code), Procedure (CPT Code) (Policy: Treatment Authorization Request (TAR) Authorization Process and Timeline Standards pg. 5 of the document). Additional medical/surgical specific information must also be included to determine medical necessity as Plan practice guidelines, Plan policies and procedures, and other accepted criteria are applied by qualified personnel in making authorization determinations. This process		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	includes the application of the guidelines and criteria based on the needs of individual patients and characteristics of the local delivery system. **(Medical Policy Development and Application of Medical Criteria; pgs 2 & 3 of the document)** • The additional information may include: • Clinical History/Findings which justify the requested procedure • Attempted treatment, other consults • Hospital records, if indicated • Diagnostic testing if indicated or applicable • Operative and pathological reports when applicable • Medications • Requested care, procedure, or test (CPT and/or HCPCS code)		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	• Description of service (inpatient, outpatient, office) Estimated length of stay (for inpatient requests) **(Policy: Treatment Authorization Request (TAR) Authorization Process and Timeline Standards pg. 5 of the document).** The facility must contact the Plan for Prior Authorization if additional care is needed after member's emergency condition is stabilized **(VCHCP EOC page 19)** For emergency admissions, the Plan requires that prior authorization be obtained for medical care that follow stabilization of an emergency medical condition. The provider of care should request authorization from the Plan to provide post-stabilization of medical care (**Policy: TAR Emergency Care Services pg. 5)** Primary care physician (PCP) must request, arrange for and obtain Plan's prior approval for referrals to certain specialists, and for hospitalizations and certain other benefits **(VCHCP EOC page 16)**		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	There are no fail first or step-therapy requirements.		
Inpatient, Out-of-Network:	Members must receive covered services from Plan providers inside the Plan's Service Area, except for Emergency care, urgent care, and post-stabilization care received from non-Plan Providers when authorized by the Plan. **(VCHCP EOC page 10)** Non-emergency services with non – participating provider are covered only when such services have been pre-authorized by the Plan **(VCHCP EOC page 21)** If member is admitted to an out of network facility as a result of an emergency medical condition, once member's condition is stabilized VCHCP has an option to transfer the member to an in-network facility, otherwise, member will be financially responsible for services rendered **(VCHCP EOC page 17)**	Members must receive covered services from USBHPC contracted providers except for Emergency care. Post-stabilization care and other behavioral health services received from non-Plan Providers when authorized by the Plan.	See USBHPC P&Ps, *Provision of Crisis & Emergency Services* and *Participating and Non-Participating Clinician and Facility Referrals*.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	The case manager manages and tracks out-of-network hospitalizations for members and arranges for transfer to an in-Plan hospital or provider as soon as the member is stable for transfer. The Medical Director has responsibility for ensuring the process and the Medical Director or his designee will have substantial involvement in the implementation of the case management. Physicians from appropriate specialty areas assist in making determinations of medical appropriateness. The staff facilitates continuity and coordination of the member's care. **(Policy: Case Management (CM) Out of Network and Out of Area Services pgs 1 &2)**		
Outpatient, Out-of-Network: Office Visits:	Members must receive covered services from Plan providers inside the Plan's Service Area, except for Emergency care, urgent care, and post-stabilization care received from non-Plan Providers when authorized by the Plan. **(VCHCP EOC page 10)** Non-emergency services with non – participating provider are covered only when such services have been pre-authorized by the Plan **(VCHCP EOC page 10)**	Members must receive covered services from USBHPC contracted providers except for Emergency care. Post-stabilization care and other behavioral health services received from non-Plan Providers when authorized by the Plan.	See USBHPC P&Ps, *Provision of Crisis & Emergency Services* and *Participating and Non-Participating Clinician and Facility Referrals*.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	If member is admitted to an out of network facility as a result of an emergency medical condition, once member's condition is stabilized VCHCP has an option to transfer the member to an in-network facility, otherwise, member will be financially responsible for services rendered **(VCHCP EOC page 10)** Elective follow-up care and /or services, (that is, elective care needs arising out of the emergency condition which was being treated), to be furnished when the patient is not in the Plan's service area, (that is, not in Ventura County), require Plan pre-authorization **(Policy: Treatment Authorization Request (TAR) Emergency Care Services – page 4**)		
Outpatient, Out-of-Network: Other Items and Services:	Non-emergency services with non – participating provider are covered only when such services have been pre-authorized by the Plan (**VCHCP EOC page 16)**	Members must receive covered services from USBHPC contracted providers except for Emergency care. Post-stabilization care and other behavioral health services received from non-Plan Providers when authorized by the Plan.	See USBHPC P&Ps, *Provision of Crisis & Emergency Services* and *Participating and Non-Participating Clinician and Facility Referrals*.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	Elective follow-up care and /or services, (that is, elective care needs arising out of the emergency condition which was being treated), to be furnished when the patient is not in the Plan's service area, (that is, not in Ventura County), require Plan pre-authorization **(Policy: Treatment Authorization Request (TAR) Emergency Care Services – page 4**)		
E. Emergency Services	No referrals or authorization are needed to access Emergency needs (**EOC page 14 under "Referrals for Health Care Services")** Members must receive covered services from Plan providers inside the Plan's Service Area, except for Emergency care, urgent care, and post-stabilization care received from non-Plan Providers when authorized by the Plan. **(VCHCP EOC page 10)** **Emergency Medical Condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the	USBHPC does not deny coverage for Emergency Services and Care to treat a Psychiatric Emergency Medical Condition. **Psychiatric Emergency Services and Care** are Medically Necessary including the medical screening, examination and evaluation by a physician, or other licensed personnel – to the extent provided by law – to determine if a Psychiatric Emergency exists. If a Psychiatric Emergency condition exists, Psychiatric Emergency Services include the care and treatment by a physician necessary to stabilize or eliminate the emergency condition within the capabilities of the facility including ambulance or ambulance transport if needed.	See USBHPC P&Ps, *Provision of Crisis & Emergency Services* and *Definitions*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	absence of immediate medical attention could reasonably be expected to result in any of the following: - Placing the patient's health in serious jeopardy. - In the case of a pregnant woman, would put the health of her unborn child in serious danger. - Serious impairment to bodily functions. - Serious dysfunction of any bodily organ or part. A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true: - The person is an immediate danger to himself or herself or to others. - The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder. Emergency Services also includes ambulance and ambulance transport services provided through the "911" emergency response system	In an Emergency, the member should get help or treatment immediately. It is appropriate to call "911" or go directly to the nearest medical facility for treatment. Within 48 hours of the Emergency, or as soon as is reasonably possible after the patient's condition is stable, the facility, member or someone acting on the member's behalf, must call Life Strategies/USBHPC at 1-800-851-7407 and communicate the extenuating circumstances. **Psychiatric Emergency Services and Care** are covered only as long as the condition continues to be an Emergency. Once the condition is under control and you can be safely transferred or discharged, additional charges incurred through the Emergency care facility will not be covered. Life Strategies/USBHPC will arrange follow up services for your condition after an Emergency. Life Strategies/USBHPC may move you to a Participating Provider in our network, as long as the move would not harm your health. USBHPC will not apply any authorization or notification-related penalties if medical necessity is established. If the member requires Behavioral Health Services following an Emergency it is desired that continued services be covered, the Behavioral Health Services must be coordinated and	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	Emergency Services means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. **Emergency Services** also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility. Examples of emergency situations include: uncontrolled bleeding, seizure or loss of consciousness,	authorized by Life Strategies/USBHPC. Failure to transfer or to obtain approval from Life Strategies/USBHPC for continued treatment may result in all further treatment being denied if the services were not Medically Necessary or did not meet the Emergency Services criteria.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	shortness of breath, chest pain or squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, severe burns, broken bones or severe pain. Members who reasonably believe that an emergency medical condition exits, should go to the nearest hospital emergency room or call 911. Prior authorization from the Plan or from the Primary Care Physician is not required if member reasonable believe that and emergency medical condition exists. The facility must contact the Plan for prior authorization if additional care is needed after the member's emergency medical condition is stabilized. If member is at an out-of network facility and requires inpatient admission, once member's condition has stabilized, VCHCP has the option to transfer the member to an in-network facility otherwise member will be financially responsible for services rendered. **(VCHCP EOC Pages 14, 15, 28)**		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	VCHCP will cover emergency or urgent services necessary to screen and stabilize members, without prior authorization, in cases where a prudent layperson, acting reasonably, would believe that an emergency medical condition or a condition requiring "urgent" care existed. (**Policy: Retro Review Emergency and Urgent Services – page 1**)		
F. Pharmacy Services Include all services for which prior-authorization is required, any step-therapy or "fail first" requirements, any other NQTLs. Tier 1:	The Plan maintains a Preferred Drug List (PDL), which is a list of covered prescription drugs by major therapeutic category. This PDL is reviewed and approved by the Plan Pharmacy and Therapeutics Committee quarterly. Medically necessary prescriptions not on the Plan's PDL may be covered when authorized by the Plan. There is a process by which members may obtain coverage for nonformulary drugs via the Plan's prior authorization process. The Plan processes requests for new prescriptions within 24 hours and requests for refills within 48 hours of the Plan's receipt of information requested by the Plan to make the decision.		**USBHPC:** USBHPC does not administer pharmacy services.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	(**EOC pages 50-51)** The following drug categories require prior authorization regardless of their status (Preferred or Non-Preferred). Note that this list is not all inclusive. Refer to the current VCHCP Preferred Drug List. • All injectables with the exception of Insulins, headache medications, epinephrine, medroxyprogesterone acetate & approved immunization products • All growth hormones • All infertility drugs • Most antivirals/protease inhibitors, except Acyclovir, Amantadine, Famciclovir, Valacyclovir, Denavir, Famvir, Flumist, Relenza, Tamiflu, Tyzeka, Valtrex, Xerese All specialty drugs require prior authorization. **(Policy: Prior Authorization of Medication Program – page 1)** VCHCP utilizes a four-tier drug classification system to determine the amount of the patient's cost share, or copayment. Drugs classified as either Tier		

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	1, Tier 2, or Tier 4 constitute VCHCP's Preferred Drug List (PDL). A description of the criteria for the four medication classification tiers follows: **Tier 1** includes all covered generic medications and are available at the lowest copayment to the patient. When appropriate, physicians are encouraged to prescribe generic medications to help patients save money and to help control health care costs. If the patient or physician requests a brand-name medication when a generic is available, in addition to the copay, the patient pays the difference in cost between the brand-name medication and the generic. **(VCHCP Prescription Medication Benefit Program –Page 2)**		
Tier 2:	**Tier 2** includes brand-name medications for which there is generally only a single manufacturing or distributing source. These medications are described in the industry as "single source brands." The patient pays a higher copayment for these than for Tier 1 generic medications. **(VCHCP Prescription Medication**		

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	Benefit Program –Page 2)		
Tier 3:	**Tier 3** includes those covered medications considered to be non-preferred. Generally a medication is considered non-preferred if VCHCP's Pharmacy Benefit Manager (PBM) has determined that there are one or more therapeutically-equivalent drug alternatives available to the patient on either Tier 1 or Tier 2. The patient pays the highest copayment amount for these medications. **(VCHCP Prescription Medication Benefit Program –Page 2)**		
Tier 4:	**Tier 4** includes "Specialty Medications" – Specialty pharmaceuticals, primarily injectables, represent a relatively new area of prescription medications, one with a small market in terms of patient populations. Yet it is the single most explosive market in terms of growth and cost. In 2009, VCHCP implemented an integrated approach to managing today's most sophisticated pharmaceuticals. Some of the components include: • Specialty pharmacy management program, including delivery,		

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	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	pharmacy partnerships and home infusion network coordination to cover all delivery options. • Utilization analysis and care management to ensure appropriate treatment initiation and continuation. • Single source for specialty pharmacy efforts to simplify and standardize billing. **(VCHCP Prescription Medication Benefit Program –Page 2)**		
G. Prescription Drug Formulary Design How are formulary decisions made for the diagnosis and medical necessary treatment of medical, mental health and substance use disorder conditions?	Express Scripts, the PBM, reviews the current PDL on a quarterly basis, evaluates any new pharmaceutical information available and researches medications newly approved by the FDA as the information becomes available. The PBM's recommendations for any changes are forwarded to VCHCP's P&T Committee for review and adoption. **(VCHCP Prescription Medication Benefit Program –Page 10)**		**USBHPC:** USBHPC does not administer pharmacy services.
Describe the pertinent pharmacy management processes, including, but not	Express Scripts is the Plan's Pharmacy Benefit Manager. Management of the		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
limited to, cost-control measures, therapeutic substitution, and step therapy.	program includes various functions and responsibilities such as: contracting with pharmacies, reimbursing contracted pharmacies for dispensed drugs, selecting and evaluating appropriate medications for the plan's preferred drug list (formulary), providing customer services to plan members and providing the plan with member cost and utilization information. Express Scripts maintains a staff of clinical professionals who develop and maintain all clinical programs, including formulary development and maintenance, on behalf of the Ventura County Health Care Plan. Given the amount of research and specialized knowledge needed to evaluate all aspects of a given medication, Express Scripts' clinical professionals, which include registered pharmacists and doctors of pharmacy (PharmDs), are divided into several committees for purposes of drug evaluation and formulary development. Each committee is dedicated to a specific area of research and performs a specific step in the formulary evaluation process.		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	Express Scripts' Drug Evaluation Unit, Therapeutic Assessment Committee, and Value Assessment Committee follow a three-step evaluation process for all medications before forwarding their recommendations to the Express Scripts National P&T Committee for final formulary placement decisions and formulary placement recommendations to clients with their own P&T committees. Steps include: • Primary Research (Drug Evaluation Unit) • Comparative Evaluation (Therapeutic Assessment Committee) • Financial Evaluation (Value Assessment Committee) During the first two stages, Express Scripts considers only clinical information. The Value Assessment Committee only evaluates a product's cost-effectiveness when the clinical parameters have first been established by the Therapeutic Assessment Committee. In collaboration with Express Scripts, VCHCP has implemented step therapy		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	programs for several different classes of drugs for which specific medications, designated as Step 2 drugs, will only be approved after a trial of Step 1 medications has been documented or under certain other conditions. Examples of classes of medications covered by this program include Angiotensin Converting Enzymes (ACE), Angiotensin Receptor Blockers (ARBs), Brand Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), COX 2 inhibitors, Proton Pump Inhibitors (PPIs), Selective Serotonin Reuptake Inhibitors (SSRIs), Other Antidepressants (SNRIs), Cholesterol Lowering medications (statins) and certain diabetic medications. **(VCHCP Prescription Medication Benefit Program – pages 6, 7, 8)**		
What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health and substance use disorder conditions.	The Express Scripts National P&T Committee includes 19 independent physician members. The committee elects its own physician chair. The Express Scripts medical director and five clinical pharmacists provide ongoing staff support to the national P&T committee. The VCHCP P&T Committee retains the final decision making for all Pharmaceutical Management		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	recommendations from Express Scripts and other sources. The P&T Committee is comprised of VCHCP physicians and QA management staff, community physicians from different specialties and management staff and pharmacists from the PBM. **(VCHCP Prescription Medication Benefit Program – pages 10, 14)**		
H. Case Management What case management services are available?	VCHCP offers Case Management Program. VCHCP has defined the scope of its CM program and has identified the following members in the following situations as those who would most benefit from its services: High Risk Diabetics (uncontrolled, hard to control, multiple co-morbidities) • Transplants • High Risk Asthmatics (uncontrolled, hard to control, multiple co-morbidities) • End Stage Renal Disease (ESRD) • High Cost Claims • Multiple ER Visits • Multiple Hospitalizations • Gaps in Care	Case management services are not required, but may be available when clinical / behavioral staff is assisting with care coordination, discharge-planning, aftercare follow-up, etc. If a member or member's Dependent(s) are receiving behavioral health services from a school district or a regional center, Life Strategies/USBHPC will coordinate with the school district or regional center to provide case management of the behavioral health treatment program. Upon Life Strategies/USBHPC's request, the member or member's Dependent(s) may be required to provide a copy of the most recent Individual Education Plan (IEP) received from the school district and/or the most recent Individual Program Plan (IPP) or Individual Family Service Plan (IFSP) from the regional center to coordinate these services.	**USBHPC:** Certain case management services may be provided but are not used to limit the scope or duration of benefits and are, therefore, not a parity non-quantitative limitation.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	• Multiple Co-morbidities that are not controlled • High Risk Social Needs (lack of caregiver/family support, financial issues) • Severe Behavioral Health and/or Substance Abuse issues as co-morbidity • Traumatic Brain Injuries • Poly-pharmacy usage VCHCP collaborates with Optum BH to address coordination of care for members with medical-behavioral health needs. (**Case Management Program Description – page 4)** Additionally, VCHCP offers case management to members who are diagnosed with Autism **(Autism Case Management Program Description-whole document)**		
What case management services are required?	DMHC requires that the Plan has a case management program and a program for members diagnosed with Autism.	None.	**USBHPC:** N/A

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What are the eligibility criteria for case management services?	Eligibility criteria: Must meet the Plan's enrollment/eligibility requirement. Eligibility criteria for the Autism Case Management Program/services is that member must have a diagnosis of Autism. Eligibility criteria for CM: CM staff evaluates referrals from each source to determine eligibility for the CM program. This is done by a VCHCP Case Manager. Members are not identified as eligible for the CM program until the evaluation process is complete. Members who do not meet eligibility criteria may be referred to alternative programs, such as one of the disease management programs or a wellness program. VCHCP has defined the scope of its CM program and has identified the following members in the following situations as those who would most benefit from its services: High Risk Diabetics (uncontrolled, hard to control, multiple co-morbidities) • Transplants	None.	**USBHPC:** N/A

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	• High Risk Asthmatics (uncontrolled, hard to control, multiple co-morbidities) • End Stage Renal Disease (ESRD) • High Cost Claims • Multiple ER Visits • Multiple Hospitalizations • Gaps in Care • Multiple Co-morbidities that are not controlled • High Risk Social Needs (lack of caregiver/family support, financial issues) • Severe Behavioral Health and/or Substance Abuse issues as co-morbidity • Traumatic Brain Injuries • Poly-pharmacy usage VCHCP collaborates with Optum BH to address coordination of care for members with medical-behavioral health needs. **(Case Management Program Description – page 4)**		

I. Process for Assessment of New Technologies Definition of experimental/investigational:	The definition of "Experimental or Investigational" includes, among other things, any drug[2], device, procedure or treatment that requires FDA approval, but for which such approval has not been granted. **(Medical Policy: Experimental and Investigational Procedures, Coverage Of – page 1)**	Unless otherwise required by federal or state law, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/ guidelines are met: • It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use. • It is a subject of a current investigation of a new drug or new device (IND) applications on file with the FDA. • It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and the Department of Health and Human Services. • It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments. • It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS). • Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect. • The predominant opinion among experts as expressed in published, authoritative medical	USBHPC P&P, *Clinical Technology Assessment*

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
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		literature is that usage should be confined to research settings. • It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab test or imaging ordered to evaluate the effectiveness of the Experimental therapy).	
Qualifications of individuals evaluating new technologies:	This new medical technology evaluation process includes identified decision criteria, a review of information from government regulatory bodies and published scientific evidence, and input from relevant specialists and professionals who have expertise in the technology being evaluated. During the new medical technology evaluation process, VCHCP solicits and obtains opinions and input from medical specialists and professionals who have expertise in the technology that is being evaluated. These may include, but are not	Clinical Technology and Assessment Committee (CTAC) receives requests to review new and existing behavioral health procedures, psychopharmacological strategies, and devices to be considered for benefit coverage. Primary reviewers of the technology are CTAC members and/or other USBHPC/Optum Behavioral Health staff with knowledge of the subject matter and/or literature review process. CTAC is comprised of professionals representing functional areas within USBHPC/Optum Behavioral Health, to include:	USBHPC P&P, *Clinical Technology Assessment*

[2] Note: The use of an FDA-approved drug for conditions that are not contained in the FDA approval (often termed "off label" use) may not be experimental or investigational. The ordering physician takes the responsibility for such off-label prescribing, and, among other things, must take into account the body of scientific and clinical information which provides for such use, as well as the accepted use of the drug for that condition, in the local as well as the national medical community. See the VCHCP policy "Prescription Medication: Coverage of Off-Label Use" for further information.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
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	limited to, physicians, doctoral level practitioners, and pharmacists. **(Policy: New Medical Technology Policy Evaluation – pages 1, 3)**	• Optum Behavioral Health Senior National Medical Director (Chair) • Optum Behavioral Health Medical Directors • OptumHealth Behavioral Solutions of California Regional Medical Director, or Associate Medical Director designee • Optum Behavioral Health Vice President, Research & Evaluation • Optum Legal • Optum Finance • Optum Affordability	
Evidence consulted in evaluating new technologies:	**RESOURCES FOR EVALUATION** Resources that the Ventura County Health Care Plan uses to conduct new medical technology evaluations include, but are not limited to, policies, position statements, consensus reports and standards of governmental agencies as well as peer reviewed medical literature and journals. **Government Regulatory Bodies** • National Institutes of Health (NIH) • Agency for HealthCare Research and Quality (AHRQ) • Centers for Medicare & Medicaid Services (CMS)	Review of scientific evidence, applicable federal and state laws regulating the use of the new technology, information and statements issued by regulatory agencies (e.g., Food and Drug Administration)	**USBHPC:** Once a request for evaluation of new technologies has been received, a CTAC member is assigned as the primary reviewer of the new technology. There is generally also a second reviewer. The primary reviewer is responsible for completing all the review sections noted below. Based on the nature of the review, a request may be made to use an external consultant to assist in arriving at an accurate appraisal of the new technology. The reviewer also collaborates with the medical delivery system when relevant to the topic under review. Selection of Scientific Evidence:

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
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	• Food and Drug Administration (FDA)
	• Other appropriate regulatory bodies
	
	Published Scientific Sources
	• Review of peer reviewed medical literature and journals from professional medical associations and health organizations, such as:
	  ○ American Medical Association
	  ○ American Association for Cancer Research (AACR)
	  ○ American College of Clinical Pharmacy (ACCP)
	  ○ American Diabetes Association
	  ○ American Institute for Cancer Research (AICR)
	• Hayes Knowledge Center, including:
	  ○ Medical Technology Directory
	  ○ Health Technology Briefs
	  ○ Genetic Test Evaluation
			CTAC uses the Hierarchy of Evidence in selecting Scientific Evidence to be reviewed.
			a. Clinical Technology Assessments are developed from clinical evidence in peer-reviewed publications.
			b. Well-designed randomized controlled trials and meta-analyses, if available, take priority in the evidence selection process. If not available, other types of studies may be considered such as non-randomized controlled trials, prospective studies, and observational studies.
			c. Websites of national organizations, such as the American Psychiatric Association (APA) and the American Medical Association (AMA), are systematically reviewed for position papers describing these technologies.
			d. National Consensus Statements may also be reviewed.
			
			Technology Assessment reports published by known research organizations such as Hayes, Inc. may be referenced. Information from subspecialty societies and subject matter experts are reviewed as relevant.
			USBHPC P&P, *Clinical Technology Assessment*

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	○ Search and Summary Reports ○ New Service **AHRQ's Evidence Based Practice Centers and Other Sources** • Blue Cross and Blue Shield Association's Technology Evaluation Center (TEC) • Brown University, Center for Evidence-based Medicine • ECRI Institute–Penn Medicine Evidence-based Practice Center • Johns Hopkins University • Kaiser Permanente Research Affiliates • Pacific Northwest Evidence-based Practice Center—Oregon Health & Science University • RTI International—University of North Carolina (UNC) at Chapel Hill • Southern California Evidence-based Practice Center—RAND Corporation • University of Alberta, Edmonton, Alberta • Minnesota Evidence-based Practice Center		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
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	• Vanderbilt University **(New Medical Technology Policy Evaluation- pages 2 & 3)**		

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	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
J. Standards for provider credentialing and contracting			
Is the provider network open or closed?	Open	Open.	**USBHPC:** LS/USBHPC has the sole right to determine which Providers it accepts and maintains as participating Providers. It is within the discretion of the Plan's Credentialing Committee whether to offer an applicant provider the opportunity to appeal any action under the Credentialing Plan, unless required by state law. Providers must meet all credentialing criteria outlined in the USBHPC 2019-20202016-2017 Credentialing Plan, **Section 3.2. A**

What are the credentialing standards for physicians?	VCHCP has established the following criteria for practitioner participation in the VCHCP network. If the practitioner does not meet one or more of the following criteria, the CC considers the practitioner's history on an individual basis pursuant to the "Criteria and Thresholds for Credentialing File Review" section of this Credentialing policy. • A current, valid, unencumbered, unrestricted, and non-probationary state license with no unresolved public records in a five year look back period. • Current, valid, and unrestricted DEA certificate for prescribing controlled substances, if applicable to his/her practice in which he/she will treat the plan's members. • Verification of clinical privileges in good standing, including status and type, from the applicant's primary admitting facility. If the applicant does not admit patients to the hospital, the verification form, indicating that the applicant has arrangements for VCHCP members to receive	Physicians must be licensed to practice independently in the state of California. Physician's license must be in good standing, free of restriction, and without probationary status. Physicians must be board certified by the American Board of Psychiatry and Neurology (ABPN) or the American Osteopathic Association (AOA) Board of Psychiatry, or have completed a residency in psychiatry or a joint psychiatric residency program with another specialty that is approved by the ABPN or the AOA. • Physicians who have completed residency training in psychiatry or a fellowship program in a psychiatry sub-specialty within the five (5) years preceding the date of their application and have not yet obtained board certification are not considered exceptions to OHBS-CA credentialing criteria. These physicians are recommended to obtain their Board Certification prior to recredentialing. The Credentialing Department sends notification of this recommendation to approved Applicants. • Physicians without a residency in psychiatry may be accepted if they are board certified by the American Society of Addictions Medicine (ASAM) or the American Board of Addiction Medicine (ABAM). • Physician addictionologists must be certified by American Society of Addictions Medicine (ASAM) or the American Board of Addiction Medicine (ABAM) or have added qualifications	*USBHPC 2019-20202016-2017 Credentialing Plan*, Section 3.2.A

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
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	needed hospital care, is completed. • Must not be currently debarred or excluded from participation in Medicare or Medicaid programs. • Current malpractice insurance coverage consistent with limits established by VCHCP. • Application and supporting documentation must not contain omissions or falsifications, (including any additional information requested by VCHCP). Attestation as to the completeness and accuracy of the application must be signed. • Education, training and certification must meet criteria for the specialty in which the applicant will treat the VCHCP members. Board Certification or Board eligibility is required for new MDs and DOs applying after October 15, 2012. If Board Eligible, applicant must become Board Certified after	in Addiction Psychiatry through the American Board of Psychiatry and Neurology (ABPN). A Developmental Behavioral Pediatrician (DBP) must be board certified in Developmental Behavioral Pediatrics by the American Board of Pediatrics (ABP). For physicians prescribing controlled substances in a state where he/she sees Optum members, a current and unrestricted DEA registration is required. State laws determine whether a clinician must hold a federal DEA or state CDS to prescribe controlled substances. Prescribing of controlled substances may also require a current and unrestricted state- controlled substance certificate (CDS), if applicable in the state. Physicians must also: • Have the ability to practice to the full extent of their professional license and qualifications without a risk to patient safety or health, including the absence of a current physical or mental condition interfering with the ability to practice the physician's specialty; • Possess a current professional license to practice in the state of California without material restrictions, conditions or other disciplinary action.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
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	completion of training, at the first opportunity to take the certification exam based on the time frame specific to each specialty board. VCHCP may consider exceptions based on network needs or other extenuating circumstances on a case by case basis. • Site visit results, if applicable, must meet VCHCP standards. • Complaints from members and/or other providers must be at levels deemed acceptable to VCHCP. • Explanations for gaps in work history must be documented and deemed acceptable to VCHCP. • History of professional liability suits, arbitrations or settlements must be within established VCHCP standards, or in the presence of suits exceeding such standards are reviewed by the CC on an individual basis. • No physical or mental impairment, (including chemical	• Have an absence of exclusions or debarment from participation in Medicare, Medicaid, Medi-Cal or any other state or federal health care programs. OHBS-CA does not contract with a Provider who is excluded from state or federal health care programs. • Have an absence of malpractice lawsuits, judgments, settlements or other incidents that indicate a Competency or quality of care issue. • Have an absence of misdemeanor (except minor traffic violations) or felony convictions or other acts involving dishonesty, fraud, deceit or misrepresentation. • Not be using illegal substances or be chemically dependent on alcohol, drugs or illegal substances. • Demonstrate Competency and have an absence of professional disciplinary action or other sanction by a managed care plan, hospital or other health care delivery setting or Facility, medical review board, licensing board or other administrative body or government agency. In the sole discretion of the Credentialing Committee, an admonishment may be considered to constitute disciplinary action. • Have an absence of violations of state or federal law or standards of ethical conduct governing the Applicant's profession.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
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	dependency and substance abuse), that would affect the practitioner's ability to practice within the scope of his or her license or pose a risk or imminent harm to members. In the presence of a history of physical or mental impairment, the nature of the impairment and other information obtained during the credentialing or recredentialing process are reviewed by the CC on an individual basis. • No history of disciplinary actions, sanctions, or revocations of privileges taken by hospitals and other healthcare facilities or entities, HMOs, PPOs, PHOs, etc. or, in the presence of such actions or sanctions, the CC's determination is based upon the nature of the disciplinary action or sanction and other information obtained during the	• Have no misrepresentation, misstatement or omission of a relevant fact on the application. • Have current professional liability insurance (malpractice) with minimum limits of $1/$3 million for physicians and $1/$1 million for non-physician Clinicians, or no less than $500,000/$1,000,000 (subject to applicable state and federal law) if OHBS-CA, in its sole discretion, determines an exception is warranted. Providers with Federal Tort Coverage are considered to meet this requirement as long as they provide a copy of the Federal Tort letter or a signed attestation that they have Federal Tort Coverage for professional liability. • For physicians, nurse practitioners and physician assistant Clinicians prescribing controlled substances in the state of California, a current and unrestricted DEA registration is required • For physicians, USBHPC does not require hospital privileges. However, if the applicant attests to having hospital privileges, the following applies: • Staff privileges must be in good standing at a participating hospital and the Clinician must primarily use participating hospitals to provide services to enrollees.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	credentialing or recredentialing process. • No open indictments, convictions, or pleadings of guilty or no contest to, a felony, and no open indictments or convictions to any offense involving moral turpitude, fraud, or any other similar offense. • No other significant information, such as information related to improper or unethical professional conduct, including, but not limited to boundary issues or sexual impropriety or illegal drug use, which might indicate a reasonable suspicion of future substandard professional conduct and/or competence. If present, the information is reviewed by the CC on an individual basis.	• Privileges at any hospital must not have been suspended during the immediate twelve (12) months prior to application, or at any time during the term of the Provider Participation Agreement, due to inappropriate, inadequate or tardy completion of medical records or quality of care issues. • Physicians without hospital staff privileges must have an acceptable process for providing inpatient care. • The Applicant must not have been denied initial participation, or terminated for cause within the preceding 24 months prior to application or at any time during the term of the Provider Participation Agreement.	

What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers.	The following non- physician types are included in the scope of the VCHCP Credentialing Program:
	
	• Physician Extenders
	  ○ Nurse practitioners (NPs)
	  ○ Physician Assistants (PAs)
	• Allied Health Professionals
	  ○ Physical Therapists (PTs)
	  ○ Pediatric Dentist
	  ○ Acupuncturist
	
	Practitioners are health care professionals who are licensed, certified or registered by the state to practice independently and provide health care services to VCHCP members. To "practice independently" means that a practitioner treats members without direct supervision.
	
	• This definition includes:
	  ○ Non-physician practitioners who have an independent relationship with VCHCP, as defined above, and who provide care under VCHCP's medical benefits,
		USBHPC credentials nurses, nurse practitioners, physician's assistants, psychologists, marriage and family therapists, and clinical social workers who are licensed to practice independently, without supervision or oversight, as determined by state law, unless otherwise specified below.
		
		Clinician's license must be in good standing, free of restriction, and without probationary status.
		
		Nurse practitioners, physician assistants and psychologists prescribing controlled substances are required to have, a current and unrestricted DEA registration is required. Prescribing of controlled substances also requires a current and unrestricted state- controlled substance certificate (CDS).
		
		Nurses with prescriptive authority must be licensed, certified and/or registered in Psychiatric / Mental Health as required by the state. State laws determine whether supervision by a physician or collaborative practice is required. State law also determines whether certification in behavioral health nursing through the American Nursing Credentialing Center (ANCC) or other national certification (such as the American Academy of Nurse Practitioners [AANP] for Family Nurse Practitioners with MH experience) is required. In lieu of a MH specialty designation, in those states which offer it, license/certification plus two (2) years MH experience is required.
			USBHPC 2019-20202016-2016 Credentialing Plan, p. 7, Section 3.2.A.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
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	including Nurse Practitioners, Physician Assistants and independent physical therapists and acupuncturists. VCHCP has established the following criteria for practitioner participation in the VCHCP network. If the practitioner does not meet one or more of the following criteria, the CC considers the practitioner's history on an individual basis pursuant to the "Criteria and Thresholds for Credentialing File Review" section of this Credentialing policy. • A current, valid, unencumbered, unrestricted, and non-probationary state license with no unresolved public records in a five year look back period. • Current, valid, and unrestricted DEA certificate for prescribing controlled substances, if applicable to his/her practice in which he/she will treat the plan's members.	Physician assistants who are licensed in California and are board certified through the National Commission of Certification of Physician Assistants (NCCPA). Physician assistants must meet a minimum of one of the following criteria for participation: • Possess the NCCPA certificate of added qualifications (CAQ) in psychiatry • .Be supervised by a participating network behavioral health physician • Demonstrate two (2) years post licensure MH experience Clinicians must also: • Have the ability to practice to the full extent of their professional license and qualifications without a risk to patient safety or health, including the absence of a current physical or mental condition interfering with the ability to practice the physician's specialty; • Not be using illegal substances or be chemically dependent on alcohol, drugs or illegal substances; • Have no misrepresentation, misstatement or omission of a relevant fact on the application;	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	• Verification of clinical privileges in good standing, including status and type, from the applicant's primary admitting facility. If the applicant does not admit patients to the hospital, the verification form, indicating that the applicant has arrangements for VCHCP members to receive needed hospital care, is completed. • Must not be currently debarred or excluded from participation in Medicare or Medicaid programs. • Current malpractice insurance coverage consistent with limits established by VCHCP. • Application and supporting documentation must not contain omissions or falsifications, (including any additional information requested by VCHCP). Attestation as to the completeness and accuracy of the application must be signed.	• Have current professional liability insurance (malpractice) with minimum limits of $1/$3 million, with no exclusions of coverage (i.e. sexual misconduct, negligence, etc); • Have clinical privileges in good standing at the facility designated by the physician as the primary admitting facility or provide an acceptable written explanation of their process for providing inpatient care; • Have an absence of exclusions or debarment from participation in Medicare, Medicaid, or other state or federal health care program; • Not have been denied initial participation, or been terminated for cause (for reasons other than network need) within in the preceding twenty-four (24) months.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	• Education, training and certification must meet criteria for the specialty in which the applicant will treat the VCHCP members. • Complaints from members and/or other providers must be at levels deemed acceptable to VCHCP. • Explanations for gaps in work history must be documented and deemed acceptable to VCHCP. • History of professional liability suits, arbitrations or settlements must be within established VCHCP standards, or in the presence of suits exceeding such standards are reviewed by the CC on an individual basis. • No physical or mental impairment, (including chemical dependency and substance abuse), that would affect the practitioner's ability to practice within the scope of his or her license or pose a risk or imminent harm to members. In		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	the presence of a history of physical or mental impairment, the nature of the impairment and other information obtained during the credentialing or recredentialing process are reviewed by the CC on an individual basis. • No history of disciplinary actions, sanctions, or revocations of privileges taken by hospitals and other healthcare facilities or entities, HMOs, PPOs, PHOs, etc. or, in the presence of such actions or sanctions, the CC's determination is based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing or recredentialing process. • No open indictments, convictions, or pleadings of guilty or no contest to, a felony, and no open indictments or convictions to any offense		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	involving moral turpitude, fraud, or any other similar offense. No other significant information, such as information related to improper or unethical professional conduct, including, but not limited to boundary issues or sexual impropriety or illegal drug use, which might indicate a reasonable suspicion of future substandard professional conduct and/or competence. If present, the information is reviewed by the CC on an individual basis.		

What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?	Currently VCHCP does not directly credential/contract with unlicensed personnel.	USBHPC contracts with and credentials Board Certified Behavior Analysts and Applied Behavior Analysis Agencies as outlined below. Behavioral Analysts must be certified as a Board-Certified Behavior Analyst (BCBA) with active certification from the national Behavior Analyst Certification Board, and possess a minimum of six (6) months employment or internship in the treatment of autism spectrum disorders under the supervision of a Board Certified Behavior Analyst or a licensed clinician. Qualified Autism Service Professionals must meet the following criteria: • **P**rovide behavioral health treatment; • Be employed and supervised by a Qualified Autism Service Provider (QASP); • Provide treatment pursuant to a treatment plan developed and approved by the QASP; • Be a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; • Have training and experience in providing services for pervasive developmental disorder or autism.	*USBHPC 2019-2020 Credentialing Plan*, pg. 3; pg. 8, Section 3.2. item 4

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
		Qualified Autism Service Paraprofessionals must meet the following criteria: • Be employed and supervised by a QASP; • Provide treatment and implements services pursuant to a treatment plan developed and approved by the QASP; • Meet criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code; • Have adequate education, training, and experience, as certified by a QASP.	
K. Exclusions for Failure to Complete a Course of Treatment Does the Plan exclude benefits for failure to complete treatment?	No	No.	**USBHPC:** The behavioral benefit does not include exclusions based on a failure to complete a course of treatment.
L. Restrictions that limit duration or scope of benefits for services Does the Plan restrict the geographic location in which services can be received; e.g., service area, within California, within the United States?	VCHCP requires that when members become effective with the Plan, that members select a participating Primary Care Physicians or medical group listed in the Plan's Provider Directory **(VCHCP EOC page 16)** The Plan has contracted with a broad range of Providers who are conveniently located to provide access to Covered Services	No, only to the extent those services outside U.S. other than emergency services are not covered.	**USBHPC:** Services are still covered when out-of-state or traveling, but only in an Emergency or Urgent situation. If the member believes he/she is experiencing an emergency or requires urgently needed services, treatment should be sought immediately. Then, as soon as reasonably possible, call Life Strategies/USBHPC Customer Service Department to ensure emergency treatment services are covered.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	(VCHCP EOC page 14) The Plan will limit referrals to its network of providers **(VCHCP EOC page 16)** The Provider Directory lists the Participating Physicians, pharmacies, hospitals, surgery centers, laboratory draw sites, imaging centers, podiatrists, and physical therapists. Primary Care Physicians are listed alphabetically by last name with and under their medical group, with information about the practice location and hours of operation. The Provider Directory does not list the names of participating hospital-based Physicians, anesthesiologists and pathologists. The Provider Directory also does not list the names of tertiary care referral hospitals and their contracted medical groups **(VCHCP EOC page 16)**		
Does the Plan restrict the type(s) of facilities in which enrollees can receive services?	Second opinions will be rendered by an appropriately qualified health care professional. This is defined as a PCP or Specialist acting within his or her scope of practice and who possesses a clinical background, including training and expertise, as it relates to the particular illness, disease, condition or conditions associated with the request for a second	No, other than appropriate to type of service and within scope of licensure.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
	opinion. The provider will be selected to render the second opinion as follows: 1. The provider chosen by the Member or by the provider who is treating the Member will be authorized if the provider meets the above definition of an appropriately qualified health care professional and if the provider is an In-Network Provider. This includes all contracted PCPs and all contracted Specialists. **(VCHCP EOC page 16)**		
M. Does the Plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?	The provider's education, training and certification must meet criteria for the specialty in which the applicant will treat the VCHCP member. Training must be consistent to the scope of practice of their active licensure. The following provider specialties are required to practice within the scope of their training: M.D, D.O, LCSW, Ph.D; MFT; NP; BCBA/agencies meeting criteria for credentialing **(Credentialing Program Policy –whole document)**	No, other than general requirements within scope of the provider's licensure, the Plan does not restrict the types of provider specialties that can provide MH/SUD benefits. The following licensed clinicians are required to practice within the scope of their expertise. M.D.; LCSW; Ph.D.; MFT; NP; BCBA/agencies meeting criteria for credentialing.	**USBHPC:** There are no restrictions or limitations based on types of provider specialties for MH/SUD benefits. Therefore, there are no parity non-quantitative treatment limits in this case.