Employer Federal Mental Health Parity and Addiction Equity Act NQTL Fact Sheet 2023

MHPAEA summary for non-quantitative treatment limits

The federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA) requires PHP to assess that there is "parity" between medical and surgical ("M/S") benefits and mental health and substance use disorder ("MH/SUD") benefits. This generally means that group health plans cannot impose less favorable benefit limitations on MH/SUD benefits than M/S benefits. In other words, the benefits must be equally provided, or provided in "parity."

The law covers several types of limitations called quantitative treatment limitations ("QTLs") and non-quantitative treatment limitations ("NQTL").

- QTLs include, but are not limited to: deductibles, copayments, coinsurance, out-of-pocket limitations, or other financial limitations. QTLs may also include the number of days or visits covered, or other limitations on the scope or duration of treatment.
- NQTLs include, but are not limited to, medical management standards limiting or excluding benefits based on medical necessity, medical appropriateness, or based on whether the treatment is experimental or investigative, including standards for concurrent review; formulary design for prescription drugs; network tier design; standards for provider admission to network; fail first policies or step therapy protocols; or restrictions based on geographic location, provider specialty, etc.

Below is a summary of PHP's NQTL assessment. If you have any questions on this summary, or regarding your specific health benefit plan, please contact the member services number on your ID card.

Medical Necessity:

Health services that are determined by PHP to be ***all*** of the following:

A. Medically appropriate and necessary to meet the member's basic health needs:
B. The most cost-effective method of treatment and rendered in the most cost effective manner and type of setting appropriate for the delivery of the health service;
C. Consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;
D. Accepted by the medical community as consistent with the diagnosis and prescribed course of treatment and rendered a frequency and duration by the medical community as medically appropriate;
E. Required for reasons other than the comfort or convenience of the member or his or her doctor;

F. Of a demonstrated medical value in treating the condition of the member; and
G. Consistent with patterns of care found in established managed care environments for treatment of the particular health condition.

For the purpose of determining whether an item or service is medically necessary, generally accepted by the medical community means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physicians Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Prior Authorization Review Process:

Inpatient. In-Network.
All inpatient, in-network admissions, including rehab, behavioral health, hospice, skilled nursing, and transitional care, require prior authorization for MH/SUD and M/S benefits.

Outpatient. In-Network: Office Visits
PHP does not require prior authorization for office visits.

PHP requires prior authorization on certain **procedures or goods** including but not limited to:

- Bariatric treatment
- Capsular endoscopy
- Cochlear implants
- Genetic testing
- Obstructive sleep apnea treatment including surgical procedures
- Oral Surgery (biopsies or treatment of oral lesions by oral surgeons, orthognathic surgery)
- Sinus endoscopy with balloon dilation
- Spine surgeries (artificial disc, dorsal column stimulators, spinal fusions)
- Total hips and knees
- Certain durable medical equipment
  - AED garments
  - Bi-pap machines
  - Chest percussion vests
  - CPAP machines
  - CPM machines
- Certain outpatient services
  - ABA therapy
  - Home health services
  - Hospice

The majority of the above will have a corresponding clinical policy providing guidance as to the appropriateness or requirements for treatment.

Inpatient, Out-of-Network.
Same as IP, In Network. If the member does not have point of service benefits, inpatient out of network, is only authorized if the health services cannot be provided by or through a participating provider; the health services are medically necessary; a par doctor refers the member to the non par provider; the health services are specified as covered by the contract;

the health services are rendered in the US and its territories; and we have approved the referral in writing before the services are rendered.

Outpatient, Out-of-Network: Office Visits.
If the member does not have point of service benefits, all out of network services would require authorization for payment as in-network benefits. Services are only authorized if the health services cannot be provided by or through a participating provider; the health services are medically necessary; a par doctor refers the member to the non-par provider; the health services are specified as covered by the contract; the health services are rendered in the US and its territories; and we have approved the referral in writing before the services are rendered.

Outpatient, Out of Network: Other Items and Services
If the member does not have point of service benefits, all out of network services would require authorization for payment at in-network benefits. Services are only authorized if the health services cannot be provided by or through a participating provider; the health services are medically necessary; a par doctor refers the member to the non par provider; the health services are specified as covered by the contract; the health services are rendered in the US and its territories; and we have approved the referral in writing before the services are rendered.

Emergency Services
PHP does not require authorization for any emergent or urgent services regardless of whether at an in-network or out of network facility/provider.

Utilization Review
Utilization review may include multiple levels of review from Utilization Review Nurse, physician review and possible peer-to-peer review. First level review happens in every medical situation requiring utilization review by the plan and is conducted by a utilization review nurse for MH/SUD.

If the first-level reviewer is unable to approve the authorization request, the request will then be sent to the Medical Director (a physician), or designated Physician Reviewer or Pharmacist to either approve the request or deny the initial request.

Peer-to-peer review happens when either of the physicians (reviewer or attending) needs to speak with the other attending physician in order to further obtain and clarify the clinical information necessary to decide on the request as medical records to not always convey the whole medical story.

NQTL - Concurrent Review Process

PHP does not distinguish concurrent review process by type of service i.e. inpatient or outpatient. To ensure that concurrent reviews of clinical services are based on severity of the patient's condition, and not conducted on a daily routine procedure, Utilization Review nurses rely on national guidelines, clinical policies and their professional judgement to plan the

frequency of concurrent reviews regardless of the clinical setting where the healthcare services are delivered.

Evidentiary standards for concurrent review criteria:

Each concurrent review is approved only for a set number of days and that number can vary based on the treating physicians estimated course of treatment. Complexity or severity of patient to support discharge planning activities.

Regardless of the length of stay, with a complex patient, (defined as one that has multiple co-morbidities or restrictions on activities of daily living (ADL's), the Utilization Review Nurse will conduct a concurrent review timed to the patient's estimated discharge to assure all continued care factors are aligned including home care, durable medical equipment needs, follow up specialty care or prescription requirements are met.

NQTL - Prescription Drug Formulary Design

Formulary decisions made for the diagnosis and medically necessary treatment of medical, mental health and substance use disorder conditions

- PHP uses two main pharmacy management tools with the drug formulary. One is prior authorization and the other is step therapy. Our drug formulary encourages the use of the most cost-effective drugs for PHP members.
- Drug selection is based on an objective evaluation of the clinical effectiveness data, safety, and cost containment strategies to prevent unnecessary product duplication within therapeutic classes.
- The pharmaceutical must be approved for marketing by the FDA.
- PHP utilizes Express Scripts National Preferred Formulary**.**

NQTL - Case Management

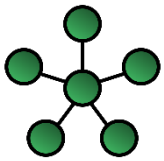
PHP partners with a case management vendor to offer case management services at no additional cost to members. Case managers assist members to maximize their benefits, offer education, and follow up on inpatient stays.

NQTL - Process for Assessment of New Technologies

New technology assessment is a process by which a treatment moves from experimental or investigational (which would be excluded from coverage) to covered as a standard of care, or at least an option for care.

PHP relies heavily on the scientific evidence of multiple organizations to assure unbiased application of new technology on both MH/SUD and M/S services and believes our process for

evaluation of new technologies is not a restrictive application of criteria limiting members' access to MH/SUD services.



NQTL - Provider Network & Credentialing

PHP has an open provider network. We attempt to credential and contract with all quality providers in our service area as well as national centers of excellence such as Cleveland Clinic or Hazelden (Betty Ford Clinic).

Our credential policies allow for multiple types of services providers from MD and PhD to therapist and social workers.

Our network adequacy is filed with the state department of insurance for all applicable states each year.

The Plan and all policies and procedures are approved by our executive leadership as well as the Credentialing Committee made up of outside physicians across several specialties.

The PHP Medical Director can approve credentialing applications that meet all criteria as outlined below. Any applicant that does not meet the criteria is presented to the Credentialing Committee for review and determination.

Initial Credentialing

Each practitioner must complete a standard application form deemed acceptable by PHP when applying for initial participation.

Recredentialing - Practitioners

The recredentialing process incorporates re-verification and the identification of changes in the practitioner's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privileges or other actions) that may reflect on the practitioner's professional conduct and competence.

Credentialing & Re-Credentialing Allied Health Professionals

The application process for Independent Licensed Allied Health Professionals with whom PHP contracts separately will not be initiated until the individual has submitted the required criteria.

Network Access and Access to Care:

At least annually, PHP assesses the Network Adequacy and Access to Care to ensure that our members have access to a network of providers that will meet their health care needs. This assessment looks at not only the geographic distribution of providers in our service area, but also the adequacy of essential community providers, mental health and substance abuse providers, specialists, and facilities.

ACCESS TO PRIMARY CARE & BEHAVIORAL HEALTH PROVIDERS – 2023:

PHP FREEDOM ENCORE COMBINED NETWORKS

PHP members have the benefit of extensive coverage in our network by primary care health professionals and mental health providers. The PHP Freedom Encore Combined Network includes 5,463 primary care providers and 3,645 behavioral health providers.

PHP OPTIONS ENCORE COMBINED NETWORK

PHP members have the benefit of extensive coverage in our network by primary care professionals and mental health providers. The PHP Options Encore Combined Network includes 962 primary care health professionals and 1,344 behavioral health providers.

NQTL - Exclusions for Failure to Complete a Course of Treatment

The only situation in which PHP denies coverage for a failure to complete a course of treatment, whether MH/SUD or M/S, is when a patient self-discharges, against professional medical advice.

NQTL - Restrictions that Limit Duration or Scope of Benefits for Services

PHP requires services to be performed in the U.S. and its territories unless an emergency occurs during travel.