# Organization Information

|  |  |
| --- | --- |
|  | |
| **Organization Name:** | Choose your organization. |
| **Submitter Name:** |  |
| **Submitter Email Address:** |  |
| **Date of Submission:** |  |
| **Initial Submission (Yes/No):** |  |
| **Resubmission Reason, if applicable:** |  |
| **Comments:** |  |

# Financial Requirements

| Financial Requirements (FRs) | | |
| --- | --- | --- |
| Definition: Payment by members for services received that are in addition to payments made by the CCO (e.g., co-payments and deductibles). | | |
| 1. Does the CCO or OHP FFS apply any **FRs** for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for mental health/substance use disorder (MH/SUD) benefits?   Yes  No → Skip to [**Section 3**](#_Section_2—Aggregate_Lifetime) | | |
| 1. Does the CCO apply any **FRs** for IP, OP, Rx, or EC services for medical/surgical (M/S) benefits?   Yes  No | | |
| 1. Describe the FRs applied to MH/SUD benefits for each service classification: | | |
| * 1. Inpatient | List and briefly describe FRs: | Documents Submitted for Desk Review: |
| * 1. Outpatient | List and briefly describe FRs: | Documents Submitted for Desk Review: |
| * 1. Pharmacy | List and briefly describe FRs: | Documents Submitted for Desk Review: |
| * 1. Emergency Care | List and briefly describe FRs: | Documents Submitted for Desk Review: |
| 1. Describe the FRs applied to M/S benefits for each service classification: | | |
| * 1. Inpatient | List and briefly describe FRs: | Documents Submitted for Desk Review: |
| * 1. Outpatient | List and briefly describe FRs: | Documents Submitted for Desk Review: |
| * 1. Pharmacy | List and briefly describe FRs: | Documents Submitted for Desk Review: |
| * 1. Emergency Care | List and briefly describe FRs: | Documents Submitted for Desk Review: |
| 1. The CCO certifies that its FRs for MH/SUD benefits are no more restrictive than the predominant FR that corresponds with M/S benefits for each service classification (i.e., IP, OP, Rx, and EC).   Yes → **Name:** Enter name. **Title:** Enter title. **→** Go to[**Section 3**](#_Section_2—Aggregate_Lifetime)**.**  No → Please explain why the CCO’s FRs for MH/SUD are more restrictive. Enter explanation. | | |

#### HSAG Evaluation

|  |  |
| --- | --- |
| HSAG Findings | HSAG Rating |
|  | Compliant  Partially Compliant  Not Compliant  Not Applicable |
| **Required Actions:** | |

# Aggregate Lifetime or Annual Dollar Limits

| Aggregate Lifetime or Annual Dollar Limits (AL/ADLs) | | |
| --- | --- | --- |
| Definition: Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis. | | |
| 1. Does the CCO apply an **AL** or any **ADLs** for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for mental health/substance use disorder (MH/SUD) benefits?   Yes  No → Skip to [**Section 4**](#_Quantitative_Treatment_Limitations) | | |
| 1. Does the CCO apply an **AL** or any **ADLs** for IP, OP, Rx, or EC services for medical/surgical (M/S) benefits?   Yes  No | | |
| 1. Describe the AL/ADLs applied to MH/SUD benefits for each service classification: | | |
| * 1. Inpatient | List and briefly describe AL/ADLs: | Documents Submitted for Desk Review: |
| * 1. Outpatient | List and briefly describe AL/ADLs: | Documents Submitted for Desk Review: |
| * 1. Pharmacy | List and briefly describe AL/ADLs: | Documents Submitted for Desk Review: |
| * 1. Emergency Care | List and briefly describe AL/ADLs: | Documents Submitted for Desk Review: |
| 1. Describe the AL/ADLs applied to M/S benefits for each service classification: | | |
| * 1. Inpatient | List and briefly describe AL/ADLs: | Documents Submitted for Desk Review: |
| * 1. Outpatient | List and briefly describe AL/ADLs: | Documents Submitted for Desk Review: |
| * 1. Pharmacy | List and briefly describe AL/ADLs: | Documents Submitted for Desk Review: |
| * 1. Emergency Care | List and briefly describe AL/ADLs: | Documents Submitted for Desk Review: |
| 1. The CCO certifies that its AL/ADLs for MH/SUD benefits apply to less than one-third of all M/S benefits for each service classification (i.e., IP, OP, Rx, and EC).   Yes → **Name:** Enter name. **Title:** Enter title. **→** Go to[**Section 4**](#_Quantitative_Treatment_Limitations)**.**  No → Please explain why the CCO’s AL/ADLs for MH/SUD are more restrictive. Enter explanation. | | |

#### HSAG Evaluation

|  |  |
| --- | --- |
| HSAG Findings | HSAG Rating |
|  | Compliant  Partially Compliant  Not Compliant  Not Applicable |
| **Required Actions:** | |

# Quantitative Treatment Limitations

| Quantitative Treatment Limitations (QTLs) | | |
| --- | --- | --- |
| Definition: Limits on the scope or duration of a benefit that are expressed numerically (e.g., days or visit limits). Soft limits, or benefit limits that allow for an individual to exceed numerical limits for M/S or MH/SUD benefits on the basis of medical necessity, also are considered NQTLs. | | |
| 1. Does the CCO apply any **QTL**s for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for mental health/substance use disorder (MH/SUD) benefits?   Yes  No → Skip to [**Section 5**](#_Non-Quantitative_Treatment_Limitati)**.** | | |
| 1. Does the CCO apply any **QTLs** for IP, OP, Rx, or EC services for medical/surgical (M/S) benefits?   Yes  No | | |
| 1. Describe the QTLs applied to MH/SUD benefits for each service classification: | | |
| * 1. Inpatient | List and briefly describe QTLs: | Documents Submitted for Desk Review: |
| * 1. Outpatient | List and briefly describe QTLs: | Documents Submitted for Desk Review: |
| * 1. Pharmacy | List and briefly describe QTLs: | Documents Submitted for Desk Review: |
| * 1. Emergency Care | List and briefly describe QTLs: | Documents Submitted for Desk Review: |
| 1. Describe the QTLs applied to M/S benefits for each service classification: | | |
| * 1. Inpatient | List and briefly describe QTLs: | Documents Submitted for Desk Review: |
| * 1. Outpatient | List and briefly describe QTLs: | Documents Submitted for Desk Review: |
| * 1. Pharmacy | List and briefly describe QTLs: | Documents Submitted for Desk Review: |
| * 1. Emergency Care | List and briefly describe QTLs: | Documents Submitted for Desk Review: |
| 1. The CCO certifies that its QTLs for MH/SUD benefits are no more restrictive than the predominant QTL that corresponds with M/S benefits for each service classification (i.e., IP, OP, Rx, and EC).   Yes → **Name:** Enter name. **Title:** Enter title. **→** Go to[**Section 5**](#_Non-Quantitative_Treatment_Limitati)**.**  No → Please explain why the CCO’s QTLs for MH/SUD are more restrictive. Enter explanation. | | |

#### HSAG Evaluation

|  |  |
| --- | --- |
| HSAG Findings | HSAG Rating |
|  | Compliant  Partially Compliant  Not Compliant  Not Applicable |
| **Required Actions:** | |

# Non-Quantitative Treatment Limitations

| Non-quantitative Treatment Limitations (NQTLs) |
| --- |
| Definition: Limits on the scope or duration of benefits, such as prior authorization or network admission standards. *Soft limits*, or benefit limits that allow for an individual to exceed numerical limits for M/S or MH/SUD benefits on the basis of medical necessity, also are considered NQTLs. |
| 1. Does the CCO apply any **NQTL**s for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for mental health/substance use disorder (MH/SUD) benefits?   Yes  No → Skip to [**Section 6**](#_Availability_of_Information)**.** |

Using the tables below, identify all NQTLs used by your organization to manage MH/SUD and M/S benefits for IP, OP, Rx, and EC services. The most common NQTL types have been listed and arranged by category (i.e., medical management, provider network, and pharmacy management). The *buttons* below can be used to skip to each section. For each NQTL reported, the CCO must provide appropriate documentation (i.e., policies, procedures, processes, flow charts, etc.) that address the following questions:

1. Why the NQTL was assigned, including what evidence supports the rationale for use of the NQTL?
2. What procedures/processes/requirements are used to apply the NQTL by benefit and service type (e.g., time frames, evidentiary standards/documentation requirements, reviewer qualifications, monitoring/oversight of processes, etc.)?
3. How frequently/strictly the NQTL is applied (e.g., frequency NQTL applied, penalties for NQTL, etc.)?
4. What evidence supports the rationale for how frequently/strictly the NQTL is applied?

[**Pharmacy** **Management**](#_Pharmacy_Management)

[**Other NQTL**](#_Other_NQTLs_Not)

[**Provider Network**](#_Provider_Network)

[**Medical Management**](#_Medical_Management)

#### Medical Management

| Medical Management | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Note: If an NQTL type is not applicable for given benefit, select “N/A.” | | | | | | | | | | | |
| 1. **Medical necessity criteria** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | Compliant  Partially Compliant  Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Practice guideline selection/criteria** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | Compliant  Partially Compliant  Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Prior Authorization** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | Compliant  Partially Compliant  Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Concurrent Review** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Retrospective Review** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Outlier Management** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Experimental/investigational determinations** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Fail-first requirements** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Failure to complete exclusions** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Medical appropriateness reviews** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Requirements for lower cost therapies to be tried first** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |

#### Provider Network

| Provider Network | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Note: If an NQTL type is not applicable for given benefit, select “N/A.” | | | | | | | | | | | |
| 1. **Provider enrollment/admission/credentialing requirements** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Reimbursement rates** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Geographic restrictions** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Specialty requirements or exclusions** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Facility type requirements or additional requirements for certain facility types** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Network tiers** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Out-of-network/Out-of-state access requirements or exclusions** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |

#### Pharmacy Management

| Pharmacy Management | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Note: If an NQTL type is not applicable for given benefit, select “N/A.” | | | | | | | | | | | |
| 1. **Methods for determining usual, customary, and reasonable charges** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Formulary design for prescription drugs** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Prescription drug benefit tiers, including generic vs. brand name, high cost vs. low cost, etc.** | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |

#### Other NQTLs Not Listed

| Other NQTLs Not Listed | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Note: If an NQTL type is not applicable for given benefit, select “N/A.” | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |
| 1. **Other:** Enter Text | | | | | | | | | | | |
| **Description:** Enter description. | | | | | | | | | | | |
|  | **MH/SUD** | | | | | **M/S** | | | | | |
| N/A | IP | OP | Rx | EC | N/A | IP | OP | | Rx | EC |
| *Documents submitted as evidence:* |  | | | | |  | | | | | |
| *Identify any delegated subcontractors:* |  | | | | |  | | | | | |
| HSAG Findings | | | | | | | | | | | |
|  | | | | | | | | | ☐ Compliant  ☐ Partially Compliant  ☐ Not Compliant | | |
| **Required Action:** | | | | | | | | | | | |

# Availability of Information

| Availability of Information | | |
| --- | --- | --- |
| Definition: The criteria for medical necessity (MN) determination for MH/SUD benefits must be made available to members, potential members, or contracting provider upon request. | | |
| 1. For each applicable service classification, identify the criteria used for medical necessity determination applied to MH/SUD benefits and the mechanism for dissemination: | | |
| * 1. Inpatient | List and briefly describe MN criteria and dissemination mechanism(s): | Documents Submitted for Desk Review: |
| * 1. Outpatient | List and briefly describe MN criteria and dissemination mechanism(s): | Documents Submitted for Desk Review: |
| * 1. Pharmacy | List and briefly describe MN criteria and dissemination mechanism(s): | Documents Submitted for Desk Review: |
| * 1. Emergency Care | List and briefly describe MN criteria and dissemination mechanism(s): | Documents Submitted for Desk Review: |

#### HSAG Evaluation

|  |  |
| --- | --- |
| HSAG Findings | HSAG Rating |
|  | Compliant  Partially Compliant  Not Compliant  Not Applicable |
| **Required Actions:** | |