2021 Parity Evaluation for NJ FamilyCare Plan A and ABP

NJFamilyCare requires all recipients, regardless of their eligibility and or population group, to be enrolled into one of five Medicaid managed care plans. The available service packages include Plans A, ABP, B, C and D. Plans A and ABP are an identical service package and are the only service packages for which the State and its contracted managed care plans are required to complete a parity analysis. The three CHIP plans B, C and D (beginning 7/1/18) provide Early Periodic Screening, Diagnosis and Treatment (EPSDT) coverage and are therefore deemed compliant with parity requirements. At present, all physical health services are provided by Managed Care Organizations (MCOs) while the majority of mental health and substance use disorder (SUD) services are provided Fee-For-Service (FFS). This applies to Medicaid and CHIP programs. Therefore, the State has completed the narrative portion for this parity analysis with input collected from each of the managed care plans.

The State's FFS program only allows prior and retro-authorization in three circumstances. The first is with programs that require treatment planning. The authorization requires a properly completed treatment plan be submitted prior to authorization for payment for services. The treatment plan is reviewed for completeness, required signatures and clinical appropriateness. An example would be community support services. Services provided and billed must match the services listed and approved in the treatment plan. The second use of prior authorization is to ensure that services are being provided at the appropriate clinical level so that the individual will best benefit from the service being offered. An example would be transportation services. The client is eligible for transportation, but may not be appropriate for the level of transport requested. Lastly, authorization is used when multiple providers may be involved in treatment. Authorization ensures fiscal responsibility and reduces the ability for two providers to bill for the same service at the same time. An example where this is utilized is private duty nursing.

For 2021, NJ declared a state of emergency under which all PA and copayments, medical-surgical and behavioral health were suspended. This suspension applied to managed care and FFS products.

The MCOs are contractually required to meet the requirements listed for any service authorized through the State plan or through the Comprehensive waiver. Additionally, unless otherwise stated in the contract, the MCOs are required to follow any applicable rules published in the New Jersey administrative code. As for Non-Quantitative Treatment Limits (NQTLs), the plans are free to utilize measures to ensure fiscal appropriateness and medical necessity. Plans may not otherwise limit services authorized by the State and must ensure that any NQTL may be overridden when determined medically necessary or as required under EPSDT. All plans have demonstrated that their prior authorization requirements meet these standards and that the concurrent or retrospective review of the member's records demonstrated that the services are appropriate and based on medical necessity criteria.

For both FFS and MCOs, all cases are reviewed by licensed clinicians. In the event that a request does not meet established national clinical criteria or other established criteria, the case is referred to a physician medical director for review. Medical directors consider the social determinants of health as well as the individual's unique clinical situation as applied to national best practice guidelines to assure that all medically necessary services are authorized. Any provider or recipient may request a second appeal to an independent medical peer for a final determination.

Within NJFamilyCare, there are three sub-population groups for which MCOs cover MH/SUD services for Plan A and ABP. They are recipients receiving Managed Long Term Services and Supports (MLTSS), Division of Developmental Disabilities (DDD) involved recipients and individuals enrolled in a Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP). Each sub-population receives the majority of their behavioral health and all of their physical health services from the managed care plan. The limited behavioral health services not covered by the MCO are programs that involve targeted case management such as Programs for Assertive Community Treatment (PACT) and community support services which are provided FFS. The remaining subpopulations of Plan A and ABP receive all of their behavioral health services through FSS. All acute inpatient admissions, regardless of the admitting diagnosis, are covered by the recipient's managed care plan for all population groups.

For the purposes of this parity analysis, behavioral health shall consist of mental health and substance use disorder services and is identified as MH/SUD and defined as those conditions listed in ICD-10-CM, Chapter 5 (with the exception of subchapter 1, "Mental disorders due to known physiological conditions"), including a subset of mental health conditions listed in ICD-10-Chapter 5 identified with the diagnosis codes F10-F19. This subset identifies conditions in which the use of one or more substances leads to a clinically significant impairment. Medical and surgical benefits shall be those services associated with the diagnosis and treatment of Medical Surgical conditions listed in ICD-10-CM, Chapters 1 through 4, and Chapter 5, subchapter 1 only, as well as Chapters 6 through 20. These services shall be identified as M/S.

For the purposes of this Parity analysis, MH/SUD and M/S services have been listed under one of four benefit classifications consisting of inpatient, outpatient, prescription drugs and emergency care. The categories have been defined as follows:

> "Inpatient" shall consist of all covered services or items provided to a beneficiary when a physician has written an order for admission to a facility. Those services provided in a facility may be for MH/SUD treatment as well as M/S services as defined above.
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> "Outpatient" shall consist of all covered services or items that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care.
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> "Emergency Care" shall consist of all covered services or items delivered in an Emergency Department (ED) setting or outside of an ED setting but provided to stabilize an emergency/crisis, other than in an inpatient setting.
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> "Pharmacy" shall consist of durable medical equipment and covered medications, drugs, and associated supplies that require a prescription as well as services delivered by a pharmacist working in a free standing pharmacy.

The core services within these categories are attached for comparison.

Under NJ FamilyCare guidelines, and in compliance with the Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA), neither the State nor the contracted Managed Care Organizations (MCOs) may impose:

- an aggregate lifetime dollar limit on any MH/SUD or M/S benefits
- an annual dollar limit on any MH/SUD or M/S benefits

- any financial requirements to MH/SUD benefits in the Inpatient classification
- any financial requirements to MH/SUD benefits in the Outpatient classification
- any financial requirements to MH/SUD benefits in the Emergency classification
- any financial requirements to MH/SUD benefits in the Pharmacy classification

Through regulations and contract language, NJ FamilyCare does not allow for any aggregate lifetime dollar limits on any benefits, M/S or MH/SUD. Since there are no annual dollar limits or any financial requirements on any M/S or MH/SUD services, NJ FamilyCare meets MHPAEA parity requirements for this section.

Under NJ FamilyCare contract guidelines and regulations, New Jersey's contracted MCOs cannot impose:

- Financial requirements—Payment by beneficiaries for services received that are in addition to payments made by the state or the MCO for those services. This includes copayments, coinsurance, and deductibles.
- Quantitative treatment limitations—Limits on the scope or duration of a benefit that are expressed numerically that are applied in a manner that is more restrictive than those that apply to M/S benefits in the same classification. This includes day or visit limits.
- Aggregate lifetime or annual dollar limits—Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.

Therefore, since the State (or any of the five contracted MCOs) cannot impose any of the above limitations, NJ FamilyCare (Medicaid and CHIP) is determined to be compliant with the parity requirements listed in MHPAEA for this section.

A detailed analysis was also completed for Non-Quantitative Treatment Limits (NQTL) to ensure compliance with parity guidelines. This detailed analysis includes the State FFS system as well as individual analyses provided by each contracted plan. The MCO NQTL analyses can be seen in the attached appendices. An NQTL is defined as a limit on the scope or duration of benefits that may be extended if determined medically necessary; thus making it a "soft" limit. Parity prohibits New Jersey and its contracted MCOs from imposing an NQTL on MH/SUD benefits in any of the four classifications unless, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification. The factors used in applying the identified NQTLs are not applied more stringently for MH/SUD benefits than the factors used to apply the NQTL in the M/S benefits in the same classification.

To allow comparison between MS and BH/SUD and to assist with the analysis, each service group was assigned to one of the four categories (inpatient, outpatient, pharmacy and emergency). Several BH/SUD NQTLs have been identified that span across categories. First, and most prominent, is the medical management criteria utilized by both the State and the contracted MCOs in all four categories for both MH/SUD and M/S services. Medical management criteria are intended to ensure services are provided at the appropriate level of care. However, they may have the effect of limiting or denying services that fail to meet medical necessity. Prior authorization, a subcomponent of applying the criteria, is required to ensure that service requests are being provided at the clinically appropriate level. This reduces fraud and abuse for the State while ensuring recipients receive the proper level of care. Prior authorizations are

based solely on Medicaid eligibility and clinical necessity and may be overridden at any time if determined medically necessary. They are NJ FamilyCare's way to ensure service requests have been evaluated and to allow payment for those services. None of the medical management criteria, including prior authorizations, that is utilized by the State or MCO for MH/SUD services require any processes, strategies, evidentiary standards or other factors that are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in each of the M/S classifications.

The State of New Jersey does have a regulation requiring the use of less expensive services if the other services are considered equivalent. This requirement is generally not applied to MH/SUD services since Mental Health services, other than acute inpatient services and SUD (ASAM), do not use medical management criteria. An example of how this law could be applied in a medical situation would be a client requesting a power wheelchair when they are capable of utilizing a manual chair. The request for the higher cost device would be denied unless medical necessity for a power chair could be provided. For MH/SUD, an example would be an individual seeking partial care services on a daily basis without demonstrating a need for this service. The State would approve individual or group therapy 2 days a week if the same outcome would be expected and treatment is determined medically appropriate by a medical professional. However, In the event this situation did arise, and it was determined medically appropriate by the State's Medical Director, the service would be approved at the higher level. For MH/SUD services, clients may choose between available services provided those services meet evidentiary standards that demonstrate an appropriate level of care. All services may be approved if medically necessary. The standard for applying restrictions to levels of care is not applied more stringently for MH/SUD than for M/S services in equivalent categories.

Geographical limitations could possibly span all four categories. However, NJ FamilyCare does not have any geographic limitations on provider inclusion. Both FFS and the MCOs contract with providers outside of New Jersey. Fee-for-service is open to any provider in any state. The MCOs limit their providers to the contiguous states surrounding New Jersey. However, both the State and MCOs offer "one time" provider agreements to providers who are outside of the network who provide urgent or emergent services outside of New Jersey. These agreements are easy to complete and ensure individuals travelling outside of New Jersey, but within the United States, can receive urgent medical care as needed. In support of the primary care model of care, the MCO contract requires routine or well care be provided by the individual's primary care physician. All providers follow the same guidelines and there are no differences between providers for MH/SUD and M/S services.

Rate setting for professional services have the potential to involve all four categories. Professional services are generally set at a specific percentage of Medicare rates. Rates do not increase with Medicare increases unless that requirement is part of the rate setting methodology. Therefore, rates across all specialties and provider types may vary. Factors such as a shortage of providers have resulted in specific rates being increased. APNs are paid 85% of the physician rate. Managed care plans generally set initial rates at the FFS rate but are free to negotiate rates independently. For professional services, rates vary depending on provider saturation and contracting needs. The rate setting process is the same for other professionals including PhDs and MA professionals. The majority of M/S service providers are reimbursed by the MCOs and the majority of BH/SUD providers are reimbursed by FFS. However, reimbursement rates are determined in an equable manner for MH/SUD and M/S providers with both sides reacting to supply and demand as well as an examination of commercial rates for similar services.

Practitioner types are limited to those that are approved through regulation and through the State plan. Under FFS, which covers the majority of MH/SUD services, the State only recognizes physicians, APNs and psychologists as billable providers. However, any provider may practice within their licensure when their services are billed through an outpatient hospital or independent clinic. Most of the MH/SUD services within FFS are provided by clinic providers. Other than psychiatrists, there does not appear to be an unusual shortage of providers. To help attract psychiatrists, FFS has worked with programs to increase rates and billing opportunities to help offset the high cost of these providers.

The managed care contract allows MCOs to contract with any provider if the service they provide is covered in the State plan. These providers can practice as an "in lieu of service". Practitioner types, facility types, or specialty providers are not excluded in writing or in operation from providing covered benefits if they complete the enrollment and contracting requirements of the managed care plan. However, the provider must be contracted with the managed care plan in order to provide services to covered beneficiaries.

The network requirements for FFS and MCOs are different. With the exception of any lawfully imposed moratoriums on provider enrollment, NJ FFS offers an "any willing provider" environment. Any willing provider can apply, and if they meet eligibility requirements (license, accreditation, no debarment history, etc.), they may enroll as a FFS provider. Managed care plans contract with networks of qualified health care providers and home and community-based service providers (as applicable to state) to the enrolled membership in its Plan. The plan performs initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements. Information and documentation on organizational providers is collected, verified, reviewed, and evaluated in order to achieve a decision to approve or deny network participation. Neither the State nor the MCOs employ different criteria for MH/SUD or M/S provider enrollment.

With the exception of a few provider groups that the State mandates be open to enrollment, MCOs are not an open provider network. However, MCOs are contractually required to contract with providers for new recipients who require continuity of care with their present provider. They are also required to cover services for specialists who offer a unique specialty or area of expertise not available within the network, such as a "center of excellence". MCOs must also have adequate providers who can meet the recipient's needs. Therefore, MCOs must also allow for out of network providers when there are no equivalent contracted providers available within the network. The provider enrollment process for the State and for MCOs does not apply different standards between M/S and MH/SUD providers.

With the exception of limited MCO pharmacy services (addressed below), neither the State nor the contracted MCOs apply requirements for the completion of a particular service prior to approval for another. This process is commonly referred to as "step therapy". Evidentiary standards are utilized to determine what service is medically appropriate based on national care guidelines. This process may resemble step therapy at times, but evidentiary guidelines are case by case, taking multiple client specific factors into account to determine the most appropriate plan of care. Any of the guideline recommendations may be overridden if determined medically necessary by providers or the MCO/FFS medical director. Each provider is entitled to speak with the medical director regarding a negative decision. This affords the provider the opportunity to provide evidentiary standards or new clinical information that may result in a revised decision. This process utilizing physician interaction and

evidentiary standards are applied evenly across M/S and MH/SUD services and are not applied more stringently for MH/SUD.

Category specific NQTLs are identified and addressed below. With only minimal time periods as an exception, all M/S services are covered by the managed care plans. For examples of national standards of care utilized by the managed care plans, and applied to M/S services, please see attached appendices.

OUTPATIENT BH/SUD

Parity allows states to apply "soft limits" which are benefit limits that allow for an individual to exceed numerical limits for M/S or MH/SUD benefits on the basis of medical necessity. These benefits are considered to be an NQTL. Mental health partial care has an example of a soft limit and is listed under the "outpatient" category of service. The MH partial care benefit is a psychiatric day care program limited to 5 hours a day, 25 hours a week. This limit was imposed based on nationally accepted standards of care and recognition of an individual's limited ability to participate in active therapy beyond five hours a day. However, if determined medically necessary, services can be authorized to exceed the program limits. This limitation does not exceed the M/S Outpatient limit imposed on medical day care which is also 5 hours a day, 5 days a week.

There are two other soft limits utilized for BH/SUD services; the American Society of Addiction Medicine (ASAM) criteria and Pre-Admission Screening and Resident Review (PASARR) criteria. ASAM is a set of nationally recognized criteria developed to provide outcome oriented and results-based care in the treatment of SUD. The M/S equivalent would be Milliman Care Guidelines (MCG) used to evaluate necessity for outpatient M/S services such as physical therapy. PASARR is an advocacy program mandated by CMS to ensure that nursing home applicants and residents with mental illness and intellectual/developmental disabilities are appropriately placed and receive necessary services to meet their needs. Neither is to be utilized to limit medically necessary services based on financial or cost-based rationale. MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the inpatient classification beyond the utilization of the American Society of Addiction Medicine (ASAM) criteria or the Pre-Admission Screening and Resident Review (PASARR) criteria authorized and required in the State Plan.

All SUD services provided by independent clinics or outpatient hospital programs, including MCO and FFS covered services, must meet ASAM criteria to ensure they are providing the appropriate level of care. These services include SUD partial care, Intensive Out-Patient services (IOP), Medically Assisted Treatment (MAT), short term rehabilitation and non-acute detoxification. Services that are determined to meet the appropriate level of care are given an authorization number which will allow the provider to bill for the service. Authorization numbers are an essential component of utilizing ASAM criteria as they ensure that the recipient was evaluated by the State (or a state contracted entity) and determined clinically appropriate for the service being billed. ASAM criteria is unique to SUD services, however, an equivalent practice would be authorization of physical therapy services. As long as the individual is making progress toward their goals, the authorization will continue. The process is clinically driven. Neither prior authorization is used for length of stay. There are no length-of-stay limits for BH/SUD or M/S services as long as the therapy is determined medically necessary.

Several SUD services have soft limits beyond the use of ASAM criteria. Outpatient psychotherapy MH/SUD services provided by independent practitioners or independent clinics (including Federally Qualified

Health Centers (FQHC)) do not require any authorization. These services include initial assessments as well as individual, group or family psychotherapy. Providers are required to ensure the service provided is medically appropriate. These services are limited to one service modality (individual, group or family) per day up to a total of five services per week. This limit is based on nationally recognized practice standards. If an individual requires more frequent or more intensive service, these limits may be overridden. However, exceeding these limits indicate individuals should be reassessed under ASAM criteria and would likely require a higher level of care.

Outpatient mental health programs such as partial care and Community Support Services (CSS) utilize prior authorization to ensure that a completed individual rehabilitation plan is properly completed and signed in addition to medical necessity. Authorization is not used to limit admission or continuation of medically necessary services. This practice was necessitated by failure of the provider types to complete an appropriate treatment plan. A proper treatment plan is essential to provide quality, patient focused services to these mental health services. This is a unique use of prior authorization limited to BH/SUD. While M/S rehab services require prior authorization, that authorization is based on medical necessity only and not the successful completion of treatment planning prior to the provision of a service.

Outpatient IOP SUD partial care services also have additional soft limits. IOP is defined as a bundled service requiring 3 hours of therapy per day, 3 days per week. While IOP is a defined service, services provided within that definition can be provided in additional quantities if medically necessary. Similarly, SUD partial care is a bundled service requiring 20 hours of psychoeducational therapy per week. Services can be provided in addition to the services included in the description of partial care. Again, if there is a need for additional services, ASAM criteria may indicate a higher level of service is required. The soft limit associated with SUD partial care is equivalent to the limit imposed on medical day care in the outpatient M/S category. As the NQTLs meet the definition of a soft limit and the identified limits on outpatient MH/SUD services do not require any processes, strategies, evidentiary standards or other factors that are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the outpatient M/S classification, Outpatient MH/SUD services are compliant with the parity requirements in MHPAEA.

INPATIENT MH/SUD

All inpatient mental health and SUD inpatient admissions are now covered by managed care for all managed care members. MCOs may not impose prior authorization on any emergent mental health admission. Concurrent review is allowable. Those who are FFS do not require prior authorization if in state and are still required to meet medical necessity criteria determined through concurrent review. This applies to M/S and BH/SUD inpatient hospitalization and short term rehabilitation. FFS providers self-attest that they are providing utilization review of Medicaid clients and they are sampled throughout the year by a contracted vendor to ensure compliance. Managed care plans provide ongoing utilization reviews to prevent fraud and abuse as well as to ensure appropriate utilization to control cost while ensuring appropriate care. Services beyond the recommendations of the approved guideline criteria, New Jersey policy or accepted industry guidelines may be approved as long as documentation supports that decision.

For both M/S and mental health admissions, medical necessity may be determined by utilizing Milliman criteria. Inpatient substance use disorder follows ASAM criteria. Both are a nationally recognized set of best practice guidelines utilized to ensure medical necessity and appropriateness of treatment. Managed

care plans provide ongoing utilization reviews to prevent fraud and abuse. In addition, utilization review ensures appropriate utilization, controls cost and ensures appropriate care. The use of Milliman criteria and ASAM criteria represent soft NQTL limits since services can be extended beyond criteria guidelines. Both clinical management criteria are utilized by MCOs and the State equally for M/S inpatient and BH/SUD inpatient services. These services do not require any processes, strategies, evidentiary standards or other factors that are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S inpatient benefits.

Beyond acute care facilities, MH/SUD inpatient services include admissions to a Psychiatric Residential Treatment Facility (PRTF) for children up to 21 years of age, Adult Mental Health Rehabilitation (AMHR), admissions to a short term SUD rehabilitation facility or admission for non-acute detoxification. PRTF and AMHR services currently do not require authorization under FFS. AMHR under an MCO does require authorization based on the presence of a mental health diagnosis and the regulatory requirements for this program. MCOs utilize this authorization to ensure fiduciary appropriateness and to evaluate individuals for less restrictive services in the community. All facility based SUD inpatient services that are FFS covered are no longer subject to the Institution for Mental Diseases (IMD) exclusion. These services have been added to the continuum of SUD services available under ASAM guidelines. Short term rehabilitation and non-acute detoxification are now authorized when determined appropriate by ASAM criteria. This is equivalent to M/S authorization for subacute rehabilitation services which are provided without limit for as long as medically necessary. There are no associated day or unit limits for any of these services. There are no processes, strategies, evidentiary standards or other factors applied more stringently than equivalent services in inpatient M/S.

All of the identified NQTLs meet the definition of a soft limit and the identified limits on inpatient MH/SUD services may be exceeded if medically necessary. Therefore, since none of the identified NQTLs require any processes, strategies, evidentiary standards or other factors that are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used when applying the NQTL to M/S benefits in the inpatient M/S classification, this category of service meets the Parity standard established by MHPAEA.

Pharmacy BH/SUD

All pharmaceutical products provided through a specialty care or traditional pharmacy, are covered by MCOs for all populations in NJ FamilyCare. Contracted managed care plans utilize a preferred drug formulary that ensures access to all drug classes. Certain drugs routinely require prior authorization including those for the treatment of addiction. The requirement for prior authorization is based on utilization, safety and the Drug Utilization Review Board (DURB) recommendations. These recommendations ensure safe and appropriate usage of certain drug classes. The State DURB program and all its managed care partners have established effective quality assurance measures and systems to reduce medication errors and adverse drug reactions while improving medication utilization.

Managed care plans should not require the completion of a course of action or failure of another treatment plan (step therapy) before approving a service for mental health or SUD treatments. Pharmaceutical services are covered by the MCO for all population groups for both M/S and BH/SUD services. Managed care entities utilize step therapy when there are several different drugs available on the Preferred Drug List (PDL) for treating a particular medical condition. A step therapy guideline that is designed to encourage the use of therapeutically-equivalent, lower-cost alternatives (first-line therapy)

before "stepping up" to more expensive alternatives is permissible if medically appropriate. For commonly prescribed drugs, the adjudication process may systematically assume a failed treatment based on previous claims history. This automated process reduces the need for prior authorization requests. To see how plans apply Step Therapy (ST) protocols, please refer to the attached appendices.

1) Step Therapy (ST) protocols specifically indicate the quantity and name(s) of the preferred alternative drug(s) that must be tried and failed within a designated time period.
2) At point-of-sale, claims history is reviewed electronically for first-line therapy. If the member has met the ST criteria, they will not be subject to the Drug Evaluation Review ("DER") process and will receive the ST medication.
3) Requests for exceptions to drugs listed on the PDL requiring ST shall be reviewed for approval.

NJ FamilyCare MCOs rely on ST and do not have prescription "tiers". The use of tiers is commonly used in commercial plans as a way for MCOs to separate the drugs they cover within classes based on safety and cost. Generally, secondary tiers require higher copayment amounts for prescription drugs in addition to the need for prior authorization. NJ FamilyCare does not allow copayments. Therefore, the MCOs rely on Step therapy. If a prescription for mental health drugs has not met the fail requirements, or the prescriber wants to bypass the lower step drug(s), a prior authorization is required. As per an executive order, substance use medication assisted treatment may not be prior authorized with the exception of non-formulary medications. The prescriber must contact the MCO and provide the required information supporting a non-formulary drug. If the correct information is received, the MCO has 24 hours to make a decision. If the decision supports the prescriber, the authorization is given and the beneficiary receives their drug. If the decision does not, the prescriber may prescribe the alternative in formulary medication. These decisions are required to be based on medical necessity. However, ST is not applied any more stringently for BH/SUD than it is for M/S prescriptions. All adverse determinations are appealable based on best practice guidelines and medical necessity. All prescribers have the right to call and speak with the medical director at the plan responsible for the negative decision. If unsuccessful, they may go to an outside peer for an independent decision.

Managed Care providers use this utilization management tool for drugs that have a high potential for inappropriate use. Step therapy is essential to maintain our recipients' safety and health. To ensure step therapy protocol remains current, these protocols are developed and reviewed at least annually. They indicate the criteria that must be met in order for the drug to be authorized (e.g., specific diagnoses, lab values, trial and failure of alternative drug(s), allergic reaction to preferred product, etc.).

Pharmacy services contain several measures beyond step therapy which include prior authorization. Authorization for certain pharmaceutical products ensures that providers comply with pharmacy practice standards, drug utilization review, internal medication error identification systems, medical therapy management programs, and pharmacy and therapeutics committee recommendations. This helps to ensure that recipients receive safe, high-quality, cost-effective pharmaceutical therapy. All prior authorizations, requirements, and edit restrictions can be overridden by the State or MCO pharmacy department staff once medical necessity is established and safety is assured. Therefore this NQTL is a soft limit which is applied equally for M/S and BH/SUD pharmaceutical services. There is no dollar or quantity limit and usage can be extended beyond DURB limits if clinically indicated. Therefore, this category of service meets the parity standard established by MHPAEA.

Emergency BH/SUD

Emergency services provided for diagnoses defined as a BH/SUD service do not have any prior authorization or service limits. There are no NQTLs, financial requirements or service limits on any BH/SUD services other than transportation in the BH/SUD Emergency category. For transportation, authorization is used to determine if the transport is emergent or non-emergent. This is the same requirement as for M/S services. Emergent transportation is the responsibility of the MCO and non-emergency transportation is the responsibility of a contracted broker. Prior authorization is used strictly to ensure proper billing to the correct payer. There is no service limitation. Emergency services in an emergency department are evaluated for medical necessity for billing purposes only. The Emergency Medical Treatment and Labor Act (EMTALA) requires that emergency screening and stabilization services cannot be denied to anyone who reasonably thinks their condition is potentially life threatening. While services are screened for medical appropriateness, the client is not assessed a copayment if the service does not meet an emergency level of care. Therefore, there are no identified financial or service limits in MH/SUD Emergency. All services are applied equally among M/S emergency and BH/SUD emergency categories. Therefore, this category meets parity requirements in MHPEA.

Conclusion:

NJ FamilyCare meets parity in each of the four required categories listed under BH/SUD. No MH/SUD service requires any processes, strategies, evidentiary standards or other factors that are applied more stringently than those applied to M/S services.

Availability

The criteria for any medical necessity determination for all MH/SUD benefits, whether provided FFS or by an MCO, will be identified. However, most evidentiary standards and treatment criteria guidelines are licensed products and reproduction of the criteria is prohibited. However, as outlined in 42 CFR 438.236(c), MCOs are required to provide, upon request, practice guidelines to all affected providers and recipients. These practice guidelines identify the criteria utilized and explain how the criteria is applied. As required by 438.915(a) the MCO shall make the criteria for medical necessity determinations available to enrollees, potential enrollees and providers upon request. Providers of MH/SUD and all Medicaid recipients are sent an initial denial letter citing the criteria utilized to make the medical necessity determination. The denial letter includes both levels of appeal available to the recipient.

The State of New Jersey is actively working on making Medicaid (including CHIP) information available to all interested parties by listing that information online.

NJ FamilyCare Plan A/ABP recipients with mental health and substance use disorder services covered by their selected managed care plan:

- Managed Long Term Services and Supports (MLTSS) recipients
- Division of Developmental Disabilities (DDD) involved recipients
- Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP) recipients

All NJ FamilyCare plan A/ABP mental health and substance use disorder benefits are covered by managed care under the NJ State Plan for each classification below. No mental health or SUD benefits were added to the Managed Care Plan (MCP) benefit package to meet the requirement in 42 CFR

438.910(b)(2). Inpatient psychiatric hospitalizations may be provided in an Institution of Mental Disease (IMD) as an "in lieu of" service.

MCOs are responsible to provide any medically necessary service to any individuals under the age of 21 that is identified during an EPSDT evaluation.

Definitions for the Purposes of Parity Analysis

Mental Health (MH)- Those conditions listed in ICD-10-CM, Chapter 5 with the exception of subchapter 1, "Mental Disorders due to know physiological conditions".

Substance Use Disorder SUD-a subset of mental health conditions listed in ICD-10-chapter 5 and identified with the diagnosis codes F10-F19, which identify conditions in which the use of one or more substances leads to a clinically significant impairment.

Medical and Surgical benefits- those services associated with the diagnosis and treatment of Medical Surgical conditions listed in ICD-10-CM, Chapters 1-4, Chapters 5 subchapter 1 and chapters 6 through 20.

Standards Used for the Classification of Benefits

Inpatient: All covered services or items provided to a beneficiary when a physician has written an order for admission to a facility. Those services provided in a facility may be for MH and/or SUD treatment as well as for Medical/Surgical services as defined above under "Definitions for the Purposes of Parity Analysis"

Outpatient: All covered services or items that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care. Outpatient MH/SUD services are those services provided for those conditions listed in ICD-10-CM Chapter 5 (with the exception of subchapter 1) while Medical/Surgical services are those services associated with the diagnosis and treatment of those conditions listed in ICD-10-CM, Chapters 1-4, Chapter 5 (subchapter 1) and Chapters 6 through 20.

Emergency Care: All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting. Those services delivered for treatment, stabilization or diagnosis of a MH/SUD as defined in the "Definitions for Purposes of Parity Analysis" above shall be considered emergency care for the treatment MH/SUD. Those services provided for the treatment, stabilization or diagnosis of a medical or surgical service as defined above in "definitions for Purposes of Parity Analysis" shall be considered emergency care for medical and surgical benefit.

Pharmacy: Durable medical equipment and covered medications, drugs and associated supplies that require a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy. Those medications, drugs and associated supplies used for the treatment of a condition listed in ICD-10-CM Chapter 5, with the exception of subchapter 1) shall be applied to and considered MH/SUD. Those medications, drugs and associated supplies used for the treatment of a condition listed in ICD-10-CM Chapters 1-4, Chapter 5 subchapter 1, and Chapters 6-20 shall be applied to and considered medical/surgical services.

Aggregate lifetime limits, Annual Dollar Limits and financial requirements

a) MCOs may not impose an aggregate lifetime dollar limit on any MH/SUD benefit.
b) MCOs may not impose an annual dollar limit on any MH/SUD benefit.
c) MCOs may not impose any financial requirements to any MH/SUD benefits in the inpatient classification.

d) MCOs may not impose any financial requirements to any MH/SUD benefits in the outpatient classification.
e) MCOs may not impose any financial requirements to any MH/SUD benefits in the emergency care classification.
f) MCOs may not impose any financial requirements to any MH/SUD benefits in the pharmacy classification.

Quantitative Treatment Limitations

a) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the inpatient classification.
b) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the outpatient classification.
c) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the emergency care classification.
d) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the pharmacy classification.
e) MCOs may not implement different tiers of prescription drug benefits.

Non-Quantitative Treatment Limitations

a) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the inpatient classification beyond the utilization of the American Society of Addiction Medicine (ASAM) criteria or the nationally accepted medical criteria they have identified on their health plan's website. ASAM is a set of nationally recognized criteria developed to provide outcome oriented and results-based care in the treatment of SUD and is required for use by the health plan in contract language. Health plans are also required to follow state PASAAR criteria which determines if residents with mental illness and intellectual/developmental disabilities are appropriate to be placed in long term care and able to receive and benefit from necessary services intended to meet their needs. No medical criteria is to be utilized to limit medically necessary services based on financial or cost-based rationale.
b) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) beyond prior authorization on MH/SUD services in the outpatient classification. MCOs must follow those limits in the State Plan/Regulations or ASAM criteria. Physician and outpatient services have regulatory limits in place that are based on established practice models and used to limit billing errors and limit fraud and abuse. All limits can be overridden if medical necessity is established. All prior authorizations are based on clinical necessity and are not based on fiscal limitations.
c) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the emergency care classification. As per contract language, MCOs cannot impose a prior authorization on emergency services.
d) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the pharmacy classification beyond step therapy and prior authorization limits utilized to ensure safety and care that is clinically appropriate and based on nationally recognized guidelines. All pharmacy services are available and prior authorization decisions and step therapy requirements can be overridden if medically necessary. Providers can appeal directly to the pharmacy unit or medical director at the MCO in addition to the required appeals and grievance requirements.

Benefit Type	Inpatient	Outpatient	Prescription Drugs	Emergency Care
	- Surgery (established medical criteria) - Anesthesia - Medical/Surgical bed (medical criteria) - Medication administered during the admission - Lab - Radiology - Acute medical detox (ASAM criteria) - Short term rehab (medical criteria) - Custodial Nursing (PAS)	- Physician visit urgent - Physician well visit (limits) - gyn/obstetrics Doulas- no PA - Outpatient surgical center and endoscopy (auth) - optometry- limits - Home-based skilled nursing (medical criteria) - home based rehab and respiratory tx (medical criteria) - Home infusion Prior authorized - PDN-(tool with auth) - PT/OT/ST (auth) - Lab - Radiology (some services authed) - Personal care provided in the beneficiary's home (Unit limit, PA) - Medical day care (limit units per day per week, PA) - Subacute acute rehab services (Criteria) - assisted living (authorized) - group homes (DCP&P) - Opioid Overdose Recovery Program (no PA) Lactation consultants	- Generic and name brand medications - Narcotic meds (may require prior auth.) - Prescription medication required prior to a radiology study - Nicotine reduction therapy - Hep C Tx (PA) - Prosthetics and Orthotics (PA) - Hearing aids (PA) - DME supply (limits and PA for beds, wheelchairs, pumps, lifts, standers, molded braces, vents, incontinence products). Breast pumps- no PA - eyewear/contacts- (limits)	- Ambulance/ALS - Air ambulance/SCT (authorized) - Consultation delivered in an ED - Medications administered during an ED visit - Lab - Radiology provided in an ED - bedside surgical tx

Benefit Type MH/SUD	Inpatient	Outpatient	Prescription Drugs	Emergency Care
	- Psychiatric hospitalization (medical criteria) - PRTF - Psychotropic medication administered in hospital - Short term SUD rehab (ASAM) - Long term SUD rehab (ASAM) - residential withdrawal management (ASAM)	- MH psychiatrist visit - SUD physician visit - MH Psychotherapy (limits) - OP MH clinic psychotherapy (limits) - Partial care/PH (PA with limits units per day/wk) - IOP (ASAM) - MAT (no PA) - Non-acute detox ambulatory (ASAM) - OP SUD psychotherapy (no PA) - AMHR group homes - PACT/ICMS - Rehabilitation services - Peer support (children PA) Care management (no PA)	- Generic and name brand medications (e.g., SSRIs, antipsychotics) - Vivitrol (No PA) - Suboxone -Sublocade (No PA) - Nicotine reduction therapy (limited PA)	- Crisis stabilization (FFS) - Psychotropic medication administered in an ED - mobile crisis

NJ FamilyCare Plan A CHIP Pregnant Women recipients with mental health and substance use disorder services covered by FFS and M/S services by their selected managed care plan

All NJ FamilyCare plan A CHIP Pregnant women mental health and substance use disorder benefits, other than acute hospital services, are covered by FFS Medicaid under the NJ State Plan for each classification below. Inpatient psychiatric and acute substance abuse detoxification are the responsibility of the MCO. No mental health or SUD benefits were added to the Managed Care Plan (MCP) benefit package to meet the requirement in 42 CFR 438.910(b)(2). Inpatient psychiatric hospitalizations may be provided in an Institution of Mental Disease (IMD) as an "in lieu of" service.

MCOs and FFS are responsible to provide any medically necessary service to any individuals under the age of 21 that is identified during an EPSDT evaluation.

Definitions for the Purposes of Parity Analysis

Mental Health (MH)- Those conditions listed in ICD-10-CM, Chapter 5 with the exception of subchapter 1, "Mental Disorders due to know physiological conditions".

Substance Use Disorder SUD-a subset of mental health conditions listed in ICD-10-chapter 5 and identified with the diagnosis codes F10-F19, which identify conditions in which the use of one or more substances leads to a clinically significant impairment.

Medical and Surgical benefits- those services associated with the diagnosis and treatment of Medical Surgical conditions listed in ICD-10-CM, Chapters 1-4, Chapters 5 subchapter 1 and chapters 6 through 20.

Standards Used for the Classification of Benefits

Inpatient: All covered services or items provided to a beneficiary when a physician has written an order for admission to a facility. Those services provided in a facility may be for MH and/or SUD treatment as well as for Medical/Surgical services as defined above under "Definitions for the Purposes of Parity Analysis"

Outpatient: All covered services or items that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care. Outpatient MH/SUD services are those services provided for those conditions listed in ICD-10-CM Chapter 5 (with the exception of subchapter 1) while Medical/Surgical services are those services associated with the diagnosis and treatment of those conditions listed in ICD-10-CM, Chapters 1-4, Chapter 5 (subchapter 1) and Chapters 6 through 20.

Emergency Care: All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting. Those services delivered for treatment, stabilization or diagnosis of a MH/SUD as defined in the "Definitions for Purposes of Parity Analysis" above shall be considered emergency care for the treatment MH/SUD. Those services provided for the treatment, stabilization or diagnosis of a medical or surgical service as defined above in "definitions for Purposes of Parity Analysis" shall be considered emergency care for medical and surgical benefit.

Pharmacy: Durable medical equipment and covered medications, drugs and associated supplies that require a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy. Those medications, drugs and associated supplies used for the treatment of a condition listed in ICD-10-CM Chapter 5, with the exception of subchapter 1) shall be applied to and considered MH/SUD. Those medications, drugs and associated supplies used for the treatment of a condition listed in ICD-10-CM Chapters 1-4, Chapter 5 subchapter 1, and Chapters 6-20 shall be applied to and considered medical/surgical services.

Aggregate lifetime limits, Annual Dollar Limits and financial requirements

g) MCOs may not impose an aggregate lifetime dollar limit on any MH/SUD benefit.
h) MCOs may not impose an annual dollar limit on any MH/SUD benefit.
i) MCOs may not impose any financial requirements to any MH/SUD benefits in the inpatient classification.
j) MCOs may not impose any financial requirements to any MH/SUD benefits in the outpatient classification.
k) MCOs may not impose any financial requirements to any MH/SUD benefits in the emergency care classification.
l) MCOs may not impose any financial requirements to any MH/SUD benefits in the pharmacy classification.

Quantitative Treatment Limitations

f) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the inpatient classification.
g) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the outpatient classification.
h) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the emergency care classification.
i) MCOs may not impose any quantitative treatment limitations to MH/SUD benefits in the pharmacy classification.
j) MCOs may not implement different tiers of prescription drug benefits.

Non-Quantitative Treatment Limitations

e) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the inpatient classification beyond the utilization of the American Society of Addiction Medicine (ASAM) criteria or the nationally accepted medical criteria they have identified on their health plan's website for M/S inpatient or rehabilitative residential services. ASAM is a set of nationally recognized criteria developed to provide outcome oriented and results-based care in the treatment of SUD and is required for use by the health plan in contract language. Health plans are also required to follow state PASAAR criteria which determines if residents with mental illness and intellectual/developmental disabilities are appropriate to be placed in long term care and able to receive and benefit from necessary services intended to meet their needs. No medical criteria is to be utilized to limit medically necessary services based on financial or cost-based rationale.
f) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) beyond the use of ASAM criteria for inpatient acute medical detoxification or their own established medical criteria (identified on each plan's website). Physician and outpatient services have regulatory limits in place that are based on established practice models and used to limit billing errors and limit fraud and abuse. All limits can be overridden if medical necessity is established. All prior authorizations are based on clinical necessity and are not based on fiscal limitations.
g) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the emergency care classification. As per contract language, MCOs cannot impose a prior authorization on emergency services.
h) MCOs may not impose any Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD services in the pharmacy classification beyond step therapy and prior authorization limits utilized to ensure safety and care that is clinically appropriate and based on nationally recognized guidelines. All pharmacy services are available and prior authorization decisions and step therapy requirements can be overridden if medically necessary. Providers can appeal directly to the pharmacy unit or medical director at the MCO in addition to the required appeals and grievance requirements.

FFS benefit Comparison

Benefit Type	Inpatient	Outpatient	Prescription Drugs	Emergency Care
M/S	- Surgery (established medical criteria) - Anesthesia - Medical/Surgical bed (medical criteria)	- Physician visit urgent - Physician well visit (limits) - gyn/obstetrics	- Generic and name brand medications - Narcotic meds (prior auth.) - Prescription medication	- Ambulance/ALS - Air ambulance/SCT (authorized) - Consultation delivered in an ED

	- Medication administered during the admission - Lab - Radiology - Acute medical detox (ASAM criteria) - Short term rehab (medical criteria) - Custodial Nursing (PAS)	- Outpatient surgical center and endoscopy (auth) - optometry- limits - Home-based skilled nursing (medical criteria) - home based rehab and respiratory tx (medical criteria) - Home infusion Prior authorized - PDN-(tool with auth) - PT/OT/ST (auth) - Lab - Radiology (some services authed) - Personal care provided in the beneficiary's home (Unit limit, PA) - Medical day care (limit units per day per week, PA) - Subacute acute rehab services (Criteria) - assisted living (authorized) - group homes (DCP&P) -Doulas -lactation consultants	required prior to a radiology study - Nicotine reduction therapy - Hep C Tx (PA) - Prosthetics and Orthotics (PA) - Hearing aids (limits and PA) - DME supply (limits and PA for beds, wheelchairs, pumps, lifts, standers, molded braces, vents, incontinence products). - eyewear/contacts-(limits)	- Medications administered during an ED visit - Lab - Radiology provided in an ED - bedside surgical tx

Benefit Type MH/SUD	**Inpatient**	**Outpatient**	**Prescription Drugs**	**Emergency Care**
	- Psychiatric hospitalization (medical criteria) - PRTF	- MH psychiatrist visit - SUD physician visit	- Generic and name brand medications (e.g., SSRIs, antipsychotics)	- Crisis stabilization (FFS) - Psychotropic medication

- Psychotropic medication administered in hospital - Short term SUD rehab (ASAM) - Long term SUD rehab (ASAM) - residential withdrawal management (ASAM)	- MH Psychotherapy (soft limits) - OP MH clinic psychotherapy (soft limits) - Partial care/PH (PA with limits units per day/wk) - IOP (ASAM) - MAT (ASAM) - Non-acute detox ambulatory (ASAM) - OP SUD psychotherapy - AMHR group homes - PACT/ICMS - Rehabilitation services - Peer support (children PA, adults no PA) -SUD care management	- Vivitrol (No PA) - Suboxone -Sublocade (No PA) - Nicotine reduction therapy (limited PA)	administered in an ED - mobile crisis