Blue Cross of Idaho Parity Response for the Dual Eligible Population

Scope of Analysis
This Mental Health Parity and Addiction Equity Act (MHPAEA) parity analysis involves the Medicare Medicaid Coordinated Program (MMCP), administered by Blue Cross of Idaho.

Underlined terms are explained in a glossary on the last page of this document.

I. Overview of the MMCP

A. Benefit Product and Role of Blue Cross of Idaho

The MMCP, which must be approved by Medicare each year, covers all medically necessary and preventive services covered under original Medicare. The MMCP provides coverage for people at least 21 years of age who are eligible for benefits in both Medicare and Medicaid and live in Blue Cross of Idaho's geographic service area. The MMCP also provides Part D prescription drug coverage and benefits for services covered by Medicaid. Services covered by Medicaid include but are not limited to Care Coordination, Developmental Disabilities Targeted Service Coordination, Behavior Health Services, Dental Services, Long Term Care Services, and Idaho Medicaid Aged and Disabled Waiver Services. Blue Cross of Idaho has contracts with Medicare and Idaho Medicaid to administer the MMCP.

B. Out-of-pocket Limitation for Medicare Covered Services

There is a limit to how much a member has to pay each year for all services covered under original Medicare. This maximum out-of-pocket limit for 2017 is $3,000 and includes services for Medical/Surgical and Mental Health/Substance Use Disorder (M/S and MH/SUD). Because our members also receive assistance from Medicaid, very few members ever reach this out-of-pocket maximum. The amounts a member owes in the form of copayments for all Medicare covered services apply to this maximum out-of-pocket, excluding the amounts paid for Part D prescription drug copayments. A copayment is the fixed amount a member owes each time covered medical services are received.

C. Cost Share for Idaho Medicaid Aged and Disabled Waiver Services

Some members qualify for Idaho Medicaid Aged and Disabled Waiver Services. The purpose of the Aged and Disabled Waiver is to provide the services and supports needed to maintain people in the community when it is safe and appropriate. Coverage of these services depends on the level of the member's Idaho Medicaid eligibility. The member's monthly cost share, if any, is determined by Idaho Department of Health and Welfare.

D. Out-of-Network Coverage Limitations

1. **Emergency Care by an Out-of-Network Provider**: Plan members must use in-network providers except in emergency or urgent-care situations or for out-of-area kidney dialysis. Emergency services are services provided due to the sudden onset of symptoms that in the absence of immediate medical attention could be considered by a prudent layperson with average knowledge of health and medicine an emergent medical condition. A condition placing the member's health in serious jeopardy, a serious impairment to bodily functions, or a serious dysfunction of any bodily organ

or part are examples of an emergent condition. As long as a member reasonably thought his or her health was in serious danger, the care is covered.

2. **Planned Care by an Out-of-Network Provider**: In most cases, planned care by an out-of-network provider without a referral from their contracted provider will not be covered, and the member will owe the entire cost of the care. If a member needs covered medical care unavailable from an in-network provider, a member or their physician should contact Blue Cross to request prior authorization for out-of-network services before seeking care. In this situation, we will cover these services as if the member received them from a network provider.

II. Definitions of Key Fundamental Terms

The following are the operational definitions Blue Cross of Idaho used as the basis of performing the parity analysis:

- **Scope of MH/SUD Diagnosis**
  - Blue Cross of Idaho has defined MH/SUD according to Medicare and Medicaid stipulations as outlined in our contract and where there are known treatments to address the conditions
- **Scope of Services**
  - Scope of MH/SUD service as outlined in the contract are listed in Grids A and B mapped by four benefit classification and designation of intermediate care services
- **Scope of NQTLs**
  - Grid C maps all the NQTL used in this product against the request around use designation, what NQTL is applied, how applied, when applied and process guiding frequency of application.
- **Benefit Classification**
  - Blue Cross of Idaho followed the benefit classification as outlined by MHPAEA as follows:
    - Inpatient in-network services
    - Inpatient out-of-network services
    - Outpatient in-network services
    - Outpatient out -of-network services
    - Emergency services
    - Pharmacy
  - Intermediatey care services were integrated into the inpatient and outpatient benefit classifications as outlined in Grids A and B

III. Quantitative Treatment Limitations Analysis

Quantitative Treatment Limitation, (QTL) refers to any quantitative or hard cap limit placed on accessing benefits such as cost-sharing, (co-payments, co-insurance, etc.) and treatment visit or day limits. MHPAEA requires health plans to offer both M/S benefits and MH/SUD benefits that are no more restrictive quantitatively than those predominantly applied to substantially all M/S benefits under the plan by benefit

classification. The federal government developed a formula that plans use to determine parity compliance.

The purpose of this section on QTLs is to describe BCI findings regarding the compliance with federal mental health parity requirement.

Direction from CMS states that a formal analysis of compliance is not required if a simpler analysis can clearly demonstrate either compliance or non-compliance.

The MMCP does not contain any of the following QTLs:

- Separate deductibles for M/S and MH/SUD benefits
- Aggregate lifetime dollar limits on any of the ACA's Essential Health Benefits
- Annual dollar maximums on individual plan benefits
- Annual maximums on the dollar value of total services received by a member per year

A. Inpatient Benefit Analysis

1. Visit/Day Limitations Analysis

a) MHPAEA requires that plans have day/visit limitation no more stringent for MH/SUD than for M/S by benefit classification.

b) There are no day or visit limits for MH/SUD services within the four benefit classifications - inpatient and outpatient in-network and inpatient and outpatient out-of-network with a referral from a contracted provider. Out-of-network benefits without a referral from a contracted provider are not covered and are a member expense.

2. Financial Treatment Limitation Analysis

Financial treatment limitation analysis is based on the examination the M/S financial structure and member financial responsibility. The analysis uses the formula definition of predominant and substantial financial requirements, to determining if, and how much of a financial responsibility can be placed on MH/SUD services. The analysis below examines the financial structure and member financial responsibilities of M/S inpatient services incurred in 2016 and paid through mid-August 2017, according to the formula requirements. Inpatient M/S services are split into two service categories, inpatient and skilled nursing facility admissions The only inpatient benefit service with member financial responsibility is co-insurance for Skilled Nursing Facility care as shown in Table 1.

TABLE 1
Hospital Inpatient Patient Cost Sharing Values, 2016 Incurred Claims
Excludes Claims with any Mental Health / Substance Use Disorder Diagnosis

Ref #	Service	Allowed Claims	Patient Coinsurance
1a	Skilled Nursing Facility	$5,085,504.68	$588,449.23
1b	All Other Inpatient	2,880,184.47	0.00
1c	**Total**	**7,965,689.15**	**588,449.23**

Skilled Nursing Facility services are the predominant services that have a member financial responsibility but the medical claim expense does not reach the necessary threshold of 2/3 of medical claims expense for the inpatient benefit classification. It represents 63.8% of total inpatient allowed medical claims, which is less than the 2/3 of services required to allow coinsurance to be charged for inpatient mental health / substance abuse services. For the 2016 benefit year, there was $269,934.84 in member coinsurance for SNF claims which had a mental health /substance abuse diagnosis.

B. Outpatient Benefit Analysis

1. Visit/Day Limitation Analysis

a) MHPAEA requires that plans have day/visit limitation no more stringent for MH/SUD than for M/S by benefit classification

b) In our analysis there are no day or visit limits placed on Mental Health and Substance Use Disorder services in the MMCP benefit for outpatient services in network or out-of-network when there is a referral.

2. Financial Limitation Analysis

The only services with member financial responsibility M/S were coinsurance for services as shown in Table 2.

TABLE 2
Outpatient Cost Sharing Values, 2016 Incurred Claims
Excludes Claims with any Mental Health / Substance Use Diagnosis

Ref #	Service	Allowed Claims	Patient Coinsurance
2a	General Facility Outpatient	$1,945,785.76	$468,856.54
2b	Private Duty Nursing / Home Health	5,884,608.96	386,328.71
2c	Hospice	5,760.80	166.30
2d	*Subtotal – Categories with Coinsurance*	*7,836,321.52*	*855,351.55*
2e	All Other Outpatient	20,733,910.64	0.00
2f	**Total**	**28,570,232.16**	**855,351.55**

Outpatient Service categories with member financial responsibilities only represent 27.4% of total outpatient allowed medical claims, which is less than the 2/3 of services required to allow coinsurance to be charged for outpatient mental health /substance abuse services.

For the 2016 benefit year, there was $21,858.26 in member coinsurance for outpatient claims which had a mental health / substance use diagnosis.

IV. Non-Quantitative Treatment Limit (NQTL) Analysis

The goal of applying NQTLs methodologies to M/S and MH/SUD benefits is to prevent inappropriate or underuse of services and assure that members are receiving medically

necessary care, (the right care, in the right setting, from the right professional). There are many processes, strategies, evidentiary standards and factors used to identify and apply NQTLs to benefit management. The selection of the NQTL methodologies is based on, but not limited to, the characteristic of the service, treatment course, presence or absence of standard practices, outlier performance and other indicators. Not all services within a benefit classification are subject to a NQTL methodology.

A. Overview of the Approach and Documents for the NQTL Analysis

The narrative and attached documents were designed with the intent of describing the processes, strategies, evidentiary standards, and other factors used in applying the NQTL (in writing and in operation) with sufficient detail such that the state/Managed Care Organization can assess the comparability and stringency with which the NQTLs are applied to MH/SUD verses M/S benefits.

The following are Blue Cross of Idaho's working definitions of the terms - processes, strategies, evidentiary standards, and other factors used in applying the NQTLs:

- **Processes** – are procedures used to identify, select and apply a NQTL to the management of a benefit. Processes, for example, could be to use a benchmark threshold based on the expected utilization of service level, (e.g. utilization target based on premium level) to determine when to use a NQTL methodology.
- **Strategies –** are overarching approaches that are designed to address common drivers of over, under or improper use of medical services, unnecessary cost and safety hazards. For example, to deal with preference- driven service request, prior authorization may be put in place for a non-urgent service where there is high cost and preference driven by providers or members
- **Evidentiary Standards** are researched or evidenced base diagnostically or treatment base selections for services. A few examples of evidentiary based standards are medical necessity criteria, practice guidelines issued by subspecialty groups that has been reviewed and approved through third organizations like the Agency for Healthcare Research and Quality, credibly derived consensus driven treatment protocols, vetted randomize clinical trials through FDA or an independent third tech review organization,
- **Factors** – are common forces that guide benefit management such as regulatory requirement through CMS or state legislation and/ or market issues that drive unnecessary utilization and cost or expose members to unnecessary harm.

B. Analysis of Each NQTL Area

This sections maps each NQTL used in this product, its definition, application specifications, frequency of use and other parameters to determine comparability and stringency between the application of NQTL for M/S vs. MH/SUD. The documents for this section consist of grids and narrative to explain comparability and no more stringent status. The grid are organized as follows

Grid A – Scope of services offered for M/S and MH

Grid B – Scope of services offered for MS and SUD

Grid C – Outlines for comparisons of the processes, strategies, evidentiary standards, and factors used for the application of NQTL. Since the individual processes,

strategies, evidentiary standards, and factors used in the application of the NQTL methodologies can be quite granular, the grid represents the presence of methodologies used for M/S benefit management and the comparable scope applied to MH/SUD for comparisons.

Grid D – Outlines the operational applications of the NQTL to M/S vs MH/SUD benefits

C. Comparability

1. Our operational understanding of comparability and stringency comes from the FAQs starting in 2011. The following is our operational interpretations of those FAQs:
   a) Identify all of the utilization management processes, strategies, evidentiary standards and factors applied to medical/surgical benefits within the a benefit classification
   b) Identify all of the utilization management NQTL applied to medical/surgical benefits within the a benefit classification
   c) From the range of medical/surgical utilization management processes, strategies, evidentiary standards and factors and NQTL methodologies used within the benefit classification, a Plan can select those that can be applied to the identified MH/SUD service benefit that has met the definition and/or threshold.
   d) Application of the NQTL should not be any more stringent than the application within medical/surgical in that same benefit classification. Stringent applications include, for example, more frequent applications, harsher penalty, and higher expectations.
   e) Comparability with medical/surgical management is determined plan-by-plan and within each benefit classification.
   f) Substantially all and predominant rules do not apply to NQTL application.

2. The application of NQTL to medical/surgical and behavioral health services is based on the use of the same factors to determine when a NQTL should be applied and which type of application would be the most productive given the nature of the service, volume, benefit classification and cost. The following are the common evidentiary standards and factors used for M/S and applied to MH/SUD benefit management:

   a) Significant changes in utilization trends year-over-year

   b) High or low performance against national or local benchmarks

   c) Identification of services where there is a wide variation in cost or practices with quality/safety concerns

   d) High-cost services that are greatly affected by supply and demand or preference rather than clinical need

   e) High-cost services with limited clarity in service application or efficacy

   f) Introduction of new technologies, medication and treatments

g) Qualitative review of codes that were considered "high value" and "low value". Codes were based on Blue Cross of Idaho's experiential data, local market considerations/dynamics, and clinical expertise/judgment

3. **Tools to Determine Medical Necessity**
Blue Cross of Idaho uses InterQual® criteria, subspecialty practice guidelines and medical policies based on evidence review and adoption to determine medical necessity of services proposed. InterQual is an external third party criteria set that is used by many health plans and health care systems for utilization review activities – prior authorization and concurrent review. InterQual Criteria sets are reviewed and updated at least annually; some criteria sets, such as molecular diagnostics, are updated more frequently. Throughout the year, InterQual releases technology updates and enhancements, regularly bringing new functions and features to the InterQual product. InterQual contains both medical/surgical and behavioral health criteria sets for inpatient, intermediate care and outpatient levels of care.

4. Criteria Development
InterQual Criteria are produced using a rigorous development process based on the principles of evidence-based medicine (EBM). InterQual clinical content is created by clinical research staff of over 40 research and clinical decision support specialists including physicians, registered nurses, clinical psychologists, physical and occupational therapists, and other healthcare professionals, including medical librarians. The physicians' backgrounds include experience or specialization in internal medicine, infectious disease, psychiatry, emergency medicine, hospital medicine, occupational medicine, public health, and surgery.

5. Investigational Reviews

For investigational reviews, Blue Cross of Idaho may create its own policies based upon peer-reviewed literature through the Blue Cross Blue Shield Association (BCBSA) tech review process. Their review process includes, but is not limited to, requiring substantial, (greater than two) peer review research evidence, rating of the strength of the evidence, review of safety measures and other factors.

Services that are considered investigation or experimental are not covered. Services that do not have sufficient research evidence in review by the BCBSA review service are considered by Blue Cross of Idaho to be investigational and therefore are not covered. Those services are reviewed yearly to determine if newer evidence has surfaced that would change the determination of investigational. Investigational services are covered only if there are life and death situations and no appropriate alternative treatment is available.

6. Fail First/Step Therapy

The expectation is that all services are applied by providers according to practice guidelines applicable to the services offered. Fail-first protocols are applied to

medical and pharmacy services where there are clear hierarchal practice guidelines and generally accepted practices are in place. Review criteria take into account step therapy protocols and exceptions to typical treatment flows. There are many medical/surgical outpatient and pharmacy step therapy protocols.

Step therapies are reviewed at least every two years and/or when there is significant advancement potentially necessitating change.

7. **Processes, Strategies, Evidentiary Standards and Factors Selection Criteria**

   Blue Cross of Idaho utilizes InterQual criteria set because the development has an equal focus on M/S and MH/SUD. Internally BCI Utilization Review Committee reviews and updates all criteria, guidelines and evidentiary standards used in the application of NQTLs.

   The Safety and Clinical Programs, Pharmacy and Therapeutic and Medical Policy committees review all medical/surgical and behavioral health practice guidelines, UM criteria and medical/pharmacy policies annually. All pharmacy and medical policies are reviewed based on the presence and rigor of the evidence. Adopted Practice Guidelines are taken from credible subspecialty societies and the AHRQ guideline clearinghouse resource. InterQual is an independently derived industry level-of-care decision tool used by over a thousand plans, hospital systems and provider groups for behavioral health and medical surgical services.

8. **Outlier Performance**

   To determine outlier performance as a trigger for the use of a NQTL, Blue Cross of Idaho uses a variety of national and regional benchmarks. We also look at local Idaho based benchmarks by aggregating performance parameters across all providers. Outlier performance against benchmarks, (e.g. average length of hospitalization or average length of treatment), is used as a trigger for assigning a NQTL and/or triggering a concurrent review. Concurrent review is performed only if the length of treatment is within one day of the benchmark for MS and MH/SUD.

9. **Exclusion Based on Failure to Complete Treatment**

   Blue Cross of Idaho's medical necessity processes do not include an exclusion based on failure to complete treatment. There is no requirement for lower cost therapies to be used first for MH/SUD. Lower cost protocols have been applied to pharmaceutic choices and are the basis for tiering the drugs into two tiers for both M/S and MH/SUD related drugs. Exception to the lower cost strategies are granted based on clinical review.

D. Stringency

1. **MHPAEA requires that NQTLs are applied no more stringently to MH/SUD benefits than they are to M/S. Our guidance around a no more stringent application is as follows**:
   a) The application of a particular NQTL within a benefit is applied in a similar manner to M/S and MH/SUD

b) The frequency of the application of a NQTL should be based on the same thresholds or standards
c) The penalties linked to the NQTLs should not be more often or unequal
d) Not all services with in a benefit classification are subject to a NQTL for MH/SUD
e) A NQTL that is applied to MH/SUD within a benefit classification must also be applied to an M/S benefit in the same benefit classification.
f) Parameters around exception determination have the same principles and process
g) Application of the same criteria for provider inclusion in the network
h) Methodologies for the determination of provider fee schedule are to be similar

2. Stringency is not determined by:

a) The comparisons of denial rates unless the services have the same indications for the application of the NQTL. Denial rates are influenced by many factors (e.g. timely submission of information, clarity of the practice, new therapies without practice guidelines) such that it is not an indicator of a more stringent application
b) The comparison of Average Length of Stay (ALOS) or Average Length of Treatment (ALOT) between M/S and MH/SUD unless the services are similar

3. Application of Medical Necessity

The performance and review requirements for reviewing the use of NQTL for M/S and MH/SUD vary depending on the NQTL. For NQTLs that have some reliance on clinical judgment, (e.g. Prior Auth, Concurrent Review and Post Service Review) there are many safe guards.

a) Medical necessity criteria are annually reviewed and updated internally or by the vendor via a vetting process involving subject matter experts.
b) Blue Cross of Idaho staff, applying the NQTL where clinical judgement is necessary, (e.g. PA and concurrent review methodology), are clinical professionals such as MD/DOs, registered nurses and licensed social workers with a minimum 3 years of practice experience.
c) Final denial decision is rendered only by the MD/DO professionals.
d) Internal interrater reliability is performed to assure that clinical interpretation and judgement is uniformly applied
e) Cases are also sent to external review organizations for a second opinion.
f) Review any appeal overturns for variance in interpretation of guidelines and judgment**.**
g) Provider and member complaints and surveys about the UM process are reviewed.

4. Applying Prior Authorization and Concurrent Review

Selection of services subject to PA and or concurrent review was determined through our literature searches, review of trends, benchmarking and with the assistance of a subject matter consultant. Numerous benchmark plans' prior authorization lists were researched to identify codes to review for addition or removal from the Blue Cross of Idaho prior authorization list. We analyzed the frequency of prior authorization code review to determine volumes of codes being considered. Qualitative review of codes that were considered "high value" and "low value" were identified. Codes were based

on BCI's experience, local market considerations, and clinical expertise/judgment. A consolidated, recommended PA list was developed and is posted on our website, ***bcidaho.com***.

5. Member Penalties

Penalties are applied for serious noncompliance with benefit stipulations to either the contracted provider or member the same for M/S and MH/SUD. The only penalty imposed on the member is for accessing elective out-of-network services without a referral. The product and financial design outlines limited coverage for elective out-of-network services. All cases are reviewed to determine whether an exception exists in assigning member liability according to established criteria. Member liability may be imposed when a member seeks a service out-of-network that is not medically necessary and there is not a gap in service.

6. Exception Determinations

Reviews are performed on a case-by-case basis. There is variance in clinical factors that could warrant an exception or alteration in the application of benefits. Variance is based on circumstances where there is a threat to life, threat of permanent disability and extreme social and/or resource issues exist. Variance decisions are made by the MD/DO professional and reviewed in aggregate as a part of interrater reliability processes (degree of agreement among raters).

7. Monitoring for Under-Utilization

Blue Cross of Idaho selected and monitored outcome measures/standards that we believe are indicators of under application of the NQTL. To detect underutilization we examine many factors:

a) We review service unit volumes against national and local benchmarks to identify population variance.
b) We review gaps-in-care metrics to identify if there is underutilization of services to manage chronic conditions and deploy prevention/early detection intervention.
c) We review network access adequacy and scope of services to determine service availability within the network. Limitation of providers in the network is based on being able to pass credentialing standards, which include valid licensure, practice in good standing, and an absence of criminal record and complaint profile.

V. Provider Network

A. Admission Requirements and Standards

Any licensed/certified provider operating within the scope of their license that passes the credentialing process and agrees to the terms of the contract may be part of Blue Cross of Idaho's provider network.

Blue Cross of Idaho maintains CMS Network Adequacy guidelines whenever possible for all Medicare Advantage products, regardless of provider type. Blue Cross of Idaho does not have Network tiers. We do not exclude practitioner or facility types or specialty providers as long as the provider/facility type is operating within the scope of their license/certification.

We apply a geographic limitation for provider inclusion in the network to provider's with a service area in Idaho or contiguous counties, as the MMCP service area is only in Idaho; the one exception is our transplant facility, as the closest facility is in Salt Lake City, Utah.

B. Standards for Access to Care by an Out-of-Network Provider

1. **Emergency Care by an Out-of-Network Provider:** Plan members must use in-network providers except in emergency or urgent care situations or for out-of-area kidney dialysis. Emergency services are services provided due to the sudden onset of symptoms that in the absence of immediate medical attention could be considered by a prudent layperson with average knowledge of health and medicine an emergent medical condition. A condition placing the member's health in serious jeopardy, a serious impairment to bodily functions, or a serious dysfunction of any bodily organ or part are examples of an emergent condition.

2. **Planned Care by an Out-of-Network Provider:** In most cases, care by an out-of-network provider will not be covered. If a member accesses care by an out-of-network provider without a referral from their contracted provider, then the member will owe the entire cost of the care. If a member needs covered medical care unavailable from an in-network provider, a member or their physician should contact Blue Cross to request prior authorization for out-of-network services

C. Basis for Reimbursement Rate Amounts and Standard for Outpatient Professionals

Reimbursement rate amounts for outpatient professionals are based on the allowable rates published by CMS. We apply the CMS standard and CMS reimbursement rates to all M/S and MH/SUD outpatient professionals. We apply the CMS standard to all provider types. Blue Cross of Idaho utilizes CMS guidelines for determining usual, customary and reasonable charges.

D. Comparison of Factors Affecting Professional Provider's Reimbursement Rates

Factor	M/S	MH/SUD
Service Type	No Affect	No Affect
Geographic Market	No Affect	Rural vs. Urban Providers
Service Demand	No Affect	No Affect
Provider Supply	Yes - In area with shortage, reimbursement may be higher	Yes - In area with shortage, reimbursement may be higher
Practice Size	No Affect	No Affect
Medicare Rates	Yes – basis for all rates	Yes – basis for all rates
Licensure	Yes – higher licensure level such as MD may be reimbursed at higher rate	Yes – higher licensure level such as MD may be reimbursed at higher rate

E. Provider Inclusion

For MH/SUD services there are many ancillary provider types. MH/ SUD services are supplied by psychologist, clinical social workers, (LCSWs), licensed clinical professional counselors (LCPC) and licensed marriage family therapist, (LMFT). Alternative services are supplied by a peer support specialist under the supervision of the licensed MS/SUD professional.

F. Reimbursement Differences

Blue Cross of Idaho uses CMS's methodology for reimbursing both M/S and MH/SUD hospital services. Inpatient M/S services are reimbursed using a method called Diagnostic Related Groups, (DRG). Each patient stay is categorized into a DRG based upon the diagnosis and procedures listed on the claim. A fixed rate is then calculated per DRG. MH/SUD inpatient facilities are reimbursed by either a DRG or a per-diem methodology, depending upon the facility.

Outpatient facility based services are reimbursed using Ambulatory Payment Classification (APC). APC's are a system using a combination of case rates and fee schedules. Like CMS, Blue Cross of Idaho uses this methodology for both M/S and MH/SUD hospital outpatient payments.

Blue Cross of Idaho utilizes CMS guidelines for determining usual, customary and reasonable charges.

VI. Prescription Drugs

The Medicare Part D prescription drug benefits are tiered. There are five tiers and each tier includes generic products. We tier prescription drug benefits to promote the use of lower cost drugs to produce a lower net cost. The Medicaid prescription drug benefits/formularies are not tiered.

1. Decision making principles to designate drugs to a tier include the following:
   a) An independent P&T committee approves all formulary decisions
   b) Evidence-based medicine generally has the greatest weight in deciding whether to place higher value treatment options in lower tiers.
   c) Preferred formulary options are available for all covered conditions when there is at least moderate certainty in the scientific evidence that treatment leads to a clinically meaningful health benefit. There is a formulary exception process available if the drug requested is not listed on the formulary.
2. The brand-generic status of a medication along with its cost affects the tier placement. Tiers are generally listed by: generics on the lowest tiers, followed by brands and specialty products on the highest tiers. The condition treated does not affect the assignment of a tier for a medication.

Glossary

Benchmark - A standard or point of reference against which things may be compared or assessed

Coinsurance – An amount a member may be required to pay as their share of the cost for services or prescription drugs, which is usually a percentage

Concurrent Review – Review of relevant medical information during an episode of treatment to determine on-going medical treatment

Criteria set – Evidenced-based rules to answer critical questions about the appropriateness of care and resource use

Intermediate care services - A level of medical care services that is less than the degree of care provided by an acute care hospital or long-term care facility

Non-quantitative Treatment Limitation (NQTL) - A limit on the scope or duration of benefits for a treatment that is not expressed numerically, such as managing the benefit through prior authorization

Prior Authorization – Review of relevant medical information to determine coverage and medical necessity prior to rendering service

Scope of Service - The types of treatment and treatment settings that are covered by health insurance