POLICY AND PROCEDURE

DEPARTMENT: Utilization Management, Behavioral Health	**REFERENCE NUMBER:** CC.BH.UM.28
EFFECTIVE DATE: 01/01/14	**P&P NAME:** Behavioral Health Covered Benefits and Services
REVIEWED/REVISED DATE: 07/20/17; 04/11/18; 7/19/19; 03/25/20; 4/9/20; 6/26/20; 7/6/20; 7/17/20; 7/20/20; 9/9/20, 10/5/20, 1/19/21,1/28/21; 3/24/21; 6/1/21; 9/22/21; 10/1/21; 11/23/21; 12/22/21	**RETIRED DATE:** N/A
BUSINESS UNIT: Centene Advanced Behavioral Health	**PRODUCT TYPE:** Medicaid, Marketplace, & Medicare
REGULATOR MOST RECENT APPROVAL DATE(S):	

SCOPE:
This policy applies to all directors, officers, and employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company"). This policy and procedure applies to all Centene Advanced Behavioral Health (CABH), a Centene company, staff involved in the design, implementation, operations, and management of the CABH Utilization Management (UM) Program services for all lines of business and product types. This policy and procedure applies to consultants, and temporary workers who may receive physician/provider calls, contacts, or complaints whether written or verbal regarding our services or staff.

PURPOSE:
To outline a list and general guidelines for the covered mental health benefits and services offered to members. Please refer to Attachments when requirements differ from CABH processes.

DEFINITIONS:
Covered Services: Covered behavioral health care benefits defined by the member's respective plan and listed as benefits and services in the summary plan documents, which could be considered either covered or non-covered, depending on the circumstances.

Emergency Medical/Behavioral Health Condition: A medical/behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Medical, Behavioral Health, and Substance Abuse Services: covered inpatient and outpatient services that are (1) furnished by a provider qualified to furnish these services and (2) needed to evaluate or stabilize an emergency medical/behavioral health condition. An emergency medical/behavioral health condition means a medical, behavioral health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; Serious impairment to bodily functions; Serious dysfunction of any bodily organ or part; Serious harm to self or others due to an alcohol or drug abuse emergency; Injury to self or bodily harm to others; or With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn.

Medical Necessity: Covered services that are prescribed based on generally accepted medical practices in light of conditions at the time of treatment. Medically necessary services are: appropriate and consistent with the diagnosis of the treating provider and the omission of such could adversely affect the member's medical/behavioral health condition; compatible with the standards of acceptable medical/behavioral health practice in the community; provided in a safe, appropriate, cost-effective setting given the nature of the diagnosis and severity of the symptoms; not provided solely for the convenience of the member, the physician, or the facility providing the care; those for which there are no other effective and more conservative or substantially less costly treatment, service or setting available.

Post-stabilization Services: Covered services related to an emergency medical condition that are provided after a member is stabilized, in order to maintain the stabilized condition, or to improve or resolve the member's condition.

Urgent Care Services: any request for care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or jeopardize safety of the member or others due to the member's psychological state, **or**
- In the opinion of a practitioner with knowledge of the member's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
- A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if CABH did not previously approve the earlier care.

POLICY:

1. CABH provides benefits and services that are reasonable and medically necessary for the screening, treatment and preventative care of eligible members across all ranges of mental health and substance abuse disorders as referenced in the most recent Diagnostic and Statistical Manual of Mental Health Disorders (DSM), excluding DM v codes. (Occupational stress, partner-relational problems, etc.). DSM V codes identify conditions other than a disease or injury and are also used to report significant factors that may influence present or future care. DSM V codes are not necessarily a primary diagnosis.

2. CABH will not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of diagnosis, type of illness, or condition of the member. All decisions are based on member's existing benefits and medical necessity, as indicated in Policy Section 1.

3. Medicaid Covered services and benefits are defined by the State Medicaid contract and the State's Medicaid Policies and Procedures Manual, as applicable. Covered Services are those services set forth in Title 22 CCR Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the State Contract.

4. Marketplace covered services and benefits are medically necessary health care services provided to members as outlined in the Health Plan's Evidence of Coverage and Summary of Benefits. Identification and management of covered services is compliant with the essential health care benefits defined and mandated under the Affordable Care Act. The Marketplace Health Plans determine and cover medically necessary services and benefits. Members are responsible for co-payments, co-insurance and deductibles based on the specific plan purchased by the member. Members are responsible to pay for any non-covered services. Some covered services may require prior authorization by the Marketplace Health Plans before services are provided.

5. Medicare Covered services are those medically necessary health care services provided to members as outlined in the Health Plan's Evidence of Coverage and Summary of Benefits as defined by CMS and/or CMS National Coverage Determinations and Local Coverage Determinations. CMS defines medically necessary as services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of a medical condition, meet the standards of good medical practice in the local area and aren't mainly for the convenience of the member or physician.

6. CABH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CABH does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. CABH does not discriminate on the basis of participation in a Medicare or Medicaid health plan.

7. Wherein CABH administers the mental health benefit; CABH complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) as it applies to its Medicaid Managed Care Organizations as described in section 1903(m) of the Social Security Act (the Act); Medicaid Alternative Benefit Plans (ABPs) as described in the Act; and Children's Health Insurance Programs (CHIP) under title XXI of the Act.

8. Wherein CABH administers the mental health benefit; CABH complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) as it applies to its Qualified Health Plan under title XX. Marketplace benefits for mental health and substance use are not more stringent than those for med/surg. They are not subject to benefit limitations.

9. CABH shall ensure that services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the Covered Services are furnished and CABH will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. CABH will

only approve services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

10. In the administration of the Medicare benefit, CABH will not render an organization determination based on application of a criteria set that is more stringent than the CMS National Coverage Determination (NCD) and Local Coverage Determinations.

11. CABH requires prior authorization and/or certification of specific covered benefits and services as outlined in the Prior Authorization List. Prior authorization requirements vary, depending on the benefit plan and the service being requested. Emergency services never require prior authorization. CABH reviews the prior authorization list regularly, in conjunction with the behavioral health Medical Director(s) and Vice President(s), Clinical Operations, to determine if any services should be added or removed from the list. The respective Health Plan client is also consulted on proposed revisions to the prior authorization list. Such decisions are based on Health Plan client program requirements, or to meet CMS or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur by CABH's Health Plan clients.

PROCEDURE:

1. Covered benefits vary by Health Plan client contract and may include any or all of the following with associated coverage limitations:

    1.1. Federally Qualified Health Center Services

    1.2. Inpatient Hospital Services

    1.3. Mental Health Crisis Stabilization

    1.4. Mental Health Day Treatment

    1.5. Mental Health Intensive Outpatient Treatment

    1.6. Mental Health Outpatient Services

    1.7. Mental Health Partial Hospitalization

    1.8. Nurse Practitioner Services

    1.9. Physician Services

    1.10. Psychiatric Residential Treatment

    1.11. Rural Health Clinic Services

    1.12. Substance Abuse Services – Inpatient and Outpatient Services

    1.13. Targeted Care Management

    1.14. Urgent Care Services

    1.15. Individual and Group Mental Health Evaluation and Treatment (Psychotherapy)

    1.16. Psychological Testing when clinically indicated to evaluate a mental health condition

    1.17. Psychiatric consultation for medication management

    1.18. Screening and Brief Intervention (SBI)

    1.19. Outpatient laboratory, supplies and supplements- Covered by CABH

    1.20. Comprehensive Diagnostic Evaluation, Assessment and On-going Applied Behavioral Analysis (ABA), under the Behavioral Health Treatment (BHT) benefit.

    1.21. Transcranial Magnetic Stimulation

    1.22. Electroconvulsive Therapy

    1.23. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

    1.24. Ambetter Health Plans (Marketplace)

1.24.1. Except for emergency treatment, all services must be obtained through Ambetter (Marketplace) network providers or prior authorized out-of-network providers, under certain circumstances. Members of Ambetter of Arkansas may seek services or benefits from out of network providers, in accordance with their Evidence of Coverage (EOC).

1.24.2. Ambetter (Marketplace) Health Plan members are responsible for co-payments, co-insurance, and deductibles based on the specific plan purchased by the member. Members are responsible to pay for any non-covered services. Some covered services may require prior authorization by the Ambetter Health Plan before services are provided.

1.24.3. Ambetter (Marketplace) Health Plans provides coverage for a broad range of medically necessary medical and behavioral health services to meet members' health care needs. To receive coverage for services, the service must be described as a covered service or benefit in the EOC, prescribed by the members treating physician, and authorized by CABH, when applicable, and if authorization is required. Certain services require the member's provider to obtain authorization within one (1) business day to rendering or delivery of the service. These include but are not limited to inpatient admissions.

1.24.4. Services are only covered if they are medically necessary as determined by Ambetter Health Plan's review the clinical records using InterQual or ASAM criteria. Medically necessary services are those that:

1.24.4.1. Are the most appropriate level of service for the member considering potential benefits and harm.

1.24.4.2. Are known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes. Ambetter uses InterQual for their review of mental health authorization requests and ASAM criteria for their review for substance use authorization requests.

2. Second Opinions

2.1. Authorization for a second opinion is granted to a network provider or an out-of-network provider, if there is no in-network provider available, when there is a question concerning diagnosis, improving and/or revising the treatment plan, ECT treatment,, or other treatment of a behavioral health condition, or when requested by any representative of the member's health care team, the member, or a parent, guardian(s) or others with custodial responsibilities. Second opinions, whether from an in-network or an out-of-network provider, are provided at no cost to the member. (See CC.BH.UM.18 Authorizations for Second Clinical Opinions Policy and Procedure for more detailed information).

3. Out-of-Network Services

3.1. **This section applies only when health plans delegate network services and claims payment for out of network services to CABH.** If a member requires behavioral health services that are not available from a qualified network practitioner, CABH will adequately and timely (i.e. according to practitioner availability and accessibility standards) cover services out-of-network for members.

3.1.1. The decision to authorize use of an out-of-network behavioral health provider will be based on continuity of care, availability and location of an in-network practitioner of the same specialty and expertise, and complexity of the case.

3.1.2. Network practitioners are prohibited from making referrals for designated behavioral health services to health care entities with which the practitioner or a member of the practitioner's family has a financial relationship.

3.1.3. Services will be authorized as long as the service is needed or until the service can be provided by an in-network provider.

3.1.4. CABH will coordinate payment with the out-of-network provider and ensure the cost to the member is not greater than it would be if the services were furnished by an in-network provider.

3.1.5. CABH will coordinate with the out-of-network provider with regard to payment and communication between member's behavioral health provider.

4. Moral or Religious Objections

4.1. CABH is required to provide and reimburse for all Covered Services. If, during the course of the contract period, pursuant to 42 CFR 438.102, CABH elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, CABH shall notify:

4.1.1. Health Plan client;

4.1.2. State Medicaid Agency/CMS within 120 calendar days prior to adopting the policy with respect to any service;

4.1.3. Health Plan clients will notify members within 90 calendar days after adopting the policy with respect to any service; and

4.1.4. Health Plan clients will notify members and potential members before and during enrollment.

5. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

5.1 The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is a Medicaid mandated program under the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) and section 1905(r)(5) of the Social Security Act (the Act). The goal of EPSDT is to assure that all Medicaid-enrolled children under age 21 receive the health care they need. EPSDT covers not only medically necessary treatment to correct or ameliorate identified conditions, but also preventive, and maintenance services. In addition, EPSDT covers age-appropriate screening services at specified times, and when health problems arise or are suspected. The broad scope of EPSDT provides states with the tools necessary to offer a comprehensive, high-quality health benefit. The EPSDT program has two primary objectives: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources. It encourages assessment of the child's health needs through initial and periodic examinations and evaluations, and promotes early diagnosis and treatment of problems, before they become more complex and costly.

CABH is committed to providing preventive behavioral health screenings and improving the overall health of children enrolled in its health plans. With the high proportion of children in our population, our ability to impact the incidence of EPSDT screening is of vital importance to the overall health and well-being of our membership. See Attachment C - Early and Periodic, Screening, Diagnostic and Treatment (EPSDT).

REFERENCES:
State Medicaid Contracts – *applicable section*
Code of Federal Regulations – 42 CFR 422
Medicare Managed Care Manual Chapter 4 Benefits and Beneficiary Protections
Medicare Managed Care Manual Chapter 13 Medicare Beneficiary Grievances, Organization Determinations and Appeals
HIM.UM.01.01 Covered Benefits and Services Policy and Procedure
CC.UM.01.01 Covered Benefits and Services Policy and Procedure
Current NCQA Health Plan Standards and Guidelines
Current NCQA UM Standards and Guidelines
EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents
CC.Q1.20 Early and Periodic, Screening, Diagnostic and Treatment (EPSDT)
HIM.UM.01.01 Covered Benefits and Services

ATTACHMENTS:
Attachment A – Iowa – Iowa Total Care
Attachment B – New Hampshire – New Hampshire Healthy Families
Attachment C – Oregon Trillium Community Health Plan
Attachment D – Early and Periodic, Screening, Diagnostic and Treatment (EPSDT)
Attachment E – Ohio Buckeye Health Plan Unique Requirements
Attachment F – Arkansas Total Care Unique Requirements
Attachment G – Illinois – Meridian Total
Attachment H – Indiana Managed Health Services
Addendum I- Nevada SilverSummit
Addendum J- New Jersey Marketplace unique requirements
Addendum K- Georgia Peach State Health Plan

SUPPORT/HELP:
Resources available to support users of the P&P. Phone numbers, training programs, classes, and/or offices available to help with carrying out the procedure/work process.

EXAMPLE:

If you need help with:	Contact: Utilization Management
Questions about ….	
Questions about ….	

REGULATORY REPORTING REQUIREMENTS:
Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Off Cycle Review	Changed policy number from CCL.294.CA to EPC.UM.294 and updated company name references. Added Mega Rule language and contractual changes.	07/20/17
Annual Review	For annual review, no content changes.	04/11/18
Off Cycle Review	Transitioned the information from EPC.UM.294 to the Centene P & P template and renumbered to CC.BH.UM.28, incorporated language from CC.UM.01.01 Covered Benefits and Services into this P & P for consistency across organizations, updated the References section.	7/19/19
Annual Review	Added Attachment A - Iowa Total Care Unique Requirements to reflect Iowa Department of Human Services MCO Contract-MED-20-001, 3.2.8 Behavioral Health Services	03/25/20
Off Cycle Review	Attachment B - New Hampshire Healthy Families - Consolidated NHHF state specific policy content from CC.BH.UM.13.01.NH, Court Ordered Services – New Hampshire into CBH policy CC.BH.UM.28, Behavioral Health Covered Benefits and Services, Attachment B on 3/25/2020. Retired CC.BH.UM.13.01.NH, Court Ordered Services – New Hampshire on 5/1/20; Consolidated NHHF state specific policy content from CC.BH.UM.14.01.NH, Covered Benefits and Services – New Hampshire into the CBH policy CC.BH.UM.28, Behavioral Health Covered Benefits and Services, Attachment B on 3/25/2020. Retired CC.BH.UM.14.01.NH, Covered Benefits and Services – New Hampshire on 5/1/20.	03/25/20
Off Cycle Review	Added Attachment C - Early and Periodic, Screening, Diagnostic and Treatment (EPSDT).	4/9/20
Off Cycle Review	Added Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) to Covered Services List, Page 4, Section 1.23. Added Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) to Page 6, Section 5.	4/9/20
Off Cycle Review	Added “EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents” and CC.Q1.20 Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) to the References section.	4/9/20
Off Cycle Review	Added reference to Attachments in Purpose Section. Added Attachment D – Oregon Trillium Community Health Plan Unique Requirements Attachment created. Changed references to “Nebraska Total Care” to “Nebraska Total Care, NHA Expansion” per Health Plan request.	6/26/20
Off Cycle Review	Attachment A – Iowa Total Care updated to include Iowa Department of Human Services Administrative Code related to Community Based Services.	7/6/20
Off Cycle Review	Revised section 3.0 and 3.1 to reflect, “This section applies only when health plans delegate network services and claims payment for out of network services to CBH.”	7/17/20
Off Cycle Review	Attachment E – Ohio Buckeye Health Plan Unique Requirements developed with content from “Use of ASAM Criteria® for Substance Use Disorder Treatment in Hospitals; Requests for Emergency Hospitalization Under ORC 5122.10 Memo.”	7/20/20

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Off Cycle Review	Added Attachment F – Illinois - Illinicare Health Unique Requirements Attachment to reflect content of MMAI Contract 2018 01 01, Section 2.9.8.4.1 related to State Operated Hospitals.	9/9/20
Off Cycle Review	Added Attachment G. to include Arkansas Total Care (ARTC) Non-Medical Support Services.	10/5/20
Off Cycle Review	Added contractual language from the HCC Exhibit 1 Scope of Work, Section 3.10 for MHS- Indiana	1/19/21
Off Cycle Review	Attachment A_G consisting of the IA, NH, OR, OH, IL markets and EPSDT services has been deleted with the creation of separate attachments for easier reference: Attachment A_IA, Attachment B_NH, Attachment C_OR, Attachment D_EPSDT, Attachment E_OH and Attachment G_IL.	1/28/21
Annual Review	Annual Review. Reviewed against the 2021 NCQA Standards and Guidelines for all product lines. Reviewed against Corporate Policy CC.UM.01.01 Covered Benefits and Services and HIM.UM.01.01 Covered Benefits and Services. Removed “Illinicare” and replaced with “MeridianTotal” in Attachment F. Added “All decisions are based on member’s existing benefits and medical necessity, as indicated in Policy Section 1” to Policy Section 2. Re-formatted the policy to align with the new template. Changed “CBH” to “Centene Advanced Behavioral Health (CABH)” to reflect name change. Third Amendment to the MED-20-001 Contract 3.2.6.13 SUPPORT Act Requirements removed from CC.BH.MM.01 Medication Monitoring Unique Requirements Attachment and added to CC.BH.UM.28 Covered Benefits and Services Attachment A – Iowa Total Care Unique Requirements, as CABH is not delegated Medication Monitoring in Iowa.	3/24/21
Ad Hoc Review	Incorporated AR PASSE requirements were added for Tier II and III contractual requirements in Attachment F; Removed revisions prior to 2017	6/1/21
Ad Hoc Review	Reviewed HIM.UM.01.01 Covered Benefits and Services, and added the following to the policy section: *The Marketplace Health Plans determine and cover medically necessary services and benefits. Members are responsible for co-payments, co-insurance and deductibles based on the specific plan purchased by the member. Members are responsible to pay for any non-covered services. Some covered services may require prior authorization by the Marketplace Health Plans before services are provided.*	9/22/21
Ad Hoc Review	Addendum I added to reflect Nevada SilverSummit Medicaid unique requirements: 7.4.2. Contractor’s Coverage of Medicaid and CHIP State Plan Services	10/1/21
Ad Hoc Review	Updates made to Addendum G (Illinois): Added unique requirements from House Bill HB2595 (Public Act 102-0579) Addendum J created to address unique requirements for New Jersey’s marketplace health plan from the State of New Jersey Department of Banking and Insurance (Bulletin No. 17-05). Replaced “carrier” with CABH.	11/23/21
Ad Hoc Review	Updated Addendum F, Arkansas Total Care (ARTC) Non-Medical Support Services information with approval from the health plan. Addendum K created to address requirements related to Georgia Medicaid (Peach State Health Plan) from the Georgia Families Medicaid contract, GA.UM.25 Court Order Services, BH-UM-14 Management of Psychological Services Benefits and Steerage and GA.UM.01.01 Covered Benefits and Services	12/22/2021

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.