

Introduction

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is used by insurers that provide behavioral health benefits to assure coverage of mental health (MH) and substance use disorder (SUD) services is no more restrictive than the coverage available for medical and surgical benefits. The intent of the law was to ensure that behavioral health services would be treated similarly to physical health services in terms of utilization management policies and other limits. In 2016, the Centers for Medicare & Medicaid Services (CMS) clarified the application of MHPAEA to Medicaid and the State Children's Health Insurance Program (CHIP) in a final rule (81 FR 18389) that addressed aggregate lifetime limits, financial requirements, quantitative treatment limitations, nonquantitative treatment limitations, and availability of information. The rule also required states and their managed care organizations (MCOs) to analyze limits placed on mental health and SUD treatment benefits in Medicaid and CHIP. This white paper outlines the Mental Health Parity Analysis conducted by Sunflower Health Plan in November 2024 to fulfill the request made by KDHE and to meet requirements outlined by the final rule.

I. Summary of Parity Compliance Analysis Process for Kancare 3.0

The CMS Toolkit and Parity regulations as applicable to MCOs provide that enrollees of Medicaid MCOs must be provided a benefit that complies with the parity requirements of the MHPAEA ("Parity"). From a benefit design perspective, Parity has two basic requirements. First, Parity requires that any financial requirements ("FR"), such as copays, deductibles, or coinsurance, or any quantitative treatment limits ("QTLs"), such as day, visit or hour limits, that apply to MH/SUD benefits be applied to at least two-thirds of the benefit payments for medical/surgical ("M/S") benefits in the same classification. Second, Parity also requires that any non-quantitative treatment limits ("NQTL") imposed on MH/SUD benefits be applied comparably and no more stringently than the same NQTL is imposed on M/S benefits in the same classification. In addition, Parity requires MCOs to provide beneficiaries with access to certain information relating to MH/SUD benefits, including the criteria for medical necessity determinations and the reasons for any denial of payment. Below is a summary of the steps that will be taken for the Kancare 3.0 parity analysis.

Step 1: Identify benefit packages to which parity applies

The following are the benefit packages identified by KDHE and Sunflower for this analysis:

- Medicaid Adults (adults 21 years of age and older) not enrolled in a 1915(c) Home- and Community-based Services (HCBS) Waiver
- Medicaid/CHIP Children (Medicaid children zero to 20 years of age and CHIP children zero to 18 years of age) not enrolled in a 1915(c) HCBS Waiver
- Medicaid Children in the Autism Waiver (children zero to 5 years of age)
- Medicaid Children in the Brain Injury (BI) Waiver (children under the age of 21)
- Medicaid Adults in the BI Waiver (adults 21 to 64 years of age)
- Medicaid Adults in the Frail Elderly Waiver (adults 65 years of age and older)
- Medicaid Children in the Intellectual and/or Developmental Disability (IDD) Waiver (children five to 20 years of age)
- Medicaid Adults in the IDD Waiver (adults 21 years of age and older)
- Medicaid Children Physical Disability (PD) Waiver (children 16 to 20 years of age)
- Medicaid Adults in the PD Waiver (adults 21 to 64 years of age)
- Medicaid Children in the Serious Emotional Disturbance (SED) Waiver (children four to 18 years of age)
- Medicaid Children in the Technology Assisted Waiver (individuals aged 21 and under)

As part of this analysis, Sunflower determined that each benefit package identified by KDHE was identical for purposes of this analysis, and therefore only one overall analysis is required.

Step 2: Define mental health, substance use disorder and medical/surgical benefits

Sunflower utilizes the following definitions for mental health, substance use disorder, and medical / surgical benefits. The ICD is based on the World Health Organization’s manual of international classification of diseases and is published by the American Medical Association. The ICD is used primarily for medical coding purposes. The ICD is a classification of diseases with codes and descriptors arranged within a tabular list of diseases. The most recent version of the ICD, the ICD-10, has 21 chapters—each based on the affected body system or the nature of the injury and disease.

For purposes of the Parity analysis of Kancare 3.0, MH/SUD benefits are defined as services for the conditions listed in ICD-10-CM, Chapter 5 “Mental, Behavioral, and Neurodevelopmental Disorders” with the exception of:

1. Subchapter 1, “Mental disorders due to known physiological conditions” (F01-F09)
2. Subchapter 8, “Intellectual disabilities” (F70-F79)
3. Subchapter 9, “Pervasive and specific developmental disorders” (F80-F89)

Thus, MH/SUD conditions include those listed in the following subchapters:

1. Subchapter 2, “Mental and behavioral disorders due to psychoactive substance use” (F10-F19)
2. Subchapter 3, “Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders” (F20-F29)
3. Subchapter 4, “Mood [affective] disorders” (F30-F39)
4. Subchapter 5, “Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders” (F40-F48)
5. Subchapter 6, “Behavioral syndromes associated with physiological disturbances and physical factors” (F50-F59)
6. Subchapter 7, “Disorders of adult personality and behavior” (F60-F69)
7. Subchapter 10, “Behavioral and emotional disorders with onset usually occurring in childhood and adolescence” (F90-F98)
8. Subchapter 11, “Unspecified mental disorder” (F99-F99)

For purposes of this Parity analysis, M/S benefits are defined as services for the conditions listed in ICD-10-CM Chapters 1–4, subchapters 1, 8, and 9 of Chapter 5, and Chapters 6–20.

Accordingly, benefits to treat IDD, including autism spectrum disorder, are defined as M/S benefits for purposes of Parity analysis.

Step 3: Define the four benefit classifications and map benefits

Sunflower first classified all MH/SUD and M/S benefits into the four classifications (inpatient, outpatient, prescription drugs, and emergency services) outlined in the CMS Toolkit. The definitions for the four benefit classifications are as follows:

- Inpatient (IP) – Benefits (including medications) provided to a member while in a setting (other than a home and community-based setting as defined in 42 CFR Part 441) that provides treatment 24 hours per day.
- Outpatient (OP) – Benefits provided to a member that do not otherwise meet the definition of inpatient, emergency care, or prescription drugs.
- Emergency Care (EC) – Benefits (including medications) provided in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting.

- Prescription Drugs (PD) – Pharmaceuticals and associated supplies that legally require a medical prescription to be dispensed and are dispensed by a pharmacy or administered in an outpatient setting.

Sunflower then mapped all benefits into the appropriate condition and benefit classification. **Sunflower identified that the mapping was identical for all benefit packages identified above, and therefore the mapping below is only included once and applies to all benefit packages.**

Kancare 3.0 Medical/Surgical and Mental Health Benefits Mapping for all benefit packages

Benefit Type	Inpatient	Outpatient	Emergency Care	Prescription Drugs
M/S	<ul style="list-style-type: none"> • Surgery • Anesthesia • Inpatient acute • Inpatient rehab/LTACH/SNF • Medication administered during the admission • Lab • Radiology • PT/OT/ST 	<ul style="list-style-type: none"> • Preventative services • Primary care visits • Home Health nursing • Medication administered during the outpatient visit • Lab • Radiology • Personal care services • Rehabilitation therapies 	<ul style="list-style-type: none"> • Ambulance • Consultation delivered in an ED • Medications administered during an ED visit • Lab • Radiology provided in an ED 	<ul style="list-style-type: none"> • Generic and name brand medications • Prescription medication required prior to a radiology study
MH	<ul style="list-style-type: none"> • Inpatient psychiatric care • Psychotropic medications • Peer support 	<ul style="list-style-type: none"> • Psychotherapy • Rehabilitation services (PRTF) • Intensive Outpatient • Lab • PHP • Peer support • Parent training • Respite • Home Health care • Personal care services 	<ul style="list-style-type: none"> • Crisis stabilization • Psychotropic medication administered in an ED • Emergency respite • Lab • Peer support 	<ul style="list-style-type: none"> • Generic and name brand medications (e.g., SSRI's, antipsychotics)

Kancare 3.0 Medical/Surgical and Substance Use Disorder Benefits Mapping for all benefit packages

Benefit Type	Inpatient	Outpatient	Emergency Care	Prescription Drugs
M/S	<ul style="list-style-type: none"> • Surgery • Skilled nursing care • Detoxification • Inpatient acute • Methadone when ordered by a 	<ul style="list-style-type: none"> • Preventative services • Primary care visits • Detoxification • Home Health nursing 	<ul style="list-style-type: none"> • Ambulance • Consultation delivered in an ED • Medications administered during an ED visit 	<ul style="list-style-type: none"> • Generic and name brand medications • Schedule II drugs

	<p>physician in a hospital for pain</p> <ul style="list-style-type: none"> • Lab • Radiology • PT/OT/ST 	<ul style="list-style-type: none"> • Medication administered during the outpatient visit • Lab • Radiology 	<ul style="list-style-type: none"> • Lab • Radiology provided in an ED 	
SUD	<ul style="list-style-type: none"> • Acute Psychiatric services • Residential SUD services • Detoxification in combination with treatment for a SUD • Buprenorphine (MAT) when prescribed by a certified physician in a hospital • Methadone when ordered by a physician in a hospital for SUD 	<ul style="list-style-type: none"> • Community-based detoxification • Intensive Outpatient Program Services • Federally certified OTP services • MAT when delivered through an OTP • Counseling and behavior therapy (required for buprenorphine) • Psychosocial rehab 	<ul style="list-style-type: none"> • Crisis stabilization • Naloxone 	<ul style="list-style-type: none"> • Generic and name brand medications • Nicotine replacement and smoking cessation drugs • MAT when prescribed by a certified clinician and combined with counseling and behavior therapy in an outpatient setting

Step 4: Identify and test each dollar limit, FR, and QTL

In accordance with the CMS toolkit, Sunflower conducts this analysis using the “substantially all” and then the “Predominant tests”. The “substantially all” test states the QTL must apply to at least two-thirds of the M/S benefits and second, if the QTL meets the first requirement, the “predominate” test is applied, meaning the QTL must also be applied to more than one-half of the M/S benefits. If a QTL does not apply to substantially all of the M/S benefits, it may not apply to MH/SUD benefits.

Per the question and answer session on 10/24/2024 and based on Sunflower’s analysis, this analysis did not test dollar limits, financial restrictions and quantitative treatment limits, as these are prohibited under the KanCare 3.0 program.

Step 5: Identify and test the comparability and stringency of each of the types of NQTLs provided in the CMS Toolkit

Sunflower Health Plan (SHP) NQTLs are structured in a five-step comparative analysis format, comparing Medical/Surgical (M/S) benefits to Mental Health and Substance Use Disorder Benefits (MH/SUD). The structure of the comparative analysis is designed to demonstrate that the processes, strategies, factors,

and evidentiary standards, and sources used to apply an NQTL to MH/SUD benefits are comparable and not more stringent to the processes, strategies, factors, evidentiary standards, and sources used to apply NQTL to M/S benefits (reference SHP Policy CC.COMP.20).

After identifying and documenting the specific NQTL criteria as applied to each specific benefit classification, Sunflower performs the comparability and stringency analysis on these NQTLs as called for by the CMS Toolkit. Sunflower's analysis of the NQTLs is based on data collection relating to the basis and application of each NQTL to each benefit classification and incorporated a review by applicable staff. Finally, because benefits covered by KanCare occur in all four classifications, Sunflower outlined details within each NQTL that applies to parity of covered benefits as outlined in Table 1.

A summary of the Comparability and Stringency Analysis of each NQTL by category is provided below:

1. Medical Necessity Criteria

The Medical Necessity Criteria for MH/SUD benefits in all applicable classifications are comparable and no more stringent than the medical necessity criteria for M/S benefits as written and in application. Sunflower applies medical necessity and appropriateness to all inpatient, outpatient, and prescription drug benefits as required by KDHE. Medical necessity is not applicable to emergency services for either MH/SUD or M/S benefits.

For all classifications, both MH/SUD and M/S medical necessity criteria are developed using the definitions provided by KDHE and supplements by comparable nationally recognized criteria (such as InterQual and ASAM). For both MH/SUD and M/S benefit classifications, Sunflower regularly reviews the Centene clinical policies for accuracy with updated clinical literature.

The medical necessity review process for both MH/SUD and M/S benefits is implemented in a comparable manner across all benefit classifications. As described in our internal policies and procedures, the frequency of reviews varies by the type of service, the treatment plan and the member's disease state. For OP services such as therapies and home health care, the severity of the member's condition and the associated treatment plan and progress to goals and limits set forth by the KDHE dictate the frequency of ongoing reviews. Sunflower follows NCQA standards in our completion of all medical necessity determinations which include guidance related to timeframes for initial review and communication of review outcomes.

2. Prior Authorization

The Prior Authorization benefits for MH/SUD benefits in three classifications (inpatient, outpatient, and prescription drugs) are comparable and no more stringent than the prior authorization requirements for M/S benefits as written and in application. Prior authorization is not applicable to emergency services for either MH/SUD or M/S benefits.

3. Concurrent Review

The concurrent review requirements for MH/SUD benefits in the inpatient and outpatient classifications are comparable and no more stringent than the concurrent review benefits in the M/S classification as written and in application. Concurrent review is not applicable to either MH/SUD or M/S Emergency Care and Prescription Drugs benefits.

4. Retrospective Review

The respective review requirements for MH/SUD benefits in the inpatient and outpatient classifications are comparable and no more stringent than the retrospective review benefits in the M/S classification as written and in application. Retrospective review is not applicable to either MH/SUD or M/S Emergency Care and Prescription Drugs benefits.

5. OON coverage standards

The out of network requirements in three MH/SUD classifications (inpatient, outpatient, and emergency care) are comparable and no more stringent as written and in application than the out of network requirements for M/S benefits in the same classifications. Out of network requirements are not applicable to either MH/SUD or M/S prescription drug benefits.

6. Geographic Restrictions

The geographic restrictions requirements for MH/SUD benefits in three classifications (inpatient, outpatient, and emergency care) are comparable and no more stringent than the geographic restrictions requirements for M/S benefits as written and in application. Geographic restrictions are not applicable to prescription services in either MH/SUD or M/S benefit classifications.

7. Experimental/Investigational Determinations

The experimental/investigational determination requirements in all classifications (inpatient, outpatient, emergency care, and prescription drugs) are comparable and no more stringent than the experimental determination requirements for M/S benefits as written and in application.

8. Exclusions for Court-Ordered Treatment or Involuntary Holds

The court-ordered treatment requirements are not applicable to either MH/SUD or M/S in three classification areas (inpatient, emergency care, and prescription drugs). The MH-SUD court-ordered treatment requirement for outpatient benefits is comparable and no more stringent as written and in application to the M/S outpatient benefit classification.

9. Internal Appeals

The internal appeals MH/SUD classifications (inpatient, outpatient and prescription drugs) are comparable and no more stringent as written and in application than the internal appeals requirements for M/S benefits in the same classifications. Internal appeals requirements are not applicable to MH/SUD benefits in emergency care as any appeals related emergency care would be processed as inpatient or outpatient appeals.

10. Provider Reimbursement

The provider reimbursement requirements for MH/SUD benefits in the inpatient, outpatient, emergency care, and prescription drugs classifications are comparable and no more stringent than the provider reimbursement requirements in the same M/S classification as written and in application.

11. Provider Credentialing

The provider credentialing requirements for MH/SUD benefits in all classifications (inpatient, outpatient, emergency care, and prescription drugs) are comparable and no more stringent than the provider credentialing requirements for M/S benefits as written and in application.

12. Certification Requirements

The certification requirements NQTL for MH/SUD benefits in all classifications (inpatient, outpatient, emergency care, and prescription drugs) are comparable and no more stringent than the certification requirements for M/S benefits as written and in application.

13. Unlicensed provider/staff requirements

The unlicensed provider/staff NQTL for MH/SUD benefits in all classifications (inpatient, outpatient, emergency care, and prescription drugs) are comparable and no more stringent than the unlicensed provider/staff requirements for M/S benefits as written and in application.

14. Provider-type exclusions

The provider type exclusions NQTL for MH/SUD benefits in all classifications (inpatient, outpatient, emergency care, and prescription drugs) are comparable and no more stringent than the provider type exclusions requirements for M/S benefits as written and in application.

15. Formulary/PDL Design

MH/SUD and M/S formulary design is determined by the Kansas DUR Board along with the Kansas PDL committee; MH/SUD drugs are required to go through the Kansas MHMAC (this requirement is set by the Kansas statute chapter 39 article 7 section 121b). The review for MH/SUD drugs is comparable and no more stringent than the review for M/S drugs as written and in application.

In addition to these NQTLs, in previous analysis and to be applied to Kancare 3.0, Sunflower also considers whether there were policies, processes and requirements related to (a) Fidelity Requirements for Evidence-Based Practices, (b) Coding Edits, (c) Outlier reviews, (d) Fail First (Step Therapy), (e) Failure to Complete Requirements and (f) Usual & Customary Rates Determinations. Sunflower has determined that these NQTLs did not apply to any of the classification areas for MH/SUD and therefore did not require a further review for Parity.

II. Implications

In addition to analysis of previous submissions, Sunflower recommends a broader evaluation of overall access to Mental Health and Substance Use Disorders across the state. Despite efforts to identify inequities in treatment limitations for behavioral health services, we concluded that MHPAEA does not appear to have substantially improved access to behavioral health care for Medicaid and beneficiaries. Parity analyses required under MHPAEA focus on a narrow set of barriers that may limit access to care (e.g., prior authorization, step therapy) and aren't as impactful to addressing access issues as were initially believed. While parity should be an ongoing focus, Kancare 3.0 includes strategies to address issues like provider and caregiver workforce shortages, rising rates of behavioral health disorders, higher acuity of patients, and access to services in disparate geographical areas. Sunflower continues our diligent focus on creating additional access and providing education to providers and communities in the state of Kansas through our Project ECHO series and other strategic partnerships. Sunflower welcomes further discussion with KDHE about previous and future analysis findings and potential partnerships to continue to increase behavioral health accessibility in the state of Kansas.

III. Disclaimers and Caveats

The analysis presented represent a good-faith effort on the part of Sunflower to complete its Parity assessment as requested by KDHE of the benefits administered as part of its contract, and

to ensure that Sunflower members receive a Parity-compliant benefit in Kansas. Any proposed analysis or findings presented in this document should not be interpreted as a warranty or legal representation of KDHE's compliance with Parity.

Sunflower Health Plan MHPAEA Analysis for Kancare 3.0 beginning January 1, 2025

NQTL	MEDICAL/SURGICAL BENEFITS	MENTAL HEALTH/SUBSTANCE USE DISORDER BENEFITS
Medical Necessity	How is medical necessity applied	<p>Medically necessary or medical necessity means any medical service, supply, or treatment authorized by a physician / APRN to prevent, stabilize, diagnose, or treat a member’s illness or injury which:</p> <ol style="list-style-type: none"> 1. Is consistent with the symptoms or diagnosis. 2. Is provided according to accepted medical practice standards. 3. Is not custodial care. 4. Is not solely for the convenience of the physician or the covered person. 5. Is not experimental or investigational. 6. Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment. 7. Is no more costly than an alternative Covered service that is likely to produce equivalent therapeutic outcome; and 8. When specifically applied to a hospital confinement, it means that the diagnosis and treatment of your medical symptoms or conditions cannot be safely provided as an outpatient. <p>Charges incurred for treatment not medically necessary are not eligible expenses.</p>

Sunflower Health Plan MHPAEA Analysis for Kancare 3.0 beginning January 1, 2025

NQTL		MEDICAL/SURGICAL BENEFITS		MENTAL HEALTH/SUBSTANCE USE DISORDER BENEFITS	
	If not considered medically necessary, is coverage excluded for:	Inpatient Services	Yes		Yes
		Outpatient Services	Yes		Yes
		Emergency Services	Yes		Yes
	Describe the process for developing the clinical criteria for determining medical necessity	Inpatient Services	All medical necessity requirements are developed by qualified medical directors and other clinical staff, and are aligned with all relevant state, federal and clinical guidelines		All medical necessity requirements are developed by qualified medical directors and other clinical staff, and are aligned with all relevant state, federal and clinical guidelines
		Outpatient Services	All medical necessity requirements are developed by qualified medical directors and other clinical staff, and are aligned with all relevant state, federal and clinical guidelines		All medical necessity requirements are developed by qualified medical directors and other clinical staff, and are aligned with all relevant state, federal and clinical guidelines
		Emergency Services	All medical necessity requirements are developed by qualified medical directors and other clinical staff, and are aligned with all relevant state, federal and clinical guidelines		All medical necessity requirements are developed by qualified medical directors and other clinical staff, and are aligned with all relevant state, federal and clinical guidelines
Prior Authorizations	Is prior authorization required for:	Inpatient Services	Yes		Yes
		Outpatient Services	In some cases The Provider Manual provides further information on these requirements. This includes a table of requirements as well as a link to the prescreen tool (https://www.sunflowerhealthplan.com/providers/preauth-check/medicaid-pre-auth.html) that provides authorization requirements. A full list of		In some cases The Provider Manual provides further information on these requirements. This includes a table of requirements as well as a link to the prescreen tool (https://www.sunflowerhealthplan.com/providers/preauth-check/medicaid-pre-auth.html) that provides authorization requirements. A full list of

Sunflower Health Plan MHPAEA Analysis for Kancare 3.0 beginning January 1, 2025

NQTL	MEDICAL/SURGICAL BENEFITS	MENTAL HEALTH/SUBSTANCE USE DISORDER BENEFITS
<p>Describe the as written and in operation processes for determining whether to apply prior authorization for all classifications for:</p>	<p>Inpatient Services</p>	<p>benefit coverage can be found on the KMAP website.</p> <p>Prior Authorization requests (medical and behavioral health) must be received by telephone, eFax, or provider web portal as follows:</p> <ol style="list-style-type: none"> 1. At least 5 days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility. 2. At least 30 days prior to receiving clinical trial services. 3. Within 24 hours of any inpatient admission. 4. At least 30 days prior to the initial evaluation for organ transplant services. <p>For medical services that the MCO has determined shall require prior authorization, only the minimally necessary information will be obtained. The information required will not be overly burdensome for the member, the practitioner/staff, or the health care facility staff. Clinical information received, as well as rationale for the medical necessity determination and/or leveling of care are documented and maintained in the clinical authorization system.</p> <p>After prior authorization has been requested and all required or applicable documentation has been submitted, we will notify you and your provider if the request has been approved as follows:</p>
		<p>benefit coverage can be found on the KMAP website.</p> <p>Prior Authorization requests (medical and behavioral health) must be received by telephone, eFax, or provider web portal as follows:</p> <ol style="list-style-type: none"> 1. At least 5 days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility. 2. At least 30 days prior to receiving clinical trial services. 3. Within 24 hours of any inpatient admission. <p>For medical services that the MCO has determined shall require prior authorization, only the minimally necessary information will be obtained. The information required will not be overly burdensome for the member, the practitioner/staff, or the health care facility staff. Clinical information received, as well as rationale for the medical necessity determination and/or leveling of care are documented and maintained in the clinical authorization system.</p> <p>After prior authorization has been requested and all required or applicable documentation has been submitted, we will notify you and your provider if the request has been approved as follows:</p> <ol style="list-style-type: none"> 1. For urgent concurrent reviews within 24 hours (1 calendar day) of receipt of the request.

Sunflower Health Plan MHPAEA Analysis for Kancare 3.0 beginning January 1, 2025

NQTL	MEDICAL/SURGICAL BENEFITS	MENTAL HEALTH/SUBSTANCE USE DISORDER BENEFITS
	<ol style="list-style-type: none"> 1. For urgent concurrent reviews within 24 hours (1 calendar day) of receipt of the request. 2. For urgent pre-service reviews, within 72 hours (3 calendar days) from date of receipt of request. 3. For non-urgent pre-service reviews within 5 days but no longer than fifteen calendar days of receipt of the request. 4. For post-service or retrospective reviews, within thirty calendar days of receipt of the request. 	<ol style="list-style-type: none"> 2. For urgent pre-service reviews, within 72 hours (3 calendar days) from date of receipt of request. 3. For non-urgent pre-service reviews within 5 days but no longer than fifteen calendar days of receipt of the request. 4. For post-service or retrospective reviews, within thirty calendar days of receipt of the request.
	Outpatient Services	Same as Inpatient
What is the process for determining whether to apply prior authorization to a particular service?	<p>Prior authorization requirements are pre-established, and not typically decided on a case-by-case basis. The Corporate Medical Management department reviews the prior authorization list regularly to determine if any services should be added or removed from the list pursuant to the factors listed below. Examples of services requiring prior authorization are enumerated in the Sunflower Health Plan Provider manual and in the prescreen tool (https://www.sunflowerhealthplan.com/providers/preauth-check/medicaid-pre-auth.html).</p>	<p>Prior authorization requirements are pre-established, and not typically decided on a case-by-case basis. The Corporate Medical Management department reviews the prior authorization list regularly to determine if any services should be added or removed from the list pursuant to the factors listed below. Examples of services requiring prior authorization are enumerated in the Sunflower Health Plan Provider manual and in the prescreen tool (https://www.sunflowerhealthplan.com/providers/preauth-check/medicaid-pre-auth.html).</p>
What factors and evidence are considered when deciding whether to recommend a service for prior authorization?	<p>Medicaid plans will require prior authorization for those procedures for which one or more of the following factors can be significantly improved by the authorization, in accordance with federal and state law: significant levels of fraud, waste, and</p>	<p>Medicaid plans will require prior authorization for those procedures for which one or more of the following factors can be significantly improved by the authorization, in accordance with federal and state law: significant levels of fraud, waste, and</p>

Sunflower Health Plan MHPAEA Analysis for Kancare 3.0 beginning January 1, 2025

NQTL		MEDICAL/SURGICAL BENEFITS	MENTAL HEALTH/SUBSTANCE USE DISORDER BENEFITS	
		<p>abuse; cost-effectiveness of prior authorization, quality of care/safety concerns; clinical efficacy.</p> <p>To evaluate these factors, the MCO consults peer-reviewed medical literature, industry standards, claims and authorizations data, SIU investigation findings, professional judgment of the UM committee members.</p>	<p>abuse; cost-effectiveness of prior authorization, quality of care/safety concerns; clinical efficacy.</p> <p>To evaluate these factors, the MCO consults peer-reviewed medical literature, industry standards, claims and authorizations data, SIU investigation findings, professional judgment of the UM committee members.</p>	
<p>Provide details regarding the use of utilization review organizations (UROs). Criteria must be the same for both Med/Surg and MH/SUD</p>		<p>Sunflower utilizes 4 NCQA accredited Third Party Vendors: National Imaging Associates, Turning Point, New Century Health, American Specialty Health. We utilize nationally recognized clinical criteria - i.e., Inter Qual. We have quarterly UM Committee meetings to monitor and have oversight of UM program. UM conducts prior authorization reviews and continued stay reviews</p>	<p>We utilize nationally recognized clinical criteria - i.e., Inter Qual. We have quarterly UM Committee meetings to monitor and have oversight of UM program. UM conducts prior authorization reviews and continued stay reviews</p>	
Concurrent Review	Is Concurrent review conducted for:	Inpatient Services	Yes	Yes
		Outpatient Services	No	No
		Emergency Services	No	No

Sunflower Health Plan MHPAEA Analysis for KanCare 3.0 beginning January 1, 2025

NQTL	MEDICAL/SURGICAL BENEFITS	MENTAL HEALTH/SUBSTANCE USE DISORDER BENEFITS	
<p>What policy or policies are used for criteria applied to concurrent review?</p>	<p>Sunflower Health Plan maintains internal policies guiding the concurrent review process to ensure all relevant cases are reviewed appropriately. These policies are themselves reviewed annually and any necessary updates are made to keep them in line with current state, federal, and clinical guidance.</p> <p>The medical necessity criteria is determined using the following hierarchy:</p> <ol style="list-style-type: none"> 1. Federal 2. KMAP 3. Sunflower Plan Specific Policy 4 Corporate Clinical / Medical Policy 4. Interqual 5. Always include any work process or meeting notes as needed 	<p>Sunflower Health Plan maintains internal policies guiding the concurrent review process to ensure all relevant cases are reviewed appropriately. These policies are themselves reviewed annually and any necessary updates are made to keep them in line with current state, federal, and clinical guidance.</p> <p>The medical necessity criteria is determined using the following hierarchy:</p> <ol style="list-style-type: none"> 1.Federal 2. KMAP 3. Sunflower Plan Specific Policy 4 Corporate Clinical / Medical Policy 4. Interqual 5. Always include any work process or meeting notes as needed 	
	<p>What factors trigger concurrent review?</p>	<p>N/A: CR is performed for all inpatient benefits throughout the inpatient stay, with additional hospital days approved based on review of the patient’s condition and evaluation of medical necessity criteria.</p>	<p>N/A: CR is performed for all inpatient benefits throughout the inpatient stay, with addition hospital days approved based on review of the patient’s condition and evaluation of medical necessity criteria.</p>
<p>Retrospective Review</p>	<p>How are claims identified for retrospective review and who makes that determination?</p>	<p>The MCO Medical Management Department makes retrospective medical necessity review decisions when:</p> <ul style="list-style-type: none"> • A member has been discharged from an inpatient admission prior to notification to the MCO, and 	<p>The MCO Medical Management Department makes retrospective medical necessity review decisions when:</p> <ul style="list-style-type: none"> • A member has been discharged from an inpatient admission prior to notification to the MCO, and notification was timely.

Sunflower Health Plan MHPAEA Analysis for Kancare 3.0 beginning January 1, 2025

NQTL	MEDICAL/SURGICAL BENEFITS	MENTAL HEALTH/SUBSTANCE USE DISORDER BENEFITS
	<p>notification was timely, including non-routine obstetrical admissions.</p> <ul style="list-style-type: none"> • Required per provider and/or state contract specifics • This review may also occur when authorization or timely notification to Sunflower Health Plan was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have his/her Sunflower Health Plan ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. • 15-day readmission reviews are performed retrospectively, as are DRG audits. Either of these types of audits would result in a recoupment for the provider. There are also SIU processes in place that result in retrospective review of services and potential recoupment. • Note: For prior authorization of genetic testing or outpatient testing for drugs of abuse, a five (5) business day grace period from the date of lab receipt of the specimen will be allowed. Any specimens already processed by the lab will be treated as a retrospective request. 	<ul style="list-style-type: none"> • Required per provider and/or state contract specifics • This review may also occur when authorization or timely notification to Sunflower Health Plan was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have his/her Sunflower Health Plan ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. • 15-day readmission reviews are performed retrospectively, as are DRG audits. Either of these types of audits would result in a recoupment for the provider. There are also SIU processes in place that result in retrospective review of services and potential recoupment. • Note: For prior authorization of genetic testing or outpatient testing for drugs of abuse, a five (5) business day grace period from the date of lab receipt of the specimen will be allowed. Any specimens already processed by the lab will be treated as a retrospective request.
What algorithms are used in retrospective review?	N/A - RR is applied pursuant only to the factors listed above.	N/A - RR is applied pursuant only to the factors listed above.

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<p>Identify the process used for identifying outliers.</p>	<p>The MCO Medical Management Department makes retrospective medical necessity review decisions when:</p> <ul style="list-style-type: none"> • A member has been discharged from an inpatient admission prior to notification to the MCO, and notification was timely, including non-routine obstetrical admissions. • Required per provider and/or state contract specifics • This review may also occur when authorization or timely notification to Sunflower Health Plan was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have his/her Sunflower Health Plan ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. • Note: For prior authorization of genetic testing or outpatient testing for drugs of abuse, a five (5) business day grace period from the date of lab receipt of the specimen will be allowed. Any specimens already processed by the lab will be treated as a retrospective request. 	<p>The MCO Medical Management Department makes retrospective medical necessity review decisions when:</p> <ul style="list-style-type: none"> • A member has been discharged from an inpatient admission prior to notification to the MCO, and notification was timely. • Required per provider and/or state contract specifics • This review may also occur when authorization or timely notification to Sunflower Health Plan was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have his/her Sunflower Health Plan ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. • Note: For prior authorization of genetic testing or outpatient testing for drugs of abuse, a five (5) business day grace period from the date of lab receipt of the specimen will be allowed. Any specimens already processed by the lab will be treated as a retrospective request.
<p>What are the processes to obtain recoupment?</p>	<p>The MCO Medical Management Department makes retrospective medical necessity review decisions when:</p>	<p>The MCO Medical Management Department makes retrospective medical necessity review decisions when:</p>

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	<ul style="list-style-type: none"> • A member has been discharged from an inpatient admission prior to notification to the MCO, and notification was timely, including non-routine obstetrical admissions. • Required per provider and/or state contract specifics • This review may also occur when authorization or timely notification to Sunflower Health Plan was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have his/her Sunflower Health Plan ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. • Note: For prior authorization of genetic testing or outpatient testing for drugs of abuse, a five (5) business day grace period from the date of lab receipt of the specimen will be allowed. Any specimens already processed by the lab will be treated as a retrospective request. 	<ul style="list-style-type: none"> • A member has been discharged from an inpatient admission prior to notification to the MCO, and notification was timely, including non-routine obstetrical admissions. • Required per provider and/or state contract specifics • This review may also occur when authorization or timely notification to Sunflower Health Plan was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have his/her Sunflower Health Plan ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. • Note: For prior authorization of genetic testing or outpatient testing for drugs of abuse, a five (5) business day grace period from the date of lab receipt of the specimen will be allowed. Any specimens already processed by the lab will be treated as a retrospective request. 	
Third Party Vendors	Identify any third-party vendors to which work is outsourced and the services	Evolent – PT, OT, SLT, Imaging New Century Health – Oncology, imaging	None

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	provided by a vendor.		
Provider Network Admission	Identify the process for Provider Network Admission	<p>In compliance with its contract with KDHE, Sunflower will establish, maintain and monitor a network of appropriate Providers that is sufficient to provide adequate access to all Covered Services taking into consideration: the anticipated number of members for the health plan, the expected utilization of services taking into consideration the characteristics and health care needs of specific Medicaid populations represented in SSHP, the number and types of providers (in terms of training, experience, and specialization) necessary to furnish the Covered Services, the number of Providers with closed panels; and the geographic location of the Providers and health plan members, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities. Sunflower will assure new and re-credentialed providers are compliant with enrolling with KMAP to obtain a unique identifier provided by the State’s Fiscal Agent for each individual participating provider. Prior to contracting with a provider, Sunflower will review the State’s active KMAP listing and the KDHE-DHCF Medicaid termination list for providers who have</p>	<p>1. Admission and Inclusion of BH and SUD Providers The policy emphasizes non-discrimination in provider network selection, ensuring that providers serving high-risk populations or specializing in BH and SUD services are not excluded based on cost or service complexity (in line with 42 CFR 438.214(c)). Sunflower Health Plan includes all licensed behavioral health practitioners, including but not limited to: Psychiatrists Psychologists Licensed clinical social workers Licensed professional counselors Licensed substance use disorder specialists Contracts are proactively offered to all Community Mental Health Centers (CMHCs) and Certified Community Behavioral Health Clinics (CCBHCs), ensuring broad access to BH and SUD services.</p> <p>2. Compliance with NQTL Standards Equal Treatment of Providers: The policy ensures BH and SUD providers are credentialed under the same criteria as other</p>

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	<p>requested to join the Sunflower network. Sunflower will not contract with persons or entities that the State has terminated from participation in the Kansas Medicaid program.</p> <p>Consistent with State requirements and 42 CFR 438.214, the provider network will include access to all service and specialty types in each region. The provider network will include the full range of covered specialists, primary care, transportation, mental health, dentists, vision providers, pharmacies, hospitals, and various ancillary services. Sunflower will not require any provider to enroll exclusively in its network to provide covered services to Sunflower members. Sunflower’s provider selection and recruitment process will not discriminate against providers who serve high risk populations or who specialize in treating conditions that require costly treatment per 42 CFR 438.214(c). Sunflower will not discriminate against providers based on their licensure or certification and shall not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act as specified in 42 CFR 438.214(d). Sunflower will credential providers as specified in 42 CFR 438.206(b)(6).</p> <p>Sunflower does not discriminate against providers with respect to participation, reimbursement, or</p>	<p>provider types, addressing licensure, certification, and training requirements without imposing discriminatory restrictions. All participating providers must comply with state and federal requirements, such as the Americans with Disabilities Act (ADA).</p> <p>Authorization Processes: The policy details streamlined and non-bureaucratic preauthorization processes for BH and SUD services to prevent undue delays or barriers to care. Single Case Agreements (SCAs) are used for non-network providers when continuity of care, member choice, or service access needs arise, ensuring timely access to BH and SUD services.</p> <p>3. Accessibility and Provider Support</p> <p>Adequacy Standards: Geographic access to BH and SUD providers is explicitly defined, with time and distance metrics ensuring sufficient provider availability in both urban and rural areas.</p> <p>Provider Support Tools: Sunflower provides resources like: Authorization access Claims status and audit tools Toll-free hotlines for provider support</p>

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	<p>indemnification of any provider acting within the scope of that provider's license or certification under applicable State law solely on the basis of the provider's license or certification. When Sunflower declines to include individual or groups of providers in its network, it gives the affected providers written notice of the reason for its decision. This does not require Sunflower to contract with providers beyond the number necessary to meet the needs of its Members or preclude Sunflower from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or preclude Sunflower from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to Members.</p>	<p>These tools help BH and SUD providers navigate administrative processes efficiently.</p> <p>Training and Quality Improvement: Providers receive education and training, including customized one-on-one sessions and orientation programs. Quality Improvement Programs and satisfaction surveys allow providers to offer feedback on Sunflower’s processes and suggest improvements.</p> <p>4. Addressing Cultural and Specialized Needs The policy prioritizes recruiting BH and SUD providers who can meet culturally and linguistically appropriate care standards, ensuring equitable access for diverse populations. Emphasis on maintaining relationships with providers who declined network inclusion and addressing dissatisfaction strengthens retention and network stability, benefiting BH and SUD services.</p> <p>Conclusion This policy ensures that BH and SUD providers are included and supported in the network through equitable credentialing, streamlined administrative processes, and robust quality improvement programs. It aligns with NQTL standards by removing barriers to network admission, ensuring access to care, and supporting providers with tools and training.</p>

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Step Therapy Requirements	<p>For pharmacy prior authorization and step therapy, Sunflower follows all of the State of Kansas Medicaid Drug Utilization Review Board approved step therapy and prior authorization policies as required by the KanCare 3.0 contract for both mental health and medical surgical drugs.</p>	<p>For pharmacy prior authorization and step therapy, Sunflower follows all of the State of Kansas Medicaid Drug Utilization Review Board approved step therapy and prior authorization policies as required by the KanCare 3.0 contract for both mental health and medical surgical drugs.</p>

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<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Access to Out of Network provider</p>	<p>Identify the process for members to access out-of-network providers</p> <p>1. General Principles for Out-of-Network Access</p> <ul style="list-style-type: none"> • Continuity of Care: • When a member is already receiving care from an out-of-network provider, Sunflower will do everything possible to allow the member to continue with that provider if desired. The provider must meet the same qualifications as network providers and agree to take Medicaid fee-for-service rates unless the service is not available in-state. • Medical Necessity: • It may approve out-of-network services when medically necessary. Prior authorization is required unless it is an emergency. • Emergency Services: • Emergency services from out-of-network providers do not require prior authorization and must be covered without additional cost to the member. <p>2. Criteria for Approving Out-of-Network Access</p> <ul style="list-style-type: none"> • Lack of In-Network Provider Availability: • If in-network providers are unavailable for a specific specialty or service type within the defined time or distance standards, out-of-network providers may be authorized to ensure timely access to care. • Complexity of the Case: • For cases requiring specialized care unavailable 	<p>1. General Principles for Out-of-Network Access</p> <ul style="list-style-type: none"> • Continuity of Care: • When a member is already receiving care from an out-of-network provider, Sunflower will do everything possible to allow the member to continue with that provider if desired. The provider must meet the same qualifications as network providers and agree to take Medicaid fee-for-service rates unless the service is not available in-state. • Medical Necessity: • It may approve out-of-network services when medically necessary. Prior authorization is required unless it is an emergency. • Emergency Services: • Emergency services from out-of-network providers do not require prior authorization and must be covered without additional cost to the member. <p>2. Criteria for Approving Out-of-Network Access</p> <ul style="list-style-type: none"> • Lack of In-Network Provider Availability: • If in-network providers are unavailable for a specific specialty or service type within the defined time or distance standards, out-of-network providers may be authorized to ensure timely access to care. • Complexity of the Case: • For cases requiring specialized care unavailable

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	<p>within the network, Sunflower will authorize out-of-network services.</p> <ul style="list-style-type: none"> • Continuity of Care Following Provider Termination: • If an in-network provider leaves the network, Sunflower may allow members to continue seeing that provider temporarily to avoid care disruptions. <p>3. Authorization Processes</p> <ul style="list-style-type: none"> • Single Case Agreements (SCAs): • SCAs are negotiated with out-of-network providers when necessary to provide specific services to a member. These are used in cases such as: • Emergency admissions. • Specialty services, such as dialysis or durable medical equipment, are not available in network. • Providers with unique skills or services that are vital to the member's care. <p>Medical Management Role:</p> <ul style="list-style-type: none"> • The Utilization Management Department is responsible for medical necessity reviews and approvals for out-of-network services when medically necessary. <p>4. Member Cost Protections</p> <ul style="list-style-type: none"> • Members will not incur additional costs for 	<p>within the network, Sunflower will authorize out-of-network services.</p> <ul style="list-style-type: none"> • Continuity of Care Following Provider Termination: • If an in-network provider leaves the network, Sunflower may allow members to continue seeing that provider temporarily to avoid care disruptions. <p>3. Authorization Processes</p> <ul style="list-style-type: none"> • Single Case Agreements (SCAs): • SCAs are negotiated with out-of-network providers when necessary to provide specific services to a member. These are used in cases such as: • Emergency admissions. • Specialty services, such as dialysis or durable medical equipment, are not available in network. • Providers with unique skills or services that are vital to the member's care. <p>Medical Management Role:</p> <ul style="list-style-type: none"> • The Utilization Management Department is responsible for medical necessity reviews and approvals for out-of-network services when medically necessary. <p>4. Member Cost Protections</p> <ul style="list-style-type: none"> • Members will not incur additional costs for out-of-network services if:

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	<p>out-of-network services if:</p> <ul style="list-style-type: none"> • The service is medically necessary and preauthorized. • A network provider is unavailable to meet the needs of the member. • Any cost-sharing does not exceed what would be required if the service or supply had been furnished by an in-network provider, so that the member is not financially disadvantaged. <p>5. Emergency and Urgent Care</p> <ul style="list-style-type: none"> • Prudent Layperson Standard: • Emergency care provided by out-of-network providers shall be covered without prior authorization when the prudent layperson standard is met, meaning the average person would believe an emergency existed. <p>Conclusion</p> <p>The policy provides access to out-of-network providers when necessary, ensuring continuity of care, member convenience, and timely access to services. The use of SCAs, protections against additional costs, and specific provisions for emergency care ensure that members receive the care they need without unnecessary barriers.</p>	<ul style="list-style-type: none"> • The service is medically necessary and preauthorized. • A network provider is unavailable to meet the needs of the member. • Any cost-sharing does not exceed what would be required if the service or supply had been furnished by an in-network provider, so that the member is not financially disadvantaged. <p>5. Emergency and Urgent Care</p> <ul style="list-style-type: none"> • Prudent Layperson Standard: • Emergency care provided by out-of-network providers shall be covered without prior authorization when the prudent layperson standard is met, meaning the average person would believe an emergency existed. <p>Conclusion</p> <p>The policy provides access to out-of-network providers when necessary, ensuring continuity of care, member convenience, and timely access to services. The use of SCAs, protections against additional costs, and specific provisions for emergency care ensure that members receive the care they need without unnecessary barriers.</p>