Each insurer that offers, issues or renews any individual or group health benefit plan providing mental health or substance use disorder benefits shall submit an ANNUAL REPORT to the Oklahoma Insurance Department on or before April 1 of each year. ***36 O.S.§6060.11.*** The following template shall be used to report Nonquantitative Treatment Limitation(NQTLs) testing outcomes to the Department by the April 1 deadline. The purpose of this template is to aid in the comparative analyses necessary to determine if a health benefit plan is in complaince with the nonquantitative treatment limitation (NQTL) requirements speficifed in ***36 O.S. §6060.11(C) & (E).***

Nonquantitative treatment limitations (NQTLs) are limits on the scope or duration of treatment that are not expressed numerically (such as medical management techniques like prior authorization). ***36 O.S. § 6060.11(C)*** states a health benefit plan shall not impose a NQTL with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the same classification.

This is not to be interpreted as an exhaustive or complete list of NQTLs. Other treatment limitations may exist and should be identified and evaluated within your response, if so.
Non-Quantitative Treatment Limits Examples:

- Prior Authorization
- Concurrent Review
- Retrospective Review
- Outlier Review
- Coding Edits
- Medical Necessity Criteria
- Out of Network (OON) Coverage Standards
- Geographic Restrictions
- Experimental/Investigational Determinations
- Exclusions for Court-Ordered Treatment or Involuntary Holds
- Fail-First Protocols
- Failure to Complete/Initiate
- Provider Reimbursement
- Plan Standards to Ensure Network Adequacy
- UCR Determination
- Provider Credentialing
- Certification Requirements
- Unlicensed Provider/Staff Requirements
- Provider Type Exclusions
- Formulary Design, or others.

To begin NQTL testing, please identify the plan number/name below:

BCS ESC5500

If other plans contain identical NQTLs, list them below:

Plan: BCS ESC5500	Benefits		Classifications						Sub-Classifications			
Non-Quantitative Treatment Limitations	Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?	Is NQTL applied to In Network Outpatient-Office subclassification?	Is NQTL applied to Out of Network Outpatient-Office subclassification?	Is NQTL applied to In Network Outpatient-All Other subclassification?	Is NQTL applied to Out of Network Outpatient-All Other subclassification?
Prior Authorization	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes	Yes
Medical Necessity Criteria	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes
Concurrent Review	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No
Formulary Design	No	No	No	No	No	No	No	No	No	No	No	No

Plan: BCS ESC5500

INN- Inpatient

NQTL	Covered Service	Step 1: Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed. Description of Med/Surg applicability:	Step 1: Description of MH/SUD applicability:	Step 2: Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits. Factors	Step 2: Sources	Step 3: Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Step 4: Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Step 5: Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Step 6: Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Prior Authorization	Inpatient Confinement	Contract Language: Review of actual or scheduled pre-Admission for Inpatient Confinement.	Contract Language: Review of actual or scheduled pre-Admission for Inpatient Confinement.	Contract Language: The Plan creates the prior authorization list for both Med/Surg and MH/SUD services using industry recognized criteria and CMS guidelines.	Prior Authorization is determined by the list of services outlined in the contract language.	The Plan uses industry recognized criteria for services that require Prior Authorization and services are subject to medical necessity review.	The Plan creates the prior authorization list and when deciding whether to require prior authorization, factors such as disproportionate utilization; cost trends and level of care and services may be taken into consideration in addition to medical necessity criteria.	In operation, the Plan applies the same prior authorization to the list of services whether Med/Surg or MH/SUD..	The factors used to develop the list of Med/Surg services subject to prior authorization are the same factors used to develop the list of MH/SUD services subject to prior authorization so the requirements are generally comparable between the benefits.
Medical Necessity Criteria	Inpatient Confinement	Contract Language: Must be prescribed by a Doctor and be appropriate according to conventional medical practice.	Contract Language: Must be prescribed by a Doctor and be appropriate according to conventional medical practice.	All treatments are reviewed for medical necessity, using nationally recognized criteria. If criteria is met, the proposed treatment is authorized.	Nationally recognized criteria and internally developed set of policies that document the medical necessity criteria. Policy is developed based on extensive literature search, CMS guidelines and input from Medical Director, Physician Reviewer and/or appropriate specialists.	The Plan uses nationally recognized criteria supported by sound research and clinical studies, which are used in determining medical necessity.	The Plan applies the same definition of medical necessity for Med/Surg and MH/SUD.	In operation, the Plan applies the same criteria for Med/Surg and MH/SUD to determine medical necessity.	The factors used to determine medical necessity are the same for both Med/Surg and MH/SUD benefits. The Plan relies on nationally recognized criteria to make a medically necessary determination. If criteria is met, treatment is approved. If criteria is not met at initial review, the treatment plan is referred to the Medical Director or a Physician Reviewer for final determination. The requirements are comparable between the benefits.
Concurrent Review	All Inpatient Services	If additional Inpatient Confinement and services are requested an updated clinical from the treating provider to support that is required, then medical necessity criteria will be applied.	If additional Inpatient Confinement and services are requested an updated clinical from the treating provider to support that is required, then medical necessity criteria will be applied.	Additional Inpatient hospital confinements are subject to medical necessity criteria and reviewed for appropriateness.	Nationally recognized criteria and internally developed set of policies that document the medical necessity criteria. Policy is developed based on extensive literature search, CMS guidelines and input from Medical Director, Physician Reviewer and/or appropriate specialists.	Updated clinical from the treating provider to determine medical necessity.	The requirement is the same for both Med/Surg and MH/SUD.	In operation, the Plan applies the same criteria for Med/Surg and MH/SUD to determine medical necessity.	The factors used to determine medical necessity are the same for both Med/Surg and MH/SUD benefits. The Plan relies on nationally recognized criteria to make a medically necessary determination. If criteria is met, treatment is approved. If criteria is not met at initial review, the treatment plan is referred to the Medical Director or a Physician Reviewer for final determination. The requirements are comparable between the benefits.

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit eligibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits.
Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies applied in the operationalizing the NQTL for medical/surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and agreed rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Plan: BCS ESC5500

OON- Inpatient

NQTL	Covered Service	Step 1: Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed. Description of Med/Surg applicability:	Step 1: Description of MH/SUD applicability:	Step 2: Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits. Factors	Step 2: Sources	Step 3: Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Step 4: Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Step 5: Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Step 6: Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Prior Authorization	Inpatient Confinement	Contract Language: Review of actual or scheduled pre-Admission for Inpatient Confinement.	Contract Language: Review of actual or scheduled pre-Admission for Inpatient Confinement.	Contract Language: The Plan creates the prior authorization list for both Med/Surg and MH/SUD services using industry recognized criteria and CMS guidelines.	Prior Authorization is determined by the list of services outlined in the contract language.	The Plan uses industry recognized criteria for services that require Prior Authorization and services are subject to medical necessity review.	The Plan creates the prior authorization list and when deciding whether to require prior authorization,factors such as disproportionate utilization; cost trends and level of care and services may be taken into consideration in addition to medical necessity criteria.	In operation, the Plan applies the same prior authorization to the list of services whether Med/Surg or MH/SUD..	The factors used to develop the list of Med/Surg services subject to prior authorization are the same factors used to develop the list of MH/SUD services subject to prior authorization so the requirements are generally comparable between the benefits.
Medical Necessity Criteria	Inpatient Confinement	Contract Language: Must be prescribed by a Doctor and be appropriate according to conventional medical practice.	Contract Language: Must be prescribed by a Doctor and be appropriate according to conventional medical practice.	All treatments are reviewed for medical necessity using nationally recognized criteria. If criteria is met, the proposed treatment is authorized.	Nationally recognized criteria and internally developed set of policies that document the medical necessity criteria. Policy is developed based on extensive literature search, CMS guidelines and input from Medical Director, Physician Reviewer and/or appropriate specialists.	The Plan uses nationally recognized criteria supported by sound research and clinical studies, which are used in determining medical necessity.	The Plan applies the same definition of medical necessity for Med/Surg and MH/SUD.	In operation, the Plan applies the same criteria for Med/Surg and MH/SUD to determine medical necessity.	The factors used to determine medical necessity are the same for both Med/Surg and MH/SUD benefits. The Plan relies on nationally recognized criteria to make a medically necessary determination. If criteria is met, treatment is approved. If criteria is not met at initial review, the treatment plan is referred to the Medical Director or a Physician Reviewer for final determination. The requirements are comparable between the benefits.
Concurrent Review	All Inpatient Services	If additional Inpatient Confinement and services are requested an updated clinical from	If additional Inpatient Confinement and services are requested an updated clinical from	Additional Inpatient hospital confinements are subject to medical necessity criteria and reviewed for appropriateness.	Nationally recognized criteria and internally developed set of policies that document the medical necessity criteria. Policy is	Updated clinical from the treating provider to determine medical necessity.	The requirement is the same for both Med/Surg and MH/SUD.	In operation, the Plan applies the same criteria for Med/Surg and MH/SUD to determine medical necessity.	The factors used to determine medical necessity are the same for both Med/Surg and MH/SUD benefits. The Plan relies on nationally recognized criteria to make a medically

		Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit eligibility.	Examples of factors for medical management and utilization review include: - Excessive utilization - Recent medical cost escalation - Lack of adherence to quality standards - High levels of variation in length of stay - High variability in cost per episode of care - Clinical efficacy of the proposed treatment or service - Provider discretion in determining diagnoses - Claims associated with a high percentage of fraud - Severity or chronicity of the MH/SUD or medical/surgical condition	Examples of sources for medical management and utilization review factors include: - Internal claims analyses - Internal quality standard studies - Expert medical review	Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards. Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations. Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include: - Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data. - Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data. - Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards. - Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay. - Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode. - More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care). - Two published RCTs required to establish a treatment or service is not experimental or investigational. - Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines. - State regulatory standards for health plan network adequacy. - Health plan accreditation standards for quality assurance. *(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)*	Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits. Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations. Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met. Examples of comparative analyses include: - Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL. - Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services. - A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols. - A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable. - Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy. - Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner. - Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational. *(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)*	Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical/surgical benefits. Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency. Illustrative analyses include: Medical Management - Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable. - Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits. - Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved. - Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews. - Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits. - Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits. - Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category. - Audit/review of utilization review documentation requirements. - Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines. - A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers. Network Adequacy - Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification. - Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided). (These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)
			Examples of factors for provider network adequacy include: - Service type - Geographic market - Current demand for services - Projected demand for services - Practitioner supply and provider-to-enrollee ratios - Wait times - Geographic access standards - Out-of-network utilization rates *(these examples are merely illustrative and not exhaustive)*	Examples of sources for provider network adequacy factors include: - State and federal regulatory requirements - National accreditation standards - Internal plan market analyses - CAHPS data				
			Examples of factors for provider reimbursement include: - Geographic market (i.e., market rate and payment type for provider type and/or specialty) - Provider type (i.e., hospital, clinic, and practitioner) and/or specialty - Supply of provider type and/or specialty - Network need and/or demand for provider type and/or specialty - Medicare reimbursement rates - Training, experience, and licensure of provider *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*	Examples of sources for provider reimbursement factors include: - External healthcare claims database (e.g., Fair Health) - Current Medicare Physician Fee Schedule - Internal market and competitive analysis - Medicare RVUs for CPT codes. *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*				

Plan: BCS ESC5500

INN- Outpatient

		Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
NQTL	Covered Service	Description of Med/Surg applicability:	Description of MH/SUD applicability:	Factors	Sources	Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Prior Authorization	Outpatient Surgery	Contract Language Review of actual or scheduled Outpatient Surgery.	Contract Language Review of actual or scheduled Outpatient Surgery.	Contract Language: The Plan creates the prior authorization list for both Med/Surg and MH/SUD services using industry recognized criteria and CMS guidelines.	Prior Authorization is determined by the list of services outlined in the contract language.	The Plan uses industry recognized criteria for services that require Prior Authorization and services are subject to medical necessity review.	The Plan creates the prior authorization list and when deciding whether to require prior authorization, factors such as disproportionate utilization; cost trends and level of care and services may be taken into consideration in addition to medical necessity criteria.	In operation, the Plan applies the same prior authorization to the list of services whether Med/Surg or MH/SUD..	The factors used to develop the list of Med/Surg services subject to prior authorization are the same factors used to develop the list of MH/SUD services subject to prior authorization so the requirements are generally comparable between the benefits.
Medical Necessity Criteria	All services must be medically necessary.	Contract Language: Services must be	Contract Language: Services must be	All treatments are reviewed for medical necessity using nationally	Nationally recognized criteria and internally developed set of	The Plan uses Nationally recognized criteria supported by sound research and	The Plan applies the same definition of medical necessity for Med/Surg and	In operation, the Plan applies the same criteria for Med/Surg and MH/SUD to	The factors used to determine medical necessity are the same for both Med/Surg and

		Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit eligibility.	Examples of factors for medical management and utilization review include: - Excessive utilization - Recent medical cost escalation - Lack of adherence to quality standards - High levels of variation in length of stay - High variability in cost per episode of care - Clinical efficacy of the proposed treatment or service - Provider discretion in determining diagnoses - Claims associated with a high percentage of fraud - Severity or chronicity of the MH/SUD or medical/surgical condition	Examples of sources for medical management and utilization review factors include: - Internal claims analyses - Internal quality standard studies - Expert medical review	Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards. Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations. Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include: - Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data. - Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data. - Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards. - Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay. - Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode. - More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care). - Two published RCTs required to establish a treatment or service is not experimental or investigational. - Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines. - State regulatory standards for health plan network adequacy. - Health plan accreditation standards for quality assurance. *(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)*	Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits. Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations. Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met. Examples of comparative analyses include: - Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL. - Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services. - A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols. - A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable. - Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy. - Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner. - Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational. *(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)*	Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits. Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability, and appropriate application stringency. Illustrative analyses include: Medical Management - Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable. - Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits. - Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved. - Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews. - Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits - Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits. - Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category. - Audit/review of utilization review documentation requirements. - Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines. - A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers. Network Adequacy - Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification. - Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided). (These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)
				Examples of factors for provider network adequacy include: - Service type - Geographic market - Current demand for services - Projected demand for services - Practitioner supply and provider-to-enrollee ratios - Wait times - Geographic access standards - Out-of-network utilization rates *(these examples are merely illustrative and not exhaustive)*	Examples of sources for provider network adequacy factors include: - State and federal regulatory requirements - National accreditation standards - Internal plan market analyses - CAHPS data			
				Examples of factors for provider reimbursement include: - Geographic market (i.e., market rate and payment type for provider type and/or specialty) - Provider type (i.e., hospital, clinic, and practitioner) and/or specialty - Supply of provider type and/or specialty - Network need and/or demand for provider type and/or specialty - Medicare reimbursement rates - Training, experience, and licensure of provider *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*	Examples of sources for provider reimbursement factors include: - External healthcare claims database (e.g., Fair Health) - Current Medicare Physician Fee Schedule - Internal market and competitive analysis - Medicare RVUs for CPT codes. *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*			

Plan: BCS ESC5500

OON- Outpatient

		Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
NQTL	Covered Service	Description of Med/Surg applicability:	Description of MH/SUD applicability:	Factors	Sources	Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Prior Authorization	Outpatient Surgery	Contract Language Review of actual or scheduled Outpatient Surgery.	Contract Language Review of actual or scheduled Outpatient Surgery.	Contract Language. The Plan creates the prior authorization list for both Med/Surg and MH/SUD services using industry recognized criteria and CMS guidelines.	Prior Authorization is determined by the list of services outlined in the contract language.	The Plan uses industry recognized criteria for services that require Prior Authorization and services are subject to medical necessity review.	The Plan creates the prior authorization list and when deciding whether to require prior authorization, factors such as disproportionate utilization; cost trends and level of care and services may be taken into consideration in addition to medical necessity criteria.	In operation, the Plan applies the same prior authorization to the list of services whether Med/Surg or MH/SUD..	The factors used to develop the list of Med/Surg services subject to prior authorization are the same factors used to develop the list of MH/SUD services subject to prior authorization so the requirements are generally comparable between the benefits.
Medical Necessity Criteria	All services must be medically necessary.	Contract Language: Must be prescribed by a Doctor and be appropriate according to conventional medical practice.	Contract Language: Must be prescribed by a Doctor and be appropriate according to conventional medical practice.	All treatments are reviewed for medical necessity using nationally recognized criteria. If criteria is met, the proposed treatment is authorized.	Nationally recognized criteria and internally developed set of policies that document the medical necessity criteria. Policy is developed based on extensive literature search, CMS guidelines and input from Medical Director, Physician Reviewer and/or appropriate specialists.	The Plan uses nationally recognized criteria supported by sound research and clinical studies, which are used in determining medical necessity.	The Plan applies the same definition of medical necessity for Med/Surg and MH/SUD.	In operation, the Plan applies the same criteria for Med/Surg and MH/SUD to determine medical necessity.	The factors used to determine medical necessity are the same for both Med/Surg and MH/SUD benefits. The Plan relies on nationally recognized criteria to make a medically necessary determination. If criteria is met, treatment is approved. If criteria is not met at initial review, the treatment plan is referred to the Medical Director or a Physician Reviewer for final determination. The requirements are comparable between the benefits.

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit eligibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical v.s. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate phy-sician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review inter-als, length of time, documentation required, etc.) of review for medical/surgical v.s. MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs)

Plan: BCS ESC5500

Emergency

NQTL	Covered Service	Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed. Description of Med/Surg applicability:	Step 1 Description of MH/SUD applicability:	Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits. Factors	Step 2 Sources	Step 3 Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Step 4 Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Step 5 Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Step 6 Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Medical Necessity Criteria	Emergency Medical Care	Contract Language: Must meet the definiton of Emergency Medical Care and be appropriate according to conventional medical practice.	Contract Language: Must meet the definiton of Emergency Medical Care and be appropriate according to conventional medical practice.	Meets the definiton of Emergency Medical Care	Nationally recognized criteria and internally developed set of policies that document the medical necessity criteria.	The Plan uses nationally recognized criteria which is used in determining medical necessity.	The Plan applies the same definition of medical necessity for Med/Surg and MH/SUD	In operation, the Plan applies the same criteria for Med/Surg and MH/SUD to determine medical necessity	The factors used to determine medical necessity are the same for both Med/Surg and MH/SUD benefits. The Plan relies on nationally recognized criteria to make a medically necessary determination.

Provide the specific language associated with the limitations, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit eligibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits.
- Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members
allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical/surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs.
MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for
medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Plan: BCS ESC5500 **Rx**

NQTL	Covered Service	**Step 1** Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		**Step 2** Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		**Step 3**	**Step 4**	**Step 5**	**Step 6**
		Description of Med/Surg applicabilty:	**Description of MH/SUD applicability:**	**Factors**	**Sources**	**Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.**	**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written**	**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation**	**Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.**

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit elegibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Plan: BCS ESC5500

INN-Outpatient-Office

		Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
NQTL	Covered Service	Description of Med/Surg applicabilty:	Description of MH/SUD applicability:	Factors	Sources	Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit elegibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
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- Network need and/or demand for provider type and/or specialty
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(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

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- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Plan: BCS ESC5500

OON-Outpatient-Office

		Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		**Step 2** Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		**Step 3**	**Step 4**	**Step 5**	**Step 6**
NQTL	Covered Service	**Description of Med/Surg applicabilty:**	**Description of MH/SUD applicability:**	**Factors**	**Sources**	**Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.**	**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written**	**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation**	**Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.**

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit elegibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
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Examples of factors for provider network adequacy include:
- Service type
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(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
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Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
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(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
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- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Plan: BCS ESC5500

INN-Outpatient-All Other

NQTL	Covered Service	Step 1: Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed. Description of Med/Surg applicability:	Step 1: Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed. Description of MH/SUD applicability:	Step 2: Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits. Factors	Step 2: Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits. Sources	Step 3: Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Step 4: Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Step 5: Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Step 6: Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Prior Authorization	Diagnostic Services (CT Scan; MRI & Pet Scan); Rehabilitative Services	Contract Language: Review of all other outpatient services	Contract Language: Review of all other outpatient services	Contract Language: The Plan creates the prior authorization list for both Med/Surg and MH/SUD services using industry recognized criteria and CMS guidelines.	Prior Authorization is determined by the list of services outlined in the contract language	The Plan uses industry recognized criteria for services that require Prior Authorization and services are subject to medical necessity review.	The Plan creates the prior authorization list and when deciding whether to require prior authorization, factors such as disproportionate utilization; cost trends and level of care and services may be taken into consideration in addition to medical necessity criteria.	In operation, the Plan applies the same prior authorization to the list of services whether Med/Surg or MH/SUD..	The factors used to develop the list of Med/Surg services subject to prior authorization are the same factors used to develop the list of MH/SUD services subject to prior authorization so the requirements are generally comparable between the benefits.
Medical Necessity Criteria	All services must be medically necessary	Contract Language: Must be prescribed by a Doctor and be appropriate according to conventional medical practice.	Contract Language Must be prescribed by a Doctor and be appropriate according to conventional medical practice.	All treatments are reviewed for medical necessity using nationally recognized criteria. If criteria is met, the proposed treatment is authorized.	Nationally recognized criteria and internally developed set of policies that document the medical necessity criteria. Policy is developed based on extensive literature search, CMS guidelines and input from Medical Director, Physician Reviewer and/or appropriate specialists.	The Plan uses nationally recognized criteria supported by sound research and clinical studies, which are used in determining medical necessity.	The Plan applies the same definition of medical necessity for Med/Surg and MH/SUD.	In operation, the Plan applies the same criteria for Med/Surg and MH/SUD to determine medical necessity.	The factors used to determine medical necessity are the same for both Med/Surg and MH/SUD benefits. The Plan relies on nationally recognized criteria to make a medically necessary determination. If criteria is met, treatment is approved. If criteria is not met at initial review, the treatment plan is referred to the Medical Director or a Physician Reviewer for final determination. The requirements are comparable between the benefits.

Step 1: Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.	Step 2: Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit eligibility.	Examples of factors for medical management and utilization review include: - Excessive utilization - Recent medical cost escalation - Lack of adherence to quality standards - High levels of variation in length of stay - High variability in cost per episode of care - Clinical efficacy of the proposed treatment or service - Provider discretion in determining diagnoses - Claims associated with a high percentage of fraud - Severity or chronicity of the MH/SUD or medical/surgical condition	Examples of sources for medical management and utilization review factors include: - Internal claims analyses - Internal quality standard studies - Expert medical review	Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. - Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards. Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations. Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include: - Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data. - Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data. - Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards. - Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay. - Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode. - More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care). - Two published RCTs required to establish a treatment or service is not experimental or investigational. - Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines. - State regulatory standards for health plan network adequacy. - Health plan accreditation standards for quality assurance. *(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)*	Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits. Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations. Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met. Examples of comparative analyses include: - Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL. - Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services. - A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols. - A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable. - Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy. - Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner. - Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational. *(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)*	Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits. Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency. Illustrative analyses include: Medical Management - Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable. - Audit results that demonstrate phy sician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits. - Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved. - Audit results that demonstrate utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews. - Audit results that demonstrate that frequency of and reason for reviewers for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits. - Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits. - Audit review of denial and appeal rates (both medical and administrative) by service type or benefit category. - Audit review of utilization review documentation requirements. - Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines. - A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers. Network Adequacy - Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification. - Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided). (These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)
	Examples of factors for provider network adequacy include: - Service type - Geographic market - Current demand for services - Projected demand for services - Practitioner supply and provider-to-enrollee ratios - Wait times - Geographic access standards - Out-of-network utilization rates *(these examples are merely illustrative and not exhaustive)*	Examples of sources for provider network adequacy factors include: - State and federal regulatory requirements - National accreditation standards - Internal plan market analyses - CAHPS data				
	Examples of factors for provider reimbursement include: - Geographic market (i.e., market rate and payment type for provider type and/or specialty) - Provider type (i.e., hospital, clinic, and practitioner) and/or specialty - Supply of provider type and/or specialty - Network need and/or demand for provider type and/or specialty - Medicare reimbursement rates - Training, experience, and licensure of provider *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*	Examples of sources for provider reimbursement factors include: - External healthcare claims database (e.g., Fair Health) - Current Medicare Physician Fee Schedule - Internal market and competitive analysis - Medicare RVUs for CPT codes. *(These are illustration of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*				

Plan: BCS ESC5500

OON-Outpatient-All Other

		Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
NQTL	Covered Service	Description of Med/Surg applicability:	Description of MH/SUD applicability:	Factors	Sources	Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Prior Authorization	Diagnostic Services (CT Scan; MRI & Pet Scan); Rehabilitative Services	Contract Language: Review of all other outpatient services	Contract Language: Review of all other outpatient services	Contract Language: The Plan creates the prior authorization list for both Med/Surg and MH/SUD services using industry recognized criteria and CMS guidelines.	Prior Authorization is determined by the list of services outlined in the contract language.	The Plan uses industry recognized criteria for services that require Prior Authorization and services are subject to medical necessity review.	The Plan creates the prior authorization list and when deciding whether to require prior authorization, factors such as disproportionate utilization; cost trends and level of care and services may be taken into consideration in addition to medical necessity criteria.	In operation, the Plan applies the same prior authorization to the list of services whether Med/Surg or MH/SUD	The factors used to develop the list of Med/Surg services subject to prior authorization are the same factors used to develop the list of MH/SUD services subject to prior authorization so the requirements are generally comparable between the benefits.
Medical Necessity Criteria	All services must be medically necessary	Contract Language: Must be prescribed by a Doctor and be appropriate according to conventional medical practice.	Contract Language: Must be prescribed by a Doctor and be appropriate according to conventional medical practice.	All treatments are reviewed for medical necessity using nationally recognized criteria. If criteria is met, the proposed treatment is authorized.	Nationally recognized criteria and internally developed set of policies that document the medical necessity criteria. Policy is developed based on extensive literature search, CMS guidelines and input from Medical Director, Physician Reviewer and/or appropriate specialists.	The Plan uses nationally recognized criteria supported by sound research and clinical studies, which are used in determining medical necessity.	The Plan applies the same definition of medical necessity for Med/Surg and MH/SUD.	In operation, the Plan applies the same criteria for Med/Surg and MH/SUD to determine medical necessity.	The factors used to determine medical necessity are the same for both Med/Surg and MH/SUD benefits. The Plan relies on nationally recognized criteria to make a medically necessary determination. If criteria is met, treatment is approved. If criteria is not met at initial review, the treatment plan is referred to the Medical Director or a Physician Reviewer for final determination. The requirements are comparable between the benefits.

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit eligibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members
allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts
evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical/surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses include:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs.
MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for
medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)