#REF!	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	Subclassify	Subclassify	No	Yes	No	N/A	Yes	N/A
Concurrent Review	Yes	Yes	Yes	Yes	No	No	No	No	No	N/A	No	N/A
Retrospective Review	Yes	Yes	Yes	Yes	Subclassify	Subclassify	No	No	N/A	N/A	Yes	N/A
Emergent/Urgent	No	No	No	No	No	No	No	No	No	No	No	No
Coding Edits	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	N/A	Yes	N/A
Medical Necessity Criteria	Yes	Yes	Yes	Yes	Subclassify	Subclassify	Yes	Yes	No	No	Yes	Yes
Geographic Restrictions	No	No	No	No	No	No	No	No	No	No	No	No
Experimental & Investigational Determinations	Yes	Yes	Yes	Yes	Subclassify	Subclassify	No	Yes	No	N/A	Yes	N/A
Court Ordered Involuntary Holds	No	No	No	No	No	No	No	No	N/A	N/A	N/A	N/A

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INN- Inpatient

		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	0126, 0200 0201, 0202, 0203 , 0207, 0210, 0211, 0212, 0213, 0174, 0203, 0208, 0681, 0682, 0683, 0684, 0685, 0686, 0687, 0688, 0689, 0120, 0121, 0110, 0171, 0172, 0170, 0121 , 0121, 0122, 0124, 0360, 0112, 0762, 0127, 0172, 0128,0124, 0125, 0137, 0360, 0190, 0191, 0192, 0193, 0194, 0195, 0199, 0173, 0732	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	Inpatient requires Prior Authorization to monitor excessive utilillization, clinical efficacy of propsed treatment or services, dishcarge planning and support, severity or chronicity of the conditions, high variability of cost per episode of care, medical cost control.	Expert Medical Review, Clincial Guidelines, Quality of Care Standards	Prior authorization is required for Medical/Surgical and MH/SUD such as inpatient admissions. We utilize MCG Guidelines including ASAM and all prior authorization criteria is reviewed and approved through our Physcian Advisory Committee (PAC). Inpatient requires Prior Authorization to monitor: excessive utililization- authorizations allow us to monitor member patterns and assist in removing barriers to care. Identifying members with chronic conditions and assist them with community and/or additional provider support to potentially decrease future admissions. clinical efficacy of propsed treatment or services-monitoring statndards of care to ensure appropriatestandards of care are being utilized. dishcarge planning and support- provide provider support in discharge planning for outpatient needs such as DME, transitions to lower level of care, finding in network providers, assisting members in follow-up with primary care, medication reconciliation. severity or chronicity of the conditions- allows us to enroll members in case management programs. Support providers/members with care needs in order to support compliance with the members care plan. medical cost control/ high variability of cost per episode of care- inpatient is generally the highest cost service and through PA and medical management for m/s and mh/sud it enables FHP to support it efforts in controlling MLR.	All inpatient Medical/Surgial and MH/SUD are subject to prior authorization policies.	Staff utilize the same prior authorization policies, procedures, MCG review criteria for all inpatient Medical/Surgial and MH/SUD services.	In the decision making process for identifying and implementing prior authorizations FHP relied upon state specific regulatory guidelines, CMS guidelines, standards and quality of care guidelines, best practices and expertise of the medical providers. In addition cost of services was also analyzed to ensure FHP was appropriately implementing the NQTLS to assist with cost-containment while taking care not to interupt the necessary care for our members, or impede their access to care services. The review process was identical for Medical/Surgical and MH/SUD and is reviewed by the same people. FHP does not differentiate between Medical/surgical and MH/SUD which allows us to be confident that we are complying with MHPAEA.
Concurrent review	0126, 0200 0201, 0202, 0203 , 0207, 0210, 0211, 0212, 0213, 0174, 0203, 0208, 0681, 0682, 0683, 0684, 0685, 0686, 0687, 0688, 0689, 0120, 0121, 0110, 0171, 0172, 0170, 0121 , 0121, 0122, 0124, 0360, 0112, 0762, 0127, 0172, 0128,0124, 0125, 0137, 0360, 0190, 0191, 0192, 0193, 0194, 0195, 0199, 0173, 0732	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	Inpatient requires Prior Authorization to monitor excessive utilillization, clinical efficacy of propsed treatment or services, dishcarge planning and support, severity or chronicity of the conditions, high variability of cost per episode of care, medical cost control.	Expert Medical Review, Clincial Guidelines, Quality of Care Standards	Concurrent review for Medical/Surgicaland MH/SUD is the same protocols for inpatient admissions. We utilize MCG Guidelines including ASAM and all prior authorization criteria is reviewed and approved through our Physcian Advisory Committee (PAC). Prior authorization is required for Medical/Surgical and MH/SUD such as inpatient admissions. We utilize MCG Guidelines including ASAM and all prior authorization criteria is reviewed and approved through our Physcian Advisory Committee (PAC). Inpatient requires Prior Authorization to monitor: excessive utililization- authorizations allow us to monitor member patterns and assist in removing barriers to care. Identifying members with chronic conditions and assist them with community and/or additional provider support to potentially decrease future admissions. clinical efficacy of propsed treatment or services-monitoring statndards of care to ensure appropriatestandards of care are being utilized. dishcarge planning and support- provide provider support in discharge planning for outpatient needs such as DME, transitions to lower level of care, finding in network providers, assisting members in follow-up with primary care, medication reconciliation. severity or chronicity of the conditions- allows us to enroll members in case management programs. Support providers/members with care needs in order to support compliance with the members care plan. medical cost control/ high variability of cost per episode of care- inpatient is generally the highest cost service and through PA and medical management for m/s and mh/sud it enables FHP to support it efforts in controlling MLR.	All inpatient Medical/Surgial and MH/SUD are subject to concurrent review policies.	Staff utilize the same concurrent review policies, procedures, MCG review criteria for all inpatient Medical/Surgial and MH/SUD services.	In the decision making process for identifying and implementing concurrent review FHP relied upon state specific regulatory guidelines, CMS guidelines, standards and quality of care guidelines, best practices and expertise of the medical providers. In addition cost of services was also analyzed to ensure FHP was appropriately implementing the NQTLS to assist with cost-containment while taking care not to interupt the necessary care for our members, or impede their access to care services. The review process was identical for Medical/Surgical and MH/SUD and is reviewed by the same people. FHP does not differentiate between Medical/surgical and MH/SUD which allows us to be confident that we are complying with MHPAEA.
Retrospective review	0126, 0200 0201, 0202, 0203 , 0207, 0210, 0211, 0212, 0213, 0174, 0203, 0208, 0681, 0682, 0683, 0684, 0685, 0686, 0687, 0688, 0689, 0120, 0121, 0110, 0171, 0172, 0170, 0121 , 0121, 0122, 0124, 0360, 0112, 0762, 0127, 0172, 0128,0124, 0125, 0137, 0360, 0190, 0191, 0192, 0193, 0194, 0195, 0199, 0173, 0732	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	Inpatient requires Prior Authorization to monitor excessive utilillization, clinical efficacy of propsed treatment or services, dishcarge planning and support, severity or chronicity of the conditions, high variability of cost per episode of care, medical cost control.	Expert Medical Review, Clincial Guidelines, Quality of Care Standards	same as above	All inpatient Medical/Surgial and MH/SUD are subject to retrospective review policies.	Staff utilize the same retrospective review policies, procedures, MCG review criteria for all inpatient Medical/Surgial and MH/SUD services.	In the decision making process for identifying and implementing retrospective review FHP relied upon state specific regulatory guidelines, CMS guidelines, standards and quality of care guidelines, best practices and expertise of the medical providers. In addition cost of services was also analyzed to ensure FHP was appropriately implementing the NQTLS to assist with cost-containment while taking care not to interupt the necessary care for our members, or impede their access to care services. The review process was identical for Medical/Surgical and MH/SUD and is reviewed by the same people. FHP does not differentiate between Medical/surgical and MH/SUD which allows us to be confident that we are complying with MHPAEA.
Coding Edits	0126, 0200 0201, 0202, 0203 , 0207, 0210, 0211, 0212, 0213, 0174, 0203, 0208, 0681, 0682, 0683, 0684, 0685, 0686, 0687, 0688, 0689, 0120, 0121, 0110, 0171, 0172, 0170, 0121 , 0121, 0122, 0124, 0360, 0112, 0762, 0127, 0172, 0128,0124, 0125, 0137, 0360, 0190, 0191, 0192, 0193, 0194, 0195, 0199, 0173, 0732	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	Monitoring claims for accurate and appropriate coding, unbundling, fraud waste and abuse.	CMS Guidelines and National Correct Coding Initiatives (NCCI)	Coding edits are applied to ensure that the billing provider/facility is accurately reflecting the services rendered and that standards of coding are applied , monitoring for fraud, waste and abuse. This assists in ensuring the members are being billed accurately for the services provided to them. Coding edits are applied to all M/S and MH/SUD. All claims are edited.	All inpatient Medical/Surgial and MH/SUD are subject to coding edit policies.	As the system receives a claim it is put through edits, finalized for payment. The process of adjudication of a claim is the same for all claims regardless of whether or not it is a Medical /Surgical MH/SUD claim type.	In the decision making process for identifying and implementing coding edits FHP relied upon national regulatory guidelines, CMS guidelines, In addition cost of services was also analyzed to ensure FHP was appropriately implementing the NQTLS to assist with cost-containment while taking care not to interupt the necessary care for our members, or impede their access to care services. The review process was identical for Medical/Surgical and MH/SUD.
Medical Necessity Criteria	0126, 0200 0201, 0202, 0203 , 0207, 0210, 0211, 0212, 0213, 0174, 0203, 0208, 0681, 0682, 0683, 0684, 0685, 0686, 0687, 0688, 0689, 0120, 0121, 0110, 0171, 0172, 0170, 0121 , 0121, 0122, 0124, 0360, 0112, 0762, 0127, 0172, 0128,0124, 0125, 0137, 0360, 0190, 0191, 0192, 0193, 0194, 0195, 0199, 0173, 0732	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	Medical necessity criteria is applied to all IP stays to ensure quality of care, safty of care, appropriate levels of care.	Expert Medical Review, Clincial Guidelines, Quality of Care Standards	Medical Necessity Criteria is utilized to ensure that the same clinical standards are used when rendering care based on nationally recognized and utilized standards. It is also used to ensure that members are receiving appropriate quality, and safe care.	All inpatient Medical/Surgial and MH/SUD are subject to medical necessity policies.	Through processes, training, procedures, all clinical staff utilize MCG for all medical necessity criteria determinations for Medica/Surgical and MH/SUD.	In the decision making process for identifying and implementing medical necessity criteria FHP relied upon MCG, UptoDate, CMS guidelines, standards and quality of care guidelines, best practices and expertise of the medical providers. In addition cost of services was also analyzed to ensure FHP was appropriately implementing the NQTLS to assist with cost-containment while taking care not to interupt the necessary care for our members, or impede their access to care services. The review process was identical for Medical/Surgical and MH/SUD and is reviewed by the same people. FHP does not differentiate between Medical/surgical and MH/SUD which allows us to be confident that we are complying with MHPAEA.

Experimental & Investigational Determinations	All requests for this service type are reviewed for medical necessity prior to approval. There are no specific codes as they vary dependent on request.	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	All inpatient services require notification. Prior authorization is required if pre-planned on not urgent/emergent.	IP stays require PA to ensure members are receiving safe and approved medcial care.	CMS Guidelines, FDA Approval, Peer Reviewed Literature and Quality of Care Standards	Procedures that are experimental and investigational are not a covered benefit. Without appropraite regualtory approval (ie. FDA) the efficacy and safety of such procedures could be in question therefore could impede safe and appropriate care and are not included in benefit plans.	All inpatient Medical/Surgial and MH/SUD are subject to experimental and investigational policies.	Clincal staff review prior authorization requests for experimnetal and investigational it is then subitted to the medical director and is reviewed agianst CMS, FDA approval guidelines and peer reviewed journals prior to a decision being rendered. The same protocols are followed for Medical/Surgical and MH/SUD requests.	In the decision making process for identifying and implementing experimental and investigational requirements FHP relied upon state specific regulatory guidelines, FDA aprproval, CMS guidelines, standards and quality of care guidelines, best practices, peer reviewed articles, and expertise of the medical providers. In addition cost of services was also analyzed to ensure FHP was appropriately implementing the NQTLS to assist with cost-containment while taking care not to interupt the necessary care for our members, or impede their access to care services. The review process was identical for Medical/Surgical and MH/SUD.

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.)

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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 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.
Claims Edits	All services	All claims are subject to coding edits.	All claims are subject to coding edits.	Monitoring claims for accurate and appropriate coding, unbundling, fraud waste and abuse.	CMS Guidelines and National Correct Coding Initiatives (NCCI)	All claims are subject to coding edits.	All outpatient Medical/Surgial and MH/SUD are subject to coding edit policies.	As the system receives a claim it is put through edits, finalized for payment. The process of adjudication of a claim is the same for all claims regardless of whether or not it is a Medical /Surgical MH/SUD claim type.	In the decision making process for identifying and implementing coding edits FHP relied upon national regulatory guidelines, CMS guidelines, In addition cost of services was also analyzed to ensure FHP was appropriately implementing the NQTLS to assist with cost-containment while taking care not to interupt the necessary care for our members, or impede their access to care services. The review process was identical for Medical/Surgical and MH/SUD.

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

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

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

		different types of NQTLs.)	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.)*	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.)