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:

4EL/GeoBlue Expatriate Health Plan

If other plans contain identical NQTLs, list them below:

Plan: 4EL/GeoBlue Expatriate Health Plan	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?
Medical Necessity Criteria	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
Prior Authorization	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No
Concurrent Review	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No
Retrospective Review	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
UCR Determination	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
Provider Credentialing	No	No	No	No	No	No	No	No	No	No	No	No
Pharmacy Formulary Design	Yes	Yes	No	No	No	No	No	Yes	No	No	No	No

Plan: 4EL/GeoBlue Expatriate Heal **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:	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	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	All Inpatient Stays	Medical/Surgical – All services eligible for coverage under the plan, must be medically necessary for the member's condition, although some services can be rendered without a preservice determination of medical necessity.	Mental Health/Substance Use Disorder – All services eligible for coverage under the plan, must be medically necessary for the member's condition, although some services can be rendered without a preservice determination of medical necessity.				InterQual is a nationally recognized evidence-based clinical criteria used to guide decisions of coverage. These validated criteria are vetted with experts in the field and are continually updated, at least annually and as frequently as quarterly. Criteria are created by teams of physicians, registered nurses and allied health professionals who monitor the latest evidence, national guidance, industry/regulatory trends to ensure the criteria are consistent with standards of medical practice. Inpatient criteria are based on evaluating severity of illness and intensity of service, and they assist our clinical services staff in evaluating the medical necessity and appropriateness of coverage based on a member's specific medical needs. The use of the InterQual guidelines help to promote consistency in determinations for similar medical issues and requests, and they reduce variation among our clinical staff to minimize subjective decision-making. InterQual is utilized for reviews of inpatient hospitalization and selected services (listed below). InterQual criteria are updated at least annually. To ensure that the criteria developed are in accordance with community standards, the corporate Quality Committee, whose membership is comprised of network participating providers, reviews the guidelines annually. The administrator does not develop the medical necessity criteria. The Plan utilizes an internally developed set of policies that document the medical necessity criteria. Medical policy is developed based on extensive literature search, CMS guidelines, and input from appropriate specialists as well as Plan Medical Directors. Medical policies are reviewed and updated as necessary but at least annually using a rigorous, evidence-based review process. Magellan uses internally developed medical necessity criteria for		For Medical Surgical, InterQual is a nationally recognized evidence-based clinical criteria used to guide decisions of coverage. These validated criteria are vetted with experts in the field and are continually updated, at least annually and as frequently as quarterly. Criteria are created by teams of physicians, registered nurses and allied health professionals who monitor the latest evidence, national guidance, industry/regulatory trends to ensure the criteria are consistent with standards of medical practice. Inpatient criteria are based on evaluating severity of illness and intensity of service, and they assist our clinical services staff in evaluating the medical necessity and appropriateness of coverage based on a member's specific medical needs. The use of the InterQual guidelines help to promote consistency in determinations for similar medical issues and requests, and they reduce variation among our clinical staff to minimize subjective decision-making. For MH/SUD Magellan uses Magellan Care Guidelines as the primary decision support tool for our Utilization Management Program. They include the 23rd edition Milliman Care Guidelines (MCG) for behavioral health acute services. They also include proprietary clinical criteria (Magellan Healthcare Guidelines) that Magellan has developed and maintains, for specialty behavioral outpatient including psychological testing and Transcranial Magnetic Stimulation (TMS). All guidelines meet federal, state, industry accreditation, and account contract requirements. They are based on sound scientific evidence for recognized settings of behavioral health services and are designed to decide the medical necessity and clinical appropriateness of services. Magellan Care Guidelines do not supersede state or Federal law or regulation, including Medicare National or Local Coverage Determinations, concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.
Prior Authorization		Pre-Admission Certification/Continued Stay Review for Hospital Confinement Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when You or Your Dependent require treatment in a Hospital: ·as a registered bed patient, except for 48/96 hour maternity stays; ·for a Partial Hospitalization at a Skilled Nursing Facility, Rehabilitation Hospital and/or Sub-Acute Facility or Residential Treatment Facility. You or Your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, You should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, You should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement. Covered Expenses incurred for which benefits	Pre-Admission Certification/Continued Stay Review for Hospital Confinement Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when You or Your Dependent require treatment in a Hospital: ·as a registered bed patient, except for 48/96 hour maternity stays; ·for a Partial Hospitalization at a Skilled Nursing Facility, Rehabilitation Hospital and/or Sub-Acute Facility or Residential Treatment Facility. You or Your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, You should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, You should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement. Covered Expenses incurred for which benefits				Preauthorization and Concurrent requests for Inpatient (includes Residential level of care); are made telephonically or by fax to Magellan subsequent to an in-person evaluation. Magellan's business operations are available 24 hours a day/ 7 days a week to receive preauthorization requests which includes licensed clinicians and physician coverage. All calls are answered by a live person. Determination of approval for Inpatient is made based on Medical Necessity Criteria (MNC). If the Licensed Care Manager feels that MNC is not met, the clinical information is reviewed with a Magellan Psychiatrist to make the final determination of MNC. The attending physician is given the opportunity to provide additional information to Magellan's physician before a final decision is made. The member must be Magellan eligible. Only a psychiatrist may deny a request. If MNC is not met for Psychiatric Inpatient Hospitalization, Magellan will issue a denial and recommend the least restrictive, medically necessary service to meet the member's individual needs. Determination of approval is made based on Medical Necessity Criteria (MNC) If the Care Manager feels that MNC is not met, the clinical information is reviewed with a Magellan Physician to make the final determination of MNC. Only a physician may deny a request. If MNC is not met for these levels, Magellan will issue a denial and recommend the least restrictive, medically necessary service to meet the member's needs. Frequency of review is determined by the circumstances and complexity of the case. Additional reviews may occur based on quality indications, such as potential gaps in care; outlier number of sessions and failure to progress in treatment.		
Concurrent Review		Retrospective Review If neither pre-service review, admission review nor continued stay review were performed, We will use retrospective review to determine if a scheduled admission to a Hospital or any surgery at a Hospital or Ambulatory Surgical Center was Medically Necessary. In the event services are determined to be Medically Necessary, benefits will be provided as described in this Plan. If it is determined that a Hospital stay or any other service is not Medically Necessary, the Covered Person is responsible for payment of the Charges for those services.	Retrospective Review If neither pre-service review, admission review nor continued stay review were performed, We will use retrospective review to determine if a scheduled admission to a Hospital or any surgery at a Hospital or Ambulatory Surgical Center was Medically Necessary. In the event services are determined to be Medically Necessary, benefits will be provided as described in this Plan. If it is determined that a Hospital stay or any other service is not Medically Necessary, the Covered Person is responsible for payment of the Charges for those services.				Using InterQual guidelines that are embedded in the medical management system, Care Management Coordinators evaluate the clinical circumstances of the admission, assessing whether the acute inpatient admission can be approved. When guidelines are met, the admission is approved. Hospital reimbursement arrangements are based on Diagnosis Related Groups (DRG) or per case arrangements (the majority). Under per diem arrangements, an initial review is performed, and the next review date is assigned. Verification of the plan of care and a review schedule is set for extensions to the initial length of stay. Concurrent reviews are performed prior to expiration of the approved length of stay to determine if the member will be discharged as expected. If continued hospitalization is medically appropriate, the Care Management Coordinator approves coverage for additional days. Concurrent reviews are ongoing until the member is discharged or until a Medical Director determines that hospitalization is no longer medically necessary.		
Retrospective Review	All Inpatient Services	Retro reviews are only performed in extenuating circumstances. Retrospective	Magellan utilizes the same medical necessity criteria for making retrospective review				Magellan conducts retrospective reviews per applicable state law and/or customer plan requirements.		
UCR Determination	All Inpatient Services	4 Ever Life Insurance Company and Worldwide Insurance Services/GeoBlue have relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program" and arrangements for payments to Non-Participating Providers. Whenever You obtain healthcare services the claims are processed through one of these arrangements. You can take advantage of the BlueCard Program when You receive covered services from hospitals, doctors, and other Providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. At times, You may also obtain care from Non-Participating Providers. Our payment calculation/practices in both instances are described below. It is important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this Plan. •Out of Area Services. We have a variety of relationships with other Blue Cross and/or	Same		For INN benefits, the contracted rates negotiated with the BlueCard provider is used.. For OON providers, the UCR is determined to be a factor of the published Medicare rate tables for that geographic region				

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.

Medically Necessary/Medical Necessity
Medically Necessary covered services and supplies are those determined by the Medical Director to be:
required to diagnose or treat an illness, Injury, disease or its symptoms;
in accordance with generally accepted standards of medical practice;
clinically appropriate in terms of type, frequency, extent, site and duration;
not primarily for the convenience of the patient, Physician or other health care Provider; and
rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Prior Authorization/Pre-Authorized
The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this Certificate.

Retrospective Review
We will use retrospective review to determine if a scheduled admission to a Hospital or any surgery at a Hospital or Ambulatory Surgical Center was Medically Necessary

Usual and Customary (Maximum Reimbursable Charge)
The Maximum Reimbursable Charge for covered services is determined based on the lesser of: 1) the Provider's normal charge for a similar service or supply; or
2) an Insurer-selected percentile of Charges made by Providers of such service or supply in the geographic area where it is received.

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: 4EL/GeoBlue Expatriate Heal **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:	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	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	All outpatient services have to be medically necessary						Magellan uses internally developed medical necessity criteria for a few outpatient mental health services and MCG Guidelines for the rest of mental health service reviews. ASAM criteria are used for substance abuse. Magellan follows URAC and NCQA standards for the development, annual review and maintenance of our medical necessity criteria. The original criteria were based on language and principles contained in the Social Security Act. Magellan criteria are reviewed annually by a multi-disciplinary team of clinicians, including psychiatrists, psychologists, social workers and licensed professional counselors. The criteria are evidence-based, according to current literature and published clinical practice guidelines. ASAM criteria and MCG Criteria are both third party developed criteria that are widely used and accepted in the industry. These criteria are developed by outside experts and regularly updated.		For Medical Surgical, InterQual is a nationally recognized evidence-based clinical criteria used to guide decisions of coverage. These validated criteria are vetted with experts in the field and are continually updated, at least annually and as frequently as quarterly. Criteria are created by teams of physicians, registered nurses and allied health professionals who monitor the latest evidence, national guidance, industry/regulatory trends to ensure the criteria are consistent with standards of medical practice. Inpatient criteria are based on evaluating severity of illness and intensity of service, and they assist our clinical services staff in evaluating the medical necessity and appropriateness of coverage based on a member's specific medical needs. The use of the InterQual guidelines help to promote consistency in determinations for similar medical issues and requests, and they reduce variation among our clinical staff to minimize subjective decision-making. For MH/SUD Magellan uses Magellan Care Guidelines as the primary decision support tool for our Utilization Management Program. They include the 23rd edition Milliman Care Guidelines (MCG) for behavioral health acute services. They also include proprietary clinical criteria (Magellan Healthcare Guidelines) that Magellan has developed and maintains, for specialty behavioral outpatient including psychological testing and Transcranial Magnetic Stimulation (TMS). All guidelines meet federal, state, industry accreditation, and account contract requirements. They are based on sound scientific evidence for recognized settings of behavioral health services and are designed to decide the medical necessity and clinical appropriateness of services. Magellan Care Guidelines do not supersede state or Federal law or regulation, including Medicare National or Local Coverage Determinations, concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.
Prior Authorization							Preauthorization and Concurrent requests for Inpatient (includes		
Concurrent Review	Inpatient, Residential, Partial Hospitalization and Intensive Outpatient Services and limited specialty outpatient services all require authorization. Medical necessity criteria are used when making determinations. If medical necessity is met at the time of the initial request, subsequent requests for inpatient, residential, partial hospitalization and IOP require that the condition is likely to improve with treatment for ongoing services to be authorized. Reviews for ongoing services are typically completed between three and seven days. depending on the level of care and severity of clinical presentation.					Magellan Care Managers use MCG and Magellan Care Guidelines for concurrent reviews. Care Managers evaluate the clinical circumstances of the request for continued stay/continued services admission and determine whether the request can be approved. For higher level of care services, concurrent reviews are performed prior to expiration of the approved length of stay to determine if the member will be discharged as expected. If continued hospitalization is medically appropriate, the Care Manager approves coverage for additional days. Concurrent reviews are ongoing until the member is discharged or until a Medical Director determines that services are no longer medically necessary. Review intervals typically vary between 3 and 7 days depending upon the level of care, depending on the level of care and severity of clinical presentation.	Preauthorization and Concurrent requests for Inpatient (includes Residential level of care); are made telephonically or by fax to Magellan subsequent to an in-person evaluation. Magellan's business operations are available 24 hours a day/ 7 days a week to receive preauthorization requests which includes licensed clinicians and physician coverage. All calls are answered by a live person. Determination of approval for Inpatient is made based on Medical Necessity Criteria (MNC). If the Licensed Care Manager feels that MNC is not met, the clinical information is reviewed with a Magellan Psychiatrist to make the final determination of MNC. The attending physician is given the opportunity to provide additional information to Magellan's physician before a final decision is made. The member must be Magellan eligible. Only a psychiatrist may deny a request. If MNC is not met for Psychiatric Inpatient Hospitalization, Magellan will issue a denial and recommend the least restrictive, medically necessary service to meet the member's individual needs. Determination of approval is made based on Medical Necessity Criteria (MNC) If the Care Manager feels that MNC is not met, the clinical information is reviewed with a Magellan Physician to make the final determination of MNC. Only a physician may deny a request. If MNC is not met for these levels, Magellan will issue a denial and recommend the least restrictive, medically necessary service to meet the member's needs. Frequency of review is determined by the circumstances and complexity of the case. Additional reviews may occur based on quality indications, such as potential gaps in care; outlier number of sessions and failure to progress in treatment.		
Retrospective Review		Retro reviews are only performed in	Magellan utilizes the same medical necessity				Magellan conducts retrospective reviews per applicable state law and/or		
UCR Determination		4 Ever Life Insurance Company and Worldwide	same		For INN benefits, the contracted rates negotiated with the BlueCard				

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: 4EL/GeoBlue Expatriate Heal **INN- Outpatient**

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:	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	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	All services must be medically necessary						Magellan uses internally developed medical necessity criteria for a few outpatient mental health services and MCG Guidelines for the rest of mental health service reviews. ASAM criteria are used for substance abuse. Magellan follows URAC and NCQA standards for the development, annual review and maintenance of our medical necessity criteria. The original criteria were based on language and principles contained in the Social Security Act. Magellan criteria are reviewed annually by a multi-disciplinary team of clinicians, including psychiatrists, psychologists, social workers and licensed professional counselors. The criteria are evidence-based, according to current literature and published clinical practice guidelines. ASAM criteria and MCG Criteria are both third party developed criteria that are widely used and accepted in the industry. These criteria are developed by outside experts and regularly updated.		For Medical Surgical, InterQual is a nationally recognized evidence-based clinical criteria used to guide decisions of coverage. These validated criteria are vetted with experts in the field and are continually updated, at least annually and as frequently as quarterly. Criteria are created by teams of physicians, registered nurses and allied health professionals who monitor the latest evidence, national guidance, industry/regulatory trends to ensure the criteria are consistent with standards of medical practice. Inpatient criteria are based on evaluating severity of illness and intensity of service, and they assist our clinical services staff in evaluating the medical necessity and appropriateness of coverage based on a member's specific medical needs. The use of the InterQual guidelines help to promote consistency in determinations for similar medical issues and requests, and they reduce variation among our clinical staff to minimize subjective decision-making. For MH/SUD Magellan uses Magellan Care Guidelines as the primary decision support tool for our Utilization Management Program. They include the 23rd edition Milliman Care Guidelines (MCG) for behavioral health acute services. They also include proprietary clinical criteria (Magellan Healthcare Guidelines) that Magellan has developed and maintains, for specialty behavioral outpatient including psychological testing and Transcranial Magnetic Stimulation (TMS). All guidelines meet federal, state, industry accreditation, and account contract requirements. They are based on sound scientific evidence for recognized settings of behavioral health services and are designed to decide the medical necessity and clinical appropriateness of services. Magellan Care Guidelines do not supersede state or Federal law or regulation, including Medicare National or Local Coverage Determinations, concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.
Retrospective Review		extenuating circumstances. Retrospective	Magellan utilizes the same medical necessity				Magellan conducts retrospective reviews per applicable state law and/or		
UCR Determination		4 Ever Life Insurance Company and Worldwide	same		For INN benefits, the contracted rates negotiated with the BlueCard				

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: 4EL/GeoBlue Expatriate He: **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 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.
Medical Necessity Criteria	All services must be medically necessary						Magellan uses internally developed medical necessity criteria for a few outpatient mental health services and MCG Guidelines for the rest of mental health service reviews. ASAM criteria are used for substance abuse. Magellan follows URAC and NCQA standards for the development, annual review and maintenance of our medical necessity criteria. The original criteria were based on language and principles contained in the Social Security Act. Magellan criteria are reviewed annually by a multi-disciplinary team of clinicians, including psychiatrists, psychologists, social workers and licensed professional counselors. The criteria are evidence-based, according to current literature and published clinical practice guidelines. ASAM criteria and MCG Criteria are both third party developed criteria that are widely used and accepted in the industry. These criteria are developed by outside experts and regularly updated.		For Medical Surgical, InterQual is a nationally recognized evidence-based clinical criteria used to guide decisions of coverage. These validated criteria are vetted with experts in the field and are continually updated, at least annually and as frequently as quarterly. Criteria are created by teams of physicians, registered nurses and allied health professionals who monitor the latest evidence, national guidance, industry/regulatory trends to ensure the criteria are consistent with standards of medical practice. Inpatient criteria are based on evaluating severity of illness and intensity of service, and they assist our clinical services staff in evaluating the medical necessity and appropriateness of coverage based on a member's specific medical needs. The use of the InterQual guidelines help to promote consistency in determinations for similar medical issues and requests, and they reduce variation among our clinical staff to minimize subjective decision-making. For MH/SUD Magellan uses Magellan Care Guidelines as the primary decision support tool for our Utilization Management Program. They include the 23rd edition Milliman Care Guidelines (MCG) for behavioral health acute services. They also include proprietary clinical criteria (Magellan Healthcare Guidelines) that Magellan has developed and maintains, for specialty behavioral outpatient including psychological testing and Transcranial Magnetic Stimulation (TMS). All guidelines meet federal, state, industry accreditation, and account contract requirements. They are based on sound scientific evidence for recognized settings of behavioral health services and are designed to decide the medical necessity and clinical appropriateness of services. Magellan Care Guidelines do not supersede state or Federal law or regulation, including Medicare National or Local Coverage Determinations, concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.
Retrospective Review		Retro reviews are only performed in extenuating circumstances. Retrospective reviews are performed within thirty days of request or notification. Medical necessity review is performed using either Plan medical policy or InterQual.	Magellan utilizes the same medical necessity criteria for making retrospective review decisions. In network providers are given 180 days to submit request and out of network providers are given 365 days to submit requests. Retro reviews are only performed in extenuating circumstances. Retrospective reviews are performed within thirty days of request or notification.				Magellan conducts retrospective reviews per applicable state law and/or customer plan requirements. Magellan conducts retrospective reviews upon provider request and following successful appeal of claim denial for failure to obtain authorization under precertification or concurrent review processes. Providers may request retrospective review if they believe there is legitimate reason for failing to obtain timely authorization. Magellan uses the clinical record to conduct retrospective reviews. Licensed clinicians (care managers) conduct the retrospective reviews. If there was a valid reason for failing to obtain timely authorization, a medical necessity review is performed by the care manager. If no valid reason is found, no retrospective review occurs. If medical necessity is met, an authorization is issued; if not, the request is referred to a physician for review. The physician approves or denies based on the clinical information available.		
UCR Determination		4 Ever Life Insurance Company and Worldwide Insurance Services/GeoBlue have relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program" and arrangements for payments to Non-Participating Providers. Whenever You obtain healthcare services the claims are processed through one of these arrangements. You can take advantage of the BlueCard Program when You receive covered services from hospitals, doctors, and other Providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. At times, You may also obtain care from Non-Participating Providers. Our payment calculation/practices in both instances are described below. It is important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this Plan. •Out of Area Services. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-	same		For INN benefits, the contracted rates negotiated with the BlueCard provider is used.. For OON providers, the UCR is determined to be a factor of the published Medicare rate tables for that geographic region				

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	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.	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.	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
	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	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*			

- 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.)*	*(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.)*	- 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.)*	- 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.)*	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: 4EL/GeoBlue Expatriate Heal **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 applicabilty:	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	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	all services must be medically necessary						Magellan uses internally developed medical necessity criteria for a few outpatient mental health services and MCG Guidelines for the rest of mental health service reviews. ASAM criteria are used for substance abuse. Magellan follows URAC and NCQA standards for the development, annual review and maintenance of our medical necessity criteria. The original criteria were based on language and principles contained in the Social Security Act. Magellan criteria are reviewed annually by a multi-disciplinary team of clinicians, including psychiatrists, psychologists, social workers and licensed professional counselors. The criteria are evidence-based, according to current literature and published clinical practice guidelines. ASAM criteria and MCG Criteria are both third party developed criteria that are widely used and accepted in the industry. These criteria are developed by outside experts and regularly updated.		For Medical Surgical, InterQual is a nationally recognized evidence-based clinical criteria used to guide decisions of coverage. These validated criteria are vetted with experts in the field and are continually updated, at least annually and as frequently as quarterly. Criteria are created by teams of physicians, registered nurses and allied health professionals who monitor the latest evidence, national guidance, industry/regulatory trends to ensure the criteria are consistent with standards of medical practice. Inpatient criteria are based on evaluating severity of illness and intensity of service, and they assist our clinical services staff in evaluating the medical necessity and appropriateness of coverage based on a member's specific medical needs. The use of the InterQual guidelines help to promote consistency in determinations for similar medical issues and requests, and they reduce variation among our clinical staff to minimize subjective decision-making. For MH/SUD Magellan uses Magellan Care Guidelines as the primary decision support tool for our Utilization Management Program. They include the 23rd edition Milliman Care Guidelines (MCG) for behavioral health acute services. They also include proprietary clinical criteria (Magellan Healthcare Guidelines) that Magellan has developed and maintains, for specialty behavioral outpatient including psychological testing and Transcranial Magnetic Stimulation (TMS). All guidelines meet federal, state, industry accreditation, and account contract requirements. They are based on sound scientific evidence for recognized settings of behavioral health services and are designed to decide the medical necessity and clinical appropriateness of services. Magellan Care Guidelines do not supersede state or Federal law or regulation, including Medicare National or Local Coverage Determinations, concerning scope of practice for licensed, independent practitioner, e.g., advanced practice nurses.
Retrospective Review		Retro reviews are only performed in extenuating circumstances. Retrospective reviews are performed within thirty days of request or notification. Medical necessity review is performed using either Plan medical policy or InterQual.	Magellan utilizes the same medical necessity criteria for making retrospective review decisions. In network providers are given 180 days to submit request and out of network providers are given 365 days to submit requests. Retro reviews are only performed in extenuating circumstances. Retrospective reviews are performed within thirty days of request or notification.				Magellan conducts retrospective reviews per applicable state law and/or customer plan requirements. Magellan conducts retrospective reviews upon provider request and following successful appeal of claim denial for failure to obtain authorization under precertification or concurrent review processes. Providers may request retrospective review if they believe there is legitimate reason for failing to obtain timely authorization. Magellan uses the clinical record to conduct retrospective reviews. Licensed clinicians (care managers) conduct the retrospective reviews. If there was a valid reason for failing to obtain timely authorization, a medical necessity review is performed by the care manager. If no valid reason is found, no retrospective review occurs. If medical necessity is met, an authorization is issued; if not, the request is referred to a physician for review. The physician approves or denies based on the clinical information available.		
UCR Determination					For INN benefits, the contracted rates negotiated with the BlueCard provider is used.. For OON providers, the UCR is determined to be a factor of the published Medicare rate tables for that geographic region				

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

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 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: 4EL/GeoBlue Expatriate Heal **Rx**

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 applicabilty:	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	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.
Pharmacy Formulary Design	Retail Prescription Drugs								The P&T Committee reviews each medication based on the clinical components of the product. The Committee objectively reviews all medications and does not have any bias with respect to impacted patient populations and/or conditions. Drugs are candidates for less favorable tiering and/or utilization management if they are unfavorably priced (relative to the competition), used in an off-label inappropriate manner, or cost ineffective.

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

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 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.
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- 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 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: 4EL/GeoBlue Expatriate Hea **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)
- 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: 4EL/GeoBlue Expatriate Hea **OON-Outpatient-Office**

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:	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	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.

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

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 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.

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- 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: 4EL/GeoBlue Expatriate Heal **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:	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	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.

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:
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- 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.

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Examples of comparative analyses include:
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- 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.
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- 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).

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Plan: 4EL/GeoBlue Expatriate Heal **OON-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.		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 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.

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
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Examples of factors for provider network adequacy include:
- Service type
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- Current demand for services
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Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
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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.)