Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Medical Necessity Criteria Development Strategy
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Clinical
Names of Person(s) Responsible for Analysis Formation	**Oscar:** Insiya Taj, MPH, Associate, UM Optimization, (Over 3 years experience in healthcare and clinical research) Marco Fossati-Bellani, MD, MPH, Senior Medical Director, UM Mimi Shim, MPH, RN, Associate Clinical Manager, Clinical Policy **Optum Behavioral Health Solutions** Positions: Chief Medical Officer, National Senior Behavioral Medical Director (MD), Director MH Parity and Benefits, Senior Director, National Policy and Standards, and Associate Director, Clinical Criteria and Guidelines. Credentials: Board Certified MDs, Licensed Psychologist, Licensed Nurse, Licensed Social Worker, and National Certified Counselor
Last Update	7/11/2022
Reviewers	Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)

oscar

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Medical Necessity Criteria Development Strategy

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

Medical Necessity Criteria Development Strategy is defined as: The process of developing or adopting medical necessity criteria to guide the application and implementation of the Plan's general definition of Medical Necessity to authorization requests and benefit determinations for specific healthcare services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: ● In accordance with generally accepted standards of medical practice; ● Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient's illness, injury or disease; ● Not primarily for the convenience of the patient, physician, or other healthcare provider; and ● Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. The Plan uses documented clinical review criteria based on sound clinical evidence to make UM decisions. Clinical criteria are based: 1. Based on nationally recognized standards; Reviewed in accordance with the current standards of national accreditation entities; Reviewed to ensure quality of care and access to needed healthcare services; Evidence-based; and Evaluated and updated at least annually.	**Mental Health/Substance Use Disorder Definition of Medical Necessity:** This term is variable and defined in the member's applicable Plan or Coverage document. Medical Necessity or Medically Necessary is defined as: services that a Physician (Medical Doctor (MD), Doctor of Osteopathy (DO), or similarly trained professional) or Provider would provide to a person in their care for the purpose of evaluating, diagnosing or treating an illness, Injury or disease, or associated symptoms, while exercising prudent clinical judgment. Prudent clinical judgment shall reflect: ● Generally accepted standards of medical practice in the United States; ● Specificity of clinical appropriateness unique to individual or circumstance (type, frequency and dosage of proposed intervention); ● Knowledge of scientifically-established effectiveness of proposed intervention Generally accepted standards of medical practice shall reflect: ● Evidence-based guidelines, including MCG (formerly Milliman Care Guidelines), that have been established in the scientific literature via their inclusion in peer-reviewed medical (or similar) journals. ● Expert opinions based on experiential history of Physicians practicing in relevant clinical area; ● Clinical guidelines established by Physician Specialty Societies, such as National Comprehensive Cancer Network (NCCN), and similar; ● Clinical guidelines that are established to Oscar Physicians with input from licensed participating Providers in Oscar's network

Current criteria used by the Plan are outlined: 1. Client Clinical Guidelines or Medical Policies, if delegated 2. Internally Developed Clinical Guidelines 3. MCG Medical criteria 4. CVS/Caremark Specialty Exceptions Criteria, if applicable 5. Hayes, Inc. 6. Up-to-Date 7. National society guidelines, Agency for Healthcare Research and Quality, and National Institutes of Health ("NIH") Consensus Statements 8. Authoritative peer-reviewed textbooks & journals All medical clinical guidelines, behavioral health clinical guidelines, and pharmaceutical clinical guidelines are reviewed and approved by OMC physicians, behavioral health practitioners, and pharmacists respectively with input from licensed Providers, or in cases where appropriate clinical expertise is not readily available, from independent licensed specialists with the needed clinical expertise.	● Any other relevant factors. Medically Necessary services shall not be: ● A reflection of convenience to Oscar Member, requesting Provider or Physician Reviewer. ● Costlier than alternative services or clinical and/or treatment pathways that have been demonstrated to produce equivalent outcomes according to peer-reviewed medical literature are at least as likely to produce equivalent outcomes. Optum Behavioral Health's (OBH) uses externally developed, evidence-based medical necessity criteria (e.g., ASAM, LOCUS, CALOCUS-CASII and ECSII), as well as internally developed evidence-based, medical necessity criteria (e.g., medical and clinical policies) when making medical necessity coverage determinations related to Mental Health/Substance Use Disorder (MH/SUD) technologies (e.g., services, interventions, etc.) that fall outside the scope of the ASAM, LOCUS, CALOCUS-CASII and ECSII criteria and/or relate to advancements in technologies or types of care that are not addressed by the most recent versions of ASAM, LOCUS, CALOCUS-CASII and ECSII criteria. ASAM is the only criteria Optum uses to make SUD medical necessity coverage determinations, unless otherwise mandated by state law or contract.

Coverage Terms (EOC language):

Medical Necessity or Medically Necessary means services that a Physician (Medical Doctor (MD), Doctor of Osteopathy (DO), or similarly trained professional) or Provider would provide to a person in their care for the purpose of evaluating, diagnosing or treating an illness, Injury or disease, or associated symptoms, while exercising prudent clinical judgment.

Prudent clinical judgment shall reflect:
● Generally accepted standards of medical practice in the United States;
● Specificity of clinical appropriateness unique to individual or circumstance (type, frequency and dosage of proposed intervention);
● Knowledge of scientifically-established effectiveness of proposed intervention

Generally accepted standards of medical practice shall reflect:
● Evidence-based guidelines, including MCG (formerly Milliman Care Guidelines), that have been established in the scientific literature via their inclusion in peer-reviewed medical (or similar) journals.

● Expert opinions based on experiential history of Physicians practicing in relevant clinical area;
● Clinical guidelines established by Physician Specialty Societies, such as National Comprehensive Cancer Network (NCCN), and similar;
● Any other relevant factors.

Medically Necessary services shall not be:
● A reflection of convenience to an Oscar Member, requesting Provider or Physician Reviewer.
● Performed in a setting other than the least costly setting; or
● Clinical and/or treatment pathways that have been demonstrated to produce equivalent outcomes according to peer-reviewed medical literature

Benefit Classification	**Medical/Surgical Services to which the NQTL applies**	**Mental Health/SUD Services to which the NQTL applies**
In-Network Inpatient Services	● All Medical/Surgical technologies subject to Utilization Management	● All MH/SUD technologies subject to Utilization Management
In-Network Outpatient Services	● All Medical/Surgical technologies subject to Utilization Management	● All MH/SUD technologies subject to Utilization Management

2. **Identify the factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits:**

Benefit Classification	**Factors Considered: Medical/Surgical**	**Factors Considered: Mental Health/SUD**
In-Network Inpatient	**Factors for medical necessity**	**Factors** for medical necessity criteria

Services	**criteria development:** 1. Clinical efficacy of the proposed treatment or service 2. Safety Risk 3. Appropriateness of the proposed technology The factors are not weighted. *Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.* **Factors used to determine whether to adopt a medical policy:** 1. Clinical Appropriateness 2. Clinical Efficacy 3. Safety Risk 4. Adoption of new medical/surgical procedures 5. Per Member Per Month Cost (PMPM) 6. If the procedure is subject to utilization management review *Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.* **Factors used to determine which source to use for the medical policy:** 1. The grade/rating of a particular medical guideline used to develop the Plan's internal medical policy 2. Presence of Systematic Reviews and Randomized Control Trials	development: Committee considerations: 1. Clinical efficacy 2. Safety 3. Appropriateness of the proposed technology The factors are not weighted.

In-Network Outpatient Services	Same as Inpatient Analysis	Same as Inpatient Analysis

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Benefit Classification	Evidentiary Standards and Sources: Medical/Surgical	Evidentiary Standards and Sources: MH/SUD
In-Network Inpatient Services	***Factors for medical necessity criteria development:*** **1. Clinical efficacy of the proposed treatment or service** Clinical efficacy is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. Clinical effectiveness is based on the evidence of clinical trials that the interventions are considered to be effective for the general population. *Evidentiary Standards:* The Plan rates efficacy by the below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition. Class I, "Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective. Class IIa, "Evidence and/or expert opinion is conflicting	Evidentiary Standards and Sources: ● Scientifically based clinical evidence ● Peer-reviewed literature ● Hierarchy of Clinical Evidence: ○ Systematic reviews and meta analyses ○ Randomized controlled trials ○ Large non-randomized controlled trials ○ Large prospective trials ○ Comparative and cohort studies ○ Cross sectional studies ○ Retrospective studies ○ Surveillance studies ○ Case Reviews/Case series ○ Anecdotal/editorial statements ○ Professional opinions In the absence of strong and compelling scientific evidence, clinical policies may be based upon: ○ National consensus statements ○ Publications by recognized authorities such as government sources and/or professional societies

	as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy." Or rating systems considering efficacy of regimen/agent is moderately effective or higher such as NCCN definition of "Modest impact on survival, but often provides control of disease,." or higher levels of efficacy. 2. **Safety Risk** is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. *Evidentiary Standard:* Substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice. 3. **Appropriateness** is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the	

	service is (a) medically necessary, (b) delivered in the appropriate setting or level or care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice. **Sources for Safety and Appropriateness:** ● Oscar's Clinical Guidelines (*see below for factors that determine development of Oscar Medical Policies*) ● MCG ● Hayes, Inc. ● Up-to-Date ● Authoritative peer-reviewed textbooks & journals ● National society guidelines ● Agency for Healthcare Research and Quality ● National Institutes of Health ("NIH") Consensus Statements ● CVS/Caremark Specialty Exceptions Criteria ● CVS Prior Authorization Criteria ● National Comprehensive Cancer Network The Plan develops clinical guidelines internally that supplement adopted criteria to support Medical Necessity determinations. Additionally, clinical evidence, as defined by published standards and	

	internal plan guidelines are used to support Medical Necessity determinations: ● The US National Library of Medicine; ● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); ● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); ● Published scientific evidence. ***Factors used to determine whether to adopt a medical policy:*** 1. **Clinical Appropriateness** is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level or care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with	***Factors used to determine whether to adopt a behavioral clinical policy:*** Committee considerations: 1. Clinical efficacy 2. Safety 3. Appropriateness of the proposed technology 4. In the absence of externally developed, evidence-based criteria, MH/SUD will use a hierarchy of clinical evidence to evaluate new technologies and develop MH/SUD policy The factors are not weighted. *Evidentiary Standards and Sources:* ● Scientifically based clinical evidence ● Peer-reviewed literature ● Hierarchy of Clinical Evidence: ○ Systematic reviews and meta analyses ○ Randomized controlled trials ○ Large non-randomized controlled trials ○ Large prospective trials ○ Comparative and cohort studies ○ Cross sectional studies ○ Retrospective studies

	evidence-based practice. *Sources:* ● Oscar's Clinical Guidelines ● MCG ● Hayes, Inc. ● Up-to-Date ● Authoritative peer-reviewed textbooks & journals ● National society guidelines ● Agency for Healthcare Research and Quality ● National Institutes of Health ("NIH") Consensus Statements ● CVS/Caremark Specialty Exceptions Criteria ● CVS Prior Authorization Criteria ● National Comprehensive Cancer Network The Plan develops clinical guidelines internally that supplement adopted criteria to support Medical Necessity determinations. Additionally, clinical evidence, as defined by published standards and internal plan guidelines are used to support Medical Necessity determinations: ● The US National Library of Medicine; ● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);	○ Surveillance studies ○ Case Reviews/Case series ○ Anecdotal/editorial statements ○ Professional opinions In the absence of strong and compelling scientific evidence, clinical policies may be based upon: ○ National consensus statements ○ Publications by recognized authorities such as government sources and/or professional societies

	• Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); • Published scientific evidence. 2. Clinical Efficacy **Clinical efficacy** is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. **Clinical effectiveness** is based on the evidence of clinical trials that the interventions are considered to be effective for the general population. *Evidentiary Standards:* The Plan rates efficacy by the below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition. Class I, "Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective. Class IIa, "Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy." Or rating systems considering efficacy of	

	regimen/agent is moderately effective such as NCCN definition of "Modest impact on survival, but often provides control of disease," or higher levels of efficacy. *Sources:* clinical or scientific peer-reviewed literature, Micromedex, NCCN, and national societies/national society guidelines 3. **Safety Risk** is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. *Evidentiary Standard:* Substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice. *Sources:* ● Oscar's Clinical Guidelines ● MCG ● Hayes, Inc. ● Up-to-Date ● Authoritative peer-reviewed textbooks & journals ● National society guidelines ● Agency for Healthcare Research and Quality ● National Institutes of Health ("NIH") Consensus	

	Statements ● CVS/Caremark Specialty Exceptions Criteria ● CVS Prior Authorization Criteria ● National Comprehensive Cancer Network The Plan develops clinical guidelines internally that supplement adopted criteria to support Medical Necessity determinations. Additionally, clinical evidence, as defined by published standards and internal plan guidelines are used to support Medical Necessity determinations: ● The US National Library of Medicine; ● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); ● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); ● Published scientific evidence. **4. Adoption of new medical/surgical procedures** *Evidentiary Standard:* Medical/surgical procedures/drugs on the	

	medical benefit that have the final approval of a licensing or regulatory agency (FDA), strong level of recommendation from consensus panels or national societies, and considered medically necessary by industry standards. *Sources:* FDA, Consensus panels, national societies 5. **Per Member Per Month Cost (PMPM)-** low, medium, high *Evidentiary Standard:* ■ Low: < $0.20 pmpm ■ Medium: <$0.5 pmpm ■ High: >=$0.5 pmpm *Source:* Claims Data **6. If the procedure is subject to utilization management review** ***Factors used to determine which source to use for the medical policy:*** 1. The grade/rating[1] of a	***Factors used to determine which source to use for the behavioral clinical policy:*** Evidence consulted includes externally developed, evidence-based medical necessity criteria (ASAM, LOCUS, CALOCUS-CASII and ECSII). In the absence of external criteria, MH/SUD will use a hierarchy of clinical evidence to evaluate new technologies and develop MH/SUD policy. When externally developed criteria is silent regarding a new or emerging technology, MH/SUD will consult the following resources to develop clinical policy: ● Plan documents ● Scientifically based clinical evidence ● Peer-reviewed literature ● Hierarchy of Clinical Evidence (Assessments are based on the following from highest to lowest): ○ Systematic reviews and meta analyses

[1] Grade Definitions: USPSTF uses the following grading system: Grade A- "The USPSTF recommends the service. There is high certainty that the net benefit is substantial." Grade B- "The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial." Hayes uses the following grading system: Rating A - " Established benefit. Published evidence shows conclusively that safety and impact on health outcomes are comparable to or better than standard treatment/testing. Long-term safety and impact on health outcomes have been established, and other important questions concerning application of the technology have been answered." Rating B- "Some proven benefit. Published evidence indicates that safety and impact on health outcomes are at least comparable to standard treatment/testing. However, there are outstanding questions regarding long-term safety and impact on health outcomes, clinical indications, contraindications, optimal treatment/testing parameters, and/or effects in different patient subpopulations."Rating C - "Potential but unproven benefit. Some published evidence suggests that safety and impact on health outcomes are at least comparable to standard treatment/testing. However, substantial uncertainty remains about safety and/or impact on health outcomes because of poor-quality studies, sparse data, conflicting study results, and/or other concerns."Rating Hayes D1 - No

	particular medical guideline used to develop the Plan's internal medical policy *Source*: United States Preventive Services Task Force *Evidentiary Standard*: Add a guideline with Grade A or B. *Source*: National Society Guidelines: *Evidentiary Standard*: Add a guideline with Grade A or B. Add guideline B unless industry standard[2] reveals guidelines are not utilized. *Source*: Hayes *Evidentiary Standard*: Add a guideline with Rating A Add a guideline with Rating B, unless industry standard reveals this guideline is not utilized. Add a guideline with Rating C unless industry standard reveals this guideline is not utilized. Reject Rating D. 2. Presence of Systematic Reviews and Randomized Controlled Trials *Source*: Systematic Reviews/Meta-Analysis *Evidentiary Standard*: At least 1 needed that shows level A evidence.	○ Randomized controlled trials ○ Large non-randomized controlled trials ○ Large prospective trials ○ Comparative and cohort studies ○ Cross sectional studies ○ Retrospective studies ○ Surveillance studies ○ Case Reviews/Case series ○ Anecdotal/editorial statements ○ Professional opinions ● In the absence of strong and compelling scientific evidence, clinical policies may be based upon: ○ National consensus statements ○ Publications by recognized authorities such as government sources and/or professional societies

proven benefit and/or not safe. Published evidence shows that the technology does not improve health outcomes or patient management for the reviewed application(s) or is unsafe. D2 - Insufficient evidence. There is insufficient published evidence to assess the safety and/or impact on health outcomes or patient management. For National Society Guidelines, ACC/AHA are examples used for grading guidelines.

[2] If market analysis reveals that the standard in question has been largely adopted by health plans (quantified by three or more plans), then the guideline receiving a lower level grade should be considered in the Plan's internal policy.

	Level B rejected if not industry standard. *Source*: Randomized Controlled Trials *Evidentiary Standard*: At least 2 or more randomized control trials with statistical significance and evaluated with the GRADE approach or other grading systems for quality of evidence and strength of recommendation that show "high" or "moderate" quality of evidence or "strong" or "moderate" recommendation	
In-Network Outpatient Services	Same as Inpatient Analysis	○ Same as Inpatient Analysis

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and

For each committee used to determine which benefits to subject to Medical Necessity Criteria Development Strategy, describe the committee's purpose, composition and member qualifications, and process:

Benefit Classification	**Committee Composition: Medical/Surgical**	**Committee Composition: MH/SUD**
In Network Inpatient Services/Outpatient Services	Oscar develops clinical guidelines internally that supplement adopted criteria to support Medical Necessity determinations. Internal clinical	To approve behavioral clinical policy and/or clinical criteria, a committee has been established and a standard process is followed. Optum's Clinical Quality and

	guidelines are developed by Oscar clinicians, with input from licensed participating Providers in Oscar's Provider Network, or in cases where appropriate clinical expertise is not readily available within the Oscar Provider Network, from independent licensed specialists with the needed clinical expertise. Oscar's internal clinical guidelines require formal approval by the Clinical Advisory Subcommittee, which reports into the Quality Improvement Committee. Internal clinical guidelines are reviewed at least annually and updated as appropriate based on new medical evidence. Oscar Clinical Guidelines and adopted criteria are reviewed and preliminarily approved by the following stakeholders: ● Vice President and National Medical Director, Clinical Operations (MD) ● Senior Manager, Clinical Operations (RN) ● Utilization Management Quality Nurse (RN) ● Pharmacist, Clinical Policy and Performance (PharmD) ● Senior Medical Director, Clinical Review (MD) ● State and Regional Medical Directors (MDs or DOs) Oscar adopted and developed clinical criteria are then presented to the Clinical Advisory Subcommittee for their approval. The Clinical Advisory Subcommittee is chaired	Operations Committee (CQOC) is responsible for assessing externally developed medical necessity criteria and developing evidence-based clinical criteria and behavioral clinical policies for select behavioral health technologies in accordance with the Hierarchy of Clinical Evidence. The CQOC informs Optum's Quality Improvement Committee (QIC). All medical/clinical policies are reviewed annually or more frequently if appropriate CQOC is comprised of, but is not limited to, Senior Behavioral Health Medical Directors, Senior Leaders of Clinical Operations and representatives from the following areas: Clinical Quality Improvement Department, Utilization Management, Clinical Operations, Appeals, Legal, Compliance, Network Strategy, and Provider Experience. All medical/clinical policies are reviewed annually or more frequently if appropriate. Qualifications of committee members include but are not limited to board certified psychiatrists (MD/DO), Psychologists (PhD/PsyD), and behavioral health clinicians (graduate degrees and/or RN).

	by a Senior Medical Director and consists of the following: ● Internal membership: ● Clinical Operations Nurse (RN) ● Senior Medical Director, Clinical Review (MD or DO) ● State/Regional Medical Directors (MD or DO) ● Designated Behavioral Health Physician (MD) ● External membership ○ At least four network participating practitioners (e.g., MDs, DOs) Finally, these updates are reported to the UM Subcommittee and ultimately through the Quality Improvement Committee.	

Briefly describe the processes by which Medical Necessity is applied:

Benefit Classification	**Process Description: Medical/Surgical**	**Process Description: MH/SUD**
In-Network Inpatient Services/Outpatient Services	**Description of IRR process:** All clinicians involved in clinical decision-making participate in annual inter-rater reliability (IRR) testing to ensure high quality, evidence-based decision making and consistent application of clinical criteria across its clinical UM staff. The IRR testing benchmark is 80%, and differences in determinations are used as the basis for quarterly clinical discussion and training. For cases where scores are below benchmark, the cases will be addressed in remediation	**Description of IRR process**: All MH/SUD clinical staff who make coverage determinations utilizing medical/clinical policies are required to participate in annual Inter-Rater Reliability (IRR) audits to ensure policies/criteria are applied in a consistent and appropriate manner "in operation." The IRR testing benchmark is 90%. For clinical staff who do not achieve a passing score, remediation may include re-education, additional mentoring, additional chart audits and call monitoring

	discussions for continued quality improvement. **Qualifications of those determining clinical criteria if applicable:** The Clinical Advisory Subcommittee is chaired by a Senior Medical Director and consists of the following: ● Internal membership: Clinical Operations Nurse (RN), Senior Medical Director, Clinical Review (MD or DO), State/Regional Medical Directors (MD or DO), Designated Behavioral Health Physician (MD) ● External membership: At least four network participating practitioners (e.g., MDs, DOs) Finally, these changes are reported to the UM Subcommittee and ultimately through the Quality Improvement Committee of the Board. *The selection and use of external or independent experts:* All medical clinical guidelines, behavioral health clinical guidelines, and pharmaceutical clinical guidelines are reviewed and approved by OMC physicians, behavioral health practitioners, and pharmacists respectively with input from licensed Providers, or in cases where appropriate clinical expertise is not readily available, from independent licensed specialists with the needed clinical expertise.	to provide clinical education and guidance on the use and application of the relevant policies/criteria. **Qualifications of those determining clinical criteria if applicable**: CQOC is comprised of, but is not limited to, Senior Behavioral Health Medical Directors, Senior Leaders of Clinical Operations and representatives from the following areas: Clinical Quality Improvement Department, Utilization Management, Clinical Operations, Appeals, Legal, Compliance, Network Strategy, and Provider Experience. Qualifications of committee members include but are not limited to board certified psychiatrists (MD/DO), Psychologists (PhD/PsyD), and licensed behavioral health clinicians (graduate degrees and/or RN). *The selection and use of external or independent experts:* All behavioral health clinical criteria are reviewed and approved by OBHS Medical Directors and behavioral health practitioners with input from licensed providers, or in cases where appropriate clinical expertise is not readily available, from independent licensed specialists with the needed clinical expertise.

Identify and define the factors and processes that are used to monitor Medical Necessity Criteria:

<table>
<tr><th>Benefit Classification</th><th>Comparative Analysis</th></tr>
<tr><td>In-Network Inpatient Services/Outpatient Services</td><td>
The Plan performs clinical inter-rater reliability testing and ensures processes for the development or adoption of medical necessity criteria and subsequent determinations are applied consistently across each benefit classification for mental health/substance use disorder services and medical/surgical services.

Scheduled Policy Reviews: All criteria are evaluated at least annually to ensure they reflect current scientific knowledge.

<u>Medical/Surgical</u>:

The Plan uses documented clinical review criteria based on sound clinical evidence to make utilization management decisions, including medical necessity coverage determinations. All clinicians involved in clinical decision-making participate in annual inter-rater reliability (IRR) testing to ensure high quality, evidence-based decision making and consistent application of clinical criteria across its clinical UM staff. The IRR testing benchmark is 80%, and differences in determinations are used as the basis for quarterly clinical discussion and training. For cases where scores are below benchmark, the cases will be addressed in remediation discussions for continued quality improvement.

<u>MH/SUD</u>:

M/S and MH/SUD utilize medical/clinical policies when making medical necessity coverage determinations related to M/S and MH/SUD technologies. All M/S and MH/SUD clinical staff who make coverage determinations utilizing medical/clinical policies are required to participate in annual Inter-Rater Reliability (IRR) audits to ensure policies/criteria are applied in a consistent and appropriate manner “in operation.” For clinical staff who do not achieve a passing score of 90%, remediation may include re-education, additional mentoring, additional chart audits and call monitoring to provide clinical education and guidance on the use and application of the relevant policies/criteria.

<table>
<tr><td>Inter-rater reliability scores clinical reviewers (M/S) 2021:</td><td>Inter-rater reliability scores clinical reviewers (MH/SUD) 2021:</td></tr>
<tr><td>● Average IRR score: 93.0%</td><td>● Average IRR score: 98.8%</td></tr>
</table>
</td></tr>
</table>

5. Provide the specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements:

Benefit Classification	Findings/Conclusions
In-Network Inpatient Services/Outpatient Services	The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA for the following reasons: 1. The factors, sources, and evidentiary standards used to develop medical necessity criteria are aligned. 2. As written, the Plan performs clinical inter-rater reliability testing and ensures processes for the development or adoption of medical necessity criteria and subsequent determinations are applied consistently across each benefit classification for mental health/substance use disorder services and medical/surgical services. 3. In-operation, the Plan performs in-operation data assessments to ensure that the underlying methodology for developing medical necessity criteria is applied no more strictly to MH/SUD services when compared to M/S services. Findings/Conclusion: The findings of the comparative analysis reveal that the methodology for medical necessity criteria development for MH/SUD benefits is comparable to, and applied no more stringently than, the methodology for medical necessity criteria for M/S benefits. When reviewing the inter-rater reliability testing scores for clinical-decision making in 2021, medical reviewers' and behavioral health reviewers' average IRR scores met the relative benchmarks of 80% and 90% respectively. Medical clinical reviewers scored an average IRR score of 93% for 2021, while behavioral health clinical reviewers scored an average IRR score of 98.8%. Inter-rater reliability testing is employed to ensure high quality, evidence-based decision making and consistent application of clinical criteria across its clinical UM staff. Since behavioral health clinical reviewers achieved an average score of 98.8% and medical clinical reviewers achieved an average score of 93%, there is evidence that reviewers apply consistent evidence-based decision-making when rendering medical necessity determinations. Thus, the underlying processes, strategies, evidentiary standards and other factors as-written and in-operation used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA.

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Prior Authorization
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Clinical
Names of Person(s) Responsible for Analysis Formation	**Oscar**: Insiya Taj, MPH, Associate, UM Optimization, (Over 3 years experience in healthcare and clinical research) Marco Fossati-Bellani, MD, MPH, Senior Medical Director, UM **Optum Behavioral Health Solutions**: Positions: Chief Medical Officer, National Senior Behavioral Medical Directors (MD), VP Benefits Integrity, VP, Outpatient and Specialty Programs, Director MH Parity and Benefits, Legal Counsel, and Senior Director, National Policy and Standards. Credentials: Board Certified MDs, Licensed Psychologist, Licensed Nurse, Licensed Social Worker, and National Certified Counselor.
Last Update	7/11/2022
Reviewers	Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Prior Authorization

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

Strategy: Prior Authorization is a component of the Plan and Optum Behavioral Health Solutions (OBHS) utilization management program that helps ensure members receive the most appropriate care, based on their specific clinical status and health care needs before care is received.

Medical/Surgical Terms	**Mental Health/Substance Use Disorder Terms**
Definition: The Plan defines prior authorization as the process by which the utilization review agent determines the medical necessity of otherwise covered health care services prior to the rendering of such health care services including, but not limited to, preadmission review, pretreatment review, utilization, and case management.	Prior authorization: A form of prospective utilization review of health care services proposed to be provided to a member. A pre-service review determines approval of services, in whole or in part, in advance of the member obtaining services.

Coverage Terms (EOC language):

Prior Authorization means the process by which Oscar determines the Medical Necessity of otherwise covered healthcare services prior to the rendering of such healthcare services including, but not limited to, preadmission review, pretreatment review, utilization management. For the purposes of this document, the term "Prior Authorization" is considered to be synonymous with "Preauthorization" or "Precertification."

Prior authorization for Inpatient and Outpatient services

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. The list of services subject to preauthorization can be accessed online at hioscar.com/prior-authorization. If You do not obtain prior authorization before an elective admission to a Hospital or certain other facilities, it may result in a penalty.

Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of this Plan limitations and exclusions, payment of premium and eligibility at the time care and services are provided. Please note that emergency admissions may be reviewed post admission. To obtain Prior Authorization or verify requirements for inpatient or outpatient services,including which services require Prior Authorization,

You or Your Provider can call Oscar at 1-855-672-2755 or online at hioscar.com/prior-authorization.
In order to minimize the potential for care delays, We recommend that Prior Authorization requests be received within the following timeframes when feasible:

- At least five (5) days prior to an elective admission as an inpatient in a Hospital, extended care or rehabilitation facility, or hospice facility
- At least thirty (30) days prior to the initial evaluation for organ transplant Services
- At least thirty (30) days prior to receiving clinical trial services
- At least five (5) days prior to a scheduled inpatient behavioral health or substance abuse treatment admission
- At least five (5) days prior to the start of home healthcare services

Benefit Classification	**Medical/Surgical Services to which the NQTL applies**	**Mental Health/SUD Services to which the NQTL applies**
In-Network Inpatient Services	All inpatient services are subject to this NQTL. • Acute/Elective Hospital • Hospice Long-Term Acute Care • Rehabilitation • Acute/Subacute • Skilled Nursing Facility • Procedures/Treatments/Surgeries,when place of service is inpatient	The following inpatient services are subject to this NQTL. • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment
In-Network Outpatient Services	• Physician-Administered Drugs • Certain DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) such as oxygen, CPAP, and diabetic supplies • Home Health Care Services • Advanced Imaging • Home-Based Speech Therapy • Physical Therapy • Occupational Therapy • Diagnostic Tests &	• Partial Hospitalization (PHP)/Day Treatment • Intensive Outpatient (IOP) • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) • Electroconvulsive Therapy (ECT) • Psychological Testing

	Evaluations, Laboratory Procedures • Non-Emergency Transportation • Unlisted Procedures • Procedures/Treatments/Surgeries, when place of service is outpatient	• Physical Therapy[1] • Occupational Therapy[2] • Home-Based Speech Therapy[3]

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
In-Network Inpatient Services	1. Safety risk 2. Clinical appropriateness 3. Cost	1. Clinical Appropriateness: The application of Prior Authorization promotes optimal clinical outcomes 2. Value: The value of applying Prior Authorization outweighs the associated costs
In-Network Outpatient Services	1. Cost variability 2. Denial rate 3. Cost percentile 4. Safety risk 5. New/emerging service/technology 6. Clinical appropriateness	1. Clinical Appropriateness: The application of Prior Authorization promotes optimal clinical outcomes 2. Value: The value of applying Prior Authorization outweighs the associated costs

[1] Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)
[2] Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)
[3] Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)

		3. Variation Identified: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Benefit Classification	Evidentiary Standards and Sources: Medical/Surgical	Evidentiary Standards and Sources: MH/SUD
In-Network Inpatient Services	1. **Clinical appropriateness** is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level or care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice. Examples: ● As per World Professional Association for Transgender	1. **Clinical Appropriateness: The application of Prior Authorization promotes optimal clinical outcomes** This factor is utilized to determine which services may be subject to prior authorization. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the prior authorization list if there are objective, evidence-based clinical criteria to be used in the prior authorization reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed technology are used to approve and develop Medical Necessity Criteria on which reviews are based.

	Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines. ● As per the American Psychological Association (APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder. ● As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of cancer and individualized needs as documented in the medical record. Sources: Clinical criteria, Clinical evidence Evidentiary Standards: Clinical criteria ● Plan Clinical Guidelines ● MCG ● ASAM (SUD only) ● Hayes ● UpToDate ● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH) Clinical evidence ● The US National Library of Medicine; ● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); ● Guidance or regulatory status	Source: Expert Medical Review and objective, evidence-based clinical criteria, and nationally recognized guidelines Evidentiary Standard: Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. Clinical Evidence Used: ● Systematic reviews and meta analyses ● Randomized controlled trials ● Large non-randomized controlled trials ● Large prospective trials ● Comparative and cohort studies ● Cross sectional studies ● Retrospective studies ● Surveillance studies ● Case Reviews/Case series ● Anecdotal/editorial statements ● Professional opinions In the absence of strong and compelling scientific evidence, clinical policies may be based upon: ● National consensus statements ● Publications by recognized authorities such as government sources and/or professional societies 2. **Value: The value of applying Prior Authorization outweighs the associated costs**

	published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); ● Published scientific evidence; ● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists). Examples: ● Physical Therapy/Occupational Therapy ● Gender affirming surgeries ● Confirming member has undergone hormone therapy and counseling ● Mastectomy - appropriate in most cases, but need to review for medical necessity ● Physician-administered drugs ● Level of care setting Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards. **2. High Cost** Evidentiary Standard: The mean cost of an inpatient episode of care is >$12,000 Source: claims data 3. **Safety risk** is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The prior authorization process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are	Source: Internal claims data, UM program operating costs, UM authorization data Evidentiary Standard: Value is defined as the value of subjecting the inpatient services to Prior Authorization exceeds the administrative costs by at least 1:1 ● The process includes a review of authorization and denied claims data to identify if there is opportunity to reduce unnecessary costs when prior authorization is applied. The projected cost savings is reviewed relative to the operating cost of administering prior authorization to determine value.

	medically necessary and appropriately administered. If there is a less restrictive level of care available to meet the member's health needs, prior authorization may be applied to ensure the member receives the least restrictive level of care that is clinically appropriate. Sources: National societies and health agencies, Clinical criteria[4], Clinical evidence[5] ● Centers for Medicare & Medicaid Services ● World Health Organization ● Institute For Safe Medication Practices ● U.S. Food and Drug Administration ● Drug labeling / safety information Evidentiary Standards: ● Treatments that increase the likelihood of adverse health effects ● Services that increase the likelihood of perioperative morbidity and mortality ● Procedures, such as high-risk operations, that carry a mortality rate of 5% or more. ● Procedures with significant or major impact on hemodynamics, fluid shifts, possible major blood loss. ● Drugs (including those dosed at	

[4] Clinical criteria includes: Plan Clinical Guidelines, MCG, ASAM (SUD only), Hayes, UpToDate, National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)

[5] Clinical evidence: The US National Library of Medicine; Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); Published scientific evidence;In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).

	higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse. *Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017 (http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf).*	
In-Network Outpatient Services	1. **Clinical appropriateness** is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level or care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice. Examples:	1. **Clinical Appropriateness** is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines This factor is utilized to determine which services may be subject to prior authorization. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the prior authorization list if there are objective, evidence-based clinical criteria to be used in the prior authorization reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and

	• As per World Professional Association for Transgender Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines. • As per the American Psychological Association (APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder. • As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of cancer and individualized needs as documented in the medical record. Sources: Clinical criteria, Clinical evidence Evidentiary Standards: Clinical criteria • Plan Clinical Guidelines • MCG • ASAM (SUD only) • Hayes • UpToDate • National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH) Clinical evidence • The US National Library of Medicine; • Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA,	appropriateness of the proposed technology are used to approve and develop Medical Necessity Criteria on which reviews are based. Source: Expert Medical Review, objective, evidence-based clinical criteria, and nationally recognized guidelines Evidentiary Standard: Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines Clinical Evidence Used: • Systematic reviews and meta analyses • Randomized controlled trials • Large non-randomized controlled trials • Large prospective trials • Comparative and cohort studies • Cross sectional studies • Retrospective studies • Surveillance studies • Case Reviews/Case series • Anecdotal/editorial statements • Professional opinions In the absence of strong and compelling scientific evidence, clinical policies may be based upon: • National consensus statements • Publications by recognized authorities such as government sources and/or professional

	NCCN); ● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); ● Published scientific evidence; ● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists). Examples: ● Physical Therapy/Occupational Therapy ● Gender affirming surgeries ● Confirming member has undergone hormone therapy and counseling ● Mastectomy - appropriate in most cases, but need to review for medical necessity ● Physician-administered drugs ● Level of care setting Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards. 2. **Denial rate** is defined as the percentage of prior authorization requests that are denied by the Plan. Source: Prior authorization data Evidentiary Standard: >10% Examples: ● Benefit: Medical/Surgical Service: Outpatient Services: Treatments & Procedures: Skin Treatments & Procedures | UV / Laser therapy	societies 2. **Value** is defined as the value of subjecting the outpatient services to prior authorization exceeds the administrative costs by at least 1:1 Source: Internal claims data, UM program operating costs, UM authorization data Evidentiary Standard: Value is defined as the value of subjecting the outpatient services to Prior Authorization exceeds the administrative costs by at least 1:1 ● The process includes a review of authorization and claims data to identify if there is opportunity to reduce unnecessary costs when prior authorization is applied. The projected cost savings is reviewed relative to the operating cost of administering prior authorization to determine value. 3. **Variability** is defined as cost per episode of service (service units X unit cost) that trigger 2x the average mean of other outpatient services and provided to a minimum of twenty unique Plan members Source: Internal claims data Evidentiary Standard: Variability is defined as cost per episode of

	Denial rate applies to this service category. Denial rate is 70% for this service category. ● Benefit: Mental Health/Substance Use Disorder Service: Partial Hospitalization Denial rate applies to this service category. Denial rate is 60% for this service category. 3. **Cost variability** is defined as the cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members. Outpatient services are subject to variability in cost per episode of service relative to other services within the classification of benefits. For each service, the Plan calculates the Average Annual Allowed Amount per Unique Patient with Outpatient Claim Events for that Primary Service. Source: Claims data Evidentiary Standard: Cost per episode of service that triggers 2x the mean of other outpatient services. Examples: ● Benefit: Medical/Surgical Service: Outpatient Services: Treatments & Procedures: Musculoskeletal Surgery | Joint arthroscopy / arthroplasty / arthrodesis	service (service units X unit cost) that trigger 2x the average mean of other outpatient services and provided to a minimum of twenty unique Plan members

	Cost variability applies to this service category. Cost variability is 5x the mean of other outpatient services. ● Benefit: Mental Health/Substance Use Disorder Service: Outpatient Psychiatric Testing Cost variability applies to this service category. Cost variability is 2.9x the mean of other outpatient services. 4. **Cost percentile** is defined as the average cost per claim event for a particular outpatient service relative to other services within the classification of benefits. Source: Claims data Evidentiary Standard: ≥ 85th Percentile Examples: ● Benefit: Medical/Surgical Service: Outpatient Services: Treatments & Procedures: Digestive Treatments & Procedures | Bariatric surgery Cost percentile applies to this service category. Cost is in the 100th percentile for this service category. ● Benefit: Mental Health/Substance Use Disorder Service: Outpatient psychiatric testing Cost percentile applies to this service category.	

	Cost is in the 100th percentile for this service category 5. **Safety risk** is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The prior authorization process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered. Sources: National societies and health agencies, Clinical criteria[6], Clinical evidence[7] ● Centers for Medicare & Medicaid Services ● World Health Organization ● Institute For Safe Medication Practices ● U.S. Food and Drug Administration ● Drug labeling / safety information **Evidentiary Standards:** ● Treatments that increase the likelihood of adverse health effects ● Services that increase the likelihood of perioperative morbidity and mortality	

[6] Clinical criteria: Plan Clinical Guidelines, MCG, ASAM (SUD only), Hayes, UpToDate, National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)

[7] Clinical evidence: The US National Library of Medicine; Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); Published scientific evidence;In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).

	● Procedures, such as high-risk operations, that carry a mortality rate of 5% or more. ● Procedures with significant or major impact on hemodynamics, fluid shifts, possible major blood loss. ● Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse. *Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017 (http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf).* Examples: ● Surgical procedures at risk for infection and complications (e.g., gastrectomy, hip replacement) ● Advanced radiology procedures with exposure to radiation (e.g., CT, MRI, nuclear medicine) ● Physician-administered drugs due to the risk for adverse effects and contraindications (e.g., chemotherapeutic agents) 6. **New/ Emerging Service/ Technology** is defined as any health care service, testing, procedure, treatment, device or prescription drug for which safety and efficacy has not been established and proven is considered experimental,	

	investigational, or unproven. Services that are not accepted as the standard medical treatment of the condition being treated are considered "new and emerging services and technologies." This includes any health care service, testing, procedure, treatment, device, or prescription drug that: ○ Is not accepted as standard medical treatment of the condition; or ○ Has not been approved by the U.S. Food and Drug Administration (FDA) to be lawfully used; or ○ Has not been identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or ○ Requires review and approval by any institutional review board (IRB) for the proposed use or are subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations; or ○ Requires any Federal or other governmental agency approval not listed above that has not been and will not be granted at the time services will be provided.	

	Sources: Clinical criteria, Clinical evidence Evidentiary Standards: Clinical criteria ● Plan Clinical Guidelines ● MCG ● ASAM (SUD only) ● Hayes ● UpToDate ● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH) Clinical evidence ● The US National Library of Medicine; ● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); ● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); ● Published scientific evidence; ● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists). Examples: ● Genetic, biomarker and molecular tests ● Medical devices and implants ● Novel therapies (e.g., gene therapy, CAR T-Cell therapy)	

***For each benefit subject to Prior Authorization, identify which of the factor(s) in Step 3 were met*:**

Inpatient M/S

	Clinical Appropriateness	Safety	High Cost
Acute/Elective Hospital Rehabilitation	**X**	**X**	**X**
Hospice Long-Term Acute Care	**X**	**X**	**X**
Acute/Subacute	**X**	**X**	**X**
Skilled Nursing Facility	**X**	**X**	**X**
Procedures/Treatments/Surgeries,when place of service is inpatient	**X**	**X**	**X**

Outpatient M/S

Service	Cost variability	Denial rate	Cost percentile	Safety risk	New/ Emerging Service/ Technology	Clinical Appropriateness
Physician-Administered Drugs		**X**		**X**	**X**	**X**
DMEPOS		**X**	**X**		**X**	**X**
Home Health Care Services		**X**				**X**
Advanced Imaging		**X**		**X**		

Diagnostic Tests & Evaluations, Laboratory Procedures		**X**	**X**		**X**	**X**
Treatments/ Procedures	**X**	**X**	**X**	**X**	**X**	**X**
Non-Emergency Transportation		**X**	**X**			
Unlisted Procedures	**X**	**X**		**X**	**X**	

Inpatient MH/SUD

	Clinical Appropriateness	Value
Inpatient, MH	**X**	**X**
Inpatient, SUD	**X**	**X**
Residential, MH	**X**	**X**
Residential, MH	**X**	**X**

Outpatient MH/SUD

	Clinical Appropriateness	Value	Variation
Partial Hospitalization/Day Treatment	**X**	**X**	**X**
Intensive Outpatient	**X**	**X**	**X**
Applied Behavior Analysis (ABA)	**X**	**X**	**X**
Transcranial Magnetic Stimulation (TMS)	**X**	**X**	**X**

Electroconvulsive Therapy (ECT)	**X**		**X**
Psychological Testing	**X**	**X**	

4. **Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits:**

Prior Authorization Process M/S	**Prior Authorization Process MH/SUD**
Purpose of PA The prior-authorization process is part of the Utilization Review (UR) activities performed by the Plan Utilization Review is the assessment performed to determine if a medical service meets the Plan's medical necessity criteria for coverage. **Services Subject to PA & Submitting PA Request** The Plan maintains a list of services that require prior authorization. This list is available on request by phone, by provider portal, or via the published provider manual. Authorizations can be submitted via phone, fax, or online through Oscar's provider portal. **Reviewers** When a prior authorization request is submitted, it is reviewed by licensed clinicians to determine if the request meets medical necessity. Licensed clinicians (e.g. physicians and nurses) review authorization requests. Clinical reviewers must have an active unrestricted professional license in a state or	**Purpose of PA** Prior Authorization is a component of the OBHS utilization management (UM) program that helps ensure members receive appropriate care, based on their specific clinical status and health care needs before care is received. The purpose of prior authorization is to enable the facility or provider and the member to have an informed pre-service review. **Services Subject to PA & Submitting PA Request** OBHS maintains a list of services that require prior authorization. This list is available on request by phone or via provider portal. Providers may submit prior authorization requests by telephone, fax, or online portal in accordance with plan requirements. Members may submit prior authorization requests via telephone, fax, or mail in accordance with plan requirements. **Reviewers** When the in-network provider or facility or member requests Prior Authorization, OBHS reviews the request utilizing applicable medical/clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Reviewers are clinical personnel who hold an active, unrestricted

territory of the United States, and within scope of practice relevant to the clinical area they are reviewing. Clinicians utilize the Plan's policies and established, evidence based clinical criteria to determine if the request meets coverage determinations and/or medical necessity. Licensed clinicians (e.g. physicians and nurses) review authorization requests; only board certified physicians can make adverse determinations. **Information Required When Requesting PA** The Plan requires the requesting provider to submit the following information when requesting an authorization: ● Member information (name, Plan ID, date of birth). ● Facility (if applicable). ● referring and treating provider name, National Provider Identifier (NPI), and Taxpayer Identification Number (TIN). ● Treatment information including diagnostic and/or procedure codes, requested amount and length of treatment(s). **Notification of Determination:** Both the providers and members are notified of the determination consistent with state, federal and accreditation requirements and applicable appeal rights are provided.	license within the United States or one of its territories, and board certification as a psychiatrist or addictionologist, or an active, unrestricted license within the United States or one of its territories, as a doctoral-level psychologist. Adverse determinations are rendered by appropriately qualified clinical reviewers (e.g., MD or Psychologist). The provider, facility, and member are notified of an adverse determination, which includes the credentials of the individual who rendered the decision, and is consistent with state, federal and accreditation requirements and applicable appeal rights are provided. **Information Required When Requesting PA** During the clinical review process, OBHS personnel gather only the critical information needed (in compliance with state-specific restrictions for the type of information that can be requested). Requests for authorization must contain the following details regarding the admission: • Member name and Member ID number • Facility/Provider name and TIN or NPI • Description for admitting diagnosis • Service start date • Clinical information sufficient to make a coverage determination **Notification of Determination:** The member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. **Note: Optum Behavioral Health Solutions (OBHS) generally structures UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.

For each committee used to determine which benefits to subject to Prior Authorization, describe the committee's purpose, composition and member qualifications, and process:

Committee Information M/S	Committee Information MH/SUD
The OMC Board of Directors has the ultimate authority and responsibility for the quality of care and services delivered to its members. The Board of Directors provides strategic planning and direction, budget approval, and staff allocation for the UM Department. The Board of Directors assigns day-to-day responsibility for implementation of the UM Program to the UM Subcommittee, which is a subcommittee of the Quality Improvement Committee. The Board of Directors oversees the implementation of and adherence to the UM Program through the UM Subcommittee. The UM Subcommittee reports to the Quality Improvement Committee at a minimum of once per quarter, per year. The UM Program and Annual Program Evaluation are approved at the UM Subcommittee portion of the Quality Improvement Committee meeting. Minutes conveying this approval are submitted to the Board of Directors, who approve the actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical). As noted above, the UM Subcommittee is a sub-committee to the Quality Improvement Committee. A senior-level physician chairs the UM Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary.	Services subject to prior authorization are reviewed at least annually, or more frequently as needed. This process is overseen by the Clinical Quality and Operations Committee (CQOC). The Clinical Quality and Operations Committee (CQOC) receives oversight from the Quality Improvement Committee (QIC). Appointed by the Chief Medical Officer, a senior-level licensed psychiatrist (MD) Medical Director Chairs the CQOC along with a Vice Chair (PhD, MBA) who is a senior leader of clinical operations responsible for UM activities. Voting membership includes representation from licensed and board-certified psychiatrists (MDs), licensed Psychologists (PhDs) and a licensed nurse (RN). Committee voting membership includes participants from the following areas: Clinical Technology Assessment Committee (MDs), Clinical Criteria (LCSW, MSN, RN, PMHNP-BC), Clinical Operations of Direct Sites (MBA), Utilization Management (PhD), Senior Leader Quality Improvement (PhD), Appeals, Care Engagement Medical Operations (MD) and Medical Operations for UM (MD). Additional internal department representatives attend as non-voting membership, including Legal Counsel, Compliance, Accreditation, the Operational Policy and Standards Committee, Network Strategy and Benefits Integrity. The Clinical Quality and Operations Committee meets monthly and ad hoc, as necessary. The CQOC undertakes, but is not limited to, the following ongoing activities: ● Oversees the development and implementation of a National Utilization Management (UM) Program (NUMP) with the Utilization Management Program Description (UMPD) serving as the source document for the NUMP ● Proposes and evaluates UM-related Clinical QIAs

The UM Subcommittee undertakes, but is not limited to, the following ongoing activities: ● Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated. ● Reviews and approves modifications to the UM Program as indicated by operational needs and/or to meet regulatory and accreditation compliance. ● Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services. ● Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.	● Evaluates the effectiveness and efficiency of our UM program across all business operation sites ● Ensures the standardization of our UM program across all business operation sites ● Reviews Operational Policy and Standards Committee policies related to UM management as necessary ● Reviews, recommends, and votes on Clinical Criteria ● Review and approval of prior authorization requirements

***Briefly describe the processes by which prior authorization is applied*:**

Benefit Classification	**Process Description: Medical/Surgical**	**Process Description: MH/SUD**
In-Network Inpatient Services/Outpatient Services	**Timelines and deadlines for review and approvals:** Urgent: If request is completed, decision and approvals are made within 72 hours of receipt of request **Forms and/or other information required to be submitted by the provider:** The Plan will collect only information necessary to make a utilization review determination and will not routinely require providers to code requests or submit medical records for all patients. During prior and concurrent reviews, only the necessary and relevant section of medical records will be requested, as needed to verify	**Timelines and deadlines for review and approvals**: Urgent: Within 72 hours from receipt of the request. **Forms and/or other information required to be submitted by the provider**: For any inpatient or outpatient service on the Prior Authorization List, the in-network facility or provider must confirm, prior to rendering the service that the prior authorization approval is on file. Providers may submit prior authorization requests by telephone, fax, or online portal in accordance with plan requirements. Members may submit prior authorization requests via telephone, fax, or mail in accordance with plan requirements.

	medical necessity. The Plan requires the requesting provider to submit the following information when requesting an authorization: ● Member information (name, Plan ID, date of birth). ● Facility (if applicable). ● referring and treating provider name, National Provider Identifier (NPI), and Taxpayer Identification Number (TIN). ● Treatment information including diagnostic and/or procedure codes, requested amount and length of treatment(s). **UM manuals and any other documentation of UM processes that are relied upon to make a determination:** The Plan conducts a full investigation of each request, taking into consideration all documents, clinical records, and other information submitted. In all cases, nurse and physician reviewers adhere to the clinical criteria and guidelines outlined in the Plan's UM Plan. The Plan uses externally developed, evidence-based medical necessity criteria and well as internally developed medical necessity criteria when making medical necessity coverage determinations related to M/S services. **Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board**	During the clinical review process, OBHS personnel gather only the critical information needed (in compliance with state-specific restrictions for the type of information that can be requested). Requests for authorization must contain the following details regarding the admission: • Member name and Member ID number • Facility/Provider name and TIN or NPI • Description for admitting diagnosis • Service start date • Clinical information sufficient to make a coverage determination **UM manuals and any other documentation of UM processes that are relied upon to make a determination**: OBHS uses externally developed, evidence-based medical necessity criteria (e.g., ASAM, LOCUS, CALOCUS-CASII and ECSII), as well as internally developed evidence-based, medical necessity criteria (e.g., medical and clinical policies) when making medical necessity coverage determinations related to Mental Health/Substance Use Disorder (MH/SUD) technologies (e.g., services, interventions, etc.) that fall outside the scope of the ASAM, LOCUS, CALOCUS-CASII and ECSII criteria and/or relate to advancements in technologies or types of care that are not addressed by the most recent versions of ASAM, LOCUS, CALOCUS-CASII and ECSII criteria. ASAM is the only criteria Optum uses to make SUD medical necessity coverage determinations, unless otherwise mandated by state law or contract. OBHS reviews the request utilizing applicable medical/clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. **Minimum standards to issue a denial (e.g. sign-off from a physician with relevant**

	certification): When a prior authorization request is submitted, it is reviewed by licensed clinicians to determine if the request meets medical necessity. Clinicians utilize the Plan's policies and established, evidence based clinical criteria to determine if the request meets coverage determinations and/or medical necessity. Licensed clinicians (e.g. physicians and nurses) review authorization requests; only board certified physicians can make adverse determinations.	**board certification)**: When the in-network provider or facility or member requests Prior Authorization, OBHS reviews the request utilizing applicable medical/clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Adverse determinations are rendered by appropriately qualified clinical reviewers (e.g., MD or Psychologist). The provider, facility, and member are notified of an adverse determination, which includes the credentials of the individual who rendered the decision, and is consistent with state, federal and accreditation requirements and applicable appeal rights are provided. **Note: Optum Behavioral Health Solutions (OBHS) generally structures UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.

Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization

Benefit Classification	**Process Description: Medical/Surgical**	**Process Description: MH/SUD**
In-Network Inpatient Services/Outpatient Services	The Plan is responsible for coordinating responses to non-quantitative treatment limitations (NQTLs) with its Behavioral Health Vendor (Optum Behavioral Health Solutions) on an annual basis or as needed when there is a change to a current methodology or process directly related to the NQTL. The Plan conducts non-quantitative treatment limitations to review that factors, sources, evidentiary standards, and processes are applied no more stringently to Mental Health/Substance Use Disorder services when compared to Medical/Surgical services. If a discrepancy is identified, the Plan coordinates with Optum Behavioral Health Solutions to investigate if there is a risk of non-compliance to perform necessary remediation. The prior authorization non-quantitative treatment limitation is approved on an annual basis by the Clinical Advisory Committee, which reports to the Utilization Management Subcommittee, in quarter three of each year. The Associate of Clinical Policy and Performance is responsible for conveying annual updates to the committee for review and formal sign-off. Non-quantitative treatment limitation changes and modifications,	

including factor updates or other modifications to the non-quantitative treatment limitation methodology, are determined during the most subsequent quarterly Clinical Advisory Subcommittee session or can be voted on by CAS committee members off-cycle.

Where Oscar delegates utilization review services, Oscar audits clinical decisions made for our members on behalf of the Plan. Clinical audits may be driven by utilization trends or by known or hypothesized compliance risks. The clinical audit is conducted by a group of clinicians either at Oscar or by an independent expert in this field. The process includes a review of decision-making, criteria or formulary application, and documentation. Review of clinical decision-making ensures our members receive high quality, cost-effective care at the right place at the right time by supporting and making consistent and evidence-based clinical decisions regarding the appropriateness of healthcare services. Oscar additionally audits clinical decisions internally to ensure members receive high quality, cost-effective care at the right place at the right time by supporting and making consistent and evidence-based clinical decisions regarding the appropriateness of healthcare services. The audits test for appropriate criteria selection and application, decision-making, internal documentation, and denial language (where applicable).

Inter-rater reliability scores clinical reviewers (M/S) 2021:	**Inter-rater reliability scores clinical reviewers (MH/SUD) 2021:**
• Average IRR score: 93.0%	• Average IRR score: 98.8%

In completing its annual MHPAEA filings in many states, the Plan performs a variety of self-assessments and mandatory in-operation analyses as required by each regulatory recipient. Because the Plan's benefit designs and internal practices are consistent across markets, the findings of these self-assessments and analyses are largely consistent across markets and serve as a validation mechanism for MHPAEA compliance more broadly.

Operationally, the Plan performs in-operation data assessments to make sure that factors, sources, and evidentiary standards are applied in a consistent manner. For UM, the Plan reviews denial rates, informal reconsideration statistics, out-of-network statistics, and overturned appeal rates for pre-service across all commercial plans and compares these metrics for med/surg benefits against MH/SUD benefits. While data outcomes are not determinative of mental health parity compliance, the Plan uses these results to guide if investigations into UM processes are necessary to ensure that underlying methodology for UM procedures are not more stringent toward behavioral health benefits.

Findings:

***Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization for M/S services*:**	***Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization for MH/SUD services*:**
Medical/Surgical: **Prior Authorization** Prior Authorization denial rates (includes partial): ● Total # of PA requests: 147,007 ● Total # of PA requests denied: 31,427 ● % of PA requests denied: 21.0% OON stats: ● Total # OON requests: 6,770 ● Percentage (from total # of requests): 4.60% ● Total # denied: 4,807 ● Percentage of denied (from total OON requests): 71.0% Overturned appeal rates: ● Total Appeals: 938 ● Total # overturned: 334 ● Overturn rate (%): 36.0%	MH/SUD: **Prior Authorization** Prior Authorization denial rates (includes partial): ● Total # of PA requests: 9560 ● Total # of PA requests denied:422 ● % of PA requests denied: 4.4% OON stats: ● Total # OON requests:190 ● Percentage (from total # of requests):1.98% ● Total # denied:122 ● Percentage of denied (from total OON requests): 64.21% Overturned appeal rates (includes partially overturned): ● Total Appeals: 33 ● Total # overturned:12 ● Overturn rate (%):36.4%

*Data is based on 2021 authorization data across Oscar commercial plans (excluding MA)

5. Provide the specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

In-Network Inpatient Services/Outpatient Services	The 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 for the following reasons: The Plan conducted a comparative analysis to determine which Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) services are subject to prior authorization “as written.” The factors that demonstrate whether inpatient benefits require Prior Authorization are aligned for MH/SUD benefits and M/S benefits. For both MH/SUD and M/S services, clinical appropriateness is a factor. Additionally, safety is a factor considered for M/S services which is also considered under medical necessity criteria when assessing the clinical appropriateness factor for MH/SUD services. Value (factor for MH/SUD benefits) is aligned with the cost (factor for M/S benefits) because both of these factors take into account the cost of services. For inpatient factors, claims data is used as a source to evaluate factors such as value and cost and objective, evidence-based clinical guidelines medical experts, and national guidelines are used as an evidentiary standard and source for factors such as clinical appropriateness and safety. The factors that demonstrate whether an outpatient benefit requires Prior Authorization are aligned for MH/SUD services and M/S services. The factors clinical appropriateness (MH/SUD and M/S) and safety (M/S) are aligned as they both take into consideration the appropriateness of a service and rely on objective, evidence-based clinical guidelines, medical experts, and national guidelines as an evidentiary standard and source. Safety is considered as an element under medical necessity criteria when assessing the clinical appropriateness factor for MH/SUD benefits and thus is aligned with the safety factor for M/S benefits. For the MH/SUD outpatient factor "value of applying a prior authorization," this factor closely aligns with M/S factors such as cost and denial rate. This is because the calculation of value takes into account the costs of rendered services compared to the administrative burden of reviewing a case which considers denial rates (e.g. considerably low denial rates might signal there is an unnecessary administrative burden of review). For these factors, authorization data and claims data is used as a source to derive the evidentiary standards to support these factors. Additionally, for both MH/SUD benefits and M/S benefits, variability in cost is considered as a factor that determines whether a service requires prior authorization. Variability for both MH/SUD and M/S benefits is evaluated by using a threshold of 2x the mean of other services and uses claims data as a source.

	One factor, new/emerging services, is considered for medical/surgical services but not for mental health services. The Plan has concluded that this does not result in more stringency towards mental health/substance use disorder benefits because this factor could result in additional services becoming subject to prior authorization for medical/surgical benefits. Operationally, the Plan performs in-operation data assessments for prior authorization procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across med/surg and MH/SUD services. The Plan concludes that in-operation, its methodology for prior authorization for mental health/substance use disorder services is comparable to and applied no more stringently than the methodology for prior authorization applied to medical/surgical services. A comparison of denial rates (including partial denials) reveals that prior authorization denial rates for M/S services are higher compared to denial rates of MH/SUD services indicating higher approval rates for MH/SUD benefits (21% v. 4.4%). This reveals that more services are denied when they are M/S services compared to MH/SUD services. Out-of-network (OON) denial rates (including partial denials) similarly reveal higher rates of denial for M/S services (71% v. 64.21%). This reveals that more OON services are denied when they are M/S services compared to MH/SUD services. Finally, overturned appeals are comparable between M/S services and MH/SUD services with a slightly higher overturn rate for MH/SUD services (36% v. 36.4%) indicating that more appealed services are approved for MH/SUD benefits. The outcome measures show comparability (or in this case are more favorable to behavioral health benefits) in processes for prior authorization because the metrics reveal more favorable outcomes for MH/SUD benefits with higher rates of approval for services overall. The Plan is responsible for coordinating responses to non-quantitative treatment limitations (NQTLs) with its Behavioral Health Vendor (Optum Behavioral Health Solutions) on an annual basis or as needed when there is a change to a current methodology or process directly related to the NQTL. The Plan conducts non-quantitative treatment limitations to review that factors, sources, evidentiary standards, and processes are applied no more strictly to Mental Health/Substance Use Disorder services when compared to Medical/Surgical services. If a discrepancy is identified, the Plan coordinates with Optum Behavioral Health Solutions to investigate if there is a risk of non-compliance to perform necessary remediation. The prior authorization non-quantitative treatment limitation is approved on an annual basis by the Clinical Advisory Committee, which reports to the Utilization Management Subcommittee, in quarter three of each year. The Associate of UM Optimization is responsible for conveying annual updates to the committee for review and formal sign-off. Non-quantitative treatment limitation changes and modifications, including factors or other modifications to the non-quantitative treatment limitation methodology, are determined during the most subsequent quarterly Clinical Advisory Subcommittee session or can be voted on by CAS committee members off-cycle Conclusion: The findings of the comparative analysis reveal that the process and methodology to apply prior authorization to mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology used to

	apply prior authorization to medical/surgical services.

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Provider Credentialing
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Provider Operations
Names of Person(s) Responsible for Analysis Formation	**Oscar**: Zeeshan Dawdani (Credentialing Operations Manager- four years experience) **Optum**: Positions: NVP, Network Contracting and Provider Relations, Credentialing Specialist, Director, Provider Network Administration, Manager & Director for Network Programs Provider Credentialing & Performance, VP Benefits Integrity, Director MH Parity and Benefits, Out-of-Network Pricing and Policy Credentials: Licensed Psychologist, Licensed Nurse, Registered Health Information Technician, Certified Professional Coder, Certified Professional Medical Auditor, Certified Professional Compliance Officer, Certified Evaluation and Management Coder
Last Update	3/31/2022
Reviewers	Alexandra Rubino, Associate Director MHP

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Provider Credentialing

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

Purpose/Description of Provider Credentialing
MH/SUD: Strategy: Credentialing is performed to determine if a provider or facility meets standards to join (credential) or maintain (re-credential) their status in Optum Behavioral Health Solutions' (OBHS) network of participating providers. OBHS uses its credentialing and re-credentialing processes to validate that its network of contracted providers and facilities providing inpatient and outpatient services meet the baseline criteria, as applicable, to the State and practicing specialty. MED/SURG: Strategy: Credentialing is performed to determine if a provider or facility meets standards to join (credential) or maintain (re-credential) their status in Oscar's network of participating providers. Oscar uses its credentialing and re-credentialing processes to validate that its network of contracted providers and facilities providing inpatient and outpatient services meet the baseline criteria, as applicable, to the State and practicing specialty.
Coverage Terms (EOC language): Network Providers: To receive In-Network Benefits as indicated on Your Schedule of Benefits, You must choose Providers within the Network for all care (other than for Emergency Services). The Oscar Network consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Members throughout the Service Area. Refer to Your Provider Directory or Visit the Oscar website at www.hioscar.com to make Your selections. The list of Network Providers may change occasionally, so make sure the Providers You select are still Network Providers at the time of service. An updated directory will be available at least annually or You may access Our website at www.hioscar.com for the most current listing to assist You in locating a Provider. Our Member Services team is available to assist you in finding the Network Provider that will best suit Your needs at 1-855-

672-2755, through our mobile application, or on our Member portal at www.hioscar.com.

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
Inpatient In-Network	Credentialing applies to all In-network providers and facilities providing covered services in the Inpatient In-Network, Outpatient In-Network classifications	Credentialing applies to all In-network providers and facilities providing covered services in the Inpatient In-Network, Outpatient In-Network classifications
Outpatient, In-Network		
Emergency		

2. **Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:**

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
Inpatient In-Network	1. The provider or facility completes and attests to the accuracy of the content of the application. 2. Oscar delegates credentialing to a CVO that verifies certain information, i.e. primary source verification, in the application 3. The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with Oscar	1. The provider or facility completes and attests to the accuracy of the content of the application 2. OBHS verifies certain information, i.e., primary source verification, in the application 3. The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with OBHS
Outpatient, In-Network		
Emergency		

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Benefit Classification	Evidentiary Standards: Medical/Surgical	Evidentiary Standards: MH/SUD
Inpatient In-Network	1. Submission of application 2. Oscar's Credentialing Policy Description describes the information that is required to complete the credentialing process (i.e. primary source verification) 3. State and federal regulatory requirements, National accreditation standards (e.g. NCQA) and the Oscar Credentialing Policy	1. Submission of application 2. The UBH Credentialing plan describes the information, i.e., primary source verification, that is required 3. ● State and federal regulatory requirements, for example, Medicare Managed Care Manual, Section 6 ● National accreditation standards, for example NCQA CR3 and CR4 ● UBH Credentialing plan
Outpatient, In-Network		
Emergency		

Benefit Classification	Sources: Medical/Surgical	Sources: MH/SUD
Inpatient In-Network	1. Submission of application 2. Oscar's Credentialing Policy Description describes the information that is required to complete the credentialing process (i.e. primary source verification) 3. State and federal regulatory requirements, National accreditation standards (e.g. NCQA) and the Oscar Credentialing Policy on an	1. Submission of application 2. The UBH Credentialing plan describes the information, i.e., primary source verification, that is required 3. ● State and federal regulatory requirements, for example, Medicare Managed Care Manual, Section 6

	ongoing basis	• National accreditation standards, for example NCQA CR3 and CR4 • UBH Credentialing plan

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and

Benefit Classification	Comparative Analysis: Medical/Surgical	Comparative analysis: MH/SUD
Inpatient In-Network	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine network admission standards for medical/surgical providers and mental health/substance use disorder providers. The factors, sources, and evidentiary standards for network admission standards for mental health/substance use disorder providers and medical/surgical providers are the same. The following factors apply to both med/surg and MH/SUD: 1. The provider or facility completes and attests to the accuracy of the content of the application 2. The verification of certain information, i.e., primary source verification, in the application 3. The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan	
Outpatient, In-Network		
Emergency		

	The following sources and evidentiary standards apply to both med/surg and MH/SUD: 1. Submission of application 2. Internal policies describing required primary source verification 3. State and federal requirements, national accreditation standards, internal credentialing policies. Findings: The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information for MH/SUD network admissions strategy as-written is comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information for M/S network admissions strategy. Operationally, the Plan performs in-operation data assessments to make sure that factors, sources, and evidentiary standards are applied in a consistent manner. For a quantitative assessment of Provider Credentialing, the Plan compares Provider Admission to the Network for MH/SUD providers and M/S providers. The Plan measures % of providers credentialed within a 30-day period and sets a target of 90% credentialed within a 30-day period for both medical/surgical and mental health/substance use disorder providers. In 2021, for Georgia, 77% of medical/surgical providers were credentialed within a 30-day period compared to 99% of MH/SUD credentialed within a 30-day period. For re-credentialing, 100% of M/S providers were re-credentialed within a 30-day period while 100% of MH/SUD providers were re-credentialed within a 30-day period.	
	M/S: **Process:** The process is triggered by a provider or facility seeking to join or continue participation in Oscar's network to determine whether the provider or facility has the appropriate level of education/licensure/certification and satisfies additional qualifications (as applicable) to provide covered care to Plan members. Oscar uses credentialing	**MH/SUD:** **Process:** The process is triggered by a provider or facility seeking to join or continue participation in the OBHS network to determine whether the provider or facility has the appropriate level of education/licensure/certification and satisfies additional qualifications (as applicable) to provide covered care to Plan members. OBHS uses credentialing processes and plans based on NCQA standards and applicable state or

	processes and plans based on NCQA standards and applicable state or Federal regulatory requirements when determining whether to credential MED/SURG providers or facilities. To successfully complete the credentialing process, MED/SURG providers and facilities must meet the baseline criteria as applicable to the State and practicing specialty, which can be found in the Oscar Credentialing Policy or state addendum. Individual (and certain facility-based) providers must complete the CAQH application, or state-mandated application where applicable, and attestation. **Ongoing Monitoring**: Plan monitors compliance with turn-around times in real-time and on a retrospective basis. Following the initial credentialing process, providers are required to continually meet all credentialing requirements. To ensure this, Plan performs monthly monitoring with respect to provider credentialing requirements. Specific monitoring examples include, but are not limited to: Medicare and Medicaid Sanctions Licensure warnings, citations, probations, limitations, sanctions, restrictions, suspensions, terminations, or voluntary surrender Member complaints regarding service and quality of care If an action and/or issue is discovered, it may result in the	Federal regulatory requirements when determining whether to credential MH/SUD providers or facilities. To successfully complete the credentialing process, MH/SUD providers and facilities must meet the baseline criteria as applicable to the State and practicing specialty, which can be found in the Behavioral Health (UBH) Credentialing Plan or state addendum. Individual (and certain facility-based) providers must complete the CAQH application, or state-mandated application where applicable, and attestation. **Ongoing Monitoring**: Plan monitors compliance with turn-around times in real-time and on a retrospective basis. Following the initial credentialing process, providers are required to continually meet all credentialing requirements. To ensure this, Plan performs monthly monitoring with respect to provider credentialing requirements. Specific monitoring examples include, but are not limited to: ● Medicare and Medicaid Sanctions ● Licensure warnings, citations, probations, limitations, sanctions, restrictions, suspensions, terminations, or voluntary surrender ● Member complaints regarding service and quality of care If an action and/or issue is discovered, it may result in the provider's credentialing information being sent to the Medical Director

	provider's credentialing information being sent to the Medical Director and/or Credentialing Committee for review. This review can lead to termination of the provider from Plan's credentialed networks. A resulting termination flag would then be entered into the Plan provider repository.	and/or Credentialing Committee for review. This review can lead to termination of the provider from Plan's credentialed networks. A resulting termination flag would then be entered into the Plan provider repository.

5. Provide the specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements:

Benefit Classification	**Process Description**
Inpatient In-Network	The 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 for the following reasons: 1. The factors are the same across MH/SUD and M/S network admissions standards. 2. The sources and evidentiary standards are the same across MH/SUD and M/S network admission standards. 3. Ongoing monitoring of network admission standards is aligned across MH/SUD and M/S. Findings/Conclusion: The findings of the comparative analysis reveal that the process and methodology to assess network admissions standards for MH/SUD as-written is comparable to, and applied no more stringently than, the process and methodology used to assess network admission standards for medical/surgical services.
Outpatient, In-Network	
Emergency	

	In-operation, the plan performs a variety of quantitative assessments to review the underlying methodologies for Provider Admission are aligned. When comparing the relative rate of providers credentialed and re-credentialed within a 30-day timeframe in 2021, MH/SUD providers consistently met targets above the 90% threshold for credentialing and re-credentialing. For M/S, 77% of providers were credentialed within a 30-day period falling below the 90% benchmark. For re-credentialing, M/S and MH/SUD credentialing met targets above the 90% benchmark at 100% for both M/S and MH/SUD providers. This reveals that standards for Provider Admission to the Network are applied no more stringently to MH/SUD providers when compared to M/S providers. The findings of the comparative analysis reveal that the process and methodology to assess network admissions standards in-operation for MH/SUD is comparable to, and applied no more stringently than, the process and methodology used to assess network admission standards for medical/surgical services.

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Retrospective Review
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Clinical
Names of Person(s) Responsible for Analysis Formation	**Oscar**: Insiya Taj, MPH, Associate, UM Optimization, (Over 3 years experience in healthcare and clinical research) Marco Fossati-Bellani, MD, MPH, Senior Medical Director, UM **Optum Behavioral Health Solutions**: Positions: Chief Medical Officer, National Senior Behavioral Medical Directors, VP Benefits Integrity, VP Outpatient and Specialty Programs, Director MH Parity and Benefits, Director National Psychologist Peer Review Team, Manager Behavioral Health Clinical Claims Review/Retrospective Review Teams, Manager Clinical Claim Review, and Senior Claims Business Process Consultant. Credentials: Board Certified MDs, Licensed Psychologists, Licensed Nurse, and Licensed Social Worker.
Last Update	7/11/2022
Reviewers	Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)

oscar

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Retrospective Review

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

Medical/Surgical Terms	**Mental Health/Substance Use Disorder Terms**
Definition: Application of Retrospective Review: A retrospective review is conducted when the Plan receives a request for coverage of medical care or services that have already been received, or when prior authorization was required but not obtained and a claim was submitted for the service.	**Definition of Retrospective Review:** A form of utilization review for health care services that have been provided to an enrollee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.
Coverage Terms (EOC language): **Retrospective Review**: After a service has been performed, Oscar may use retrospective (post-service) review to determine if an admission or service was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this Plan. If it is determined that a service was not Medically Necessary, You may be responsible for payment of the charges for those services. For emergency admissions, Oscar may use retrospective review to confirm that the services provided qualify as Emergency Services as defined in this Policy.	

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
In-Network Inpatient Services	• Acute/Elective Hospital • Hospice Long-Term Acute Care • Rehabilitation • Acute/Subacute • Skilled Nursing Facility • Procedures/Treatments/Surgeries, when place of service is inpatient	• MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment
In-Network Outpatient Services	• Physician-Administered Drugs • Certain DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) such as oxygen, CPAP, and diabetic supplies • Home Health Care Services • Advanced Imaging • Home-Based Speech Therapy • Physical Therapy • Occupational Therapy • Diagnostic Tests & Evaluations, Laboratory Procedures • Non-Emergency Transportation • Unlisted Procedures • Procedures/Treatments/Surgeries, when place of service is outpatient	• Applied Behavioral Analysis (ABA) • Psychological Testing • Partial Hospitalization (PHP)/ Day Treatment • Intensive Outpatient (IOP) • Transcranial Magnetic Stimulation (TMS) • Electroconvulsive Therapy (ECT) • Physical Therapy[1] • Occupational Therapy[2]

[1] Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)
[2] Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)

2. **Identify the factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits:**

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
In-Network Inpatient Services	1. Safety risk 2. Clinical appropriateness 3. Cost	1. Clinical Appropriateness: The application of retrospective review promotes optimal clinical outcomes 2. Value: The value of applying retrospective review outweighs the associated costs
In-Network Outpatient Services	1. Cost variability 2. Denial rate 3. Cost percentile 4. Safety risk 5. New/emerging service/technology 6. Clinical appropriateness	1. Clinical Appropriateness: The application of retrospective review promotes optimal clinical outcomes 2. Value: The value of applying retrospective review outweighs the associated costs 3. Variation Identified: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits.

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Benefit Classification	Evidentiary Standards and Sources: Medical/Surgical	Evidentiary Standards and Sources: MH/SUD
In-Network Inpatient Services	1. **Clinical appropriateness** is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level or care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice. Examples: ● As per World Professional Association for Transgender Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines. ● As per the American Psychological Association	1. **Clinical Appropriateness: The application of retrospective review promotes optimal clinical outcomes** This factor is utilized to determine which services may be subject to retrospective review. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the retrospective review list if there are objective, evidence-based clinical criteria to be used in the retrospective reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed technology are used to approve and develop Medical Necessity Criteria on which reviews are based. Source: Expert Medical Review and Objective, evidence-based clinical criteria, and nationally recognized guidelines Evidentiary Standard: Clinical

	(APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder. ● As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of cancer and individualized needs as documented in the medical record. Sources: Clinical criteria, Clinical evidence Evidentiary Standards: Clinical criteria ● Plan Clinical Guidelines ● MCG ● ASAM (SUD only) ● Hayes ● UpToDate ● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH) Clinical evidence ● The US National Library of Medicine; ● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); ● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); ● Published scientific evidence; ● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified	Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines Clinical Evidence Used: ● Systematic reviews and meta analyses ● Randomized controlled trials ● Large non-randomized controlled trials ● Large prospective trials ● Comparative and cohort studies ● Cross sectional studies ● Retrospective studies ● Surveillance studies ● Case Reviews/Case series ● Anecdotal/editorial statements ● Professional opinions In the absence of strong and compelling scientific evidence, clinical policies may be based upon: ● National consensus statements ● Publications by recognized authorities such as government sources and/or professional societies **2. Value: The value of applying retrospective review outweighs the associated costs** Source: Internal claims data, UM program operating costs, and UM authorization data Evidentiary Standard: Value is defined as the value of subjecting the inpatient services to

	physician specialists). Examples: ● Physical Therapy/Occupational Therapy ● Gender affirming surgeries ● Confirming member has undergone hormone therapy and counseling ● Mastectomy - appropriate in most cases, but need to review for medical necessity ● Physician-administered drugs ● Level of care setting Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards. Examples: ● Public Health Service Act (PHS Act) section 2719A generally provides, among other things, that if a group health plan or health insurance coverage provides any benefits for emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without regard to whether a particular health care provider is an in-network provider with respect to the services, and generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network. ● The Affordable Care Act mandates that health plans cover recommended preventive services without charging a deductible, copayment, or co-insurance.	Retrospective Review exceeds the administrative costs by at least 1:1 ● The process includes a review of authorization and denied claims data to identify if there is opportunity to reduce unnecessary costs when retrospective review is applied. The projected cost savings is reviewed relative to the operating cost of administering retrospective review to determine value.

	3. High Cost Evidentiary Standard: The mean cost of an inpatient episode of care is >$12,000 Source: claims data 2. **Safety Risk** is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The authorization process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered. If there is a less restrictive level of care available to meet the member's health needs, authorization may be applied to ensure the member receives the least restrictive level of care that is clinically appropriate. Sources: National societies and health agencies, Clinical criteria[3], Clinical evidence[4] ● Centers for Medicare & Medicaid Services ● World Health Organization ● Institute For Safe Medication Practices ● U.S. Food and Drug	

[3] Clinical criteria includes: Plan Clinical Guidelines, MCG, ASAM (SUD only), Hayes, UpToDate, National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)

[4] Clinical evidence: The US National Library of Medicine; Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); Published scientific evidence;In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).

	Administration ● Drug labeling / safety information Evidentiary Standards: ● Treatments that increase the likelihood of adverse health effects ● Services that increase the likelihood of perioperative morbidity and mortality ● Procedures, such as high-risk operations, that carry a mortality rate of 5% or more. ● Procedures with significant or major impact on hemodynamics, fluid shifts, possible major blood loss. ● Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse. *Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017 (http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf).*	

In-Network Outpatient Services	1. **Clinical appropriateness** is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level or care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice. Examples: ● As per World Professional Association for Transgender Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines. ● As per the American Psychological Association (APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder. ● As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of	1. **Clinical Appropriateness: The application of retrospective review promotes optimal clinical outcomes** This factor is utilized to determine which services may be subject to retrospective review. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the retrospective review list if there are objective, evidence-based clinical criteria to be used in the retrospective reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed technology are used to approve and develop Medical Necessity Criteria on which reviews are based. Source: Expert Medical Review and Objective, evidence-based clinical criteria, and nationally recognized guidelines Evidentiary Standard: Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines

	cancer and individualized needs as documented in the medical record. Evidentiary Standards: Clinical criteria ● Plan Clinical Guidelines ● MCG ● ASAM (SUD only) ● Hayes ● UpToDate ● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH) Clinical evidence ● The US National Library of Medicine; ● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); ● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); ● Published scientific evidence; ● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists). Examples: ● Physical Therapy/Occupational Therapy ● Gender affirming surgeries ● Confirming member has undergone hormone therapy and counseling ● Mastectomy - appropriate in most cases, but need to review for medical necessity	Clinical Evidence Used: ● Systematic reviews and meta analyses ● Randomized controlled trials ● Large non-randomized controlled trials ● Large prospective trials ● Comparative and cohort studies ● Cross sectional studies ● Retrospective studies ● Surveillance studies ● Case Reviews/Case series ● Anecdotal/editorial statements ● Professional opinions In the absence of strong and compelling scientific evidence, clinical policies may be based upon: ● National consensus statements ● Publications by recognized authorities such as government sources and/or professional societies **2. Value: The value of applying retrospective review outweighs the associated costs** Source: Internal claims data, UM program operating costs, and UM authorization data Evidentiary Standard: Value is defined as the value of subjecting the outpatient services to Retrospective Review exceeds the administrative costs by at least 1:1 ● The process includes a review of authorization and denied claims data to identify if there is opportunity to reduce

	● Physician-administered drugs ● Level of care setting Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards. Examples: ● Public Health Service Act (PHS Act) section 2719A generally provides, among other things, that if a group health plan or health insurance coverage provides any benefits for emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without regard to whether a particular health care provider is an in-network provider with respect to the services, and generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network. ● The Affordable Care Act mandates that health plans cover recommended preventive services without charging a deductible, copayment, or co-insurance. **2. Denial rate** is defined as the percentage of prior authorization requests that are denied by the Plan. Source:Prior authorization data Evidentiary Standard: >10% Examples: ● Benefit: Medical/Surgical	unnecessary costs when retrospective review is applied. The projected cost savings is reviewed relative to the operating cost of administering retrospective review to determine value. **3. Variation Identified:** Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits Source: Internal claims data Evidentiary Standard: Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the average mean of other outpatient services and provided to a minimum of twenty unique Plan members

	Service: Outpatient Services: Treatments & Procedures: Skin Treatments & Procedures | UV / Laser therapy Denial rate applies to this service category. Denial rate is 70% for this service category. ● Benefit: Mental Health/Substance Use Disorder Service: Partial Hospitalization Denial rate applies to this service category. Denial rate is 60% for this service category. 3. **Cost variability** is defined as the cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members. Outpatient services are subject to variability in cost per episode of service relative to other services within the classification of benefits. For each service, the Plan calculates the Average Annual Allowed Amount per Unique Patient with Outpatient Claim Events for that Primary Service. Source: Claims data Evidentiary Standard: Cost per episode of service that triggers 2x the mean of other outpatient services. Examples: ● Benefit: Medical/Surgical Service: Outpatient Services: Treatments & Procedures: Musculoskeletal Surgery | Joint arthroscopy / arthroplasty /	

	arthrodesis Cost variability applies to this service category. Cost variability is 5x the mean of other outpatient services. ● Benefit: Mental Health/Substance Use Disorder Service: Outpatient Psychiatric Testing Cost variability applies to this service category. Cost variability is 2.9x the mean of other outpatient services. **4. Cost percentile** is defined as the average cost per claim event for a particular outpatient service relative to other services within the classification of benefits. Source: Claims data `Evidentiary Standard: ≥ 85th Percentile` Examples: ● Benefit: Medical/Surgical Service: Outpatient Services: Treatments & Procedures: Digestive Treatments & Procedures | Bariatric surgery Cost percentile applies to this service category. Cost is in the 100th percentile for this service category. ● Benefit: Mental Health/Substance Use Disorder Service: Outpatient psychiatric testing	

	Cost percentile applies to this service category. Cost is in the 100th percentile for this service category **5. Safety risk** is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The authorization process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered. Sources: National societies and health agencies, Clinical criteria[5], Clinical evidence[6] ● Centers for Medicare & Medicaid Services ● World Health Organization ● Institute For Safe Medication Practices ● U.S. Food and Drug Administration ● Drug labeling / safety information Evidentiary Standards: ● Treatments that increase the likelihood of adverse health effects ● Services that increase the likelihood of perioperative morbidity and mortality ● Procedures, such as high-risk operations, that carry a mortality rate of 5% or more. ● Procedures with significant or major impact on hemodynamics, fluid	

	shifts, possible major blood loss. ● Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse. *Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017 (http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf).* Examples: ● Surgical procedures at risk for infection and complications (e.g., gastrectomy, hip replacement) ● Advanced radiology procedures with exposure to radiation (e.g., CT, MRI, nuclear medicine) ● Physician-administered drugs due to the risk for adverse effects and contraindications (e.g., chemotherapeutic agents) **6. New/ Emerging Service/ Technology** is defined as any health care service, testing, procedure, treatment, device or prescription drug for which safety and efficacy has not been established and proven is considered experimental, investigational, or unproven. Services that are not accepted as the standard medical treatment of the condition being treated are considered "new and	

	emerging services and technologies." This includes any health care service, testing, procedure, treatment, device, or prescription drug that: ● Is not accepted as standard medical treatment of the condition; or ● Has not been approved by the U.S. Food and Drug Administration (FDA) to be lawfully used; or ● Has not been identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or ● Requires review and approval by any institutional review board (IRB) for the proposed use or are subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations; or ● Requires any Federal or other governmental agency approval not listed above that has not been and will not be granted at the time services will be provided. Sources: Clinical criteria, Clinical evidence Evidentiary Standards: Clinical criteria ● Plan Clinical Guidelines ● MCG ● ASAM (SUD only) ● Hayes ● UpToDate ● National Society Guidelines (e.g., ACOG, APA, NCCN,	

	WPATH) Clinical evidence ● The US National Library of Medicine; ● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); ● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); ● Published scientific evidence; ● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists). Examples: ● Genetic, biomarker and molecular tests ● Medical devices and implants ● Novel therapies (e.g., gene therapy, CAR T-Cell therapy)	

***For each benefit subject to Retrospective Review, identify which of the factor(s) in Step 3 were met*:**

Inpatient M/S

	Clinical Appropriateness	Safety	High Cost
Acute/Elective Hospital Rehabilitation	**X**	**X**	**X**
Hospice Long-Term Acute Care	**X**	**X**	**X**
Acute/Subacute	**X**	**X**	**X**
Skilled Nursing Facility	**X**	**X**	**X**
Procedures/Treatments/Surgeries,when place of service is inpatient	**X**	**X**	**X**

Outpatient M/S

Service	Cost variability	Denial rate	Cost percentile	Safety risk	New/ Emerging Service/ Technology	Clinical Appropriateness
Physician-Administered Drugs		**X**		**X**	**X**	**X**
DMEPOS		**X**	**X**		**X**	**X**
Home Health Care Services		**X**				**X**

Advanced Imaging		**X**		**X**		
Diagnostic Tests & Evaluations, Laboratory Procedures		**X**	**X**		**X**	**X**
Treatments/ Procedures	**X**	**X**	**X**	**X**	**X**	**X**
Non-Emergency Transportation		**X**	**X**			
Unlisted Procedures	**X**	**X**		**X**	**X**	

Inpatient MH/SUD

	Clinical Appropriateness	Value
Inpatient, MH	**X**	**X**
Inpatient, SUD	**X**	**X**
Residential, MH	**X**	**X**
Residential, MH	**X**	**X**

Outpatient MH/SUD

	Clinical Appropriateness	Value	Variation
Partial Hospitalization/Day Treatment	**X**	**X**	**X**
Intensive Outpatient	**X**	**X**	**X**

Applied Behavior Analysis (ABA)	**X**	**X**	**X**
Transcranial Magnetic Stimulation (TMS)	**X**	**X**	**X**
Electroconvulsive Therapy (ECT)	**X**		**X**
Psychological Testing	**X**	**X**	

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and

Retro Process M/S	**Retro Review Process MH/SUD**
A retrospective review is conducted when the Plan receives a request for coverage of medical care or services that have already been received, or when prior authorization was required but not obtained and a claim was submitted for the service. A written notification is issued to the member and provider within state, federal, or accreditation required timeframes; the written notification includes information on appeal rights. The Plan follows all state, federal, and accreditation timeframe requirements. After an adverse determination has been issued, the Plan offers the opportunity for the provider to discuss the request with a Plan physician. This peer to peer discussion is not considered part of a grievance or appeal process.	Retrospective Review begins after OBHS receives notification post discharge or post service. Inpatient or outpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Director) determines that an inpatient service was not medically necessary and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. **Note: Optum Behavioral Health (OBH) generally structures UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.

For each committee used to determine which benefits to subject to Retro Review, describe the committee's purpose, composition and member qualifications, and process:

Committee Information M/S	Committee Information MH/SUD
The OMC Board of Directors has the ultimate authority and responsibility for the quality of care and services delivered to its members. The Board of Directors provides strategic planning and direction, budget approval, and staff allocation for the UM Department. The Board of Directors assigns day-to-day responsibility for implementation of the UM Program to the UM Subcommittee, which is a subcommittee of the Quality Improvement Committee. The Board of Directors oversees the implementation of and adherence to the UM Program through the UM Subcommittee. The UM Subcommittee reports to the Quality Improvement Committee at a minimum of once per quarter, per year. The UM Program and Annual Program Evaluation are approved at the UM Subcommittee portion of the Quality Improvement Committee meeting. Minutes conveying this approval are submitted to the Board of Directors, who approve the actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical). As noted above, the UM Subcommittee is a sub-committee to the Quality Improvement Committee. A senior-level physician chairs the UM Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including	Services subject to retrospective review are reviewed at least annually, or more frequently as needed. This process is overseen by the Clinical Quality and Operations Committee (CQOC). CQOC receives oversight from the Quality Improvement Committee (QIC). Appointed by the Chief Medical Officer, a senior-level licensed psychiatrist (MD) Medical Director Chairs the CQOC along with a Vice Chair (PhD, MBA) who is a senior leader of clinical operations responsible for UM activities. Voting membership includes representation from licensed and board-certified psychiatrists (MDs), licensed Psychologists (PhDs) and a licensed nurse (RN). Committee voting membership includes participants from the following areas: Clinical Technology Assessment Committee (MDs), Clinical Criteria (LCSW, MSN, RN, PMHNP-BC), Clinical Operations of Direct Sites (MBA), Utilization Management (PhD), Senior Leader Quality Improvement (PhD), Appeals, Care Engagement Medical Operations (MD) and Medical Operations for UM (MD). Additional internal department representatives attend as non-voting membership, including Legal Counsel, Compliance, Accreditation, the Operational Policy and Standards Committee, Network Strategy and Benefits Integrity. The Clinical Quality and Operations Committee meets monthly and ad hoc, as necessary. The CQOC undertakes, but is not limited to, the following ongoing activities: ● Oversees the development and implementation of a National Utilization Management (UM) Program (NUMP) with the Utilization

participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary. The UM Subcommittee undertakes, but is not limited to, the following ongoing activities: ● Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated. ● Reviews and approves modifications to the UM Program as indicated by operational needs and/or to meet regulatory and accreditation compliance. ● Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services. ● Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.	Management Program Description (UMPD) serving as the source document for the NUMP ● Proposes and evaluates UM-related Clinical QIAs ● Evaluates the effectiveness and efficiency of our UM program across all business operation sites ● Ensures the standardization of our UM program across all business operation sites ● Reviews Operational Policy and Standards Committee policies related to UM management as necessary ● Reviews, recommends, and votes on Clinical Criteria ● Review and approval of prior authorization requirements

Identify and define the factors and processes that are used to monitor and evaluate the application of Retro Review:

Benefit Classification	**Process Description: Medical/Surgical**	**Process Description: MH/SUD**
In-Network Inpatient Services/Outpatient Services	Where Oscar delegates utilization review services, Oscar audits clinical decisions made for our members on behalf of the Plan. Clinical audits may be driven by utilization trends or by known or hypothesized compliance risks. The clinical audit is conducted by a group of clinicians either at Oscar or by an independent expert in this field. The process includes a review of decision-making, criteria or formulary application, and documentation. Review of clinical decision-making ensures our members receive high quality, cost-effective care at the right place at the right time by supporting and making consistent and evidence-based clinical decisions regarding the appropriateness of healthcare services. Oscar additionally audits clinical decisions internally to ensure members receive high quality, cost-effective care at the right place at the right time by supporting and making consistent and evidence-based clinical decisions regarding the appropriateness of healthcare services. The audits test	

for appropriate criteria selection and application, decision-making, internal documentation, and denial language (where applicable).

Inter-rater reliability scores clinical reviewers (M/S) 2021:	**Inter-rater reliability scores clinical reviewers (MH/SUD) 2021:**
• Average IRR score: 93.0%	• Average IRR score: 98.8%

In completing its annual MHPAEA filings in many states, the Plan performs a variety of self-assessments and mandatory in-operation analyses as required by each regulatory recipient. Because the Plan's benefit designs and internal practices are consistent across markets, the findings of these self-assessments and analyses are largely consistent across markets and serve as a validation mechanism for MHPAEA compliance more broadly.

Operationally, the Plan performs in-operation data assessments to make sure that factors, sources, and evidentiary standards are applied in a consistent manner. The Plan reviews denial rates, informal reconsideration statistics, and overturned appeal rates for retrospective review across all commercial plans and compares these metrics for med/surg benefits against MH/SUD benefits. While data outcomes are not determinative of mental health parity compliance, the Plan uses these metrics to guide if investigations ifnto UM processes are necessary to ensure that underlying methodology for UM procedures are not more stringent toward behavioral health services.

Findings:

Medical/Surgical: **Retrospective Review**	MH/SUD: **Retrospective Review**
Post service denial rates: • Total # of requests: 6,543 • Total # of requests denied: 2680 • % of requests denied: 41% Informal Reconsideration statistics: • Total # of requests: 528 • Total # of requests overturned: 223	Post service denial rates: • Total # of requests: 855 • Total # of requests denied:0 • % of requests denied: 0 Informal Reconsideration statistics: • Total # of requests: 0 • Total # of requests overturned:0 • Percentage of overturned: 0

	<table><tr><td>• Percentage of overturned: 42% Overturned appeal rates (includes partially overturned): • Total # overturned: 566 • Overturn rate (%): 36%</td><td>Overturned appeal rates (includes partially overturned): • Total # overturned:368 • Overturn rate (%):62.8%</td></tr></table>

5. Provide the specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

In-Network Inpatient Services/Outpatient Services	The 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 for the following reasons: The Plan conducted a comparative analysis to determine which Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) services are subject to retrospective review "as written." The factors that trigger whether inpatient benefits require Retrospective Review are aligned for MH/SUD services and M/S services. For both MH/SUD and M/S services, clinical appropriateness is a factor. Additionally, safety is a factor considered for M/S services which is also considered under medical necessity as described in the clinical appropriateness factor for MH/SUD services. Value (factor for MH/SUD benefits) is aligned with the cost (factor for M/S benefits) because both of these factors take into account the cost of services. For inpatient factors, claims data is used as a source to evaluate factors such as value and cost and objective, evidence-based clinical guidelines, medical experts, and national guidelines are used as an evidentiary standard and source for factors such as clinical appropriateness and safety. The factors that trigger whether an outpatient benefit requires Retrospective Review are aligned for MH/SUD services and M/S services. The factors clinical appropriateness (MH/SUD and M/S) and safety (M/S) are aligned as they both take into consideration the appropriateness of a service and rely on objective, evidence-based clinical guidelines, medical experts, and national guidelines as an evidentiary standard and source. Safety is considered as an element under medical necessity as described in the clinical appropriateness factor for MH/SUD benefits and thus is aligned with the safety factor for M/S benefits.

	For the MH/SUD outpatient factor "value of applying a retrospective review," this factor closely aligns with M/S factors such as cost and denial rate. This is because the calculation of value takes into account the costs of rendered services compared to the administrative burden of reviewing a case which considers denial rates (e.g. considerably low denial rates might signal there is an unnecessary administrative burden of review). For these factors, authorization data and claims data is used as a source to derive the evidentiary standards to support these factors. Additionally, for both MH/SUD benefits and M/S benefits, variability in cost is considered as a factor that determines whether a service requires retrospective review. Variability for both MH/SUD and M/S benefits is evaluated by using a threshold of 2x the mean of other services and uses claims data as a source. One factor, new/emerging services, is considered for medical/surgical services but not for mental health services. The Plan has concluded that this does not result in more stringency towards mental health/substance use disorder benefits because this factor could trigger additional services becoming subject to retrospective review for medical/surgical benefits. Operationally, the Plan performs in-operation data assessments for retrospective review procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across M/S and MH/SUD services. The Plan concludes that in-operation, its methodology for retrospective review for mental health/substance use disorder services is comparable to and applied no more stringently than the methodology for retrospective review applied to medical/surgical services. A comparison of denial rates (including partial denials) reveals that retrospective review denial rates for M/S services are higher compared to denial rates of MH/SUD services indicating higher approval rates for MH/SUD benefits (41% v. 0%). This reveals that more services are denied when they are M/S services compared to MH/SUD services. Informal reconsideration statistics reveal higher rates of reconsideration for M/S services compared to MH/SUD services (42% v. 0%). This finding is not very determinative as there were no informal reconsiderations for MH/SUD services. Finally, overturned appeals are higher for MH/SUD services when compared to M/S services (62.8% v. 36%) indicating that more appealed services are approved for MH/SUD benefits. The outcome measures show comparability (or in this case are more favorable to behavioral health benefits) in processes for retrospective review because the metrics reveal more favorable outcomes for MH/SUD benefits with higher rates of approval for services overall. The Plan is responsible for coordinating responses to non-quantitative treatment limitations (NQTLs) with its Behavioral Health Vendor (Optum Behavioral Health Solutions) on an annual basis or as needed when there is a change to a current methodology or process directly related to the NQTL. The Plan conducts non-quantitative treatment limitations to review that factors, sources, evidentiary standards, and processes are applied no more stringently to Mental Health/Substance

	Use Disorder services when compared to Medical/Surgical services. If a discrepancy is identified, the Plan coordinates with Optum Behavioral Health Solutions to investigate if there is a risk of non-compliance to perform necessary remediation. The retrospective review non-quantitative treatment limitation is approved on an annual basis by the Clinical Advisory Committee which reports to the Utilization Management Subcommittee, in quarter three of each year. The Associate of UM Optimization is responsible for conveying annual updates to the committee for review and formal sign-off. Non-quantitative treatment limitation changes and modifications, including factors or other modifications to the non-quantitative treatment limitation methodology, are determined during the next quarterly Clinical Advisory Subcommittee session or can be voted on by CAS committee members off-cycle Conclusion: The findings of the comparative analysis reveal that the process and methodology to apply retrospective review to mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology used to apply retrospective review to medical/surgical services.

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Concurrent Review
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Clinical
Names of Person(s) Responsible for Analysis Formation	**Oscar:** Insiya Taj, MPH, Associate, UM Optimization, (Over 3 years experience in healthcare and clinical research) **Optum Behavioral Health Solutions**: Positions: Chief Medical Officer, National Senior Behavioral Medical Directors, VP Benefits Integrity, VP Outpatient and Specialty Programs, and Director MH Parity and Benefits. Credentials: Board Certified MDs, Licensed Psychologists, Licensed Nurse, and Licensed Social Worker.
Last Update	7/15/2022
Reviewers	Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)

oscar

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Concurrent Review

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

Medical/Surgical Terms	Mental Health/Substance Use Disorder Terms
Definition: Concurrent review is a review of services when the member is actively receiving services or review for an extension of a previously approved number of treatments or ongoing course of treatment over a period of time.	**Definition:** A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Coverage Terms (EOC language):

Concurrent Care For any concurrent review of an urgent care request, coverage for the treatment shall be continued without additional liability to You until You are notified of the review decision. A concurrent request is a request for a benefit determination relating to care that is already being received at the time of the request. For appeals of urgent concurrent cases (including if you are hospitalized at the time of the adverse determination), we will make our determination and notice will be provided within 1 working day or 72 hours of when we receive the request, whichever is shorter. For nonurgent concurrent cases, we will make our determination and notice will be provided within 30 days of receipt of Your request.

Utilization Review Decisions and Procedures

For initial determinations, Oscar will make our determinations within the following timeframes:

- For pre-service urgent requests: within 3 calendar days
- For pre-service non-urgent requests: within 15 calendar days
- For concurrent urgent requests (submitted in a timely manner -- for an extension of care approved previously, where the request is received >24 hours before the expiration of the urgent authorization): within 1 calendar day
- For post-service requests: within 30 days

For approvals, Oscar will provide written notification of our decision within 2 business days of our decision. For denials (Adverse Determinations), we will provide verbal and

written notification within 1 business day of our determination.
For a concurrent review of the provision of prescription drugs or intravenous infusions for which you are receiving health benefits under your policy, we will make our decision and provide notification in writing not later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.
In any case where NCQA or federal authorization time frames conflict with Texas standards, Oscar will adhere to the stricter of all relevant time frames.

For concurrent urgent cases (including a member who is hospitalized at the time of the adverse determination), we will make a decision and provide notice to you and your Provider within 24 hours (1 calendar day) or 1 working day, whichever is shorter. We may choose to issue this notification by telephone to you or your Provider. In such cases, written notification will be issued to you and your Provider within 3 calendar days or 3 business days (whichever is shorter) of the oral notification.

For concurrent standard cases (for outpatient care), for approvals, we will make our decision and provide notice to you and your Provider in writing within 2 business days of receipt of all necessary information. For adverse determinations, we will make our decision and provide notice to you and your Provider in writing within 3 business days. OSC-TX-IVL-EOC-2022 In the case of an elective inpatient Hospital admission, Oscar recommends that the call for Concurrent review is made at least two (2) business days before You are admitted unless it would delay Emergency Care. In an emergency, Oscar recommends that Preauthorization takes place within two (2) business days after admission, or as soon thereafter as reasonably possible.

Benefit Classification	**Medical/Surgical Services to which the NQTL applies**	**Mental Health/SUD Services to which the NQTL applies**
In-Network Inpatient Services	All inpatient services are subject to this NQTL. ● Acute/Elective Hospital ● Hospice, Long-Term Acute Care ● Rehabilitation ● Acute/Subacute ● Skilled Nursing Facility ● Procedures/Treatments/Surgeries when place of service is inpatient	Applies to all inpatient services for facilities reimbursed on a per diem basis. Facilities reimbursed on a diagnostic related group (DRG) basis are not included in this NQTL comparative analysis because DRG payment rates generally do not vary by length of stay and do not trigger value as a result.
	● Physician-Administered Drugs ● Certain DMEPOS (Durable	● Partial Hospitalization (PHP)/ Day Treatment ● Intensive Outpatient (IOP)

In-Network Outpatient Services	Medical Equipment, Prosthetics, Orthotics, and Supplies) such as oxygen, CPAP, and diabetic supplies • Home Health Care Services • Advanced Imaging • Home-Based Speech Therapy • Physical Therapy • Occupational Therapy • Diagnostic Tests & Evaluations, Laboratory Procedures • Non-Emergency Transportation • Unlisted Procedures • Procedures/Treatments/Surgeries, when place of service is outpatient	• Physical Therapy[1] • Occupational Therapy[2] • Home-Based Speech Therapy[3]

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
In-Network Inpatient Services	1. Safety risk 2. Clinical appropriateness 3. Cost	1. Clinical Appropriateness: The application of Concurrent Review promotes optimal clinical outcomes 2. Value: The value of applying Concurrent Review outweighs the associated costs

[1] Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)
[2] Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)
[3] Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/A analysis)

In-Network Outpatient Services	1. Cost variability 2. Denial rate 3. Cost percentile 4. Safety risk 5. New/emerging service/technology 6. Clinical appropriateness	1. Clinical Appropriateness: The application of Concurrent Review promotes optimal clinical outcomes 2. Value: The value of applying Concurrent Review outweighs the associated costs 3. Variation Identified: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Benefit Classification	**Evidentiary Standards and Sources: Medical/Surgical**	**Evidentiary Standards and Sources: MH/SUD**
In-Network Inpatient Services	1. **Clinical appropriateness** is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level or care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g.,	1. **Clinical Appropriateness: The application of Concurrent Review promotes optimal clinical outcomes** This factor is utilized to determine which services may be subject to concurrent review. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the concurrent review list if there are objective, evidence-based clinical criteria to be used in the concurrent reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed

	DNP, DO, MD, PA) in accordance with evidence-based practice. Examples: ● As per World Professional Association for Transgender Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines. ● As per the American Psychological Association (APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder. ● As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of cancer and individualized needs as documented in the medical record. Sources: Clinical criteria, Clinical evidence Evidentiary Standards: Clinical criteria ● Plan Clinical Guidelines ● MCG ● ASAM (SUD only) ● Hayes ● UpToDate ● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH) Clinical evidence ● The US National Library of Medicine;	technology are used to approve and develop Medical Necessity Criteria on which reviews are based. Source: Expert Medical Review and objective, evidence-based clinical criteria, and nationally recognized guidelines Evidentiary Standard: Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. Clinical Evidence Used: ● Systematic reviews and meta analyses ● Randomized controlled trials ● Large non-randomized controlled trials ● Large prospective trials ● Comparative and cohort studies ● Cross sectional studies ● Retrospective studies ● Surveillance studies ● Case Reviews/Case series ● Anecdotal/editorial statements ● Professional opinions In the absence of strong and compelling scientific evidence, clinical policies may be based upon: ● National consensus statements ● Publications by recognized authorities such as government sources and/or professional societies

	• Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); • Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); • Published scientific evidence; • In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists). Examples: • Physical Therapy/Occupational Therapy • Gender affirming surgeries • Confirming member has undergone hormone therapy and counseling • Mastectomy - appropriate in most cases, but need to review for medical necessity • Physician-administered drugs • Level of care setting Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards. **2. High Cost** Evidentiary Standard: The mean cost of an inpatient episode of care is >$12,000 Source: claims data 3. **Safety risk** is defined as healthcare services that have the potential to harm patients and	2. **Value**: The value of applying concurrent review reduces unnecessary variation in inpatient utilization when a facility has a per diem reimbursement methodology Source: Facility / Service per diem reimbursement model Evidentiary Standard: Value is defined as reducing unnecessary variation in inpatient utilization of services

	increase the risk of adverse events. The concurrent review process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered. If there is a less restrictive level of care available to meet the member's health needs, concurrent review may be applied to ensure the member receives the least restrictive level of care that is clinically appropriate. Sources: National societies and health agencies, Clinical criteria[4], Clinical evidence[5] ● Centers for Medicare & Medicaid Services ● World Health Organization ● Institute For Safe Medication Practices ● U.S. Food and Drug Administration ● Drug labeling / safety information Evidentiary Standards: ● Treatments that increase the likelihood of adverse health effects ● Services that increase the likelihood of perioperative morbidity and mortality	

[4] Clinical criteria includes: Plan Clinical Guidelines, MCG, ASAM (SUD only), Hayes, UpToDate, National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)

[5] Clinical evidence: The US National Library of Medicine; Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); Published scientific evidence;In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).

	• Procedures, such as high-risk operations, that carry a mortality rate of 5% or more. • Procedures with significant or major impact on hemodynamics, fluid shifts, possible major blood loss. • Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse. *Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017 (http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf).*	
In-Network Outpatient Services	1. **Clinical appropriateness** is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level or care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g.,	**1. Clinical Appropriateness: The application of Concurrent Review promotes optimal clinical outcomes** This factor is utilized to determine which services may be subject to concurrent review. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the concurrent review list if there are objective, evidence-based clinical criteria to be used in the concurrent reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed

	DNP, DO, MD, PA) in accordance with evidence-based practice. Examples: ● As per World Professional Association for Transgender Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines. ● As per the American Psychological Association (APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder. ● As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of cancer and individualized needs as documented in the medical record. Sources: Clinical criteria, Clinical evidence Evidentiary Standards: Clinical criteria ● Plan Clinical Guidelines ● MCG ● ASAM (SUD only) ● Hayes ● UpToDate ● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH) Clinical evidence ● The US National Library of Medicine;	technology are used to approve and develop Medical Necessity Criteria on which reviews are based. Source: Expert Medical Review and objective, evidence-based clinical criteria, and nationally recognized guidelines Evidentiary Standard: Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. Clinical Evidence Used: ● Systematic reviews and meta analyses ● Randomized controlled trials ● Large non-randomized controlled trials ● Large prospective trials ● Comparative and cohort studies ● Cross sectional studies ● Retrospective studies ● Surveillance studies ● Case Reviews/Case series ● Anecdotal/editorial statements ● Professional opinions In the absence of strong and compelling scientific evidence, clinical policies may be based upon: ● National consensus statements ● Publications by recognized authorities such as government sources and/or professional societies

	• Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); • Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); • Published scientific evidence; • In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists). Examples: • Physical Therapy/Occupational Therapy • Gender affirming surgeries • Confirming member has undergone hormone therapy and counseling • Mastectomy - appropriate in most cases, but need to review for medical necessity • Physician-administered drugs • Level of care setting Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards. 2. **Denial rate** is defined as the percentage of authorization requests that are denied by the Plan. Source: Authorization data Evidentiary Standard: >10% Examples: • Benefit: Medical/Surgical Service: Outpatient	2. **Value**: The value of applying concurrent review outweighs the associated costs Source: Internal claims data, UM program operating costs, UM authorization data Evidentiary Standard: Value is defined as the value of subjecting the outpatient services to concurrent review exceeds the administrative costs by at least 1:1 • The process includes a review of authorization and denied claims data to identify if there is opportunity to reduce unnecessary costs when authorization is applied. The projected cost savings is reviewed relative to the operating cost of administering concurrent review to determine value. 3. **Variation Identified**: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits Source: Internal claims data Evidentiary Standard: Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the average mean of other outpatient services and provided to a minimum of twenty unique Plan members

	Services: Treatments & Procedures: Skin Treatments & Procedures | UV / Laser therapy Denial rate applies to this service category. Denial rate is 70% for this service category. ● Benefit: Mental Health/Substance Use Disorder Service: Partial Hospitalization Denial rate applies to this service category. Denial rate is 60% for this service category. 3. **Cost variability** is defined as the cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members. Outpatient services are subject to variability in cost per episode of service relative to other services within the classification of benefits. For each service, the Plan calculates the Average Annual Allowed Amount per Unique Patient with Outpatient Claim Events for that Primary Service. Source: Claims data Evidentiary Standard: Cost per episode of service that triggers 2x the mean of other outpatient services. Examples: ● Benefit: Medical/Surgical Service: Outpatient Services: Treatments & Procedures:	

	Musculoskeletal Surgery | Joint arthroscopy / arthroplasty / arthrodesis Cost variability applies to this service category. Cost variability is 5x the mean of other outpatient services. ● Benefit: Mental Health/Substance Use Disorder Service: Outpatient Psychiatric Testing Cost variability applies to this service category. Cost variability is 2.9x the mean of other outpatient services. 4. **Cost percentile** is defined as the average cost per claim event for a particular outpatient service relative to other services within the classification of benefits. Source: Claims data Evidentiary Standard: ≥ 85th Percentile Examples: ● Benefit: Medical/Surgical Service: Outpatient Services: Treatments & Procedures: Digestive Treatments & Procedures | Bariatric surgery Cost percentile applies to this service category. Cost is in the 100th percentile for this service category. ● Benefit: Mental Health/Substance Use Disorder Service: Outpatient	

	psychiatric testing Cost percentile applies to this service category. Cost is in the 100th percentile for this service category 5. **Safety risk** is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The authorization process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered. Sources: National societies and health agencies, Clinical criteria[6], Clinical evidence[7] ○ Centers for Medicare & Medicaid Services ○ World Health Organization ○ Institute For Safe Medication Practices ○ U.S. Food and Drug Administration ○ Drug labeling / safety information Evidentiary Standards: ● Treatments that increase the likelihood of adverse	

[6] Clinical criteria: Plan Clinical Guidelines, MCG, ASAM (SUD only), Hayes, UpToDate, National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)

[7] Clinical evidence: The US National Library of Medicine; Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); Published scientific evidence;In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).

	health effects ● Services that increase the likelihood of perioperative morbidity and mortality ● Procedures, such as high-risk operations, that carry a mortality rate of 5% or more. ● Procedures with significant or major impact on hemodynamics, fluid shifts, possible major blood loss. ● Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse. *Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017 (http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf).* Examples: ● Surgical procedures at risk for infection and complications (e.g., gastrectomy, hip replacement) ● Advanced radiology procedures with exposure to radiation (e.g., CT, MRI, nuclear medicine) ● Physician-administered drugs due to the risk for adverse effects and contraindications (e.g., chemotherapeutic agents)	

	6. **New/ Emerging Service/ Technology** is defined as any health care service, testing, procedure, treatment, device or prescription drug for which safety and efficacy has not been established and proven is considered experimental, investigational, or unproven. Services that are not accepted as the standard medical treatment of the condition being treated are considered "new and emerging services and technologies." This includes any health care service, testing, procedure, treatment, device, or prescription drug that: ○ Is not accepted as standard medical treatment of the condition; or ○ Has not been approved by the U.S. Food and Drug Administration (FDA) to be lawfully used; or ○ Has not been identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or ○ Requires review and approval by any institutional review board (IRB) for the proposed use or are subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations; or	

	○ Requires any Federal or other governmental agency approval not listed above that has not been and will not be granted at the time services will be provided. Sources: Clinical criteria, Clinical evidence Evidentiary Standards: Clinical criteria ● Plan Clinical Guidelines ● MCG ● ASAM (SUD only) ● Hayes ● UpToDate ● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH) Clinical evidence ● The US National Library of Medicine; ● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); ● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH); ● Published scientific evidence; ● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists). Examples: ● Genetic, biomarker and	

	molecular tests ● Medical devices and implants ● Novel therapies (e.g., gene therapy, CAR T-Cell therapy)	

***For each benefit subject to Concurrent Review, identify which of the factor(s) in Step 3 were met*:**

Inpatient M/S

	Clinical Appropriateness	Safety	High Cost
Acute/Elective Hospital Rehabilitation	**X**	**X**	**X**
Hospice Long-Term Acute Care	**X**	**X**	**X**
Acute/Subacute	**X**	**X**	**X**
Skilled Nursing Facility	**X**	**X**	**X**
Procedures/Treatments/Surgeries,when place of service is inpatient	**X**	**X**	**X**

Outpatient M/S

Service	Cost variability	Denial rate	Cost percentile	Safety risk	New/ Emerging Service/ Technology	Clinical Appropriateness
Physician-		**X**		**X**	**X**	**X**

Administered Drugs						
DMEPOS		**X**	**X**		**X**	**X**
Home Health Care Services		**X**				**X**
Advanced Imaging		**X**		**X**		
Diagnostic Tests & Evaluations, Laboratory Procedures		**X**	**X**		**X**	**X**
Treatments/ Procedures	**X**	**X**	**X**	**X**	**X**	**X**
Non-Emergency Transportation		**X**	**X**			
Unlisted Procedures	**X**	**X**		**X**	**X**	

Inpatient MH/SUD

	Clinical Appropriateness	Value
Inpatient, MH	**X**	**X**
Inpatient, SUD	**X**	**X**
Residential, MH	**X**	**X**
Residential, MH	**X**	**X**

Outpatient MH/SUD

	Clinical Appropriateness	Value	Variation

Partial Hospitalization/ Day Treatment	**X**	**X**	**X**
Intensive Outpatient	**X**	**X**	**X**

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits:

Concurrent Review Process M/S	**Concurrent Review Process MH/SUD**
Description and Application of Concurrent Review: Concurrent review is a review of services when the member is actively receiving services or review for an extension of a previously approved number of treatments or ongoing course of treatment over a period of time. A concurrent review is conducted when the Plan receives a request for coverage for medical care or services made while the member is in the process of receiving the requested medical care or services. **Concurrent Review Submissions:** Requests for authorization for procedures and services, including Prospective, Concurrent, and Retrospective Reviews, are made by contacting Oscar directly, either by phone, fax, or electronically through the Provider Web Portal. Additionally, in cases where a UM delegate is used to review a specific service type or service area, Oscar provides direction on its web site or through customer service for contacting the vendor for authorization requests. **Concurrent Review Process:** During concurrent reviews, only the necessary and relevant sections of medical records are requested, i.e., those needed to verify medical necessity. In cases where the Plan does not receive the specific information requested, or if the information is not complete by the timeframe in	**Description and Application of Concurrent Review:** Inpatient Concurrent review begins after notification of admission. Outpatient Concurrent Reviews include requests for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services. This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by OBHS. Review for in-network outpatient benefits begins when OBHS receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., urgent, or non-urgent). If the request is not “urgent”, the request may be reclassified as a non-urgent pre-service request. A pre-service concurrent review is a review of all reasonably necessary supporting information that occurs prior to the delivery of provision of a health care service and results in a decision to approve or deny payment for the health care services. **Concurrent Review Submissions:** Concurrent review requests may be submitted via fax, phone, or electronically via portal. **Concurrent Review Process:** The clinical reviewer’s assessment of whether an admission, continued

which a notification of determination must be made, a determination will be made based upon the information available at that time. All reviews are conducted by licensed clinicians; the clinicians assess if the services being requested meet medical necessity based on established clinical criteria. **Guidelines/Criteria used:** Clinicians make determinations based on plan benefits and established evidence-based clinical criteria. **Staff qualifications:** Concurrent reviews are conducted by licensed clinicians (nurses and physicians); only board certified physicians make adverse determinations. **Notification of Determination:** A written notification is issued to the member and provider within state, federal, or accreditation required timeframes; the written notification includes information on appeal rights. **Timeframe for the Plan to respond:** The Plan follows all state, federal, and accreditation timeframe requirements. **Peer to Peer:** After an adverse determination has been issued, the Plan offers the opportunity for the provider to discuss the request with a Plan physician.	inpatient stay, or continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. When the appropriately qualified clinical reviewer (e.g., MD) determines that a continued stay at the facility or continuing course of treatment is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An in-network provider, depending on the provider contract, may bill the member for non-covered charges. **Guidelines/Criteria used:** Optum Behavioral Health Solutions (OBHS) uses externally developed, evidence-based medical necessity criteria (e.g., ASAM, LOCUS, CALOCUS-CASII and ECSII), as well as internally developed evidence-based, medical necessity criteria (e.g., medical and clinical policies) when making medical necessity coverage determinations related to Mental Health/Substance Use Disorder (MH/SUD) technologies (e.g., services, interventions, etc.) that fall outside the scope of the ASAM, LOCUS, CALOCUS-CASII and ECSII criteria and/or relate to advancements in technologies or types of care that are not addressed by the most recent versions of ASAM, LOCUS, CALOCUS-CASII and ECSII criteria. ASAM is the only criteria OBHS uses to make SUD medical necessity coverage determinations, unless otherwise mandated by state law or contract. **Staff qualifications:** MH/SUD is staffed by clinical and administrative personnel. All clinical reviews are performed by appropriate clinical staff (i.e., RN, LPC, LCSW, etc.) and all adverse determinations are made by Medical Directors or Psychologists. **Notification of Determination:** The member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.

	Timeframe for the Plan to respond: Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements. **Peer to Peer:** A practitioner/facility may request an opportunity to discuss reconsideration of a non-coverage determination with the Peer Reviewer who made the decision within 24 hours of the verbal notification of the non-coverage determination. **Note: Optum Behavioral Health (OBH) generally structures UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.

For each committee used to determine which benefits to subject to Concurrent Review, describe the committee's purpose, composition and member qualifications, and process:

Committee Information M/S	Committee Information MH/SUD
The OMC Board of Directors has the ultimate authority and responsibility for the quality of care and services delivered to its members. The Board of Directors provides strategic planning and direction, budget approval, and staff allocation for the UM Department. The Board of Directors assigns day-to-day responsibility for implementation of the UM Program to the UM Subcommittee, which is a subcommittee of the Quality Improvement Committee. The Board of Directors oversees the implementation of and adherence to the UM Program through the UM Subcommittee. The UM Subcommittee reports to the Quality Improvement Committee at a minimum of once per quarter, per year. The UM Program and Annual Program Evaluation are approved at the UM Subcommittee portion of the Quality Improvement Committee meeting. Minutes conveying this approval are submitted to the Board of Directors, who approve the	Services subject to concurrent review are reviewed at least annually, or more frequently as needed. This process is overseen by the Clinical Quality and Operations Committee (CQOC). The Clinical Quality and Operations Committee (CQOC) receives oversight from the Quality Improvement Committee (QIC). Appointed by the Chief Medical Officer, a senior-level licensed psychiatrist (MD) Medical Director Chairs the CQOC along with a Vice Chair (PhD, MBA) who is a senior leader of clinical operations responsible for UM activities. Voting membership includes representation from licensed and board-certified psychiatrists (MDs), licensed Psychologists (PhDs) and a licensed nurse (RN). Committee voting membership includes participants from the following areas: Clinical Technology Assessment Committee (MDs), Clinical Criteria (LCSW, MSN, RN, PMHNP-BC), Clinical Operations of Direct Sites (MBA), Utilization Management (PhD), Senior Leader Quality

actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical). As noted above, the UM Subcommittee is a sub-committee to the Quality Improvement Committee. A senior-level physician chairs the UM Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary. The UM Subcommittee undertakes, but is not limited to, the following ongoing activities: ● Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated. ● Reviews and approves modifications to the UM Program as indicated by operational needs and/or to meet regulatory and accreditation compliance. ● Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services. ● Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.	Improvement (PhD), Appeals, Care Engagement Medical Operations (MD) and Medical Operations for UM (MD). Additional internal department representatives attend as non-voting membership, including Legal Counsel, Compliance, Accreditation, the Operational Policy and Standards Committee, Network Strategy and Benefits Integrity. The Clinical Quality and Operations Committee meets monthly and ad hoc, as necessary. The CQOC undertakes, but is not limited to, the following ongoing activities: ● Oversees the development and implementation of a National Utilization Management (UM) Program (NUMP) with the Utilization Management Program Description (UMPD) serving as the source document for the NUMP ● Proposes and evaluates UM-related Clinical QIAs ● Evaluates the effectiveness and efficiency of our UM program across all business operation sites ● Ensures the standardization of our UM program across all business operation sites ● Reviews Operational Policy and Standards Committee policies related to UM management as necessary ● Reviews, recommends, and votes on Clinical Criteria ● Review and approval of prior authorization requirements

Identify and define the factors and processes that are used to monitor and evaluate the application of Concurrent Review:

<table>
<tr><th>Benefit Classification</th><th>Process Description: Medical/Surgical</th><th>Process Description: MH/SUD</th></tr>
<tr><td>In-Network Inpatient Services/Outpatient Services</td><td colspan="2">Where Oscar delegates utilization review services, Oscar audits clinical decisions made for our members on behalf of the Plan. Clinical audits may be driven by utilization trends or by known or hypothesized compliance risks. The clinical audit is conducted by a group of clinicians either at Oscar or by an independent expert in this field. The process includes a review of decision-making, criteria or formulary application, and documentation. Review of clinical decision-making ensures our members receive high quality, cost-effective care at the right place at the right time by supporting and making consistent and evidence-based clinical decisions regarding the appropriateness of healthcare services. Oscar additionally audits clinical decisions internally to ensure members receive high quality, cost-effective care at the right place at the right time by supporting and making consistent and evidence-based clinical decisions regarding the appropriateness of healthcare services. The audits test for appropriate criteria selection and application, decision-making, internal documentation, and denial language (where applicable).

<table>
<tr><th>Inter-rater reliability scores clinical reviewers (M/S) 2021:</th><th>Inter-rater reliability scores clinical reviewers (MH/SUD) 2021:</th></tr>
<tr><td>• Average IRR score: 93.0%</td><td>• Average IRR score: 98.8%</td></tr>
</table>

In completing its annual MHPAEA filings in many states, the Plan performs a variety of self-assessments and mandatory in-operation analyses as required by each regulatory recipient. Because the Plan's benefit designs and internal practices are consistent across markets, the findings of these self-assessments and analyses are largely consistent across markets and serve as a validation mechanism for MHPAEA compliance more broadly.

Operationally, the Plan performs in-operation data assessments to make sure that factors, sources, and evidentiary standards are applied in a consistent manner. For UM, the Plan reviews denial rates, informal reconsideration statistics, out-of-network statistics, and overturned appeal rates for pre-service across all commercial plans and compares these metrics for med/surg benefits against MH/SUD benefits. While data outcomes are not determinative of mental health parity compliance, the Plan uses these results to guide if investigations into UM processes are necessary to ensure that</td></tr>
</table>

underlying methodology for UM procedures are not more stringent toward behavioral health benefits.

Findings:

***Identify and define the factors and processes that are used to monitor and evaluate the application of CR for M/S services*:**	***Identify and define the factors and processes that are used to monitor and evaluate the application of CR MH/SUD services*:**
Medical/Surgical: **Concurrent Review** Concurrent Review denial rates: ● Total # of CR requests: 65,449 ● Total # of CR requests denied: 15,900 ● % of CR requests denied: 24% OON stats: ● Total # OON requests: 12,490 ● Percentage (from total # of requests): 19% ● Total # denied: 4,042 ● Percentage of denied (from total OON requests): 32% Overturned appeal rates (includes partially overturned): ● Total # overturned:48 ● Overturn rate (%): 42%	MH/SUD: **Concurrent Review** Concurrent Review denial rates: ● Total # of CR requests: 5309 ● Total # of CR requests denied:77 ● % of CR requests denied: 1.45% OON stats: ● Total # OON requests:70 ● Percentage (from total # of requests): 1.3% ● Total # denied:14 ● Percentage of denied (from total OON requests): 20% Overturned appeal rates (includes partially overturned): ● Total # overturned:14 ● Overturn rate (%): 56%

5. Provide the specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

In-Network Inpatient Services/Outpatient Services	The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to mental health/substance use disorder (MH/SUD) benefits and to medical/surgical (M/S) benefits have led the Plan to conclude compliance with MHPAEA for the following reasons: The Plan conducted a comparative analysis to determine which Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) services are subject to concurrent review “as written.” The factors that demonstrate whether inpatient benefits require Concurrent Review are aligned for MH/SUD services and M/S services. For both MH/SUD and M/S services, clinical appropriateness is a factor. Additionally, safety is a factor considered for M/S services which is also considered under medical necessity as described in the clinical appropriateness factor for MH/SUD services. One difference is that mental health/substance use disorder benefits use value as a factor while medical/surgical benefits use cost as a factor. For inpatient factors, objective, evidence-based clinical guidelines, medical experts, and national guidelines are used as evidentiary standards and sources for factors such as clinical appropriateness and safety. Claims data is used to evaluate cost for medical/surgical benefits, while value for mental health/substance use disorder benefits is defined as the value of applying concurrent review reduces unnecessary variation in inpatient utilization. While cost and value are measured differently, these factors are still aligned as both factors take into consideration measures to optimize the value of applying concurrent review by providing oversight for the utilization of inpatient services which is the highest/most restrictive level of care. The factors that demonstrate whether an outpatient benefit requires Concurrent Review are aligned for MH/SUD services and M/S services. The factors clinical appropriateness (MH/SUD and M/S) and safety (M/S) are aligned as they both take into consideration the appropriateness of a service and rely on objective, evidence-based clinical guidelines, medical experts, and national guidelines as an evidentiary standard and source. Safety is considered as an element under medical necessity as described in the clinical appropriateness factor for MH/SUD benefits and thus is aligned with the safety factor for M/S benefits. For the MH/SUD outpatient factor "value of applying a concurrent review," this factor closely aligns with M/S factors such as cost and denial rate. This is because the calculation of value takes into account the costs of rendered services compared to the administrative burden of reviewing a case which considers denial rates (e.g. considerably low denial rates might signal there is an unnecessary administrative burden of review). For these factors, authorization data and claims data is used as a source to derive the evidentiary standards to support these factors.

	Additionally, for both MH/SUD benefits and M/S benefits, variability in cost is considered as a factor that determines whether a service requires concurrent review. Variability for both MH/SUD and M/S benefits is evaluated by using a threshold of 2x the mean of other services and uses claims data as a source. One factor, new/emerging services, is considered for medical/surgical services but not for mental health services. The Plan has concluded that this does not result in more stringency towards mental health/substance use disorder benefits because this factor could result in additional services becoming subject to concurrent review for medical/surgical benefits. Operationally, the Plan performs in-operation data assessments for concurrent review procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across med/surg and MH/SUD services. The Plan concludes that in-operation, its methodology for concurrent review for mental health/substance use disorder services is comparable to and applied no more stringently than the methodology for concurrent review applied to medical/surgical services. A comparison of denial rates (including partial denials) reveals that concurrent review denial rates for M/S services are higher compared to denial rates of MH/SUD services indicating higher approval rates for MH/SUD benefits (24% v. 1.45%). This reveals that more services are denied when they are M/S services compared to MH/SUD services. Out-of-network (OON) denial rates (including partial denials) similarly reveal higher rates of denial for M/S services (32% v. 20%). This reveals that more OON services are denied when they are M/S services compared to MH/SUD services. Finally, the rate of overturned appeals is lower for M/S services when compared to MH/SUD services with (42% v. 56%) indicating that more appealed services are approved for MH/SUD benefits. The outcome measures show comparability (or in this case are more favorable to behavioral health benefits) in processes for concurrent review because the metrics reveal more favorable outcomes for MH/SUD benefits with higher rates of approval for services overall. The Plan is responsible for coordinating responses to non-quantitative treatment limitations (NQTLs) with its Behavioral Health Vendor (Optum Behavioral Health Solutions) on an annual basis or as needed when there is a change to a current methodology or process directly related to the NQTL. The Plan conducts non-quantitative treatment limitations to review that factors, sources, evidentiary standards, and processes are applied no more stringently to Mental Health/Substance Use Disorder services when compared to Medical/Surgical services. If a discrepancy is identified, the Plan coordinates with Optum Behavioral Health Solutions to investigate if there is a risk of non-compliance to perform necessary remediation. The concurrent review non-quantitative treatment limitation is approved on an annual basis by the Clinical Advisory Committee, which reports to the Utilization Management Subcommittee, in quarter three of each year. The Associate of UM Optimization is responsible for conveying annual updates to the committee for review and formal sign-off. Non-quantitative treatment limitation changes and modifications,

	including factors or other modifications to the non-quantitative treatment limitation methodology, are determined during the most subsequent quarterly Clinical Advisory Subcommittee session or can be voted on by CAS committee members off-cycle Conclusion: The findings of the comparative analysis reveal that the process and methodology to apply concurrent review to mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology used to apply concurrent review to medical/surgical services.

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Experimental/Investigational Determinations
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Clinical
Names of Person(s) Responsible for Analysis Formation	**Oscar:** Insiya Taj, MPH, Associate, UM Optimization, (Over 3 years experience in healthcare and clinical research) Marco Fossati-Bellani, MD, MPH, Senior Medical Director, UM Mimi Shim, MPH, RN, Associate Clinical Manager, Clinical Policy **Optum Behavioral Health Solutions Positions**: Chief Medical Officer, National Senior Behavioral Medical Director (MD), Director MH Parity and Benefits, Senior Director, National Policy and Standards, and Associate Director, Clinical Criteria and Guidelines. Credentials: Board Certified MDs, Licensed Psychologist, Licensed Nurse, Licensed Social Worker, and National Certified Counselor.
Last Update	7/11/2022
Reviewers	Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)

oscar

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Experimental/Investigational Determinations

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

Medical/Surgical Terms	Mental Health/Substance Use Disorder Terms
Definition/Coverage Terms: Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition for which one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought: 1. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA"), or other licensing or regulatory agency, and such final approval has not been granted; 2. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply has been determined by the FDA to be contraindicated for the specific use; 3. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, supply is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; 4. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; 5. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is	**Definition/Coverage Terms:** Experimental/Investigational means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition for which one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought: ● The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the FDA or other licensing or regulatory agency, and such final approval has not been granted; ● The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply has been determined by the FDA to be contraindicated for the specific use; ● The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is provided as part of a clinical research protocol or Clinical Trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; ● The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function

provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation. Any service not deemed Experimental/Investigational based on the criteria above may still be deemed Experimental/Investigational by Oscar based on assessment as to whether; 1. The scientific evidence is conclusory concerning the effect of the service on health outcomes; 2. The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects; 3. The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and 4. The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings. The information considered or evaluated by Oscar to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigational under the above criteria may include one or more items from the following list, which is not all inclusive: 1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or 2. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or 3. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or 4. Documents of an IRB or other similar body	● The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

performing substantially the same function; or 5. Consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or 6. Medical records; or 7. The opinions of consulting providers and other experts in the field.	

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
In-Network Inpatient Services	• All Medical/Surgical technologies determined to be Experimental/Investigational	• All technologies determined to be Experimental/Investigational
In-Network Outpatient Services	• All Medical/Surgical technologies determined to be Experimental/Investigational	• All technologies determined to be Experimental/Investigational

2. **Identify the factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits:**

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD

In-Network Inpatient Services	• Clinical Efficacy • Clinical Safety • Appropriateness of the proposed technology for the underlying condition **Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.	1. Exclusions for EIU technologies and EIU definitions as outlined in plan documents 2. Committee considerations: • Clinical efficacy • Safety • Appropriateness of the proposed technology • Whether the technology is an unproven treatment for a specific diagnosis
In-Network Outpatient Services	Same as Inpatient Analysis	Same as Inpatient Analysis

3. **Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:**

Benefit Classification	**Evidentiary Standards and Sources: Medical/Surgical**	**Evidentiary Standards and Sources: MH/SUD**
In-Network Inpatient Services	**<u>Evidentiary Standards and Sources</u>**: Overall, Clinical Criteria are: • Based on nationally-recognized standards; • Developed in accordance with the current standards of national accreditation entities; • Developed to ensure quality of care and access to needed healthcare services; • Evidence-based; and • Evaluated and updated at	**<u>Evidentiary Standards and Sources</u>** 1. Plan documents 2. • Scientifically based clinical evidence • Peer-reviewed literature • Hierarchy of Clinical Evidence: ○ Systematic reviews and meta analyses ○ Randomized controlled trials ○ Large non-randomized controlled trials ○ Large prospective trials ○ Comparative and cohort studies

	least annually. Any health care service, testing, procedure, treatment, device or prescription drug for which safety and efficacy has not been established and proven is considered experimental, investigational, or unproven. Services that are not accepted as the standard medical treatment of the condition being treated are considered "new and emerging services and technologies." To determine whether a service, device, treatment or procedure has proven safety and efficacy, the available reliable evidence is reviewed, which may include but is not limited to (listed in order of decreasing reliability): 1. Published technology assessments and/or high quality meta analyses 2. Randomized, controlled trials 3. Other controlled studies or cohort studies 4. Case reports or case series 5. Reports of expert opinion **Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards	○ Cross sectional studies ○ Retrospective studies ○ Surveillance studies ○ Case Reviews/Case series ○ Anecdotal/editorial statements ○ Professional opinions No MH/SUD service is deemed unproven solely on the basis of a lack of randomized controlled trials particularly for new and emerging behavioral health technologies. In the absence of strong and compelling scientific evidence, clinical policies may be based upon: ● National consensus statements ● Publications by recognized authorities such as government sources and/or professional societies
In-Network Outpatient Services	Same as Inpatient Analysis	**<u>Evidentiary Standards and Sources</u>** 1. Plan documents 2. ● Scientifically based clinical evidence ● Peer-reviewed literature ● Hierarchy of Clinical Evidence: ○ Systematic reviews and meta analyses

		○ Randomized controlled trials ○ Large non-randomized controlled trials ○ Large prospective trials ○ Comparative and cohort studies ○ Cross sectional studies ○ Retrospective studies ○ Surveillance studies ○ Case Reviews/Case series ○ Anecdotal/editorial statements ○ Professional opinions No MH/SUD service is deemed unproven solely on the basis of a lack of randomized controlled trials particularly for new and emerging behavioral health technologies. In the absence of strong and compelling scientific evidence, clinical policies may be based upon: ● National consensus statements ● Publications by recognized authorities such as government sources and/or professional societies

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits:

For each committee used to determine which benefits to subject to Experimental/Investigational Determinations, describe the committee's purpose, composition and member qualifications, and process:

Benefit	Committee Composition:	Committee Composition: MH/SUD

Classification	Medical/Surgical	
In Network Inpatient Services/Outpatient Services	The OMC Board of Directors has the ultimate authority and responsibility for the quality of care and services delivered to its members. The Board of Directors provides strategic planning and direction, budget approval, and staff allocation for the UM Department. The Board of Directors assigns day-to-day responsibility for implementation of the UM Program to the UM Subcommittee, which is a subcommittee of the Quality Improvement Committee. The Board of Directors oversees the implementation of and adherence to the UM Program through the UM Subcommittee. The UM Subcommittee reports to the Quality Improvement Committee at a minimum of once per quarter, per year. The UM Program and Annual Program Evaluation are approved at the UM Subcommittee portion of the Quality Improvement Committee meeting. Minutes conveying this approval are submitted to the Board of Directors, who approve the actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical). As noted above, the UM Subcommittee is a sub-committee to the Quality Improvement	For MH/SUD, the Clinical Technology Assessment Committee (CTAC) is responsible for developing evidence-based Behavioral Clinical Policies for select behavioral health technologies and obtains approval from the Clinical Quality and Operations Committee (CQOC). The CTAC receives oversight from the CQOC. CTAC is Co-Chaired by two licensed and board-certified psychiatrists (MDs) who are Medical Directors. Voting membership includes licensed and board-certified psychiatrists (MDs) and Medical Directors whose specialties includes General Psychiatry, Addiction Medicine, Research, Geriatrics, Child/Adolescent Psychiatry, Adult Psychiatry, Forensic Psychiatry as well as a PhD, VP of Research and Evaluation. Additional representatives attend as non-voting membership, including Legal Counsel, Compliance, Clinical Review (MD and RN) and Clinical Policy (MSN, RN, LCSW, MBA, M.A, N.C.C). The Clinical Technology Assessment Committee meets three times annually and ad hoc, as necessary. Once a technology has been assessed, a behavioral clinical policy is updated or developed which outlines CTAC's findings. The behavioral clinical policies are reviewed and voted upon by CTAC's oversight Committee, the Clinical Quality and Operations Committee (CQOC). All behavioral clinical policies are reviewed and/or updated at least once annually. The CTAC undertakes, but is not limited to, the following ongoing activities: ● Evaluating new behavioral health technologies/services and new applications of existing behavioral health technologies/services as per the

	Committee. A senior-level physician chairs the UM Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary. The UM Subcommittee undertakes, but is not limited to, the following ongoing activities: ● Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated. ● Reviews and approves modifications to the UM Program as indicated by operational needs and/or to meet regulatory and accreditation compliance. ● Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services. ● Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.	policy, Clinical Technology Assessments. ● Reviewing requests for evaluation of new technologies/services received from any of the organization's business units or directly from contracted health plans as appropriate. ● Providing parameters, when available, to inform implementation of the technology.

Briefly describe the processes by which Experimental/Investigational Determinations are applied:

Benefit Classification	Process Description: Medical/Surgical	Process Description: MH/SUD
In-Network Inpatient Services/Outpatient Services	**Process for E/I determination**: A senior-level physician chairs the Utilization Management Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary.The Utilization Management Subcommittee is a sub-committee to the Quality Improvement Committee, which ultimately determines whether a service, device, treatment or procedure has proven safety and efficacy, the available reliable evidence[1] is reviewed, which may include but is not limited to (listed in order of decreasing reliability): 1. Published technology assessments and/or high quality meta analyses 2. Randomized, controlled trials 3. Other controlled studies or cohort	**Process for E/I determination**: OBHS uses committees to assess technologies and conduct a thorough review of the scientifically based clinical evidence and peer-reviewed literature in accordance with the Hierarchy of Clinical Evidence in order to develop medical/clinical policies that apply to the technologies. The Clinical Technology Assessment Committee (CTAC) is responsible for developing evidence-based Behavioral Clinical Policies for select behavioral health technologies and obtains approval from the Clinical Quality and Operations Committee (CQOC). CTAC is comprised of board-certified psychiatrists, addictionologists, behavioral health professionals and clinical representatives from Optum's Research & Evaluation organization. MH/SUD technologies assessed by the CTAC committee as NOT being safe, clinically effective and/or appropriate are determined to be EIU. Once a technology has been assessed, a medical/clinical policy is developed which outlines CTAC's findings. All medical/clinical policies are reviewed and/or updated at least once annually. **IRR Process**: All MH/SUD clinical staff utilize behavioral clinical policies when making coverage determinations of EIU technology services.

[1] "Reliable Evidence" means reports and articles with scientifically valid data published in authoritative, peer reviewed medical and scientific literature. Reports, articles, or statements by providers or groups of providers that only contain abstracts, anecdotal evidence or personal professional opinions are not considered reliable evidence.

	studies **IRR Process**: All clinicians (nurses, pharmacists, physicians, behavioral health practitioners) involved in clinical decision-making participate in IRR testing to ensure high quality, evidence-based decision-making and the consistent application of clinical criteria across its clinical UM staff. In IRR testing, clinicians are given the same clinical scenario cases. The IRR cases include hypothetical cases designed by OMC or complex cases where a learning opportunity has been identified. The IRR testing benchmark is 80%, and differences in determinations are used as the basis for quarterly clinical discussion and training. For cases where scores are below benchmark, the cases will be addressed in remediation discussions for continued quality improvement. **Qualifications of E/I reviewers**: The Clinical Advisory Subcommittee is chaired by a Senior Medical Director and consists of the following: ● Internal membership: Clinical Operations Nurse (RN), Senior Medical Director, Clinical Review (MD or DO), State/Regional Medical Directors (MD or DO), Designated Behavioral Health Physician (MD) ● External membership: At least four network participating practitioners (e.g., MDs, DOs) Finally, these changes are reported to the UM Subcommittee and ultimately through the Quality Improvement Committee of the Board.	All MH/SUD clinical staff who make coverage determinations utilizing behavioral clinical policies are required to participate in annual Inter-Rater Reliability (IRR) assessments to ensure policies are applied in a consistent and appropriate manner "in operation." Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff and provides additional training on the use and application of the relevant policies to those who do not achieve a passing score. If necessary, remediation planning and training will be directed by a Supervisor/Manager. **Qualifications of E/I reviewers**: CTAC is board-certified psychiatrists, addictionologists, behavioral health professionals and clinical representatives from Optum's Research & Evaluation organization. In addition to board certified psychiatrists (MD/DO), committee qualifications also include Psychologists (PhD/PsyD) and behavioral health clinicians (graduate degrees and/or RN).

Identify and define the factors and processes that are used to monitor and evaluate the application of Experimental/Investigational determinations

Benefit Classification	Comparative Analysis
In-Network Inpatient Services/Outpatient Services	**Monitoring and Oversight:** The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) services are subject to experimental/investigational determinations "as written." The Plan ensures that the criteria and processes used for medical necessity are no more stringently applied to MH/SUD than medical/surgical benefits in operation, whether utilization review is conducted by the same or different entities. The Plan maintains a clinical criteria hierarchy crosswalk between the M/S and MH/SUD benefits, performs clinical interrater reliability testing, and ensures processes are applied consistently across each benefit classification. Medical/Surgical: The Plan uses documented clinical review criteria based on sound clinical evidence to make utilization management decisions, including medical necessity coverage determinations. All clinicians involved in clinical decision-making participate in annual inter-rater reliability (IRR) testing to ensure high quality, evidence-based decision making and consistent application of clinical criteria across its clinical UM staff. The IRR testing benchmark is 80%, and differences in determinations are used as the basis for quarterly clinical discussion and training. For cases where scores are below benchmark, the cases will be addressed in remediation discussions for continued quality improvement. MH/SUD: MH/SUD utilizes behavioral clinical policies when making coverage determinations of EIU technology services. All MH/SUD clinical staff who make coverage determinations utilizing behavioral clinical policies are required to participate in annual Inter-Rater Reliability (IRR) assessments to ensure policies are applied in a consistent and appropriate manner "in operation." Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff and provides additional training on the

use and application of the relevant policies to those who do not achieve a passing score. If necessary, remediation planning and training will be directed by a Supervisor/Manager.

In-Operation Metrics:

Inter-rater reliability scores clinical reviewers (M/S) 2021:	**Inter-rater reliability scores clinical reviewers (MH/SUD) 2021:**
• Average IRR score: 93.0%	• Average IRR score: 98.8%

Identify and define the factors and processes that are used to monitor and evaluate the application of E/I Treatment policies to M/S benefits	***Identify and define the factors and processes that are used to monitor and evaluate the application of E/I Treatment policies to MH/SUD benefits***
• Number of claim denials by service based on a determination that the service was E/I: **514 Claims denied based on E/I determination.**	• Number of claim denials by service based on a determination that the service was E/I: **No denials based on E/I determination.**

5. Provide the specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

Benefit Classification	**Findings and Conclusions**
In-Network	The underlying processes, strategies, evidentiary standards and other factors used to apply

Inpatient Services/Outpatient Services	the NQTL to MH/SUD benefits and to medical/surgical benefits have led the Plan to conclude compliance with MHPAEA for the following reasons: The factors are aligned for experimental/investigational across M/S and MH/SUD. The same factors are used to determine whether a service is experimental/investigational for M/S and MH/SUD and include: 1. Clinical efficacy 2. Clinical safety 3. Appropriateness of the proposed technology Additionally, For sources and evidentiary standards, both M/S and MH/SUD rely on the source and evidentiary standard information for medical necessity criteria to support whether services are experimental/investigational. One difference in the analysis is that for MH/SUD benefits, an additional factor is listed in step 2. This factor is "whether the technology is an unproven treatment for a specific diagnosis." The Plan has concluded that this difference does not result in more stringency for MH/SUD benefits when compared to M/S benefits because this factor is closely aligned with the M/S factor "appropriateness of the proposed technology **for the underlying condition."** Experimental/Investigational determinations for M/S and MH/SUD benefits both rely on whether the technology is appropriate for the treatment of a specific condition and therefore are aligned in methodology for such determinations. For both MH/SUD and M/S, IRR testing is commenced to ensure that clinical criteria is closely adhered to. MH/SUD requires a higher passing score of 90% which is more beneficial for MH/SUD services as it ensures that clinical criteria are applied as consistently and accurately as possible when applying medical necessity criteria. **Findings**: Both M/S and MH/SUD clinical reviewers are required to successfully complete an annual IRR assessment. The same standards are used; clinical reviewers are expected to pass the IRR assessment with a score of 80% or better for M/S and 90% or better for MH/SUD. The average IRR score for MH/SUD clinicians was slightly higher in 2021 compared to the IRR score for M/S providers. Both MH/SUD clinicians and M/S clinicians on average meet the appropriate benchmarks for rendering appropriate medical necessity determinations revealing that this NQTL is applied no more stringently to MH/SUD benefits. These results show that clinical reviewers appropriately applied medical/behavioral clinical policies when making utilization review determinations. Additionally, no claims were denied for experimental/investigational indications in 2021 for MH/SUD services when compared to the over 500 claims denied for medical/surgical services for being experimental/investigational in nature. This further reveals that less stringency is applied to MH/SUD benefits in the context of experimental/investigational procedures. The findings of the comparative analysis reveal that the process and methodology for

	experimental/investigational determinations for mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology for experimental/investigational determinations for medical/surgical services.

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Formulary Design/Formulary Tiering
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Pharmacy
Names of Person(s) Responsible for Analysis Formation	Kemper May, PharmD, Manager, Formulary Operations (Six years experience in Pharmacy at a Health Plan) Jeenal Patel, PharmD, Senior Clinical Formulary Pharmacist (Eight years Pharmacy experience, two of which were dedicated to Pharmacy at a Health Plan)
Last Update	9/1/22
Reviewers	Alexandra Rubino, MPH, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)

oscar

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Formulary Design/Formulary Tiering

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

General Description/Explanation of the NQTL:
A formulary is a list of prescription drugs covered by a drug plan offering prescription drug benefit. A formulary is sometimes referred to as a covered drug list. The copay tiers on a formulary determine the amount that the member pays for coverage of a prescription. The copay tiers are based on whether the drug is formulary-eligible, included as covered on the formulary, available as a generic or a brand product, and whether the brand or generic drug product is considered preferred, non-preferred, or formulary-excluded. The classification of specialty drug status typically includes higher-cost drugs that require special handling, special storage, or close clinical monitoring of the member. Due to the special handling of the drug or the drug's limited distribution, the prescription may need to be dispensed from a specialty pharmacy. The applicable copay for a specialty drug would apply. **For Oscar 3-tier formularies:** Tier 0: The prescription drug tier which consists of select generics and brand products at no cost-share to the member. Tier 1: The prescription drug tier which consists of the lowest cost tier of prescriptions drugs, most are generic. Tier 2: The prescription drug tier which consists of medium-cost prescription drugs, most are generic, and some brand-name prescription drugs. Tier 3: The prescription drug tier which consists of highest-cost prescription drugs, some are brand-name prescription drugs, and most are specialty drugs. **For Oscar 4-tier formularies:** Tier 0: The prescription drug tier which consists of select generics and brand products at no cost-share to the member. Tier 1: The prescription drug tier which consists of the lowest cost tier of prescription drugs, most are generic. Tier 2: The prescription drug tier which consists of medium-cost prescription drugs, most are generic, and some brand-name prescription drugs. Tier 3: The prescription drug tier which consists of higher-cost prescription drugs, most are brand-name prescription drugs, and some are specialty drugs. Tier 4: The prescription drug tier which consists of the highest-cost prescription drugs, most are specialty drugs. **For Oscar 5-tier formularies:** Tier 0: The prescription drug tier which consists of select generics and brand products at no cost-share to the member. Tier 1: The prescription drug tier which consists of the lowest cost tier of prescription drugs, most are generic. Tier 2: The prescription drug tier which consists of medium-cost prescription drugs, most are generic, and some brand name prescription drugs.

Tier 3: The prescription drug tier which consists of high-cost prescription drugs, most are brand-name prescription drugs.
Tier 4: The prescription drug tier which consists of the higher-cost prescription drugs, most are brand-name prescription drugs, and some specialty drugs.
Tier 5: The prescription drug tier which consists of the highest-cost prescription drugs, most are specialty drugs.

For Oscar 6-tier formularies:
Tier 0: The prescription drug tier which consists of select generics and brand products at no cost-share to the member.
Tier 1: The prescription drug tier which consists of the lowest cost tier of prescription drugs, most are generic.
Tier 2: The prescription drug tier which consists of medium-cost prescription drugs, most are generic, and some brand name prescription drugs.
Tier 3: The prescription drug tier which consists of high-cost prescription drugs, most are brand-name prescription drugs.
Tier 4: The prescription drug tier which consists of the higher-cost prescription drugs, most are brand-name prescription drugs, and some specialty drugs.
Tier 5: The prescription drug tier which consists of some of the highest-cost prescription drugs, most are specialty drugs.
Tier 6: The prescription drug tier which consists of the highest-cost prescription drugs, most are specialty drugs.

A list of covered medications may be found here: https://www.hioscar.com/search-documents/drug-formularies/

Plan/Coverage Terms and Definitions:

Coverage Terms (Evidence of Coverage):

Prescription Drug: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Formulary: Formulary means the list that identifies those Prescription Drugs for which coverage may be available under this Plan. You may determine to which tier a particular Prescription Drug has been assigned by visiting www.hioscar.com or by calling Oscar at 1-855-672-2755.

The Oscar Formulary is a list of drugs we typically cover. Oscar maintains a list of medications, typically a portion of those approved by FDA, that Oscar will cover. This list, referred to as the Oscar Formulary, is reviewed and updated by Oscar on a regular cycle. Oscar's Pharmaceutical and Therapeutics Committee oversees the review process to ensure clinical, quality and cost considerations are appropriately considered. The Oscar Formulary includes medications in almost all classes of medications, but does not necessarily include all forms of a given Prescription Drug (e.g. oral tablets, liquids, topical etc.).

Brand Name Drug: A drug or product manufactured by a single manufacturer as defined by a nationally recognized Provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from generic to Preferred Brand Name due to a change in the market resulting in the generic being a single

source, or the drug product database information changing, which would also result in a corresponding change in cost- sharing obligations from generic to Preferred Brand Name.

Generic Drug or Generic Equivalent: A drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding Member Cost-Sharing Amount responsibility, Oscar utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information.

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
Pharmacy	Please see: *https://www.hioscar.com/forms/2022/ny* All other drug classes not listed under MH/SUD	Please see: *https://www.hioscar.com/forms/2022/ny* • Attention Deficit/Hyperactivity Disorder (ADHD) agents/stimulants • Antianxiety agents • Antidepressants • Antipsychotics • Hypnotics • Mood Stabilizers (specifically Lamotrigine) • Substance Use Disorder (SUD) agents

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Medical Surgical and Mental Health/Substance Use Disorder Factors, Sources, and Evidentiary Standards:

Factor	Sources	Evidentiary Standards/Thresholds
Brand or generic status of the drug (including	Medispan MONY code designation of MON = Brand; Y = Generic; Rx/OTC	The P&T Committee reviews the brand/generic status of the drug. AB

generic releases upcoming)	designation where MediSpan qualifier O/P = OTC and R/S = Rx	rated Generic drugs are typically assigned to tiers 1 and 2. Non specialty brand drugs drugs are typically assigned to tier 2 or 3. Speciality drugs are typically assigned to tier 3
Availability of therapeutic alternatives	Consensus documents and nationally sanctioned guidelines: Milliman Care Guidelines (MCG), Hayes, Inc., Up-To-Date Recognized drug compendia: US Pharmacopeia, Clinical Pharmacology, Lexicomp, Micromedex Publications of the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), and other organizations or government agencies Evidence-based reviews of peer-reviewed medical literature and relevant clinical information: American Journal of Medicine, SAMHSA, American Journal of Psychiatry, Journal of Clinical Oncology, NCCN etc. Standards of care recommended by clinical literature, medical or pharmacy societies, standard clinical drug references: Nexis, Orange Book, PubMed, UpToDate, JAMA, NCCN, American Heart Association, American Academy of Neurology Appropriate clinical drug information from other sources as applicable: FDA.gov, Clinicaltrial.gov, ASHP (American Society of Health-System Pharmacists)	The P&T Committee will review the category/class to determine if a FDA approved AB-rated drug with similar therapeutic efficacy and safety exists or if there is a unique indication or population that may benefit from the addition of the comparator product based on standards of practice, clinical guideline recommendation, and evidence-based reviews. Availability of therapeutic alternatives is assessed by evaluating clinical efficacy. **Clinical efficacy** is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. **Clinical effectiveness** is based on the evidence of clinical trials that the interventions are considered to be effective for the general population. The Plan measures efficacy by the below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition. Class I: “Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective. Class IIa: "Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy." Clinical Pharmacology Rating:

		• Strength of Recommendation of "strong". • Level of evidence rating of "High, Moderate" Or rating systems considering efficacy of regimen/agent is moderately effective such as NCCN definition of 2b evidence "Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate" or higher levels of efficacy.
Average daily drug cost	Pharmacy Claims Data	• The generic tier includes all generic drugs under $356.78 of 30-day ingredient cost (Tier 1 and Tier 2) • The brand tier includes non-generic drugs under $356.78 and any drugs with a cost between $356.78 and $3650.90 (Tier 3 and Tier 4) • The specialty tier includes all drugs above $3650.90 dollars regardless of generic status (Tier 5 and Tier 6)
Applicable manufacturer agreement	CVS CFC Team - Proprietary Trade Agreements	Manufacturers may offer competitive rebates in order for the Health Plan to employ the lowest net cost strategy for both the plan and members. As a result, manufacturers in certain instances may dictate which tier a drug needs to fall on. Example: 2023 Pfizer trade agreement states Norditropin must be placed on the preferred specialty tier in order to offer a low net cost growth hormone strategy.
Regulatory requirements - certain prescription drugs are mandated to be	Government regulations/state legislation websites, memos, bulletins	Examples include but are not limited to: 1) ACA: The Affordable Care Act

covered as essential health benefits; drug formularies are often regulated at the state level regarding formulary design (e.g., limitations with select drugs needing to be on certain tiers).		mandates that health plans cover recommended preventive services without charging a deductible, copayment, or co-insurance (at the lowest tier: Tier 0) 2) Orally Administered Chemotherapy: Oscar covers orally administered chemotherapy for the treatment of cancer on a basis no less favorable than the intravenously administered or injected chemotherapy regardless of the formulation or benefit category determination by Oscar. Oscar may meet this requirement by limiting the total amount paid by a Member through Member Cost Sharing to no more than $200.00 per filled prescription for any orally administered chemotherapy. 3) Drug Coverage of Contraceptives: Oscar will not impose upon any person receiving prescription contraceptive benefits: Copayment, coinsurance payment, or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level or copayment level, receiving benefits for prescription drugs; or reduction in allowable reimbursement for prescription drug benefits.

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits:

Benefit Classification	Comparative Analysis: Medical/Surgical and Mental Health/Substance Use Disorder
Pharmacy	**As-Written:** ***Process*:** *General*: Tiered benefit design encourages generic utilization and curbs pharmacy cost through copay differentials. This encourages behaviors that will ultimately lead to appropriate utilization of generics with similar efficacy and safety with no additional clinical advantage and preferred brand drugs. The goal is to provide the lowest net cost within each therapeutic class while ensuring that options available on our drug lists are consistent with current standards of practice and clinical guidelines. All tiering decisions are voted on and approved by the external P&T committee. ***Description of Pharmacy & Therapeutics Committee (P&T Committee)*:** *Purpose:* Oscar's Pharmacy and Therapeutics (P&T) Committee promotes the safe and appropriate use of cost-effective pharmaceuticals for members. The committee operates in compliance with NCQA standards and state/federal regulations for Oscar's individual, small group, and self-insured drug formularies in all states. The committee regularly reviews new drugs, drug classes, new drug indications, and new safety information. Policies & Procedures for pharmaceutical management and all formularies are reviewed at least annually. *Structure:* Oscar's P&T Committee commences at least quarterly and reports to the Utilization Management Committee. At least fifty percent of Oscar's ten voting members must be present to establish a quorum. Committee members represent a sufficient number of clinical specialties to adequately meet the needs of members. At least two-thirds of members are practicing physicians (MD/DO), practicing pharmacists (PharmDs), and other practicing health care professionals (RNs) who are licensed to prescribe drugs. At least one member shall be a pharmacist. Committee Chairs are appointed annually by Oscar's Vice President of Pharmaceuticals. Membership changes are reported to CMS during the contract year. Members complete a Conflict of Interest and Non-Disclosure Agreement, annually.

Voting Members	Qualifications
VP Medical Director	Licensure: Medical Doctor Specialty: Internal Medicine
External Member	Licensure: Medical Doctor Speciality: Rheumatology
External Member	Licensure: PharmD
External Member	Licensure: Pharm D Specialty: Infectious disease
External Member	Licensure: Medical Doctor Specialty: Family Practice
Senior Director, Data Science	Data Science
Senior Medical Director	Licensure: Medical Doctor Specialty: Family Practice
Director, Clinical Pharmacy Operations	Licensure: PharmD
External Member	Licensure: Medical Doctor and Masters of Public Health Specialty: Preventive Medicine
External Member	Specialty: Psychiatry

Responsibilities:
The Committee will develop and document procedures to ensure appropriate drug review and inclusion on Oscar's formularies. Minutes reflect the rationale for all decisions regarding formulary drug list development or revision. Clinical decisions will be based on the strength of scientific evidence and standards of practice, including: assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and the therapeutic advantages of drugs in terms of safety and effectiveness. The committee will review policies that guide exceptions and other utilization management processes, including prior authorization criteria, step therapy protocols, quantity limit restrictions, drug utilization review, and therapeutic interchange. The Committee ensures that Oscar's formulary covers a range of drugs across a broad distribution of therapeutic categories and classes and recommended

drug treatment regimens that treat all disease states, and does not discourage enrollment by any group of enrollees. The committee provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

Internal oversight of the P&T Committee:
The Board of Directors oversees the implementation of and adherence to the UM Program through the UM Subcommittee. The UM Subcommittee reports to the Quality Improvement Committee at a minimum of once per quarter, per year. The P&T minutes are approved at the UM Subcommittee portion of the Quality Improvement Committee meeting. Minutes conveying this approval are submitted to the Board of Directors, who approve the actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical).

As noted above, the UM Subcommittee is a sub-committee to the Quality Improvement Committee. A senior-level physician chairs the UM Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary.

The UM Subcommittee undertakes, but is not limited to, the following ongoing activities:

- Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated.
- Reviews and approves modifications to the UM Program as indicated by operational needs and/or to meet regulatory and accreditation compliance.
- Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services.
- Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.

FDA-approved drug products are reviewed and considered for inclusion on the formulary by the P&T Committee. In evaluating new drugs for formulary inclusion, the P&T Committee reviews the individual drug monographs, pivotal clinical trials accompanying the drug monographs, and therapeutic class reviews. The Committee members share insights based on their clinical practice and the quality of published literature. Additionally, the P&T members are tasked with reviewing and approving all

	utilization management (UM) criteria (i.e., prior authorization, step therapy and quantity limits outside of FDA-approved labeling). The P&T Committee reviews all formulary additions and removals as well as all tier changes and the formulary is reviewed annually. ***MHPAEA Summary*** The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to mental health and substance use disorder (MH/SUD) benefits and to medical/surgical (M/S) benefits have led the Plan to conclude compliance with MHPAEA for the following reasons: The factors that determine the formulary design are the same for both MH/SUD drugs and M/S drugs. Formulary design is determined by brand or generic status of the drug (including generic releases upcoming), availability of therapeutic alternatives, average daily drug cost, applicable manufacturer agreement, and regulatory requirements. The plan also uses the same evidentiary standards and sources to determine the thresholds and supporting information for the aforementioned factors across all drug types (M/S and MH/SUD). There is no discrepancy between the factors, evidentiary standards, sources, and processes used to determine formulary design because all drugs, regardless of drug-type, are subject to the same underlying methodology. However, the Plan has conducted an in-operation quantitative analysis below to quantify the extent to which a discrepancy may exist for formulary design operationally. The methodology for formulary benefit design and tiering is applied consistently across all drugs and drug classes and does not discriminate against individuals based on medical/surgical condition, mental health/substance use disorder diagnosis, or other health conditions. Any pharmacy coverage factors, processes, development or implementation strategies, and evidentiary standards applied to drugs used to treat mental health or substance use disorder are comparable to, and are applied no more stringently than the coverage factors, processes, development or implementation strategies, evidentiary standards used in applying the limitations to drugs used to treat medical or surgical disorders as evidenced by the above as-written NQTL analysis. **In-Operation:** ***Overview*:** Operationally, the Plan performs in-operation data assessments for formulary design to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across M/S and MH/SUD drugs.

Table 1 - Number and proportion of MH, SUD, and M/S drugs placed in each tier				
Tier	**Condition**		**Total Drugs in Tier**	**Proportion of drugs in tier by condition**
Tier 0	**ACA**	MH	0	0%
		SUD	754	43%
		M/S	1000	57%
Tier 1	**Generic - preferred**	MH	887	16%
		SUD	91	2%
		M/S	4413	82%
Tier 2	**Generic - non-preferred**	MH	2586	16%
		SUD	194	1%
		M/S	13545	83%
Tier 3	**Brand - preferred**	MH	465	19%
		SUD	25	1%
		M/S	1959	80%
Tier 4	**Brand - non-preferred**	MH	198	12%
		SUD	0	0%
		M/S	1477	88%
Tier 5	**Specialty - preferred**	MH	0	0%
		SUD	0	0%
		M/S	1319	100%
Tier 6	**Specialty - non-preferred**	MH	1	1%
		SUD	0	0%
		M/S	90	99%

The following regression analysis designed by the plan examines the likelihood that a MH/SUD drug is assigned to a specific tier.

Regression Analysis:

For tiering, we use the decision tree[1] and logistic regression together to model the probability that an on-formulary drug is assigned to a certain tier. The explanatory variables used are indicators for whether a given drug is a controlled substance, used for mental health, a generic drug, and/or a maintenance drug, and cost indicators. The coefficients of BH status from the logistic regression were examined to determine if BH drugs are more likely to be assigned to higher tiers.

The reasoning for this framework is as follows:

[1] The decision is a non-parametric model that predicts the value of a target variable by learning simple decision rules inferred from the data features. These decision rules are general are a list of if/else conditions based on thresholds of explanatory variables.

	1. The tiering is not a simple binary outcome as the case for UM. While it's possible to use one single complex model, this two-step modeling approach makes it easier to frame the analysis with more explainable/interpretable models. 2. The tiers are grouped into three main tiers in the decision tree step because the formularies in certain states do not have preferred and non-preferred. This grouping makes it possible to apply a general approach to all states. 3. Tier zero (Preventative drugs and Contraceptives) is omitted because it is largely determined by regulatory rules, and not driven by cost and drug type. The first step is to use a decision tree to estimate the three major tiers including generic, brand, and specialty. We treat the output of this step as the expected tiers. This decision tree model can be summarized as below: - The generic tier includes all generic drugs under $356.78 of 30-day ingredient cost - The brand tier includes non-generic drugs under $356.78 and any drugs with a cost between $356.78 and $3650.90 - The specialty tier includes all drugs above $3650.90 dollars regardless of generic status Based on the expected tiers, in the second step, the Plan uses three logistic regression models to assess the three hypotheses independently: - If BH drugs have higher than expected tiers - If BH drugs are more likely to be non-preferred generic than preferred generic - If BH drugs are more likely to be non-preferred brand than preferred brand The p-value for Georgia is greater than the conventional threshold of 0.05. This means that there is no statistical evidence that BH drugs are more or less likely to have higher than expected tiers or to be put on non-preferred tiers than preferred tiers.

5. The specific findings and conclusions reached by the Plan or issuer with respect to the health insurance coverage, including any results of the analyses described in the previous steps that indicate that the Plan or issuer is or is not in compliance with the MHPAEA NQTL requirements:

Benefit Classification	Findings and Conclusions
Pharmacy	The 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 for the following reasons: The Plan conducted a comparative analysis to determine formulary design methodology for Medical/Surgical (M/S) drugs and Mental Health/Substance Use Disorder (MH/SUD) drugs are comparable "as written." The factors, evidentiary standards, sources, and processes for formulary design for medical/surgical drugs are the same as the factors, evidentiary standards, sources, and processes for mental health/substance use disorder drugs. The Plan's formulary design is applied consistently across all drugs and drug classes and does not discriminate against individuals based on age, expected length of life, disability, degree of medical dependency, quality of life, gender identity, medical or mental health diagnosis, or other health conditions. Any coverage factors, processes, development or implementation strategies, and evidentiary standards applied to drugs used to treat mental health or substance use disorder (MH/SUD) are comparable to, and are applied no more stringently than the coverage factors, processes, development or implementation strategies, evidentiary standards used in applying the limitations to drugs used to treat medical or surgical disorders (M/S). Operationally, the Plan performs in-operation data assessments for formulary design procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across M/S and MH/SUD services. The Plan concludes that in-operation, its methodology for formulary design for mental health/substance use disorder drugs is comparable to and applied no more stringently than the methodology for formulary design applied to M/S drugs because there is no statistical evidence that MH/SUD drugs are more or less likely to have higher than expected tiers or to be put on non-preferred tiers than preferred tiers. The regression analysis for formulary design demonstrates that the Plan does not discriminate against individuals based on M/S diagnosis, MH/SUD diagnosis, or other health conditions. Conclusion: The findings of the comparative analysis reveal that the process and methodology for formulary design as applied to MH/SUD drugs is comparable to, and applied no more stringently than, the process and methodology used for formulary design for M/S drugs.

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Network Adequacy Standards
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Network and Contract Performance
Names of Person(s) Responsible for Analysis Formation	**Oscar:** John Amy, Director, Network Optimization (10 years experience in provider network development) **Optum Behavioral Health Solutions:** Positions: Director, Policy and Process Provider Network Administration, VP Benefits Integrity, Director MH Parity and Benefits Credentials: Licensed Psychologist, Licensed Nurse
Last Update	10/26/2022
Reviewers	Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)

Network Management - Network Adequacy

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

Strategy: Optum Behavioral Health Solutions (OBHS) and Oscar Health Insurance (OHI) assesses the adequacy of their networks based on regulatory requirements and/or whether business or organizational needs are satisfied.

Definitions
Access or **Accessibility**: The extent to which a member can obtain timely covered services from a contracted provider at the appropriate level of care, and appropriate location. **Available** or **Availability**: The extent to which the plan has contracted providers of the appropriate type and numbers at geographic locations to afford members access to timely covered services. **Network exception**: A member receives covered services from a non-contracted provider either: o Because there is no contracted provider accessible or available that can provide the enrollee timely covered services, or o For any reason the HCSO determines it is in the enrollee's best interests to receive care from a non-contracted provider.
Plan/Coverage Terms
In-Network Benefits: This Plan only covers In-Network Benefits. To receive In-Network Benefits, You must make sure Your care is received exclusively from Network Providers in Our Network. You're responsible for paying the cost of all care that is provided by Out-of-Network Providers, unless the care is for an Emergency Medical Condition or if the services You need aren't available from Network Providers. How to Find a Provider in the Network: There are two (2) ways You can find out if a Provider or Facility is in the network for this Agreement. You can also find out where they are located and details about their license or training. ● See Our directory of In-Network Providers at www.hioscar.com, which lists the Physicians, Providers and Facilities that participate in Our network. This includes information such as: ● Name, address, telephone numbers. ● Professional qualifications.

- Specialty.
- Medical school attended.
- Residency completion.
- Board certification status.

Call Member Services at 1-855-672-2755 or access Our website at www.hioscar.com for a list of Physicians, Providers and Facilities that participate in Our network, based on specialty and geographic area.

Benefit Classification	**Medical/Surgical Services to which the NQTL applies**	**Mental Health/SUD Services to which the NQTL applies**
Inpatient and Outpatient In-Network	All In-Network M/S services	All In-Network MH/SUD services

2. **Identify the factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits:**

Benefit Classification	**Factors Considered: Medical/Surgical**	**Factors Considered: Mental Health/SUD**
Inpatient In-Network and Outpatient In-Network	1. State regulations defining quantifiable network adequacy measurement for geographic, appointment and numeric availability 2. Centers for Medicare & Medicaid Services (CMS)/ Network Adequacy Criteria Guidance	1. State-specific standards when state regulations identify a quantifiable network adequacy measurement for geographic and numeric availability 2. Centers for Medicare & Medicaid Services (CMS)/ Health Services Deliver (HSD) Table

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Benefit Classification	Evidentiary Standards: Medical/Surgical	Evidentiary Standards: MH/SUD
Inpatient In-Network and Outpatient In-Network	1. Applicable state regulatory requirements 2. State/CMS/CCIIO (Marketplace) Network Adequacy Criteria Guidance[1]	1. Applicable state regulatory requirements 2. CMS/ Health Services Deliver (HSD) Table

Benefit Classification	Sources: Medical/Surgical	Sources: MH/SUD
Inpatient In-Network and Outpatient In-Network	1. Applicable state regulatory requirements 2. CMS/Medicare Advantage Network Adequacy Criteria Guidance	1. Applicable state regulatory requirements 2. CMS/ Health Services Deliver (HSD) Table

[1] https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and

Benefit Classification	**Process Description Medical/Surgical**	**Process Description: Mental Health/Substance Use Disorder**
Inpatient In-Network and Outpatient In-Network	**Process**: The Plan assesses network adequacy based on access standards that are in accordance with Centers for Medicare & Medicaid Services and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), the Plan considers Network adequacy and access reports, which	**Process**: OBHS assesses network adequacy based on access standards that are in accordance with Centers for Medicare & Medicaid Services and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), OBHS considers Network adequacy and access reports, which standards are based by the Centers for Medicare & Medicaid

	standards are based by the Centers for Medicare & Medicaid Services. Network adequacy and access reports are prepared on a regular basis (no less than quarterly) and shared with the Plan's network teams for recruitment purposes to ensure regulatory network access requirements are met. If the Plan determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by stated or federal requirements, the Plan will actively seek to add providers to the network in that specialty or provider type If there is a supply gap, we allow members to seek an exception and receive services from an out-of-network provider at the in-network benefit level via Single Case Agreements. Access to out-of-network provider at the in-network benefit level (Single Case Agreement) is determined by the availability of an in-network provider within the geographic standards (time or distance) and appointment availability of an in-network provider within the time standards. If a Member obtains Prior Authorization for Covered Services from an Out-of-Network Provider due to an access gap, OMC will approve the Covered Services at the same Member cost-sharing as if the services were rendered by an In-Network Provider. When an In-Network Provider cannot meet the Member's health care needs, the Member should contact the Member's Concierge team. The Concierge team Care Guide will verify that there is no available In-Network	Services. Network adequacy and access reports are prepared on a regular basis (no less than quarterly) and shared with OBHS network teams for recruitment purposes to ensure regulatory network access requirements are met. If OBHS determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by stated or federal requirements, OBHS will actively seek to add providers to the network in that specialty or provider type. If there is a supply gap, plan language allows members to seek an exception and receives services from an out-of-network provider at the in-network benefit level via a Single Case Agreement. Access to out-of-network provider at the in-network benefit level (Single Case Agreement) is determined by the availability of an in-network provider within the geographic standards (time or distance) and appointment availability of an in-network provider within the time standards. If a Member obtains Prior Authorization for Covered Services from an Out-of-Network Provider due to an access gap, OHBS will approve the Covered Services at the same Member cost-sharing as if the services were rendered by an In-Network Provider. If a member is unable to identify an In-Network provider to meet their needs, OBHS will assist the Member in finding a Network Provider. If it is confirmed that an In-Network provider is unavailable, OBHS will assist the Member in obtaining services from an out-of-network provider at the in-network benefit level via a Single Case Agreement.

	Provider that can meet the Member's needs. Once the Care Guide has confirmed that the In-Network Provider cannot meet the Member's needs, the Care Guide will escalate the Member's request to the Navigation team. The Navigation team will verify whether In-Network Providers are available to meet the Member's needs within the access standards. If there is no In-Network Provider available, the Navigation team will refer to the Member's request for Out-of-Network approval. The Plan also considers Single Case Agreement volume and out-of-network utilization to identify and prioritize areas where we can attempt to contract with these providers or other providers in the area or that provide the items or services. The Plan's Sales team may also notify the network team about a customer requests to contract with a specific provider. In response, the network team will review adequacy and access reports and determine whether there are available in-network alternatives, whether it's necessary to expand or enhance the network panel and pursue a contract with the provider, as appropriate. **The following include strategies for provider recruitment:** *Claims Data Outlier Analysis*	The OBHS Sales team may also notify the network team about a customer request to contract with a specific provider. In response, the network team will review adequacy and access reports and determine whether there are available in-network alternatives, whether it's necessary to expand or enhance the network panel and pursue a contract with the provider, as appropriate. **The following include strategies for provider recruitment:** *Claims Data Outlier Analysis* Review of out-of-network utilization is performed monthly and presented to a monthly committee for review.[4] When reviewing historical out-of-network claims utilization per 1k members, **a series of 3 or more points above the mean will prompt a root cause analysis and potential improvement plan.** A rolling 12 or 24 month control chart is used to make these determinations. Out-of-Network utilization is assessed by product and state and is analyzed at the specialty level by member counties when an issue is identified. *Single Case Agreement (SCA) and/or Gap Exception reports* Single-Case Agreements are reviewed under the out-of-network utilization analysis described above. Review of out-of-network utilization is performed monthly and presented to a monthly committee for review.[5] When reviewing historical out-of-network claims utilization per 1k members, a series of 3 or more points above the mean will

[4] Network Performance Steering Committee consists of members from Data Science (Vice President and Director level), P&L (Regional Vice President level), InsurCo (Vice President and Director level), Network Strategy (Director level), Network Optimization (Director level), Market Insights (Director level), Regional Medical Directors (MD level), National Contracting

[5]

	Review of out-of-network utilization is performed monthly and presented to a monthly committee for review.[2] When reviewing historical out-of-network claims utilization per 1k members, **a series of 3 or more points above the mean will prompt a root cause analysis and potential improvement plan.** A rolling 12 or 24 month control chart is used to make these determinations. Out-of-Network utilization is assessed by product and state and is analyzed at the specialty level by member counties when an issue is identified. *Single Case Agreement (SCA) and/or Gap Exception reports* Single-Case Agreements are reviewed under the out-of-network utilization analysis described above. Review of out-of-network utilization is performed monthly and presented to a monthly committee for review.[3] When reviewing historical out-of-network claims utilization per 1k members, a series of 3 or more points above the mean will prompt a root cause analysis and potential improvement plan. A rolling 12 or 24 month control chart is used to make these determinations. Out-of-Network utilization is assessed by product and state and is analyzed at the specialty level by member counties when an issue is identified. *Member access complaint data* The member access complaint is documented with one of the following	prompt a root cause analysis and potential improvement plan. A rolling 12 or 24 month control chart is used to make these determinations. Out-of-Network utilization is assessed by product and state and is analyzed at the specialty level by member counties when an issue is identified. *Member access complaint data* The member access complaint is documented with one of the following subtags dependant upon the provider type: ● Insufficient in-network PCP options (excl. BH) ● Insufficient in-network specialist options (excl. BH) ● Insufficient in-network DME options ● Insufficient in-network Hospital / Facility options ● Insufficient in-network Behavioral Health provider options ● Insufficient in-network Pharmacies When member access complaints are identified, they are escalated to the network team to identify opportunities for recruitment.

[2] Network Performance Steering Committee consists of members from Data Science (Vice President and Director level), P&L (Regional Vice President level), InsurCo (Vice President and Director level), Network Strategy (Director level), Network Optimization (Director level), Market Insights (Director level), Regional Medical Directors (MD level), National Contracting

[3]

	subtags dependant upon the provider type: ● Insufficient in-network PCP options (excl. BH) ● Insufficient in-network specialist options (excl. BH) ● Insufficient in-network DME options ● Insufficient in-network Hospital / Facility options ● Insufficient in-network Behavioral Health provider options ● Insufficient in-network Pharmacies When member access complaints are identified, they are escalated to the network team to identify opportunities for recruitment.	
	Oscar's Quality of Member Experience Subcommittee reviews network adequacy data inclusive of mental health and medical/surgical providers, no less than quarterly, including GeoAccess Reports, out-of-network utilization trends, gap exceptions, enrollee access complaints, and/or enrollee satisfaction with access survey results. This review pertains to network adequacy assessments for both medical/surgical services and mental health/substance use disorder services. Oscar's Quality of Member Experience Subcommittee's includes representatives (Director level and above) from: ● Care Delivery and Clinical Concierge Services ● Claims Production ● Clinical Review Team Operations ● Configuration and Support ● Complaints, Grievances and Appeals ● Quality Improvement ● Member Services Operations, esp. Concierge Services ● Network Strategy and Growth ● Insurance Operations ● Operational Compliance ● Regulatory Operations ● Product & Design ● Marketing ● Pharmacy	

- Regional Medical Directors

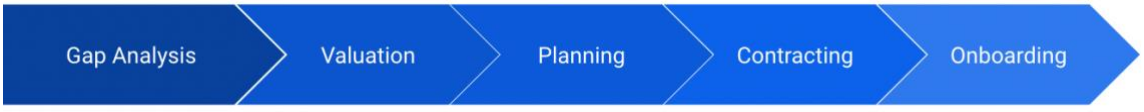
Oscar's Quality of Member Experience Subcommittee surfaces areas where there are network inadequacies in quarterly and annual reports, and then works to understand the underlying issues through root-cause and barrier analyses developed in collaboration between business owners and the Quality Department. The Plan works with the regional network team to determine where there are actionable and inactionable gaps in the network and to highlight opportunities for improvement. In actionable areas, the Plan fills those gaps through recommended actions; and in inactionable areas, the Plan develops the right strategies to mitigate when a member's need arises.

Network Adequacy determinations for medical/surgical and mental health/substance use disorder benefits have a similar process in place which includes the preparation of network adequacy reports on at least a quarterly basis to ensure regulatory access requirements are met. For both M/S and MH/SUD, when a deficiency is detected, there may be exceptions made for a member to seek care with a provider not currently in-network. For both med/surg and MH/SUD, where there is a supply gap detected, there are processes in place to remediate these gaps by contracting with the appropriate providers and services to fulfill the network need.

Network Adequacy Monitoring results

State	BH gaps	M/S gaps	Total
GA	0	15	15
*Gap = county/specialty does not meet regulatory adequacy standards			

The plan takes the following steps address network adequacy gaps:



Gap Analysis: Oscar's provider network is analyzed for compliance with internal and regulatory requirements.

Valuation: Network deficiencies are prioritized and assigned.

	Planning: The provider network team defines the network strategy and identifies contracting or operational opportunities within network design parameters for remediating deficiencies. **Contracting: The provider network team negotiates mutually agreeable contracts with providers as necessary.** **Onboarding: Providers are onboarded into Oscar's system and network by Provider Relations.**

5. The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements:

Benefit Classification	Process Description
Inpatient In-Network and Outpatient In-Network	The network adequacy process for MH/SUD benefits and M/S benefits are aligned. The Plan and OBHS assess network adequacy based on access standards that are in accordance with Centers for Medicare & Medicaid Services and/or applicable state laws. Further, network adequacy reports are prepared on a quarterly basis to inform recruitment practices. For both MH/SUD and M/S benefits, if there is a supply gap, members may seek an exception and receive services from an out-of-network provider at the in-network benefit level via Single Case Agreements. The availability of an in-network provider is evaluated the same and takes into account time/distance standards and appointment availability standards. The Plan and OBHS employ the same strategies which consists of: 1. Claims data outlier analysis; 2. Gap exception analysis reports; and 3. Member access complaint data analysis to inform provider recruitment. A comparison of the factors, evidentiary standards and source information used to determine network adequacy for medical/surgical services and mental health/substance use disorder reveals that the underlying methodology by which network adequacy is established is comparable and applied no more strictly to mental health/substance use disorder benefits.

	For network adequacy for both medical/surgical and mental health/substance use disorder benefits, the same factors are considered which include state specific standards and CMS. Additionally, similar evidentiary standards and sources are used to support the factors which include state regulatory requirements and CMS Network Adequacy criteria guidance. Operationally, the plan performs data analysis to compare network adequacy gaps for each state by reviewing network adequacy gaps for MH/SUD providers and M/S providers. Network Adequacy gaps are defined as a county or specialty that does not meet regulatory adequacy standards. For Georgia, there were fifteen gaps reported for M/S providers and 0 gaps reported for MH/SUD providers in 2021. When measured in the same manner, there are more gaps identified for M/S providers when compared to MH/SUD providers in Georgia. For gaps identified, the Plan follows the steps described in Step 4 above which include an assessment of the gap, valuation, planning, contracting, and onboarding. This methodology is utilized for both M/S network gaps and MH/SUD network gaps. Therefore, in-operation, network adequacy methodology for mental health/substance use disorder providers is comparable to, and applied no more stringently than network adequacy methodology for medical/surgical providers. **Findings/Conclusion**: The findings of the comparative analysis reveal that the process and methodology to assess network adequacy for mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology used to assess network adequacy for medical/surgical services.

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Prior Authorization Pharmacy
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Formulary Design and Strategy
Names of Person(s) Responsible for Analysis Formation	Kemper May, PharmD, Manager, Formulary Operations (Six years experience in Pharmacy at a Health Plan) Jeenal Patel, PharmD, Senior Clinical Formulary Pharmacist (Eight years Pharmacy experience, two of which were dedicated to Pharmacy at a Health Plan)
Last Update	9/1/2022
Reviewers	Alexandra Rubino, MPH, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Prior Authorization- Pharmacy

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

Medical/Surgical Terms	Mental Health/Substance Use Disorder Terms
Prior authorization (PA) is an utilization management process used by the health plan to determine if a prescribed medication will be covered. This process ensures that the requested medication is clinically appropriate to achieve a positive outcome for the member. Prior authorization is applied to a subset of formulary drugs and formulary exceptions to ensure the medication is medically necessary. The claim will not be eligible for reimbursement if the prior authorization request does not meet the criteria set forth by the health plan. Additionally, the use of non-formulary products for any indication that is not supported by the FDA or compendia is considered not medically necessary by the Plan, as it is deemed to be experimental, investigational, or unproven. Please note the implementation of a prior authorization edit should not cause delay of care or have an impact on, impede or prevent emergency or urgent access to medication.	Prior authorization (PA) is an utilization management process used by the health plan to determine if a prescribed medication will be covered. This process ensures that the requested medication is clinically appropriate to achieve a positive outcome for the member. Prior authorization is applied to a subset of formulary drugs and formulary exceptions to ensure the medication is medically necessary. The claim will not be eligible for reimbursement if the prior authorization request does not meet the criteria set forth by the health plan. Additionally, the use of non-formulary products for any indication that is not supported by the FDA or compendia is considered not medically necessary by the Plan, as it is deemed to be experimental, investigational, or unproven. Please note the implementation of a prior authorization edit should not cause delay of care or have an impact on, impede or prevent emergency or urgent access to medication.

Plan/Coverage Terms:
<u>Coverage Terms (Evidence of Coverage):</u> Prior Authorization for Prescription Drugs: Prior Authorization is required for certain prescription drugs and related supplies. For complete, detailed

information about prescription drug authorization procedures, exceptions and Step Therapy, please refer to the PHARMACY BENEFITS section of this Plan. To verify Prior Authorization requirements for prescription drugs and supplies, including which prescription drugs and supplies require Authorization.

You can call Member Services at 1-855-672-2755 or search for medications on Our website at www.hioscar.com

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which theNQTL applies
Pharmacy	All other drug classes on formulary which are not listed under the MH/SUD category. A list of medications requiring prior authorization may be found here: https://www.hioscar.com/search-documents/drug-formularies/	A list of medications requiring prior authorization may be found here: https://www.hioscar.com/search-documents/drug-formularies/

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Medical Surgical and Mental Health/Substance Use Disorder Factors, Sources, and Evidentiary Standards:

Factor	Sources	Evidentiary Standards/Thresholds
Average ingredient cost for a 30 day supply for generics vs brand drugs	Pharmacy claims data	Thresholds: (generics vs brands) Generic drugs with an average 30-day ingredient cost of ~$3,000 or higher require a PA.

		Brand drugs with an average 30 day cost of ~$3700 or higher require a PA.
Clinical Appropriateness	Clinical criteria ● Plan Clinical Guidelines ● CVS Caremark Clinical Guidelines ● MCG Clinical evidence 1) The US National Library of Medicine; 2) Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN) 3) UpToDate 4) National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)	Clinical Appropriateness is applicable when evidence-based criteria is required to confirm the drug is (a) medically necessary, (b) delivered in the appropriate setting or level or care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as diagnosis, specialist care, and duration. Examples: 1) As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of cancer and individualized needs as documented in the medical record. 2) As per the American Psychological Association (APA), concurrent or planned course of therapy or counseling [e.g., interpersonal psychotherapy, cognitive-behavioral therapy, dialectical behavior therapy] is appropriate prior to requesting pharmacological treatment in binge eating disorder
Regulatory Requirements - Certain prescription drugs are mandated to be covered as essential health benefits; drug formularies are often regulated at the state	Government regulations/state legislation websites, memos, bulletins	Examples include but are not limited to: 1) ACA: The Affordable Care Act mandates that health plans cover recommended preventive services without charging a deductible, copayment, or co-insurance (at the lowest tier: Tier 0)

level regarding utilization management edits such as prior authorization		2) Orally Administered Chemotherapy: Oscar covers orally administered chemotherapy for the treatment of cancer on a basis no less favorable than the intravenously administered or injected chemotherapy regardless of the formulation or benefit category determination by Oscar. Oscar may meet this requirement by limiting the total amount paid by a Member through Member Cost Sharing to no more than $200.00 per filled prescription for any orally administered chemotherapy. 3) Drug Coverage of Contraceptives: Oscar will not impose upon any person receiving prescription contraceptive benefits: Copayment, coinsurance payment, or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level or copayment level, receiving benefits for prescription drugs; or reduction in allowable reimbursement for prescription drug benefits. ***Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.*
Manufacturer Trade Agreements	CVS CFC Team - Proprietary Trade Agreements	Manufacturers may offer competitive rebates in order for the Health Plan to employ the lowest net cost strategy for both the plan and members. As a result, manufacturers in certain instances may dictate if a prior authorization is allowed in order to offer competitive pricing. Example A: GLP-1s, DPP-IVs, and SGLT-2 inhibitors are <u>not</u> allowed to

		have prior authorization edits. Example B: The Hepatitis C category must treat all drugs at parity with regards to UM edits such as prior authorization.
Non-formulary status	Formularies posted on web: https://www.hioscar.com/search-documents/drug-formularies/	Prior authorization is applied to all non-formulary drugs as a basis to review for medical necessity to ensure available formulary alternatives have been tried (if appropriate), the medication is being used for a FDA or compendia supported indication and up-to-date chart notes along with relevant labs/imaging/test results have been provided. Non-formulary status is an independently determinative factor and it is not weighted against other factors.

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits:

Prior Authorization Process M/S	**Prior Authorization Process MH/SUD**
Process: The prior-authorization process is part of the Utilization Management (UM) activities and is an assessment performed to determine if the request for the prescription drug meets the plan's criteria for coverage. The Plan maintains a list of services that require prior authorization. This list is available on request by phone, by provider portal, or via the published formularies online. Authorizations can be submitted via phone, fax, or online through Oscar's provider portal. When a prior authorization request is submitted, it is reviewed by licensed clinicians to determine if the request meets medical necessity. Clinicians utilize the Plan's policies and established, evidence based clinical criteria to determine if the request meets coverage determinations and/or medical necessity. Licensed clinicians (e.g., physicians and pharmacists) review authorization requests; in most states, pharmacists can make adverse determinations. However, in all Oscar states, only appeals can be denied by a licensed physician.	

The Plan requires the requesting provider to submit the following information when requesting an authorization:

- Member information (name, Plan ID, date of birth).
- Diagnosis, previous history of medications used to treat the condition and the outcome (if applicable), up-to-date chart notes, relevant test results and labs, requested amount and length of treatment(s).

Both the providers and members are notified of the determination consistent with state, federal and accreditation requirements and applicable appeal rights are provided.

For each committee used to determine which benefits to subject to Prior Authorization, describe the committee's purpose, composition and member qualifications, and process:

Committee Information M/S	Committee Information MH/SUD

Description: Pharmacy & Therapeutics Committee (P&T Committee)

Purpose:
Oscar's Pharmacy and Therapeutics (P&T) Committee promotes the safe and appropriate use of cost-effective pharmaceuticals for members. The committee operates in compliance with NCQA standards and state/federal regulations for Oscar's individual, small group, and self-insured drug formularies in all states. The committee regularly reviews new drugs, drug classes, new drug indications, and new safety information. Policies & Procedures for pharmaceutical management and all formularies are reviewed at least annually.

Structure:
Oscar's P&T Committee commences at least quarterly and reports to the Utilization Management Committee. At least fifty percent of Oscar's ten voting members must be present to establish a quorum. Committee members represent a sufficient number of clinical specialties to adequately meet the needs of members. At least two-thirds of members are practicing physicians (MD/DO), practicing pharmacists (PharmDs), and other practicing health care professionals (RNs) who are licensed to prescribe drugs. At least one member shall be a pharmacist. Committee Chairs are appointed annually by Oscar's Vice President of Pharmaceuticals. Membership changes are reported to CMS during the contract year. Members complete a Conflict of Interest and Non-Disclosure Agreement, annually.

Voting Members	Qualifications
VP Medical Director	Licensure: Medical Doctor Specialty: Internal Medicine

External Member	Licensure: Medical Doctor Speciality: Rheumatology
External Member	Licensure: PharmD
External Member	Licensure: Pharm D Specialty: Infectious disease
External Member	Licensure: Medical Doctor Specialty: Family Practice
Senior Director, Data Science	Data Science
Senior Medical Director	Licensure: Medical Doctor Specialty: Family Practice
Director, Clinical Pharmacy Operations	Licensure: PharmD
External Member	Licensure: Medical Doctor and Masters of Public Health Specialty: Preventive Medicine
External Member	Specialty: Psychiatry

Responsibilities:
The Committee will develop and document procedures to ensure appropriate drug review and inclusion on Oscar's formularies. Minutes reflect the rationale for all decisions regarding formulary drug list development or revision. Clinical decisions will be based on the strength of scientific evidence and standards of practice, including: assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and the therapeutic advantages of drugs in terms of safety and effectiveness. The committee will review policies that guide exceptions and other utilization management processes, including prior authorization criteria, step therapy protocols, quantity limit restrictions, drug utilization review, and therapeutic interchange. The Committee ensures that Oscar's formulary covers a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states, and does not discourage enrollment by any group of enrollees. The committee provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

Internal oversight of the P&T Committee:
The Board of Directors oversees the implementation of and adherence to the UM Program through the UM Subcommittee. The UM Subcommittee reports to the Quality Improvement Committee at a minimum of once

per quarter, per year. The P&T minutes are approved at the UM Subcommittee portion of the Quality Improvement Committee meeting. Minutes conveying this approval are submitted to the Board of Directors, who approve the actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical).

As noted above, the UM Subcommittee is a sub-committee to the Quality Improvement Committee. A senior-level physician chairs the UM Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary.

The UM Subcommittee undertakes, but is not limited to, the following ongoing activities:

- Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated.
- Reviews and approves modifications to the UM Program as indicated by operational needs and/or to meet regulatory and accreditation compliance.
- Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services.
- Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.

***Briefly describe the processes by which prior authorization is applied*:**

Benefit Classification	**Process Description: Medical/Surgical**	**Process Description: MH/SUD**
Pharmacy	**Timeline and deadlines for review and approval:** *Urgent Prior Authorizations*: Urgent PA decisions should be rendered within 72 hours of receipt of a complete urgent request. If an urgent request is incomplete, information should be requested within 24 hours of request receipt. Provider has a pending period of 48 hours to provide the additional information. If additional information is received, a decision should be rendered within 48 hours of receipt of additional information. If no information is received, a decision should be rendered within 48 hours of the pending period expiring. If an urgent request is for an expedited formulary exception request, decision should be rendered within 24 hours of receipt of the request. This TAT applies to both	

	complete and incomplete NF exception requests. There are no extensions or pend times for NF exception requests. This is a federal & state requirement. *Non-Urgent Prior Authorizations*: If a non-urgent PA is complete, a decision should be rendered within 15 business days of receipt of the request. If the PA request is incomplete, Oscar should request information within 15 business days. Provider has a pending period of 45 calendar days to provide the additional information. If additional information is received, a decision should be rendered within 15 business days of receipt of additional information. If no information is received, a decision should be rendered within 15 calendar days of the pending period expiring. For a standard formulary exception request, a decision should be rendered within 72 hours of receipt of the request. This TAT applies to both complete and incomplete NF exception requests. There are no extensions or pend times for NF exception requests. This is a federal & state requirement. *Appeals*: Urgent appeals should have a decision rendered within 72 hours from receipt of request, whichever is shorter. Non-urgent appeals should have a decision rendered within 30 calendar days of receipt of request. **Forms and/or other information required to be submitted by the provider:** The Plan will collect only information necessary to make a utilization review determination. During prior and concurrent reviews, only the necessary and relevant section of medical records will be requested, as needed to verify medical necessity. All records are maintained electronically in the Plan's PHI-compliant systems. Any PHI is protected as per the Plan's HIPAA and PHI protection policies. In no event will information obtained by the Plan be used by persons other than health care professionals, medical record technologists, or personnel who have been appropriately trained. **UM manuals and any other documentation of UM processes that are relied upon to make a determination:** The Plan conducts a full investigation of each request, taking into consideration all documents, clinical records, and other information submitted. In all cases, pharmacist and physician reviewers adhere to the clinical criteria and guidelines outlined in the Plan’s UM Plan. **Qualifications of UM reviewers:** Licensed clinicians (e.g., pharmacists and medical directors) review authorization requests; only board certified pharmacists and physicians can make adverse determinations based on the specific state exchange. Clinical reviewers must have an

	active unrestricted professional license in a state or territory of the United States, and within scope of practice relevant to the clinical area they are reviewing. **Minimum standards to issue a denial (e.g., sign-off from a physician with relevant board certification):** When a prior authorization request is submitted, it is reviewed by licensed clinicians to determine if the request meets medical necessity. Clinicians utilize the Plan's policies and established, evidence based clinical criteria to determine if the request meets coverage determinations and/or medical necessity. Licensed clinicians (e.g., pharmacist and physicians) review authorization requests and can make adverse determinations based on the market.

Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization

Pharmacy	As-written, the underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to mental health and substance use disorder (MH/SUD) benefits and to medical/surgical (M/S) benefits have led the Plan to conclude compliance with MHPAEA for the following reasons: The factors that determine whether a drug is subject to prior authorization requirements are the same for both MH/SUD drugs and M/S drugs. The factors that determine whether prior authorization is applied to a drug are the following: average ingredient cost for a 30-day supply for generics v. brand drugs, clinical appropriateness, regulatory requirements, manufacturer trade agreements, and non-formulary status. The plan also uses the same evidentiary standards and sources to determine the thresholds and supporting information for the aforementioned factors across all drug types (M/S and MH/SUD). There is no discrepancy between the factors, evidentiary standards, sources, and processes used to determine if a drug is subjected to prior authorization because all drugs, regardless of drug-type, are subject to the same underlying methodology. However, the Plan has conducted in-operation quantitative analyses below to quantify the extent to which a discrepancy may exist for prior authorization application operationally. The methodology for prior authorization is applied consistently across all drugs and drug classes and does not discriminate against individuals based on medical/surgical condition, mental health/substance use disorder diagnosis, or other health conditions. Any pharmacy coverage factors, processes, development or implementation strategies, and evidentiary standards applied to drugs used to treat mental health or substance use disorder are comparable to, and are applied no more stringently than the coverage factors, processes, development or implementation strategies,

evidentiary standards used in applying the limitations to drugs used to treat medical or surgical disorders as evidenced by the above as-written NQTL analysis.

Operationally, the Plan performs in-operation data assessments to make sure that factors, sources, and evidentiary standards are applied in a consistent manner. For utilization management for Pharmacy, the Plan uses a logistic regression[1] that models the probability that a given on-formulary, non-specialty drug is subject to utilization management (either step therapy or prior authorization). If the coefficient on the indicator for BH drugs is positive and statistically significant, that is evidence that BH drugs are more likely to face UM restrictions.

Findings:

	PA	
state	p_value	coef
GA	0.71	0.25

The p-value is greater than 0.05. The standard interpretation of this is that there's no statistical evidence that MH/SUD drugs are more or less likely to have an application of prior authorization.

Table 3 - Proportion of drugs subject to PA

Condition	Total # subject to PA	% subject to PA
MH	94	2%
SUD	61	6%
M/S	2709	11%

Prior Authorization Analysis:

The Plan evaluates the proportion of drugs subject to prior authorization for mental health drugs (MH), substance use disorder drugs (SUD) , and medical/surgical (M/S) drugs. When the factors for prior authorization are considered consistently across all drug types, the outcome shows that prior authorization is applied to a varying

[1] Logistic regression is a mathematical model used in statistics to estimate the probability of an event occurring having been given some previous data. It is a generalized version of drawing a best fit line to understand the relationship between different data points.

	proportion of drugs across MH, SUD, and M/S categories. Prior authorization is applied to: ● 11% of the drugs in the Medical/Surgical category. ● 2% of the drugs in the Mental Health category. ● 6% of the drugs in the Substance Use Disorder category.

Step 5. Provide the specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

Pharmacy	The 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 for the following reasons: The Plan conducted a comparative analysis to determine which Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) services are subject to prior authorization "as written." The factors, evidentiary standards, sources, and processes for applying prior authorization to medical/surgical drugs are the same as the factors, evidentiary standards, sources, and processes for applying prior authorization to mental health/substance use disorder drugs. Conclusions: Operationally,the Plan performs in-operation data assessments for prior authorization procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across med/surg and MH/SUD services. Operationally, there is no statistical evidence that MH/SUD drugs are more or less likely to have utilization management requirements. Further, when assessing the proportion of drugs subject to prior authorization requirements, a higher proportion of M/S drugs are subject to prior authorization when compared to MH drugs and SUD drugs. This reveals that prior authorization requirements are not applied more stringently to MH and SUD drugs when compared to M/S drugs in-operation. The findings of the comparative analysis reveal that the process and methodology to apply prior authorization to mental health/substance use disorder drugs is comparable to, and applied no more stringently than, the process and methodology used to apply prior authorization to medical/surgical drugs.

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Provider Reimbursement
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Contracting
Names of Person(s) Responsible for Analysis Formation	Oscar's Manager of Contracting Strategy & Analytics in collaboration with Optum Behavioral Health Solutions
Last Update	7/19/2022
Reviewers	Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Provider Reimbursement: Professional Services

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

General Description/Explanation of the NQTL:
Strategy: Optum Behavioral Health Services (OBHS) and Oscar Insurance Company use the methodologies described below to establish reimbursement for professional service providers. **Process:** Using the factors described below, OBH and Oscar Insurance Company establish base reimbursement for providers. If the provider rejects the reimbursement, then OBH and OHI may negotiate with the provider using the factors described in the steps below.

Benefit Classification	**Medical/Surgical Services to which the NQTL applies**	**Mental Health/SUD Services to which the NQTL applies**
Professional Services Subject to In-Network Provider Reimbursement Methodology	In-network professional services rendered by licensed medical professionals, e.g., primary care providers, surgeons, endocrinologists, etc.	In-network professional services rendered by independently licensed behavioral health care professionals, e.g., psychotherapy, medication management, etc.
Professional Services Subject to Out-of-Network Provider Reimbursement Methodology	N/A Plan does not have OON benefits	N/A Plan does not have OON benefits
Emergency	OON Emergency Care rendered by independently licensed behavioral health care professionals	OON Emergency Care rendered by independently licensed behavioral health care professionals

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
Professional Services Subject to In-Network Provider Reimbursement Methodology	1. Provider type (e.g., physician vs. non-physician) and/or specialty including provider licensure, board certification, education, and training 2. Services and/or procedures provided along with relevant modifiers 3. CMS reference with locality 4. Market dynamics including: o Adequacy standards o Provider leverage o Network need o Provider member volume o Internal agreements rate 5. Market benchmark rates The factors are not weighted.	1. Provider type (e.g., physician vs. non-physician) and/or specialty including provider licensure, board certification, education, and training 2. Services and/or procedures provided 3. CMS Resource-Based Relative Value Scale (RBRVS) using Relative Value Units (RVUs) to define the value of the service or procedure relative to all services and procedures on the scale. The value of the service is based upon the following factors: o Provider Work (work) o Provider Expense (PE) o Provider Malpractice Insurance Expense (MP) o Geographic Practice Cost Indices (GCPI) o Conversion Factor (CF) 4. Market dynamics including: o Provider leverage o Network need o Provider member volume The factors are not weighted.
Professional Services Subject to Out-of-Network Provider Reimbursement Methodology	Not applicable	Not applicable

Emergency	See above for in-network reimbursement methodologies. Out-of-network reimbursement methodologies for out-of-network emergency care complies with all federal and state law (e.g., No Surprises Act)	See above for in-network reimbursement methodologies. Out-of-network reimbursement methodologies for out-of-network emergency care complies with all federal and state law (e.g., No Surprises Act)

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Benefit Classification	**Evidentiary Standards: Medical/Surgical**	**Evidentiary Standards: MH/SUD**
Professional Services Subject to In-Network Provider Reimbursement Methodology	1. The provider type and/or specialty is assessed based upon the provider's credentials, licensure, board certification, education, and training 2. Most current versions of industry standard code sets, e.g., CPT, HCPCS, etc. 3. CMS locality-specific Fee Schedules 4. • **Adequacy standards:** Regulatory adequacy standards (CMS) that define the need of certain specialties • **Provider leverage:** Providers owned or employed by large health systems within a given geographic market have more leverage than those who are not, e.g., solo practitioner.	1. The provider type and/or specialty is assessed based upon the provider's credentials, licensure, board certification, education, and training 2. Most current versions of industry standard code sets, e.g., CPT, HCPCS, etc. 3. The CMS RVU for a given service or procedure is derived using the following mathematical formula: (work RVU x work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI) x CF = CMS benchmark rate • Work = Provider work reflects the provider's work when performing a procedure or service including provider's technical skills, physical effort, mental effort and judgment, stress related to patient risk, and the amount of time required to perform the service or procedure.

	• **Network need:** Supply and demand for a provider type is evaluated by looking at the volume of network providers of the same or similar provider type within the relevant geographic region relative to the Plan's membership and its network access and/or availability standards. • **Provider member volume:** Measured by looking at the volume of members treated by the provider, and/or volume of services billed by the provider, in a given year relative to the same or similar provider types in the same geographic market during the same timeframe. • **Internal agreements rate:** Internally derived average market pricing based upon available data including claims data, state published rates, CMS PPS 5. Market benchmark rates are purchased from third party data sources in order to inform industry norms	• PE = Provider Expense reflects the costs for medical supplies, office supplies, clinical and administrative staff, and pro rata costs of building space, utilities, medical equipment, and office equipment. • MP = Malpractice Insurance expense reflects the cost of professional liability insurance based on an estimate of the relative risk associated with procedure or service. • CF = Conversion Factor • GPCI = Geographic Practice Cost Indices When there is no CMS RVU available for a given service or procedure, other rate-setting benchmark sources are used such as the FAIR Health Medicare GapFill Plus database. 4. • **Provider leverage:** Providers owned or employed by large health systems within a given geographic market have more leverage than those who are not, e.g., solo practitioner. • **Network need:** Supply and demand for a provider type is evaluated by looking at the volume of network providers of the same or similar provider type within the relevant geographic region relative to the Plan's membership and its network access and/or availability standards. • **Provider member volume:** Measured by looking at the volume of members treated by the provider, and/or volume of services billed by the provider, in a given year relative to the same or similar provider types in the same

		geographic market during the same timeframe.

Professional Services Subject to Out-of-Network Provider Reimbursement Methodology	Not applicable.	Not applicable.
Emergency	See above for in-network reimbursement methodologies. Out-of-network reimbursement methodologies for emergency care comply with all federal and state law (including the No Surprises Act)	See above for in-network reimbursement methodologies. Out-of-network reimbursement methodologies for emergency care comply with all federal and state law (including the No Surprises Act)

Benefit Classification	**Sources: Medical/Surgical**	**Sources: MH/SUD**
Professional Services Subject to In-Network Provider Reimbursement Methodology	1. Provider application 2. Most current version of industry standard code sets, e.g., CPT, HCPCS, etc. 3. CMS market price 4. • Provider research • Provider Directory; state GeoAccess reports • Provider claims data 5. Market benchmark rates are purchased from Truven	1. Provider application 2. Most current version of industry standard code sets, e.g., CPT, HCPCS, etc. 3. • Applicable CMS RVU • FAIR Health Medicare GapFill PLUS database 4. • Provider research • Provider Directory; state GeoAccess reports; member reported access data • Provider claims data
Professional Services Subject to Out-of-Network	Not applicable.	Not applicable.

Provider Reimbursement Methodology		
Emergency	See above for in-network reimbursement methodologies. Reimbursement methodologies comply with all federal and state law (including the No Surprises Act)	See above for in-network reimbursement methodologies. Reimbursement methodologies comply with all federal and state law (including the No Surprises Act)

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits:

Benefit Classification	Process Description
Professional Services Subject to In-Network Provider Reimbursement Methodology	The Plan conducted a comparison analysis of the factors, evidentiary standards, and source information used to determine provider reimbursement for medical/surgical and mental health/substance use disorder professional services "as written." Provider reimbursement for in-network services for both medical/surgical and mental health/substance use disorder considers the following factors: provider type, services provided, CMS resources and market dynamics. The same evidentiary standards are taken into account which include: provider licensure, services provided, CMS resources, market dynamics which include provider leverage, network need, and provider member volume, and third-party data sources that inform industry norms with respect to reimbursement rates. Additionally, the sources which define the factors for in-network reimbursement overlap and include: provider applications, the most up-to-date industry standard code sets, CMS resources, provider research, provider claims data, geo-access reports, and benchmark rates from third party resources. There are minor differences in the analysis: namely that member reported access data is used as a source for mental health/substance use disorder. This source is taken into consideration to ensure that behavioral health member needs and demand are met as behavioral health supply has historically been less robust than on the medical/surgical side across the health care industry. Additionally, for med/surg, market benchmark rates are

	a factor considered for reimbursement rates, while for mental health/SUD, market benchmark rates are used as a source to support the factors that determine provider reimbursement. Since market benchmark rates are taken into consideration for the reimbursement rate methodology for both MH/SUD and M/S, the underlying processes are comparable. The Plan adheres to state and federal requirements regarding out-of-network reimbursement across medical/surgical and mental health/substance use disorder services. Further, the Plan conducted a comparison analysis using the allowed amounts for common CPT codes paid to medical/surgical providers and mental health/substance use disorder providers relative to 2021 CMS rates to assess whether the methodology used to reimburse mental health/substance use disorder providers is comparable to and applied no more stringently than the methodology used to reimburse medical/surgical providers.

Step 5. The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

Benefit Classification	Process Description
Professional Services Subject to In-Network Provider Reimbursement Methodology	The 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 for the following reasons: 1. Provider reimbursement for professional services for both medical/surgical and mental health/substance use disorder considers the same following factors: provider type, services provided, CMS resources, and market dynamics. 2. Sources and evidentiary standards are aligned with the exception of member reported access data that is used as a source for mental health/substance use disorder. This source is taken into consideration to ensure that behavioral health member needs and demand are met as behavioral health supply has historically been less robust than on the medical/surgical side across the health care industry. 3. Operationally, the Plan conducted a comparison analysis using the allowed amounts for common CPT codes paid to medical/surgical

	providers and mental health/substance use disorder providers relative to 2021 CMS rates to assess whether the methodology used to reimburse mental health/substance use disorder providers is comparable to and applied no more stringently than the methodology used to reimburse medical/surgical providers. **Findings:** The findings of the analysis confirms that the factors, sources, and evidentiary standards used to determine provider reimbursement rates for medical/surgical services, are aligned with the factors, sources, and evidentiary standards used to determine provider reimbursement rates for mental health/substance use disorder services as-written. The Plan conducted a comparison analysis using the allowed amounts for common CPT codes paid to medical/surgical providers and mental health/substance use disorder providers relative to 2021 CMS rates to assess whether the methodology used to reimburse mental health/substance use disorder providers is comparable to and applied no more stringently than the methodology used to reimburse medical/surgical providers. In the Plan's analysis, the claims sample size was too small to derive a representative metric (this threshold is measured by having <50 claims) to make this comparison. While outcomes are not determinative of parity non-compliance, the outcomes act as a warning sign to ensure that the underlying methodology for provider reimbursement is aligned for M/S and MH/SUD. It was determined by the non-quantitative treatment limitation analysis that the process and methodology used to determine and negotiate mental health/substance use disorder professional reimbursement rates in-operation is comparable to and applied no more stringently than the process and methodology used to negotiate medical/surgical professional reimbursement rates. Therefore, the provider reimbursement methodology for mental health/substance use disorder services is comparable to and applied no more stringently than the provider reimbursement methodology for medical/surgical services.

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Step Therapy
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Pharmacy
Names of Person(s) Responsible for Analysis Formation	Jeenal Patel, PharmD, Senior Clinical Formulary Pharmacist (Eight years Pharmacy experience, two of which were dedicated to Pharmacy at a Health Plan) Kemper May, PharmD, Manager, Formulary Operations (Six years experience in Pharmacy at a Health Plan)
Last Update	9/1/2022
Reviewers	Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)

Non-Quantitative Treatment Limitation (NQTL) Analysis for the Mental Health Parity and Addiction Equity Act (MHPAEA)

Step Therapy (Pharmacy)

1. **Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply:**

General Description/Explanation of the NQTL:
Step Therapy (ST) is a pharmacy UM strategy typically employed in therapeutic classes with broad generic availability. ST is generally used to promote the use of the most cost-effective products in the therapeutic class, provided efficacy and safety are equivalent, and therefore, the decision to implement is largely based on the cost of brand products and the potential for reduced cost with greater utilization of generics and/or lower cost brands. Utilization management criteria are developed based upon published clinical evidence supporting the different uses of a drug and coverage conditions are not affected or altered by the medication's intended area of utilization. Step therapy protocols require that alternative drugs be tried first, when clinically warranted, and for a certain duration before the prescribed drug can be covered by a plan. A prior authorization or exceptions process is available when the protocol is not satisfied, to collect information so that coverage consistent with the conditions included by the step therapy protocol can be evaluated and coverage determined under the benefit, based on medical necessity, can be made. Messaging is provided to the dispensing pharmacy advising that the plan's step therapy protocols require alternative drugs first before the prescribed drug will be covered.

Plan/Coverage Terms:
<u>Coverage Terms (Evidence of Coverage):</u> **Step Therapy**: We sometimes require you to try an alternate drug before taking the one you were prescribed. Some medications, despite being prescribed by your Healthcare Provider, are covered by Oscar only after you have first tried a clinically appropriate alternative. Your pharmacist or Health Care Provider may refer to this as a 'Step Therapy Requirement'. Oscar uses our history of your previous prescriptions (via submitted pharmaceutical claims) to automatically confirm if you have already tried the necessary alternative.

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies	Rationale/Comparability
Pharmacy	All other drug classes on formulary which are not listed under the MH/SUD category. A list of medications requiring step therapy may be found here: https://www.hioscar.com/search-documents/drug-formularies/	A list of medications requiring step therapy may be found here: https://www.hioscar.com/search-documents/drug-formularies/	

2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:

3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:

Medical Surgical and Mental Health/Substance Use Disorder Factors, Sources, and Evidentiary Standards:

Factor	Sources	Evidentiary Standards/Thresholds
Multiple dosage forms available for the same or similar chemical entities or availability of unique dosage forms	Medispan dosage form field indicator	Medications come in multiple dosage forms and the different dosage forms do not provide any additional clinical efficacy of the medication (e.g tablet vs. oral disintegrating tablet, vs. oral solution). Different dosage forms can provide easier administration but in most cases do not provide additional efficacy of the medication. Example: Tizanidine (2mg, 4mg, 6mg) tablets are much more cost effective with equivalent efficacy

		compared to Tizandidine capsules (2mg, 4mg, 6mg). Example: Brand only Quillivant XR (Methylphenidate Hydrochloride Extended Release Oral Suspension) vs generic methylphenidate extended release capsules/tablets have equivalent efficacy. Multiple dosage forms are assessed by evaluating clinical efficacy. **Clinical efficacy** is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. **Clinical effectiveness** is based on the evidence of clinical trials that the interventions are considered to be effective for the general population. *Evidentiary Standards:* The Plan measures efficacy by the below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition. Class I: "Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective. Class IIa: "Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy." Clinical Pharmacology Rating: ● Strength of Recommendation of "strong". ● Level of evidence rating of "High, Moderate" Or rating systems considering efficacy of regimen/agent is moderately effective such as NCCN definition of 2b evidence "Based upon lower-level evidence, there is NCCN consensus that the intervention

		is appropriate" or higher levels of efficacy.
Clinical Appropriateness	Clinical criteria ● Plan Clinical Guidelines ● CVS Caremark Clinical Guidelines ● MCG Clinical evidence 1) The US National Library of Medicine; 2) Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN) 3) UpToDate 4) National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)	Clinical Appropriateness is applicable when evidence-based criteria is required to confirm the drug is (a) medically necessary, (b) delivered in the appropriate setting or level or care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as diagnosis, specialist care, and duration. Examples: 1) For the treatment of binge eating disorder, it is appropriate to require documentation of trial and failure of 6 weeks of nonoperative therapy such as anti-inflammatory medications, epidural steroid injections, analgesics, or physical therapy according to the current clinical practice guidelines. 2) The ADA guidelines recommend the use of metformin prior to escalating to another therapeutic class (SGLT-2s, DPP-IVs, GLP-1s).
Regulatory Requirements - Certain prescription drugs are mandated to be covered as essential health benefits; drug formularies are often regulated at the state level regarding utilization management edits such as prior authorization	Government regulations/state legislation websites, memos, bulletins	1) ACA: The Affordable Care Act mandates that health plans cover recommended preventive services without charging a deductible, copayment, or co-insurance (at the lowest tier: Tier 0) 2) Orally Administered Chemotherapy: Oscar covers orally administered chemotherapy for the treatment of cancer on a basis no less favorable than the intravenously administered or injected chemotherapy regardless of the

		formulation or benefit category determination by Oscar. Oscar may meet this requirement by limiting the total amount paid by a Member through Member Cost Sharing to no more than $200.00 per filled prescription for any orally administered chemotherapy. 3) Drug Coverage of Contraceptives: Oscar will not impose upon any person receiving prescription contraceptive benefits: Copayment, coinsurance payment, or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level or copayment level, receiving benefits for prescription drugs; or reduction in allowable reimbursement for prescription drug benefits. ***Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.*
Manufacturer Trade Agreements	CVS CFC Team - Proprietary Trade Agreements	Manufacturers may offer competitive rebates in order for the Health Plan to employ the lowest net cost strategy for both the plan and members. As a result, manufacturers in certain instances may dictate if a prior authorization is allowed in order to offer competitive pricing. Example A: GLP-1s, DPP-IVs, and SGLT-2 inhibitors are <u>not</u> allowed to have prior authorization edits. Example B: The Hepatitis C category must treat all drugs at parity with regards to UM edits such as prior authorization.
Availability of therapeutic alternatives	Consensus documents and nationally sanctioned guidelines: Milliman Care	The P&T Committee will review the category/class to determine if an AB-

	Guidelines (MCG), Hayes, Inc., Up-To-Date Recognized drug compendia: US Pharmacopeia, Clinical Pharmacology, Lexicomp, Micromedex Publications of the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), and other organizations or government agencies Evidence-based reviews of peer-reviewed medical literature and relevant clinical information: American Journal of Medicine, SAMHSA, American Journal of Psychiatry, Journal of Clinical Oncology, NCCN etc. Standards of care recommended by clinical literature, medical or pharmacy societies, standard clinical drug references: Nexis, Orange Book, PubMed, UpToDate, JAMA, NCCN, American Heart Association, American Academy of Neurology Appropriate clinical drug information from other sources as applicable: FDA.gov, Clinicaltrial.gov, ASHP (American Society of Health-System Pharmacists)	rated drug with similar therapeutic efficacy and safety exists or if there is a unique indication or population that may benefit from the addition of the comparator product based on standards of practice, clinical guideline recommendation, and evidence-based reviews. Availability of therapeutic alternatives is assessed by evaluating clinical efficacy. **Clinical efficacy** is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. **Clinical effectiveness** is based on the evidence of clinical trials that the interventions are considered to be effective for the general population. *Evidentiary Standards:* The Plan measures efficacy by the below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition. Class I: "Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective. Class IIa: "Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy." Clinical Pharmacology Rating: ● Strength of Recommendation of "strong". ● Level of evidence rating of "High, Moderate" Or rating systems considering efficacy of regimen/agent is moderately effective such as NCCN definition of 2b evidence "Based upon lower-level evidence, there

		is NCCN consensus that the intervention is appropriate" or higher levels of efficacy.

4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits:

Benefit Classification	Comparative Analysis: Medical/Surgical and Mental Health/Substance Use Disorder
Pharmacy	***Process*:** *General:* The step therapy process is part of the Utilization Management (UM) activities and is an assessment performed to determine if the member has tried and failed, or has an intolerance or contraindication to the preferred formulary agent(s). The Plan maintains a list of services that require step therapy. This list is available on request by phone, by provider portal, or via the published formularies online. A prior authorization request for step therapy medications will be required if the member does not have a preferred medication(s) in their pharmacy claims history. If a member does have a paid claim for preferred medication(s) within a certain time frame, the step therapy medication will automatically pay for the member at the pharmacy. Prior authorizations can be submitted via phone, fax, or online through Oscar's provider portal. When a step therapy request is submitted, it is reviewed by licensed clinicians to determine if the request meets plan criteria. Clinicians utilize the Plan's policies and established, evidence based clinical criteria to determine if the request meets coverage determinations and/or medical necessity. Licensed clinicians (e.g., physicians and pharmacists) review step therapy requests; in most states, pharmacists can make adverse determinations. However, in all Oscar states, only appeals can be denied by a licensed physician. If an urgent request is for an expedited formulary exception request, decision should be rendered within 24 hours of receipt of the request. This TAT applies to both complete and incomplete NF exception requests. There are no extensions or pend

times for NF exception requests. This is a federal & state requirement.

The Plan requires the requesting provider to submit the following information when requesting an authorization:

- Member information (name, Plan ID, date of birth).
- Diagnosis, previous history of medications used to treat the condition and the outcome (if applicable)

Both the providers and members are notified of the determination consistent with state, federal and accreditation requirements and applicable appeal rights are provided.

***Description of Pharmacy & Therapeutics Committee (P&T Committee)*:**

Purpose:
Oscar's Pharmacy and Therapeutics (P&T) Committee promotes the safe and appropriate use of cost-effective pharmaceuticals for members. The committee operates in compliance with NCQA standards and state/federal regulations for Oscar's individual, small group, and self-insured drug formularies in all states. The committee regularly reviews new drugs, drug classes, new drug indications, and new safety information. Policies & Procedures for pharmaceutical management and all formularies are reviewed at least annually.

Structure:
Oscar's P&T Committee commences at least quarterly and reports to the Utilization Management Committee. At least fifty percent of Oscar's ten voting members must be present to establish a quorum. Committee members represent a sufficient number of clinical specialties to adequately meet the needs of members. At least two-thirds of members are practicing physicians (MD/DO), practicing pharmacists (PharmDs), and other practicing health care professionals (RNs) who are licensed to prescribe drugs. At least one member shall be a pharmacist. Committee Chairs are appointed annually by Oscar's Vice President of Pharmaceuticals. Membership changes are reported to CMS during the contract year. Members complete a Conflict of Interest and Non-Disclosure Agreement, annually.

Voting Members	Qualifications
VP Medical Director	Licensure: Medical Doctor

	Specialty: Internal Medicine
External Member	Licensure: Medical Doctor Speciality: Rheumatology
External Member	Licensure: PharmD
External Member	Licensure: Pharm D Specialty: Infectious disease
External Member	Licensure: Medical Doctor Specialty: Family Practice
Senior Director, Data Science	Data Science
Senior Medical Director	Licensure: Medical Doctor Specialty: Family Practice
Director, Clinical Pharmacy Operations	Licensure: PharmD
External Member	Licensure: Medical Doctor and Masters of Public Health Specialty: Preventive Medicine
External Member	Specialty: Psychiatry

Responsibilities:
The Committee will develop and document procedures to ensure appropriate drug review and inclusion on Oscar's formularies. Minutes reflect the rationale for all decisions regarding formulary drug list development or revision. Clinical decisions will be based on the strength of scientific evidence and standards of practice, including: assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and the therapeutic advantages of drugs in terms of safety and effectiveness. The committee will review policies that guide exceptions and other utilization management processes, including prior authorization criteria, step therapy protocols, quantity limit restrictions, drug utilization review, and therapeutic interchange. The Committee ensures that Oscar's formulary covers a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states, and does not discourage enrollment by any group of enrollees. The committee provides appropriate access to

drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

Internal oversight of the P&T Committee:
The Board of Directors oversees the implementation of and adherence to the UM Program through the UM Subcommittee. The UM Subcommittee reports to the Quality Improvement Committee at a minimum of once per quarter, per year. The P&T minutes are approved at the UM Subcommittee portion of the Quality Improvement Committee meeting. Minutes conveying this approval are submitted to the Board of Directors, who approve the actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical).

As noted above, the UM Subcommittee is a sub-committee to the Quality Improvement Committee. A senior-level physician chairs the UM Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary.

The UM Subcommittee undertakes, but is not limited to, the following ongoing activities:

- Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated.
- Reviews and approves modifications to the UM Program as indicated by operational needs and/or to meet regulatory and accreditation compliance.
- Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services.
- Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization and/or Step Therapy.

MHPAEA Summary

The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to mental health and substance use disorder (MH/SUD) benefits and to medical/surgical (M/S) benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:

The factors that determine whether step therapy applies to a drug are the same for both MH/SUD drugs and M/S drugs. Factors for determining whether step therapy applies include: multiple dosage forms available for the same or, similar chemical entities or availability of unique dosage forms, clinical appropriateness, regulatory requirements, manufacturer trade agreements, and availability of therapeutic alternatives. The plan also uses the same evidentiary standards and sources to determine the thresholds and supporting information for the aforementioned factors across all drug types (M/S and MH/SUD). There is no discrepancy between the factors, evidentiary standards, sources, and processes used to determine if a drug is subjected to step therapy because all drugs, regardless of drug-type, are subject to the same underlying methodology. However, the Plan has conducted in-operation quantitative analyses below to quantify the extent to which a discrepancy may exist for step therapy application operationally.

The methodology for step therapy application is applied consistently across all drugs and drug classes and does not discriminate against individuals based on medical/surgical condition, mental health/substance use disorder diagnosis, or other health conditions. Any pharmacy coverage factors, processes, development or implementation strategies, and evidentiary standards applied to drugs used to treat mental health or substance use disorder are comparable to, and are applied no more stringently than the coverage factors, processes, development or implementation strategies, evidentiary standards used in applying the limitations to drugs used to treat medical or surgical disorders as evidenced by the above as-written NQTL analysis.

In-Operation:

Operationally, the Plan performs in-operation data assessments to make sure that factors, sources, and evidentiary standards are applied in a consistent manner. For utilization management for Pharmacy, the Plan uses a logistic regression[1] that models the probability that a given on-formulary, non-specialty drug is subject to utilization management (either step therapy or prior authorization). If the coefficient on the indicator for BH drugs is positive and statistically significant, that is evidence that BH drugs are more likely to face UM restrictions.

	ST	
state	p_value	coef
GA	1.00	-19.60

[1] Logistic regression is a mathematical model used in statistics to estimate the probability of an event occurring having been given some previous data. It is a generalized version of drawing a best fit line to understand the relationship between different data points.

	Findings: The p-value is greater than 0.05. The standard interpretation of this is that there's no statistical evidence that MH/SUD drugs are more or less likely to have an application of step therapy. **Table 4 - Proportion of drugs subject to ST** Condition / Total # subject to ST / % subject to ST MH / 26 / 1% SUD / 0 / 0% M/S / 164 / 1% ***Step Therapy Analysis:*** The Plan evaluates the proportion of drugs subject to step therapy for mental health drugs (MH), substance use disorder drugs (SUD) , and medical/surgical (M/S) drugs. When the factors for step therapy are considered consistently across all drug types, the outcome shows that step therapy is applied to a similar proportion of drugs across MH, SUD, and M/S categories. Step therapy is applied to: ● 1% of the drugs in the Medical/Surgical category. ● 1% of the drugs in the Mental Health category. ● 0% of the drugs in the Substance Use Disorder category.

5. Provide the specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements:

Benefit Classification	**Findings and Conclusions**
Pharmacy	The 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 for the following reasons: The Plan conducted a comparative analysis to determine which

	Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) services are subject to step therapy "as written." The factors, evidentiary standards, sources, and processes for applying step therapy to medical/surgical drugs are the same as the factors, evidentiary standards, sources, and processes for applying step therapy to mental health/substance use disorder drugs. Conclusions: Operationally,the Plan performs in-operation data assessments for step therapy procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across med/surg and MH/SUD services. Operationally, there is no statistical evidence that MH/SUD drugs are more or less likely to have utilization management requirements such as step therapy. Further, when assessing the proportion of drugs subject to step therapy requirements, the proportion of drugs that require step therapy for M/S, MH, and SUD drugs is comparable across all three drug types. This reveals that step therapy requirements are not applied more stringently to MH and SUD drugs when compared to M/S drugs in-operation. The findings of the comparative analysis reveal that the process and methodology to apply step therapy to mental health/substance use disorder drugs is comparable to, and applied no more stringently than, the process and methodology used to apply step therapy to medical/surgical drugs.