

Self-Funded Mental Health Parity NQTL Analysis

The analysis below explains how Aetna’s various clinical management and network development policies, procedures, and practices comply with the non-quantitative treatment limitation (NQTL) requirements of the Mental Health Parity and Addiction Equity Act (“MHPAEA”) based on Aetna’s standard fully-insured plan design. The analysis includes links to publicly available information concerning clinical policy and procedure including medical management, i.e.) medical necessity criteria and utilization management criteria as well as network development standards and procedures. This analysis is reviewed and updated periodically, but not less than annually. Self-funded plan sponsors are encouraged to request an updated version of this analysis as they conduct their periodic MHPAEA reviews.

While self-funded customers are responsible for determining plan compliance with MHPAEA, Aetna has evaluated the benefits provided for its insured plans and concluded that such benefits are MHPAEA compliant. This analysis assesses our standard practices for management of our fully insured business. While we are unable to provide legal advice to our self-insured plan sponsors, it may be assumed that unless a self-funded plan sponsor has requested exceptions to our standard practices, the clinical and administrative management would be the same as that which is done for our fully insured plans; thus, this analysis would be instructive to self-insured customers as they assess their NQTL compliance obligation. However, you should be aware of any NQTL your plan has in place that differs from this analysis as Aetna does not provide such custom NQTL analysis. To understand where your self-funded plan may differ you need to review your plan design, as primarily captured in your plan documents. Additionally, it may be helpful to assess any plan deviations filed with the Standards Management Unit. Please contact your account management team to secure such reporting.

There is a variety of information discussed in the comparability analysis below that is memorialized in greater detail in various policies, procedures, reports, and other documents (“Supplemental Information”). Generally, such Supplemental Information is available for your review upon request. Additionally, Supplemental Information requested by regulators may include plan specific reports (e.g., plan specific preauthorization denial rates). Please contact your account management team to secure such reporting.

Non-quantitative Treatment Limitations (NQTLs)

In accordance with state and federal law, Aetna’s plans comply with the nonquantitative treatment limitation requirements of the Mental Health Parity and Addiction Equity Act (“MHPAEA”). Aetna utilizes comparable processes, strategies, evidentiary standards, and other factors to determine NQTL requirements, including medical management review requirements such as precertification, for all plan benefits, including behavioral health, substance use disorder, medical, and surgical treatments. Moreover, these determinants are applied equally and no more stringently to behavioral health and substance use disorder benefits than they are applied to medical and surgical benefits. More information on Aetna’s compliance with regard to the particular types of NQTLs is set forth below.

Note -“Processes”, “strategies”, “evidentiary standards”, and “other factors” are terms of equivalence; none of which have to be individually articulated in order to be sufficient NQTL analysis. A plain reading interpretation of the MHPAEA Final Rule makes it clear that “any (emphasis added) processes, strategies, evidentiary standards, or other factors” used in applying the MH/SUD NQTL can be compared to any process, strategy, evidentiary standard, or other factors used in applying the medical/surgical NQTL for the purposes of

comparability and stringency analysis. See 29 CFR 2590.712(c)(4). Therefore, throughout a portion of these answers you will see content populated as both a process, strategy, or evidentiary standard—some of which may be supported qualitatively or some of which may be supported quantitatively (e.g. “cost” as a factor to add a service to the NPL).

Service Definitions

In Network Inpatient (IP): Acute medical, psychiatric or substance use disorder services requiring an overnight stay at a designated place of service and within a network of providers established or recognized under a plan.

Out of Network Inpatient (IP): Acute medical, psychiatric or substance use disorder services requiring an overnight stay at a designated place of service by providers that do not participate in Aetna's network.

In Network Outpatient Office Visit (OP OV): Refers to services provided by a healthcare professional in such a manner that the predominant trait of the outpatient services is direct, personal interaction with the professional. Such interactions typically, but not exclusively, occur in a healthcare professional's office, with limited reliance on technological interventions and within a network of providers established or recognized under a plan.

Out of Network Outpatient Office Visit (OP OV): Refers to services provided by a healthcare professional in such a manner that the predominant trait of the outpatient services is direct, personal interaction with the professional. Such interactions typically, but not exclusively, occur in a healthcare professional's office, with limited reliance on technological interventions, and are delivered by providers that do not participate in Aetna's network.

In Network Outpatient All Other (OP AO): Refers to outpatient services provided by a healthcare professional in a manner that the predominant trait of the outpatient service is something other than direct, personal interaction with the professional. Examples include outpatient services that are primarily dependent on a technological test or device, that are characterized by some type of physical intervention (e.g., a surgery or other procedure), or where services are provided as part of an integrated program. Outpatient services in the "other" sub-classification may be delivered in a variety of settings, including a healthcare facility, the community and or the home and are provided within a network of providers established or recognized under a plan.

Out of Network Outpatient All Other (OP AO): Refers to outpatient services provided by a healthcare professional in a manner that the predominant trait of the outpatient service is something other than direct, personal interaction with the professional. Examples include outpatient services that are primarily dependent on a technological test or device, that are characterized by some type of physical intervention (e.g., a surgery or other procedure), or where services are provided as part of an integrated program. Outpatient services in the "other" sub-classification may be delivered in a variety of settings, including a healthcare facility, the community and or the home, and are delivered by providers that do not participate in Aetna's network.

Emergency Care: Services provided in response to a medical emergency or urgent condition as well as emergency medical transportation.

Prescription drugs: Formulary brand name, formulary generic or covered non-formulary medications that require a prescription and are mailed to, delivered to, or picked up by the patient or designee.

Medical versus MH/SUD benefits: In keeping with MHPAEA guidance, benefits that are provided for the treatment of Mental Health/Substance Use Disorder (MH/SUD) conditions, as those conditions are defined by the most recent version of the Diagnostic and Statistical Manual (DSM), are MH/SUD benefits. All other benefits are considered medical/surgical benefits.

NQTL Applicability Summary

Non-Quantitative Treatment Limitations	Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?	Is NQTL applied to In Network Outpatient-Office subclassification?	Is NQTL applied to Out of Network Outpatient- Office subclassification?	Is NQTL applied to In Network Outpatient-All Other subclassification?	Is NQTL applied to Out of Network Outpatient-All Other subclassification?
Prior Authorization/Precertification	Yes	Yes	Yes	Yes	Subclassify	Subclassify	Yes (only for one medical/surgical benefit)	See separate Pharmacy NQTL comparability analysis	No	No	Yes	Yes
Concurrent Review	Yes	Yes	Yes	Yes	Subclassify	Subclassify	No		No	No	Yes	Yes
Retrospective Review	Yes	Yes	No	Yes	Subclassify	Subclassify	Yes (only for one medical/surgical benefit)		No	No	No	Yes
Medical Necessity Criteria	Yes	Yes	Yes	Yes	Subclassify	Subclassify	Yes		Yes	Yes	Yes	Yes
Sequenced Treatment	Yes	Yes	Yes	Yes	Subclassify	Subclassify	No		No	No	Yes	Yes
Treatment Plan requirement	Yes	Yes	No	No	Subclassify	Subclassify	No		No	No	Yes	Yes
Benefit Exclusion including for experimental and investigational purposes	Yes	Yes	Yes	Yes	Subclassify	Subclassify	Yes		Yes	Yes	Yes	Yes
Network Provider Reimbursement	Yes	Yes	Yes	No	Subclassify	Subclassify	Yes		Yes	No	Yes	No
Non-Participating Provider Reimbursement/UCR Determination	Yes	Yes	No	Yes	Subclassify	Subclassify	Yes		No	Yes	No	Yes
Network Facility Reimbursement	Yes	Yes	Yes	No	Subclassify	Subclassify	Yes		Yes	No	Yes	No

Non-Participating Facility Reimbursement/UCR Determination	Yes	Yes	No	Yes	Subclassify	Subclassify	Yes		No	Yes	No	Yes
Plan Standards to Ensure Network Adequacy	Yes	Yes	Yes	No	Subclassify	Subclassify	Yes		Yes	No	Yes	No
Physician Credentialing/Admission Standards	Yes	Yes	Yes	No	Subclassify	Subclassify	Yes		Yes	No	Yes	No

*Consistent with the NQTL types identified in the Final Rules and recent guidance

Network NQTLs

The following framework organizes the factors, sources, methods, analysis and stringency application applied to the inpatient and outpatient benefit classifications for NQTLs in the following categories: participating provider reimbursement, non-participating provider reimbursement, participating facility reimbursement, non-participating facility reimbursement, network adequacy, provider admission standards for outpatient, group and individual plans and provider admission standards for facility and facility-based practitioners.

Participating Provider Reimbursement NQTL

Negotiated charge is the amount a network provider has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

NQTL applies to MH/SUD	NQTL applies to M/S	Factors: <i>Factors used in the development of the limitation</i>	Sources: <i>Processes, Strategies, and evidentiary standards</i>	Comparability Analysis: <i>Results of the comparison of MH/SUD and Medical/Surgical</i>	Stringency: <i>Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits</i>
Applies to all MH/SUD benefits delivered in-network	Applies to all M/S benefits delivered in-network	<p>Note: All factors are the same for medical/surgical and MH/SUD</p> <ul style="list-style-type: none"> Reimbursement rate indices (e.g. Medicare reimbursement rates) Market dynamics (e.g. supply and demand) Provider type (e.g. MD, NP) Service type (e.g. counseling, initial assessment) Performance based programs 	<ul style="list-style-type: none"> Standard fee schedules: <ul style="list-style-type: none"> Benchmarked from Medicare reimbursement rates Developed for each market based on market analysis Final negotiated rate – either standard rates or a negotiated fee schedule 	<p>MH/SUD standard fee schedule rates can be higher but are not lower than medical rates for the same codes that can be used by BH and medical/surgical providers. The process to determine provider network reimbursement between Medical/Surgical and MH/SUD is as follows:</p> <p>Medical informs Behavioral Health that they are adjusting the standard rates for a given market. Medical supplies the new medical rates for the codes shared with the behavioral health fee schedule.</p> <p>BH will provide rates to medical for MH/SUD services in the BH Network. Behavioral Health will compare the rates to the medical rates. If the medical rate is the higher rate, Behavioral Health will adopt the medical rate. Behavioral Health will cascade the rate down to the lower level providers using the following CMS guidelines and commensurate with level of training :</p> <ul style="list-style-type: none"> MD's (MH/SUD and medical/surgical) & Clinical Psychologists receive 100% of the rate Nurse Practitioners, Physician Assistants and Certified Nurse Specialist (MH/SUD and 	<p>As Written: Aetna maintains uniform reimbursement practices that are equally applicable to MH/SUD and medical/surgical. See Appendix 1 for a listing of core policies.</p> <p>In Operation: Aetna monitors the application of this NQTL through several initiatives:</p> <ul style="list-style-type: none"> Mental Health Parity (MHP) Task Force: Multi-disciplinary team that meets monthly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care. Rates are updated, and new schedules are completed and reviewed by a different person to make sure they are accurate. The rates are reviewed on both Medical and BH by members

NQTL applies to MH/SUD	NQTL applies to M/S	Factors: <i>Factors used in the development of the limitation</i>	Sources: <i>Processes, Strategies, and evidentiary standards</i>	Comparability Analysis: <i>Results of the comparison of MH/SUD and Medical/Surgical</i>	Stringency: <i>Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits</i>
				<p>medical/surgical) receives 85% of the new rate**</p> <ul style="list-style-type: none">• Drug and Alcohol Counselor, Licensed Professional Counselor, Marriage and Family Therapist, Pastoral Counselor, Social Worker receives 75% of the new rate***• Audiologist, Registered Dietician, Genetic Counselor, Massage Therapist, Nutritionist, Respiratory Therapist receives 75% of the new rate <p>** If the existing MH/SUD rate is higher than 85% of the new rate, the already existing rate stays in place *** If the existing MH/SUD rate is higher than the 75% of the new rate, the already existing rate stays in place</p> <p>The rates are effective at the same time as the new medical rates.</p> <p>MH/SUD rates can be updated in addition to the rate updates triggered by the Medical rate updates.</p>	<p>of the enterprise senior network team as well as by members of the senior regional market team.</p>

Participating Facility Reimbursement NQTL

Negotiated charge is the amount a network provider has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

NQTL applies to MH/SUD	NQTL applies to M/S	Factors: <i>Factors used in the development of the limitation</i>	Sources: <i>Processes, Strategies, and evidentiary standards</i>	Comparability Analysis: <i>Results of the comparison of MH/SUD and Medical/Surgical</i>	Stringency: <i>Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits</i>
Applies to all MH/SUD benefits delivered in-network	Applies to all M/S benefits delivered in-network	<p>Note: <u>All factors are the same for medical/surgical and MH/SUD</u></p> <ul style="list-style-type: none">market dynamics (e.g. supply and demand, volume with Aetna)Performance based programsScope and complexity of services providedAetna membership presence within region	<ul style="list-style-type: none">Benchmarked from Medicare Inpatient Psychiatric Facility Prospective Payment SystemMarket analysisNegotiated reimbursement models (e.g. per diem versus DRG)Final rate negotiated from standard target ranges	<p>Prior to negotiating such rates with a particular facility provider, Aetna has developed a set of standard target rates based on the average rates paid for similar services in a particular market. These target rates are updated annually based on average rate increases.</p> <p>Rates are then negotiated on the basis of these target ranges, rather than a set fee schedule. In general, the majority of rates negotiated with freestanding facilities fall within a targeted rate range differential to the average as a whole.</p>	<p>As Written: Aetna maintains uniform reimbursement practices that are equally applicable to MH/SUD and medical/surgical. See Appendix 1 for a listing of core policies.</p> <p>In Operation: Aetna monitors the application of this NQTL through:</p> <ul style="list-style-type: none">Mental Health Parity (MHP) Task Force: Multi-disciplinary team that meets monthly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care.

Network Adequacy NQTL

Aetna maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network. Aetna maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership. Aetna establishes mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services. Aetna provides and maintains appropriate access to primary care services, behavioral healthcare services and specialty care services.

NQTL applies to MH/SUD	NQTL applies to M/S	Factors: <i>Factors used in the development of the limitation</i>	Sources: <i>Processes, Strategies, and evidentiary standards</i>	Comparability Analysis: <i>Results of the comparison of MH/SUD and Medical/Surgical</i>	Stringency: <i>Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits</i>
Applies to all MH/SUD benefits delivered in-network	Applies to all M/S benefits delivered in-network	<p>Note: <u>All factors are the same for medical/surgical and MH/SUD</u></p> <ul style="list-style-type: none"> Applicable state law, federal law, and accreditation network adequacy requirements 	<ul style="list-style-type: none"> Aetna's standards approved by NCQA in accrediting Aetna. Aetna has NCQA accreditation as a Health Plan and a Managed Behavioral Healthcare Organization ("Aetna's NCQA Standards") Network adequacy indicators are based on NCQAs NET 1 (AVAILABILITY OF PRACTITIONERS) and NET 2 (ACCESSIBILITY OF SERVICES) State specific Network Adequacy as applicable 	The same standards are used to define and monitor minimum requirements for network composition, ensure compliance with applicable state and federal regulatory standards, and to ensure compliance with applicable accreditations standards for both M/S and MH/SUD.	<p>As Written: Aetna maintains uniform network adequacy practices that are equally applicable to MH/SUD and medical/surgical. See Appendix 1 for a listing of core policies.</p> <p>In operation: Aetna monitors the application of this NQTL through several initiatives:</p> <ul style="list-style-type: none"> Oversight of network adequacy reporting by the National Quality Oversight Committee NQOC. <ul style="list-style-type: none"> A qualitative and quantitative analysis by product/product line is performed using network adequacy data which includes member complaints/grievances and appeals, accessibility, availability, out of network requests, and member experience data (CAHPS or member experience survey). Network adequacy complaints/grievances and appeals at or in excess of .01 per thousand member months will trigger an additional review. The rate per thousand member months shall be calculated as follows: [# of complaints or appeals]/(monthly total for 12 months of membership/1000)] Out-Of-Network requests for and utilization services will be reported at the product line-level per thousand members. The rate per thousand members shall be calculated as follows: [# of Out-of-Network requests]/1,000 enrollees] (membership/1000).

NQTL applies to MH/SUD	NQTL applies to M/S	Factors: <i>Factors used in the development of the limitation</i>	Sources: <i>Processes, Strategies, and evidentiary standards</i>	Comparability Analysis: <i>Results of the comparison of MH/SUD and Medical/Surgical</i>	Stringency: <i>Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits</i>
					The results of the above analysis will be reviewed in conjunction with the findings of the network availability and accessibility analyses to identify and prioritize opportunities for improvement. One improvement for non-behavioral health and one for behavioral health will be implemented.

Provider Admission Standards NQTL: Outpatient group and individual providers

Credentialing is a process by which a health care organization reviews and evaluates qualifications of licensed independent practitioners to provide services to its members/enrollees. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, as well as for conformity to the organization’s utilization and quality management requirements.

NQTL applies to MH/SUD	NQTL applies to M/S	Factors: <i>Factors used in the development of the limitation</i>	Sources: <i>Processes, Strategies, and evidentiary standards</i>	Comparability Analysis: <i>Results of the comparison of MH/SUD and Medical/Surgical</i>	Stringency: <i>Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits</i>
Applies to all MH/SUD benefits delivered in-network	Applies to all M/S benefits delivered in-network	<p>Note: <u>All factors are the same for medical/surgical and MH/SUD</u></p> <ul style="list-style-type: none">Applicable state law, federal law, and accreditation practice requirements	<ul style="list-style-type: none">Aetna’s NCQA StandardsVerification from Aetna, National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans and CMS approved primary sources. Aetna utilizes the Council for Affordable Quality Healthcare (CAQH) data warehouse.	The provider admission standards and process are the same between M/S and MH/SUD providers. The variances will only be dependent upon licensing board requirements	<p>As Written Aetna maintains one set of credentialing policies that are equally applicable to MH/SUD and medical/surgical. See Appendix 1 for a listing of core policies.</p> <p>In Operation: Aetna monitors the application this NQTL through several initiatives:</p> <ul style="list-style-type: none">Mental Health Parity (MHP) Task Force: Multi-disciplinary team that meets monthly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care.Credentialing rate and turnaround time reports (refer to Appendix 8)

Provider Admission Standards NQTL: Facility and Facility-Based Practitioners

Credentialing is a process by which a health care organization reviews and evaluates qualifications of licensed independent practitioners to provide services to its members/enrollees. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, as well as for conformity to the organization’s utilization and quality management requirements.

NQTL applies to MH/SUD	NQTL applies to M/S	Factors: <i>Factors used in the development of the limitation</i>	Sources: <i>Processes, Strategies, and evidentiary standards</i>	Comparability Analysis: <i>Results of the comparison of MH/SUD and Medical/Surgical</i>	Stringency: <i>Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits</i>
Applies to all MH/SUD benefits delivered in-network	Applies to all M/S benefits delivered in-network	<p>Note: <u>All factors are the same for medical/surgical and MH/SUD</u></p> <ul style="list-style-type: none">Applicable state law, federal law, and accreditation practice requirements	<ul style="list-style-type: none">Aetna’s NCQA StandardsFacility qualifications are reviewed to ensure facility meets Aetna’s established requirements for organizational credentialing, including state licensing board, operating/certificate of occupancy, accreditation entity.	The provider admission standards and credentialing process are the same between M/S and MH/SUD providers. The variances will only be dependent upon licensing and/or accreditation requirements per facility type.	<p>As Written: Aetna maintains one set of credentialing policies that are equally applicable to MH/SUD and medical/surgical. See Appendix 1 for a listing of core policies.</p> <p>In Operation: Aetna monitors the application this NQTL through several initiatives:</p> <ul style="list-style-type: none">Mental Health Parity (MHP) Task Force: Multi-disciplinary team that meets monthly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care.Credentialing rate and turnaround time reports (refer to Appendix 9)

Appendix 1

Relevant Core Policies

NCS 100-01 Precertification Policy
NCS 200-01 Concurrent Review Policy
NCS-300-01 Retrospective Review Policy
NCS 503-01 Medical Review Policy
NCS 504-01 Timeliness Standards for Coverage Decisions and Notification Policy
NCS 505-01 Denial of Coverage Policy and Notification
NCS 506-01 Peer-to-Peer Review Policy
NCS 510-01 Internal Quality Review Policy
QM 7 Member Access to Practitioners and Member Services
QM 10 Provider Availability Standards
QM 51 Assessment of Organizational Providers
QM 53 Credentialing Allied Health Practitioners
QM 54 Practitioner Credentialing/Recredentialing Policy

APPENDIX 8

Outpatient Services

Please note:

- *The responses below included data for initial applications. The below is based on National level data.*
- *Aetna does not track credentialed providers by Inpatient vs. Outpatient. A provider may be a provider that practices in a facility (i.e., surgery center), but also sees patients at their office. The outpatient data below reflects credentialing information/data for providers who are office based.*
- Please provide a comparison of the application process for MH/SUD and MS providers, including:
 - the number of applications received, accepted or denied/withdrawn.

Applications	MH/SUD	MS
Received	29,510	31,728
Accepted	29,491	31,696
Denied/Withdrawn	19	32
% Approved	99.9%	99.9%

- The average number of days from receipt of a completed credentialing application to approval to be contracted (2021).

MS Providers: 31 Days MH/SUD Providers: 21 Days

- The number of times additional documentation has been requested to establish credentialing standards are met.

Aetna is unable to report the number of times additional documentation may be requested to establish credentialing standards are met. Aetna will follow with providers as part of the credentialing process as needed. Examples would include, but not be limited to incomplete applications, missing information (i.e., licensure, liability insurance, etc.). During 2021, there were also providers that were not able to provide information for recredentialing due to office or state closure related to Covid-19.

APPENDIX 9

Inpatient Services

Please note:

- ***The responses below included data for initial applications. The below is based on National level data.***
- ***Aetna does not track credentialed providers by Inpatient vs. Outpatient. A provider may be a provider that practices in a facility (i.e., surgery center), but also sees patients at their office. The inpatient data below reflects Facility credentialing information/data.***
- Please provide a comparison of the application process for MH/SUD and MS providers, including:
 - The number of applications received; accepted, denied/withdrawn;

Applications	MH/SUD	MS
Received	1060	2607
Accepted	1011	2474
Denied/Withdrawn	49	133
% Approved	95.3%	94.8%

- The length of time to process the application;

Aetna does not produce a report that shows the length of time to process a credentialing application for facilities broken out by MH/SUD vs MS. Aetna’s initial credentialing turnaround time for all facilities is an average of 18 calendar days from receipt of a completed credentialing application to approval to be contracted.

- The number of times additional documentation has been requested to establish credentialing standards are met.

Aetna is unable to report the number of times additional documentation may be requested to establish credentialing standards are met. Aetna will follow with facilities as part

of the credentialing process as needed. Examples would include, but not be limited to incomplete applications, missing information (i.e., licensure, liability insurance, etc.). During 2021, there were also facilities that were not able to provide information for recredentialing due to facility or state closure related to Covid-19.



MENTAL HEALTH PARITY COMPARATIVE ANALYSIS

DATE PREPARED: March 1, 2023
SUBJECT MATTER: Credentialing
PREPARED BY: Karin Vicioso-Segovia, Manager, Credentialing Operations

INTRODUCTION

This comparative analysis is intended to measure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), as amended by the Consolidated Appropriations Act of 2021.

Effective February 10, 2021, group health plans must ensure that the financial requirements and treatment limitations on mental health or substance use disorder benefits they provide are no more restrictive than those on medical or surgical benefits. Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment.¹ NQTLs are processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Examples of NQTLs include, but are not limited to, medical management standards limiting benefits based on medical necessity, and network admission standards such as credentialing or reimbursement rates. Group health plans must perform an annual comparative analysis of NQTLs that apply to mental health and substance use disorder (“MH/SUD”) treatments to ensure that such NQTLs are comparable to, and no less restrictive than, those treatment limitations applicable for medical and/or surgical (“Medical/Surgical”) services. The law does not prohibit the use of NQTLs as long as they are not applied more stringently to MH/SUD benefits as compared to Medical/Surgical benefits. Disparate results do not necessarily indicate a violation of the MHPAEA, so long as comparable processes are followed.

MultiPlan, on behalf of itself and its subsidiaries (collectively “MultiPlan”) is not a health plan and does not provide health insurance coverage. Additionally, MultiPlan does not make benefit or coverage determinations. Therefore, the federal regulations prohibiting the imposition of a discriminatory NQTL for MH/SUD services does not directly apply to MultiPlan. However, MultiPlan clients purchasing access to MultiPlan’s Network Services may require information from MultiPlan to assist with their compliance of these federal requirements. MultiPlan’s services include access to both MH/SUD providers and Medical/Surgical services.

¹ See 29 CFR 2590.712(c)(2)-(3) for the test for financial requirements and QTLs and 29 CFR 2590.712(c)(4) for the requirements for NQTLs. 26 CFR 54.9812-1(c)(2)-(4); 29 CFR 2590.712(c)(2)-(4); 45 CFR 146.136(c)(2)-(4); and 147.160.



The comparative analysis below is specific to MultiPlan’s credentialing process for those clients that purchase access to MultiPlan’s Network Services, as defined below. MultiPlan has adopted the six-step analysis outlined by the Kennedy Forum for conducting a comparative analysis.²

1. DESCRIPTION OF NQTL: CREDENTIALING/RECREREDENTIALING

By definition, credentialing processes are identified as NQTLs requiring a comparative analysis to ensure the processes are applied no more stringently to MH/SUD providers than to Medical/Surgical providers.³

“Network Providers” are health care providers contracted with MultiPlan for participation in MultiPlan networks which include, but are not limited to, the PHCS Network, the MultiPlan Network, the Beech Street Network, the HealthEOS Network, Rural Arizona Network, Health Management Network and MultiPlan’s Government Program Networks (e.g. Medicare Advantage and Medicaid) (collectively “MultiPlan Networks” or “Network”), as applicable. MultiPlan clients access Network Providers to offer health care services to their members at discounted rates (“Network Services”)⁴. MultiPlan credentials providers applying to the MultiPlan Networks, and recredentials the same providers every 36 months, unless otherwise required by law. MultiPlan has implemented a standard set of credentialing criteria for all MultiPlan Networks, and does not differentiate in the application of that criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. All non-hospital based providers that are newly contracted with MultiPlan are subject to the credentialing process. Only MultiPlan’s PHCS Network is National Committee for Quality Assurance⁵ (“NCQA”) Accredited in Credentialing, however, MultiPlan has adopted the NCQA standards (“National Accreditation Standards”) as the basis for credentialing/recredentialing for all MultiPlan Networks. MH/SUD provider applications and related documentation are processed and maintained in accordance with NCQA standards, and the same NCQA standards for credentialing are followed for all other providers.

MultiPlan credentials and recredentials Network practitioners according to National Accreditation Standards and takes the following steps every 36 months, as applicable:

1. Collects a complete application
2. Verifies current licensure
3. Verifies DEA certification
4. Verifies education/training
5. Verifies board certification, if applicable
6. Verifies work history
7. Reviews professional liability claim history

² Tim Clement, MPH, et al, *The “Six-Step” Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements*, the Kennedy Forum, Sep. 2017, https://s3.amazonaws.com/pjk-wp-uploads/www.paritytrack.org/uploads/2017/09/six_step_issue_brief.pdf.

³ See 42 U.S.C. 300gg–26(a)(7)(C)

⁴ Depending on the type of Network Services accessed (e.g., primary network, complementary network, etc.), MultiPlan client’s may pay for covered services at an in-network or out-of-network benefit level.

⁵ The National Committee for Quality Assurance (“NCQA”) is the leading accrediting body for quality healthcare in the industry. It should be noted, MultiPlan is prohibited from releasing the NCQA standards as the material is copyrighted and would violate MultiPlan’s agreement with NCQA for access to the NCQA standards. NCQA’s website can provide additional information. <https://www.ncqa.org/programs/health-plans/credentialing/>.



8. Reviews board actions and Medicare sanctions

(“MultiPlan Practitioner Credentialing Criteria”).

MultiPlan credentials and recredentials Network facilities, including at a minimum, acute care hospitals, home health agencies, skilled nursing facilities, free-standing ambulatory surgical centers, inpatient/acute physical rehabilitation facilities, inpatient MH/SUD facilities, residential MH/SUD facilities, and ambulatory MH/SUD facilities⁵, and verifies the following every 36 months:

1. Submission of complete application
2. Verification of licensure
3. Verification of Accreditation/CMS Certification⁶
4. Acceptable EPLS/SAM and OIG query with no exclusions
5. Acceptable liability insurance limits

(“MultiPlan Facility Credentialing Criteria”)

As supported by the comparative analysis below, MultiPlan does not establish NQTLs on, or implied through, relationships with providers that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services, whether in writing or in operation. MultiPlan’s policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

PROVIDER TYPES ANALYZED FOR PURPOSES OF THE CREDENTIALING/RECREREDENTIALING NQTL

The grid below defines the scope of MultiPlan’s credentialing/recredentialing processes as it relates to both Medical/Surgical services and MH/SUD services.

Provider Type	Description	MH/SUD Providers	Medical/Surgical Providers
Non-Hospital Based Practitioners	MultiPlan requires all non-hospital based practitioners applying to, and those participating in, the MultiPlan Networks to meet MultiPlan Practitioner Credentialing Criteria	✓	✓
Hospital-Based Practitioners	Hospital-based practitioners solely practicing in a Network facility location are not subject to the credentialing/recredentialing process	✓	✓
Facilities	MultiPlan requires all acute care hospitals, home health agencies, skilled nursing facilities, free-standing ambulatory surgical centers, inpatient/acute physical rehabilitation facilities, inpatient behavioral health/mental health/substance use disorder facilities, residential behavioral health/mental health/substance use disorder facilities, and ambulatory behavioral health/mental	✓	✓

⁵ The scope of facility credentialing may include additional facility specialty types based on the Network to be consistent with state and/or federal law (e.g. Medicare Advantage). All credentialing processes remain consistent between facility types regardless of the Network in which the facility participates, and are not more stringently applied to MH/SUD providers.

⁶ MultiPlan does not perform on-site visits and, therefore, does not routinely accept facilities in the Network that do not have the appropriate accreditation or CMS certification.



	health/substance use disorder facilities applying to, and participating in, the Network, to meet the MultiPlan Facility Credentialing Criteria. Additional facility types are required to be credentialed for Government program Network Services as prescribed by CMS.		
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2. FACTORS USED IN DEVELOPING THE CREDENTIALING/RE-CREDENTIALING PROGRAM:

The Credentialing Factors identified in this section have been established by MultiPlan to ensure that members accessing MultiPlan Network Services have access to high quality Network Providers that meet minimum professional competency requirements, including but not limited to, hospitals, physicians, MH/SUD providers, and other providers. In addition, the Credentialing Factors enable MultiPlan to maintain NCQA Network Accreditation in Credentialing for MultiPlan's PHCS Network and comply with applicable federal and/or state laws.⁷

The grid below shows the rationale for applying the credentialing/recredentialing NQTL that was used in developing the Credentialing Factors, as it relates to both Medical/Surgical services and MH/SUD services.

Rationale for Applying NQTL Factors	MH/SUD Providers	Medical/Surgical Providers
MultiPlan applies Credentialing Factors to ensure Network Providers meet minimum participation criteria including professional competency.	✓	✓
MultiPlan applies Credentialing Factors to ensure members have access to high quality care and Network Providers that meet minimum professional competency requirements.	✓	✓
MultiPlan applies Credentialing Factors to meet NCQA accreditation requirements.	✓	✓
MultiPlan applies Credentialing Factors to meet state and/or federal requirements.	✓	✓

"CREDENTIALING FACTORS" CONSIDERED WHEN ESTABLISHING SPECIFIC PRACTITIONER AND FACILITY CREDENTIALING CRITERIA

The grid below identifies the Credentialing Factors used in developing credentialing/recredentialing processes for all providers applying to or participating in the MultiPlan Network(s).

⁷ MultiPlan's PHCS Network is the only network that is NCQA Accredited in Credentialing, however all other network offerings utilize the NCQA credentialing criteria as the basis for credentialing.

Factor	Description	Outpatient (Physician) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Credentialing Application/	Credentialing applications are required by the accreditation standards to collect information on a practitioner or facility to determine eligibility for participation in the Network and provide authorization for verification of application contents. All practitioners and specified facilities are required to complete a comprehensive application to verify the applicant is in full compliance with MultiPlan's Network participation criteria.	✓	✓	✓	N/A
Credentials Verification	To ensure practitioners and facilities are qualified to provide services and quality care, verification of the application contents is required. Verification of the contents of the provider application is done directly through primary sources or secondary sources, as permitted by the National Accreditation Standards and state laws. Verifications are completed every 36 months or earlier as defined by state laws. Credentials Verifications include the MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria, as defined above in Section 1.	✓	✓	✓	N/A

Factor	Description	Outpatient (Physician) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Practitioner Specialty Assignment	Practitioner specialties are verified to ensure practitioners are practicing within the scope of their training and licensing; and to ensure provider directories are consistent with the assigned specialty. Practitioners that do not have a valid state license (or certification) and verifiable training are not eligible for participation in the Network. MultiPlan only accepts the accepted practice standard for certification within a specialty field. In states that do not issue licensure for a specific specialty, MultiPlan accepts the certification that is recognized by most states that do license such specialty. In rare instances, MultiPlan may accept a certification recognized by licensing boards in lieu of licensure. MultiPlan applies this criteria no more stringently to MH/SUD provider specialties as compared to Medical/Surgical provider types.	✓	N/A	N/A	N/A ⁸
Facility Type Assignment	Facility Type is verified to ensure Facilities meet Network participation criteria and are appropriately listed in provider directories. Facility Type is consistent with state licensing and/or accreditation/certification requirements.	N/A	✓	✓	N/A
Credentialing Decisions	The Credentials Committee makes all credentialing determinations. It is a multidisciplinary committee with representation from different types of practitioners that participate in the Networks, and is composed of the Medical Director and four Network Providers. All clinical aspects of the MultiPlan Credentialing Plan are the responsibility of the Medical Director as dictated by National Accreditation Standards.	✓	✓	✓	N/A

⁸ May apply to emergency service providers that have an independent practice location outside of a facility setting.

Factor	Description	Outpatient (Physician) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Credentialing Timeframes	Timely credentialing is required to ensure prompt Network participation and access to services in the Network. Credentialing Decisions are made within the timeframes specified by the National Accreditation Standards or as required by law.	✓	✓	✓	N/A
Monitoring Activities	Performance of monitoring activities is required to ensure that Network Providers continue to meet MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria and have not been the subject of licensing or board actions, as required by the National Accreditation Standards.	✓	✓	✓	N/A
Credentialing Oversight	Credentialing oversight is required to ensure that processes are consistent with National Accreditation Standards and Network Providers meet, and continue to meet, high quality standards to treat members.	✓	✓	✓	N/A
Hospital-Based Providers	Hospital-Based Providers are providers that solely practice within a facility setting and do not receive direct referrals for care. Verification of Hospital-Based Providers is out-of-scope for the credentialing program, as MultiPlan does not directly credential these practitioners. Facilities that employ Hospital-Based Providers, directly or indirectly, have the sole responsibility of ensuring these providers are appropriately credentialed.	N/A	N/A	N/A	✓

Emergency Services in-network (Physician and Facility services)

Emergency services provided by physicians are out-of-scope for the credentialing program, as this practitioner type is considered a Hospital-Based Provider, and does not receive direct referrals for care. In certain circumstance, emergency service providers may be subject to the credentialing program, if they have an independent practice location outside of a facility setting (Hospital-Based Provider) contracted with MultiPlan. In this instance, emergency service providers follow the same credentialing criteria required for out-patient physician services. Emergency services for facility services are not differentiated from the standard facility type factors defined above.

3. EVIDENTIARY STANDARDS RELIED UPON TO DESIGN THE CREDENTIALING/REREDENTIALING NQTL:

MultiPlan Practitioner Credentialing Criteria, MultiPlan Facility Credentialing Criteria, National Accreditation Standards, and federal/state laws are used by MultiPlan to define the criteria that establish the Credentialing Factors. These evidentiary standards support MultiPlan's determinations on what constitutes an effective credentialing program.

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING SPECIFIC PRACTITIONER AND FACILITY CREDENTIALING CRITERIA

The grid below identifies the various evidentiary standards for the factors used in developing credentialing/recredentialing processes for all providers applying to, or participating in, the MultiPlan Network(s) as applied to Medical/Surgical providers or to MH/SUD providers.

Factor	Documentation	MH/SUD Providers	Medical Surgical Providers
Credentialing Application	1. National Accreditation Standards 2. State Mandated Applications	✓	✓
Credentials Verification	1. National Accreditation Standards 2. Medicare Managed Care Manual for Government Programs 3. State laws 4. Facility Accreditation/Certification Bodies	✓	✓
Practitioner Specialty Assignment	1. National Accreditation Standards 2. State Licensing Boards	✓	✓
Facility Type Assignment	1. National Accreditation Standards 2. State Licensing Requirements	✓	✓
Credentialing Decisions	1. National Accreditation Standards	✓	✓
Credentialing Timeframes	1. National Accreditation Standards 2. State Laws	✓	✓
Monitoring Activities	1. National Accreditation Standards	✓	✓
Credentialing Oversight	1. National Accreditation Standards	✓	✓
Hospital-Based Providers	1. National Accreditation Standards	✓	✓

4. WRITTEN POLICY AND PROCESS COMPARATIVE ANALYSIS:

This section includes a comparative analysis of MultiPlan's credentialing/recredentialing processes to ensure that MultiPlan processes are applied no more stringently to MH/SUD providers than they would be to Medical/Surgical service providers. The information below includes a summary of processes as outlined in MultiPlan policies and procedures.

DESCRIPTION OF THE CREDENTIALING/REREDENTIALING NQTL PROCESSES

All clinical aspects of the MultiPlan Credentialing Plan are the responsibility of the Medical Director. MultiPlan has established MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing



Criteria for provider types admitted to the MultiPlan Network(s), inclusive of MH/SUD provider types and Medical/Surgical service provider types. All MultiPlan credentialing policies and procedures are reviewed and approved annually for operational implementation of credentialing processes.

All applications are reviewed for completeness in accordance with MultiPlan's Complete Applications Policy. Practitioners are notified when relevant information is missing and/or if additional information is required to complete the credentialing process. In accordance with National Accreditation Standards and applicable state laws, portions of the application are verified with appropriate sources as specified in MultiPlan policies and procedures. All clean and complete applications that meet MultiPlan Practitioner Credentialing Criteria and/or MultiPlan Facility Credentialing Criteria are reviewed and approved by the Medical Director. All completed applications, including required attachments that do not meet MultiPlan Practitioner Credentialing Criteria and/or MultiPlan Facility Credentialing Criteria, are presented to the Credentials Committee. Credentialing decisions are made within 180 days of the attestation date on the application. MultiPlan's turnaround times for processing credentialing applications are typically 90 to 120 days from receipt of a complete application.

The Credentials Committee makes Credentialing Decisions related to the acceptance, rejection, continued participation, and termination of practitioners (including MH/SUD and Medical/Surgical practitioner specialties), acute care hospitals, home health agencies, skilled nursing facilities, free standing ambulatory surgical centers, inpatient acute physical rehabilitation facilities, and behavioral health facilities (all MH/SUD facility types). The Credentials Committee meets in person and/or telephonically on a weekly basis. It is a multidisciplinary committee with representation from different types of practitioners that participate in the MultiPlan Network(s). Specifically, the Credentials Committee is composed of the Medical Director and three Network practitioners. The Credentials Committee may invite an MH/SUD practitioner to participate on the committee, as needed, for review of MH/SUD provider applicants. The Credentials Committee reviews and has final authority regarding Network participation for all Network practitioners and facilities. All applicants or Network practitioners under recredentialing review are presented to the committee for consideration and approval.

Providers that do not meet MultiPlan Practitioner Credentialing Criteria or MultiPlan Facility Credentialing Criteria for their discipline are discussed by the Credentials Committee to determine whether they are meeting reasonable standards of care. After review, the committee votes on all applicants and determines whether to accept or reject the applicants. Cases are presented by the Medical Director or Credentialing Specialist to the Credentials Committee. In instances where matters arise that require subject matter expertise beyond that available from the members of the committee, the Medical Director seeks consultation from participating MultiPlan Network(s) provider specialists in the same or similar specialty as the practitioner being discussed (including MH/SUD providers as needed). This information is made available to the other members of the committee prior to a deciding vote being taken.

All Credentials Committee actions are documented, and the committee maintains minutes for each meeting. MultiPlan's internal Quality Management Committee receives a quarterly report of credentialing metrics, including but not limited to, the number of credentialed/recruited practitioners, delegation oversight results, and sanctions monitoring results. Information presented by the Manager of Credentialing Operations/PNQ in these quarterly reports is used to measure the overall effectiveness of the credentialing program.



All rejected and terminated practitioners (inclusive of MH/SUD providers) are informed of their right to a two level appeal process. This process is detailed within MultiPlan's Network Provider Appeal Policy, and conforms to National Accreditation Standards and applicable state and federal laws.

Formal recredentialing occurs on a 36-month cycle and is conducted in accordance with MultiPlan's Credentialing policies. All policies are structured to be in full compliance with National Accreditation Standards and state and federal laws. In addition, MultiPlan will initiate off-cycle recredentialing of practitioners as a result of complaints and grievances received through Corporate Quality Management or as a result of information obtained from our ongoing monitoring process.

CREDENTIALING/REREDENTIALING NQTL POLICY AUDIT RESULTS

The description of the processes in the previous subsection is a general overview of the content of the policies reviewed to ensure consistent application to all providers, Medical/Surgical or MH/SUD, equally. The chart below includes the findings of an internal review of MultiPlan's written policies.

Policy Applicable to Provider Type	MH/SUD Providers	Medical/Surgical Providers
Practitioner Credentialing Policy	✓	✓
Credentials Committee Policy	✓	✓
Network Provider Appeal Policy	✓	✓
Complete Applications	✓	✓
Facility Credentialing Policy	✓	✓

5. OPERATIONAL IMPLEMENTATION OF PROCESSES AND STRATEGIES COMPARATIVE ANALYSIS:

NETWORK REJECTION ANALYSIS

The data in the tables below reflects the results of the credentialing process for both MH/SUD and Medical/Surgical providers applying for participation with the MultiPlan Networks. Overall acceptance and rejections percentages are broken out by state. These data demonstrate that the criteria are not applied more stringently to MH/SUD providers than Medical/Surgical providers, and instead, are applied comparably to both categories. Overall rejection rates demonstrate that the processes are comparable in practice with a difference of less than two tenths of a percentage point.

Data from Jan 1, 2022 to December 31, 2022 were used in this analysis. The rejection percentage is slightly higher in certain states (i.e., LA, UT, and WA), however, this is a result of lower volume of MH/SUD applicants applying to the MultiPlan Networks and not a disparity in the application of the Credentialing Factors. The same phenomenon can be observed for medical/surgical in Alaska.

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
National	Total Medical/Surgical	31057	30999	58	99.81%	0.19%
	Total MH/SUD Providers	10224	10214	10	99.90%	0.10%
	<i>Mental Health Only</i>	3056	3051	5	99.84%	0.16%
	<i>Substance Use Disorder Only</i>	100	100	0	100%	0.00%
	<i>Both Mental Health/ Substance Use Disorder*</i>	7068	7063	5	99.93%	0.16%
	Grand Total	41281	41213	68	99.84%	0.16%

* Practitioner type offers both Mental Health and Substance Use Disorder services

Appendix A contains a comparison among MH practitioners, SUD practitioners, and Medical/Surgical practitioners on a state-by-state basis that were rejected during the credentialing process.

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Percent Rejected	Percent Rejected
National	Total Medical/Surgical	3450	3450	0	0.00%
	Total MH/SUD Providers	664	664	0	0.00%
	<i>Mental Health Only</i>	345	345	0	0.00%
	<i>Substance Use Disorder Only</i>	202	202	0	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	117	117	0	0.00%
	Grand Total	4114	4114	0	0.00%

* Facility offers both Mental Health and Substance Use Disorder services

Appendix B contains a comparison among MH facilities, SUD facilities, and Medical/Surgical facilities on a state-by-state basis that were rejected during the credentialing process.

NON-DISCRIMINATION AUDIT RESULTS

On a quarterly basis, Multiplan reports credentialing outcomes data to the Quality Management Committee and conducts a discrimination audit where no less than a random sampling of 5% of all credentialing decisions resulting in a termination or rejection, including both Medical/Surgical and MH/SUD practitioners and facilities are reviewed for discriminatory decision making practices. A Network practitioner, not involved in the original credentialing decision, reviews the original credentialing decision and all contents of the credentialing file for evidence of discrimination. Results from calendar year 2022 are reflected below.

2022	Practitioners Rejected	Practitioners Terminated	Practitioners Reviewed for Non-Discrimination	Percent reviewed	Comment
Q1	31	128	8	5.03%	No instances of discrimination found
Q2	20	156	13	7.39%	No instances of discrimination found
Q3	21	169	14	7.37%	No instances of discrimination found
Q4	20	164	10	5.43%	No instances of discrimination found

PRACTITIONER CREDENTIALING COMPLETION TIME

MultiPlan credentialing decisions are required to be made within 180 days of the attestation date on the application to comply with the NCQA standards and MPI's Credentialing Policies. MultiPlan's turnaround times for processing credentialing applications for all provider specialties are typically 90 to 120 days from receipt of a complete application.

The data below includes the overall processing time of provider applications for participation in the MultiPlan network as compared to the 90 to 120 day goal.

2022	Type of Provider	Percentage of Total Providers	Average Processing Time
Providers Approved and Credentialed by the Network			
<i>Inpatient IN and Outpatient IN</i>	Medical /Surgical Providers	99.79%	90-120 Calendar Days
	MH/SUD Providers	99.92%	90-120 Calendar Days
Providers Denied Credentialing by the Network			
<i>Inpatient IN and Outpatient IN</i>	Medical /Surgical Providers	0.21%	90-120 Calendar Days
	MH/SUD Providers	0.08%	90-120 Calendar Days

As indicated below, MultiPlan's national average application processing time in 2022 was less than 26 days for all provider types. Furthermore, the average processing time for MH/SUD provider applications was two to five days shorter than the average processing time for Medical/Surgical provider applications. MultiPlan complies with the application processing time frames specified by applicable state and/or federal laws, as well as NCQA in order to maintain NCQA Network Accreditation in Credentialing for MultiPlan's PHCS Network. It should be noted that in 2022, MultiPlan's average processing time was



significantly shorter than the typical goal of processing within 90 to 120 days of receipt of completed application.

Practitioner Credentialing Data - TAT – 2022		
Practitioner Type	Calendar Days	Business Days
Total Medical/Surgical	25.32	18.04
Total MH/SUD Providers	22.74	16.18
<i>Mental Health Only</i>	23.02	16.37
<i>Substance Use Disorder Only</i>	19.73	14.01
<i>Both Mental Health/Substance Use Disorder*</i>	22.66	16.13
Aggregate Average	24.68	17.58

* Practitioner type offers both Mental Health and Substance Use Disorder services

RESCINDED APPLICATIONS

The table below shows the number of providers that voluntarily ended the application process without completing the credentialing process by category.

Practitioner Type	2022 Counts of Rescinded Applications
Medical/Surgical Practitioner Total	303
MH/SUD Practitioner Total	37
<i>MH Practitioner Only</i>	26
<i>SUD Practitioner Only</i>	0
<i>Both MH/SUD Practitioner</i>	11
Hospital Based Practitioner Total*	36
Specialty not identified Total	236
Grand Total of Rescinded Applications	612

*Hospital Based Practitioners are not subject to MultiPlan's Credentialing Program.

The majority of the rescinded applications were Medical/Surgical practitioners. The second largest grouping were providers that did not indicate their specialty designation prior to rescinding their application. The data indicates the application process is no more stringently applied to MH/SUD providers than Medical/Surgical providers, as shown by the significantly lower volume of MH/SUD providers rescinding their application. The percentage of MH/SUD provider applications rescinded compared to the MH/SUD provider applications received is 0.3%. The percentage of Medical/Surgical provider applications rescinded compared to the Medical/Surgical provider applications received is 0.9%. The MH/SUD provider application rescinded rate is lower than the rate for Medical/Surgical. As such, no inference can be made as to the inequitable implementation of the application process as it relates to rescinded applications.

6. FINDINGS/COMPLIANCE DETERMINATION:

Multiplan applies MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria to both Medical/Surgical and MH/SUD providers in the same manner, as written and in operation. The same set of policies and procedures are utilized to process and make Credentialing Decisions regarding Network participation for all provider applications, and the same staff members process MH/SUD provider files and Medical/Surgical provider files. As evidenced by the data and policy review depicted above, no criteria are applied more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan also conducts discrimination audits on a quarterly basis. An impartial physician reviewer audits a sample of credentialing rejections/terminations for any evidence of potential discrimination, including



any bias based on specialty or area of practice as well as any other form of discrimination. These findings, along with data on all credentialing outcomes, are reported to MultiPlan's Quality Management Committee where the information is reviewed to ensure quality and the equal application of policies and procedures.

The Credentialing Factors defined above are reflective of the credentialing process for all MultiPlan Network practitioners and facilities including both inpatient and outpatient services. All practitioners are credentialed to the same standard regardless of practice setting with the exception of Hospital Based Providers which are out of scope for credentialing in accordance with National Accreditation Standards. The MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria are not more stringently applied to any one provider population over another as evidenced by the credentialing outcome data, which shows no marked disparities between MH/SUD providers and Medical/Surgical providers. In fact, the data shows that, on average, the network rejects 0.21% of Medical/Surgical providers and only rejects 0.08% of MH/SUD providers. Although the volume of Medical/Surgical applicants is much larger than the MH/SUD providers, many more specialty categories fall into the Medical/Surgical category, which may explain the deviation.

Based on the above analysis, MultiPlan's processes, as applied in writing and operation, are comparable to and no more stringently applied to MH/SUD providers than to Medical/Surgical providers.

HISTORY:

Effective Date of Action	Description of Action
7/1/2021	Finalized Initial Analysis
9/1/2021	Revised for consistency between MultiPlan analyses
3/1/2022	Annual Review and Data Update Split out MH and SUD in reporting data
3/28/2022	Moved Data to Appendix
3/1/2023	Annual Review and Data Update Clarified acceptable provider certifications

APPENDIX A

NETWORK REJECTION ANALYSIS – PRACTITIONERS

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
AK	Total Medical/Surgical	146	144	2	98.63%	1.37%
	Total MH/SUD Providers	34	34	0	100.00%	0.00%
	<i>Mental Health Only</i>	4	4	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	30	30	0	100.00%	0.00%
	State Total	180	178	2	98.89%	1.11%
AL	Total Medical/Surgical	419	417	2	99.52%	0.48%
	Total MH/SUD Providers	38	38	0	100.00%	0.00%
	<i>Mental Health Only</i>	8	8	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	30	30	0	100.00%	0.00%
	State Total	457	455	2	99.56%	0.44%
AR	Total Medical/Surgical	292	292	0	100.00%	0.00%
	Total MH/SUD Providers	106	106	0	100.00%	0.00%
	<i>Mental Health Only</i>	27	27	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	78	78	0	100.00%	0.00%
	State Total	398	398	0	100.00%	0.00%
AZ	Total Medical/Surgical	750	744	6	99.20%	0.80%
	Total MH/SUD Providers	230	230	0	100.00%	0.00%
	<i>Mental Health Only</i>	135	135	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	3	3	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	92	92	0	100.00%	0.00%
	State Total	980	974	6	99.39%	0.61%
CA	Total Medical/Surgical	1108	1108	0	100.00%	0.00%
	Total MH/SUD Providers	474	474	0	100.00%	0.00%
	<i>Mental Health Only</i>	319	319	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	154	154	0	100.00%	0.00%
	State Total	1582	1582	0	100.00%	0.00%

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
CO	Total Medical/Surgical	914	913	1	99.89%	0.11%
	Total MH/SUD Providers	288	288	0	100.00%	0.00%
	<i>Mental Health Only</i>	114	114	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	6	6	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	168	168	0	100.00%	0.00%
	State Total	1202	1201	1	99.92%	0.08%
CT	Total Medical/Surgical	729	728	1	99.86%	0.14%
	Total MH/SUD Providers	185	185	0	100.00%	0.00%
	<i>Mental Health Only</i>	43	43	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	3	3	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	139	139	0	100.00%	0.00%
	State Total	914	913	1	99.89%	0.11%
DC	Total Medical/Surgical	41	41	0	100.00%	0.00%
	Total MH/SUD Providers	18	18	0	100.00%	0.00%
	<i>Mental Health Only</i>	4	4	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	14	14	0	100.00%	0.00%
	State Total	59	59	0	100.00%	0.00%
DE	Total Medical/Surgical	214	214	0	100.00%	0.00%
	Total MH/SUD Providers	53	53	0	100.00%	0.00%
	<i>Mental Health Only</i>	6	6	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	47	47	0	100.00%	0.00%
	State Total	267	267	0	100.00%	0.00%
FL	Total Medical/Surgical	2750	2747	3	99.89%	0.11%
	Total MH/SUD Providers	282	282	0	100.00%	0.00%
	<i>Mental Health Only</i>	100	100	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	181	181	0	100.00%	0.00%
	State Total	3032	3029	3	99.90%	0.10%

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
GA	Total Medical/Surgical	643	643	0	100.00%	0.00%
	Total MH/SUD Providers	262	261	1	99.62%	0.38%
	<i>Mental Health Only</i>	91	90	1	98.90%	1.10%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	171	171	0	100.00%	0.00%
	State Total	905	904	1	99.89%	0.11%
HI	Total Medical/Surgical	74	73	1	98.65%	1.35%
	Total MH/SUD Providers	18	18	0	100.00%	0.00%
	<i>Mental Health Only</i>	4	4	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	14	14	0	100.00%	0.00%
	State Total	92	91	1	98.91%	1.09%
IA	Total Medical/Surgical	208	207	1	99.52%	0.48%
	Total MH/SUD Providers	91	91	0	100.00%	0.00%
	<i>Mental Health Only</i>	21	21	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	5	5	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	65	65	0	100.00%	0.00%
	State Total	299	298	1	99.67%	0.33%
ID	Total Medical/Surgical	348	347	1	99.71%	0.29%
	Total MH/SUD Providers	200	200	0	100.00%	0.00%
	<i>Mental Health Only</i>	26	26	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	174	174	0	100.00%	0.00%
	State Total	548	547	1	99.82%	0.18%
IL	Total Medical/Surgical	761	760	1	99.87%	0.13%
	Total MH/SUD Providers	576	576	0	100.00%	0.00%
	<i>Mental Health Only</i>	98	98	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	477	477	0	100.00%	0.00%
	State Total	1337	1336	1	99.93%	0.07%

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
IN	Total Medical/Surgical	816	814	2	99.75%	0.25%
	Total MH/SUD Providers	201	201	0	100.00%	0.00%
	<i>Mental Health Only</i>	64	64	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	3	3	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	134	134	0	100.00%	0.00%
	State Total	1017	1015	2	99.80%	0.20%
KS	Total Medical/Surgical	535	533	2	99.63%	0.37%
	Total MH/SUD Providers	92	92	0	100.00%	0.00%
	<i>Mental Health Only</i>	18	18	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	3	3	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	71	71	0	100.00%	0.00%
	State Total	627	625	2	99.68%	0.32%
KY	Total Medical/Surgical	1125	1122	3	99.73%	0.27%
	Total MH/SUD Providers	382	381	1	99.74%	0.26%
	<i>Mental Health Only</i>	94	94	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	5	5	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	283	282	1	99.65%	0.35%
	State Total	1507	1503	4	99.73%	0.27%
LA	Total Medical/Surgical	365	365	0	100.00%	0.00%
	Total MH/SUD Providers	90	89	1	98.89%	1.11%
	<i>Mental Health Only</i>	25	24	1	96.00%	4.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	64	64	0	100.00%	0.00%
	State Total	455	454	1	99.78%	0.22%
MA	Total Medical/Surgical	1032	1032	0	100.00%	0.00%
	Total MH/SUD Providers	293	293	0	100.00%	0.00%
	<i>Mental Health Only</i>	66	66	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	10	10	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	217	217	0	100.00%	0.00%
	State Total	1325	1325	0	100.00%	0.00%

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
MD	Total Medical/Surgical	461	460	1	99.78%	0.22%
	Total MH/SUD Providers	144	144	0	100.00%	0.00%
	<i>Mental Health Only</i>	43	43	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	100	100	0	100.00%	0.00%
	State Total	605	604	1	99.83%	0.17%
ME	Total Medical/Surgical	390	390	0	100.00%	0.00%
	Total MH/SUD Providers	191	191	0	100.00%	0.00%
	<i>Mental Health Only</i>	30	30	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	160	160	0	100.00%	0.00%
	State Total	581	581	0	100.00%	0.00%
MI	Total Medical/Surgical	746	742	4	99.46%	0.54%
	Total MH/SUD Providers	690	690	0	100.00%	0.00%
	<i>Mental Health Only</i>	60	60	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	3	3	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	627	627	0	100.00%	0.00%
	State Total	1436	1432	4	99.72%	0.28%
MN	Total Medical/Surgical	281	280	1	99.64%	0.36%
	Total MH/SUD Providers	143	143	0	100.00%	0.00%
	<i>Mental Health Only</i>	48	48	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	95	95	0	100.00%	0.00%
	State Total	424	423	1	99.76%	0.24%
MO	Total Medical/Surgical	505	505	0	100.00%	0.00%
	Total MH/SUD Providers	128	128	0	100.00%	0.00%
	<i>Mental Health Only</i>	28	28	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	99	99	0	100.00%	0.00%
	State Total	633	633	0	100.00%	0.00%

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
MS	Total Medical/Surgical	132	132	0	100.00%	0.00%
	Total MH/SUD Providers	29	29	0	100.00%	0.00%
	<i>Mental Health Only</i>	9	9	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	20	20	0	100.00%	0.00%
	State Total	161	161	0	100.00%	0.00%
MT	Total Medical/Surgical	21	21	0	100.00%	0.00%
	Total MH/SUD Providers	4	4	0	100.00%	0.00%
	<i>Mental Health Only</i>	0	0	0	N/A	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	4	4	0	100.00%	0.00%
	State Total	25	25	0	100.00%	0.00%
NC	Total Medical/Surgical	726	722	4	99.45%	0.55%
	Total MH/SUD Providers	181	181	0	100.00%	0.00%
	<i>Mental Health Only</i>	39	39	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	9	9	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	133	133	0	100.00%	0.00%
	State Total	907	903	4	99.56%	0.44%
ND	Total Medical/Surgical	42	42	0	100.00%	0.00%
	Total MH/SUD Providers	9	9	0	100.00%	0.00%
	<i>Mental Health Only</i>	3	3	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	6	6	0	100.00%	0.00%
	State Total	51	51	0	100.00%	0.00%
NE	Total Medical/Surgical	111	111	0	100.00%	0.00%
	Total MH/SUD Providers	35	35	0	100.00%	0.00%
	<i>Mental Health Only</i>	4	4	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	30	30	0	100.00%	0.00%
	State Total	146	146	0	100.00%	0.00%

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
NH	Total Medical/Surgical	385	384	1	99.74%	0.26%
	Total MH/SUD Providers	78	78	0	100.00%	0.00%
	<i>Mental Health Only</i>	18	18	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	5	5	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	55	55	0	100.00%	0.00%
	State Total	463	462	1	99.78%	0.22%
NJ	Total Medical/Surgical	1358	1355	3	99.78%	0.22%
	Total MH/SUD Providers	265	265	0	100.00%	0.00%
	<i>Mental Health Only</i>	77	77	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	3	3	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	185	185	0	100.00%	0.00%
	State Total	1623	1620	3	99.82%	0.18%
NM	Total Medical/Surgical	267	267	0	100.00%	0.00%
	Total MH/SUD Providers	70	70	0	100.00%	0.00%
	<i>Mental Health Only</i>	18	18	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	52	52	0	100.00%	0.00%
	State Total	337	337	0	100.00%	0.00%
NV	Total Medical/Surgical	505	505	0	100.00%	0.00%
	Total MH/SUD Providers	75	75	0	100.00%	0.00%
	<i>Mental Health Only</i>	27	27	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	48	48	0	100.00%	0.00%
	State Total	580	580	0	100.00%	0.00%
NY	Total Medical/Surgical	2127	2124	3	99.86%	0.14%
	Total MH/SUD Providers	514	513	1	99.81%	0.19%
	<i>Mental Health Only</i>	148	148	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	366	365	1	99.73%	0.27%
	State Total	2641	2637	4	99.85%	0.15%

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
OH	Total Medical/Surgical	1277	1276	1	99.92%	0.08%
	Total MH/SUD Providers	360	358	2	99.44%	0.56%
	<i>Mental Health Only</i>	117	117	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	9	9	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	233	232	1	99.57%	0.43%
	State Total	1637	1634	3	99.82%	0.18%
OK	Total Medical/Surgical	650	649	1	99.85%	0.15%
	Total MH/SUD Providers	86	86	0	100.00%	0.00%
	<i>Mental Health Only</i>	25	25	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	60	60	0	100.00%	0.00%
	State Total	736	735	1	99.86%	0.14%
OR	Total Medical/Surgical	300	299	1	99.67%	0.33%
	Total MH/SUD Providers	63	63	0	100.00%	0.00%
	<i>Mental Health Only</i>	26	26	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	37	37	0	100.00%	0.00%
	State Total	363	362	1	99.72%	0.28%
PA	Total Medical/Surgical	2017	2017	0	100.00%	0.00%
	Total MH/SUD Providers	584	584	0	100.00%	0.00%
	<i>Mental Health Only</i>	72	72	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	2	2	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	510	510	0	100.00%	0.00%
	State Total	2601	2601	0	100.00%	0.00%
RI	Total Medical/Surgical	301	301	0	100.00%	0.00%
	Total MH/SUD Providers	71	71	0	100.00%	0.00%
	<i>Mental Health Only</i>	13	13	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	58	58	0	100.00%	0.00%
	State Total	372	372	0	100.00%	0.00%

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
SC	Total Medical/Surgical	343	341	2	99.42%	0.58%
	Total MH/SUD Providers	50	50	0	100.00%	0.00%
	<i>Mental Health Only</i>	9	9	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	41	41	0	100.00%	0.00%
	State Total	393	391	2	99.49%	0.51%
SD	Total Medical/Surgical	73	73	0	100.00%	0.00%
	Total MH/SUD Providers	16	16	0	100.00%	0.00%
	<i>Mental Health Only</i>	2	2	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	14	14	0	100.00%	0.00%
	State Total	89	89	0	100.00%	0.00%
TN	Total Medical/Surgical	848	848	0	100.00%	0.00%
	Total MH/SUD Providers	152	152	0	100.00%	0.00%
	<i>Mental Health Only</i>	64	64	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	88	88	0	100.00%	0.00%
	State Total	1000	1000	0	100.00%	0.00%
TX	Total Medical/Surgical	2081	2072	9	99.57%	0.43%
	Total MH/SUD Providers	1458	1458	0	100.00%	0.00%
	<i>Mental Health Only</i>	665	665	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	10	10	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	783	783	0	100.00%	0.00%
	State Total	3539	3530	9	99.75%	0.25%
UT	Total Medical/Surgical	327	327	0	100.00%	0.00%
	Total MH/SUD Providers	124	124	0	100.00%	0.00%
	<i>Mental Health Only</i>	37	36	1	97.30%	2.70%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	89	88	1	98.88%	1.12%
	State Total	451	451	0	100.00%	0.00%

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
VA	Total Medical/Surgical	677	677	0	100.00%	0.00%
	Total MH/SUD Providers	245	245	0	100.00%	0.00%
	<i>Mental Health Only</i>	54	54	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	3	3	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	188	188	0	100.00%	0.00%
	State Total	922	922	0	100.00%	0.00%
VT	Total Medical/Surgical	91	91	0	100.00%	0.00%
	Total MH/SUD Providers	32	32	0	100.00%	0.00%
	<i>Mental Health Only</i>	10	10	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	1	1	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	21	21	0	100.00%	0.00%
	State Total	123	123	0	100.00%	0.00%
WA	Total Medical/Surgical	231	230	1	99.57%	0.43%
	Total MH/SUD Providers	68	67	1	98.53%	1.47%
	<i>Mental Health Only</i>	35	35	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	33	32	1	96.97%	3.03%
	State Total	299	297	2	99.33%	0.67%
WI	Total Medical/Surgical	253	253	0	100.00%	0.00%
	Total MH/SUD Providers	401	401	0	100.00%	0.00%
	<i>Mental Health Only</i>	100	99	1	99.00%	1.00%
	<i>Substance Use Disorder Only</i>	7	7	0	100.00%	0.00%
	<i>Both Mental Health/Substance Use Disorder*</i>	296	295	1	99.66%	0.34%
	State Total	654	654	0	100.00%	0.00%
WV	Total Medical/Surgical	213	212	1	99.53%	0.47%
	Total MH/SUD Providers	37	37	0	100.00%	0.00%
	<i>Mental Health Only</i>	7	7	0	100.00%	0.00%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	30	30	0	100.00%	0.00%
	State Total	250	249	1	99.60%	0.40%

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
WY	Total Medical/Surgical	49	49	0	100.00%	0.00%
	Total MH/SUD Providers	5	5	0	100.00%	0.00%
	<i>Mental Health Only</i>	0	0	0	N/A	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	5	5	0	100.00%	0.00%
	State Total	54	54	0	100.00%	0.00%

** Practitioner type offers both Mental Health and Substance Use Disorder services*

APPENDIX B

NETWORK REJECTION ANALYSIS – FACILITIES

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
AK	Total Medical/Surgical	10	10	0	0.00%
	Total MH/SUD Providers	0	0	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	10	10	0	0.00%
AL	Total Medical/Surgical	35	35	0	0.00%
	Total MH/SUD Providers	0	0	0	0.00%
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	35	35	0	0.00%
AR	Total Medical/Surgical	32	32	0	0.00%
	Total MH/SUD Providers	2	2	0	0.00%
	<i>Mental Health Only</i>	2	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	State Total	34	34	0	0.00%
AZ	Total Medical/Surgical	80	80	0	0.00%
	Total MH/SUD Providers	15	15	0	0.00%
	<i>Mental Health Only</i>	11	11	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	3	3	0	N/A
	State Total	95	95	0	0.00%
CA	Total Medical/Surgical	221	221	0	0.00%
	Total MH/SUD Providers	170	170	0	0.00%
	<i>Mental Health Only</i>	82	82	0	N/A
	<i>Substance Use Disorder Only</i>	54	54	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	34	34	0	N/A
	State Total	391	391	0	0.00%

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
CO	Total Medical/Surgical	105	105	0	0.00%
	Total MH/SUD Providers	8	8	0	0.00%
	<i>Mental Health Only</i>	6	6	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	2	2	0	N/A
	State Total	113	113	0	0.00%
CT	Total Medical/Surgical	26	26	0	0.00%
	Total MH/SUD Providers	7	7	0	0.00%
	<i>Mental Health Only</i>	4	4	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	1	1	0	N/A
	<i>Substance Use Disorder Only</i>	2	2	0	N/A
	State Total	33	33	0	0.00%
DE	Total Medical/Surgical	4	4	0	0.00%
	Total MH/SUD Providers	0	0	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	State Total	4	4	0	0.00%
DC	Total Medical/Surgical	0	0	0	N/A
	Total MH/SUD Providers	0	0	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	State Total	0	0	0	N/A
FL	Total Medical/Surgical	223	223	0	0.00%
	Total MH/SUD Providers	20	20	0	0.00%
	<i>Mental Health Only</i>	11	11	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	8	8	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	State Total	243	243	0	0.00%

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
GA	Total Medical/Surgical	98	98	0	0.00%
	Total MH/SUD Providers	1	1	0	0.00%
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	99	99	0	0.00%
HI	Total Medical/Surgical	9	9	0	0.00%
	Total MH/SUD Providers	7	7	0	0.00%
	<i>Mental Health Only</i>	1	1	0	N/A
	<i>Substance Use Disorder Only</i>	6	6	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	16	16	0	0.00%
IA	Total Medical/Surgical	17	17	0	0.00%
	Total MH/SUD Providers	5	5	0	0.00%
	<i>Mental Health Only</i>	1	1	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	4	4	0	N/A
	State Total	22	22	0	0.00%
ID	Total Medical/Surgical	30	30	0	0.00%
	Total MH/SUD Providers	0	0	0	0.00%
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	30	30	0	0.00%
IL	Total Medical/Surgical	162	162	0	0.00%
	Total MH/SUD Providers	52	52	0	0.00%
	<i>Mental Health Only</i>	31	31	0	N/A
	<i>Substance Use Disorder Only</i>	11	11	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	10	10	0	N/A
	State Total	214	214	0	0.00%

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
IN	Total Medical/Surgical	102	102	0	0.00%
	Total MH/SUD Providers	12	12	0	0.00%
	<i>Mental Health Only</i>	5	5	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	6	6	0	N/A
	State Total	114	114	0	0.00%
KS	Total Medical/Surgical	62	62	0	0.00%
	Total MH/SUD Providers	7	7	0	0.00%
	<i>Mental Health Only</i>	3	3	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	4	4	0	N/A
	State Total	69	69	0	0.00%
KY	Total Medical/Surgical	83	83	0	0.00%
	Total MH/SUD Providers	0	0	0	0.00%
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	83	83	0	0.00%
LA	Total Medical/Surgical	53	53	0	0.00%
	Total MH/SUD Providers	1	1	0	0.00%
	<i>Mental Health Only</i>	1	1	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	54	54	0	0.00%
MA	Total Medical/Surgical	31	31	0	0.00%
	Total MH/SUD Providers	6	6	0	0.00%
	<i>Mental Health Only</i>	5	5	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	1	1	0	N/A
	State Total	37	37	0	0.00%

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
MD	Total Medical/Surgical	58	58	0	0.00%
	Total MH/SUD Providers	5	5	0	0.00%
	<i>Mental Health Only</i>	4	4	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	63	63	0	0.00%
ME	Total Medical/Surgical	6	6	0	0.00%
	Total MH/SUD Providers	0	0	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	6	6	0	0.00%
MI	Total Medical/Surgical	86	86	0	0.00%
	Total MH/SUD Providers	31	31	0	0.00%
	<i>Mental Health Only</i>	17	17	0	N/A
	<i>Substance Use Disorder Only</i>	14	14	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	117	117	0	0.00%
MN	Total Medical/Surgical	34	34	0	0.00%
	Total MH/SUD Providers	15	15	0	0.00%
	<i>Mental Health Only</i>	11	11	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	3	3	0	N/A
	State Total	49	49	0	0.00%
MO	Total Medical/Surgical	63	63	0	0.00%
	Total MH/SUD Providers	17	17	0	0.00%
	<i>Mental Health Only</i>	10	10	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	6	6	0	N/A
	State Total	80	80	0	0.00%

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
MS	Total Medical/Surgical	30	30	0	0.00%
	Total MH/SUD Providers	2	2	0	0.00%
	<i>Mental Health Only</i>	2	2	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	32	32	0	0.00%
MT	Total Medical/Surgical	8	8	0	0.00%
	Total MH/SUD Providers	0	0	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	8	8	0	0.00%
NC	Total Medical/Surgical	98	98	0	0.00%
	Total MH/SUD Providers	5	5	0	0.00%
	<i>Mental Health Only</i>	2	2	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	2	2	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	State Total	103	103	0	0.00%
ND	Total Medical/Surgical	5	5	0	0.00%
	Total MH/SUD Providers	0	0	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	State Total	5	5	0	0.00%
NE	Total Medical/Surgical	37	37	0	0.00%
	Total MH/SUD Providers	5	5	0	N/A
	<i>Mental Health Only</i>	3	3	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	2	2	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	State Total	42	42	0	0.00%

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
NH	Total Medical/Surgical	29	29	0	0.00%
	Total MH/SUD Providers	1	1	0	N/A
	<i>Mental Health Only</i>	1	1	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	30	30	0	0.00%
NJ	Total Medical/Surgical	75	75	0	0.00%
	Total MH/SUD Providers	15	15	0	0.00%
	<i>Mental Health Only</i>	6	6	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	9	9	0	N/A
	State Total	90	90	0	0.00%
NM	Total Medical/Surgical	10	10	0	0.00%
	Total MH/SUD Providers	3	3	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	3	3	0	N/A
	State Total	13	13	0	0.00%
NV	Total Medical/Surgical	24	24	0	0.00%
	Total MH/SUD Providers	1	1	0	0.00%
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	1	1	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	State Total	25	25	0	0.00%
NY	Total Medical/Surgical	122	122	0	0.00%
	Total MH/SUD Providers	20	20	0	0.00%
	<i>Mental Health Only</i>	12	12	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	4	4	0	N/A
	<i>Substance Use Disorder Only</i>	4	4	0	N/A
	State Total	142	142	0	0.00%

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
OH	Total Medical/Surgical	207	207	0	0.00%
	Total MH/SUD Providers	12	12	0	0.00%
	<i>Mental Health Only</i>	8	8	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	2	2	0	N/A
	<i>Substance Use Disorder Only</i>	2	2	0	N/A
	State Total	219	219	0	0.00%
OK	Total Medical/Surgical	34	34	0	0.00%
	Total MH/SUD Providers	5	5	0	N/A
	<i>Mental Health Only</i>	3	3	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	1	1	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	State Total	39	39	0	0.00%
OR	Total Medical/Surgical	31	31	0	0.00%
	Total MH/SUD Providers	10	10	0	0.00%
	<i>Mental Health Only</i>	9	9	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	State Total	41	41	0	0.00%
PA	Total Medical/Surgical	136	136	0	0.00%
	Total MH/SUD Providers	33	33	0	0.00%
	<i>Mental Health Only</i>	15	15	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	8	8	0	N/A
	<i>Substance Use Disorder Only</i>	10	10	0	N/A
	State Total	169	169	0	0.00%
RI	Total Medical/Surgical	7	7	0	0.00%
	Total MH/SUD Providers	0	0	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	State Total	7	7	0	0.00%

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
SC	Total Medical/Surgical	27	27	0	0.00%
	Total MH/SUD Providers	8	8	0	0.00%
	<i>Mental Health Only</i>	6	6	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	2	2	0	N/A
	State Total	35	35	0	0.00%
SD	Total Medical/Surgical	6	6	0	0.00%
	Total MH/SUD Providers	0	0	0	0.00%
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	6	6	0	0.00%
TN	Total Medical/Surgical	94	94	0	0.00%
	Total MH/SUD Providers	4	4	0	0.00%
	<i>Mental Health Only</i>	2	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	2	0	0	N/A
	State Total	98	98	0	0.00%
TX	Total Medical/Surgical	598	598	0	0.00%
	Total MH/SUD Providers	99	99	0	0.00%
	<i>Mental Health Only</i>	36	36	0	N/A
	<i>Substance Use Disorder Only</i>	58	58	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	5	5	0	N/A
	State Total	697	697	0	0.00%
UT	Total Medical/Surgical	27	27	0	0.00%
	Total MH/SUD Providers	27	27	0	0.00%
	<i>Mental Health Only</i>	14	14	0	N/A
	<i>Substance Use Disorder Only</i>	11	11	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	2	2	0	N/A
	State Total	54	54	0	0.00%

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
VA	Total Medical/Surgical	42	42	0	0.00%
	Total MH/SUD Providers	12	12	0	0.00%
	<i>Mental Health Only</i>	11	11	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	54	54	0	0.00%
VT	Total Medical/Surgical	3	3	0	0.00%
	Total MH/SUD Providers	0	0	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	State Total	3	3	0	0.00%
WA	Total Medical/Surgical	42	42	0	0.00%
	Total MH/SUD Providers	7	7	0	0.00%
	<i>Mental Health Only</i>	2	2	0	N/A
	<i>Substance Use Disorder Only</i>	2	2	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	3	3	0	N/A
	State Total	49	49	0	0.00%
WI	Total Medical/Surgical	81	81	0	0.00%
	Total MH/SUD Providers	14	14	0	0.00%
	<i>Mental Health Only</i>	8	8	0	N/A
	<i>Substance Use Disorder Only</i>	5	5	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	1	1	0	N/A
	State Total	95	95	0	0.00%
WV	Total Medical/Surgical	40	40	0	0.00%
	Total MH/SUD Providers	0	0	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	40	40	0	0.00%

Facility Credentialing Data - 2022					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
WY	Total Medical/Surgical	7	7	0	0.00%
	Total MH/SUD Providers	0	0	0	N/A
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	0	0	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	7	7	0	0.00%



MENTAL HEALTH PARITY COMPARATIVE ANALYSIS

DATE PREPARED: March 1, 2023

SUBJECT MATTER: MultiPlan, Inc. Negotiation Services

PREPARED BY: Allison Russell, AVP, Negotiation Services

INTRODUCTION

This comparative analysis is intended to measure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), as amended by the Consolidated Appropriations Act of 2021.

Group health plans must ensure that the financial requirements and treatment limitations on mental health or substance use disorder benefits they provide are no more restrictive than those on medical or surgical benefits. Treatment limitations may be quantitative treatment limitations (“QTLs”) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (“NQTLs”), which are non-numerical limits on the scope or duration of benefits for treatment.¹ NQTLs are processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Examples of NQTLs include, but are not limited to, medical management standards limiting benefits based on medical necessity, and network admission standards such as credentialing or reimbursement rates. Effective February 10, 2021, group health plans must perform a comparative analysis of NQTLs that apply to mental health and substance use disorder (“MH/SUD”) treatments to ensure that such NQTLs are comparable to, and no more restrictive than, those treatment limitations applicable for medical and/or surgical (“Medical/Surgical”) services. The law does not prohibit the use of NQTLs as long as they are not applied more stringently to MH/SUD benefits as compared to Medical/Surgical benefits. Disparate results do not necessarily indicate a violation of the MHPAEA, so long as comparable processes are followed.

MultiPlan, on behalf of itself and its subsidiaries (collectively “MultiPlan”) is neither a healthcare provider nor an insurance company, and does not reimburse physicians, hospitals, or other healthcare providers for their services. MultiPlan does not pay claims, determine eligibility, or make benefit determinations; those responsibilities lie with MultiPlan clients (collectively “Clients”), which include insurance companies, third-party administrators, health plans, HMOs, Taft-Hartley Funds, and other organizations. The federal regulations prohibiting the imposition of a discriminatory NQTL for MH/SUD services does not directly apply to MultiPlan. However, Clients purchasing access to MultiPlan’s Negotiation Services, as defined below, may require information from MultiPlan to assist with their compliance of these federal requirements. MultiPlan’s services include access to both MH/SUD and Medical/Surgical providers.

¹ See 29 CFR 2590.712(c)(2)-(3) for the test for financial requirements and QTLs and 29 CFR 2590.712(c)(4) for the requirements for NQTLs. 26 CFR 54.9812-1(c)(2)-(4); 29 CFR 2590.712(c)(2)-(4); 45 CFR 146.136(c)(2)-(4); and 147.160.



This comparative analysis is specific to MultiPlan’s Negotiation Services, including an analysis of MultiPlan’s Financial Negotiation Services and Clinical Negotiation Services, for those Clients that purchase access to MultiPlan’s Negotiation Services. Please note that although the regulation refers to the parity of “reimbursement,” this document will discuss the parity of the amount negotiated with providers, as described below, since MultiPlan does not “reimburse” providers. MultiPlan has adopted the six-step analysis outlined by the Kennedy Forum for conducting a comparative analysis.²

1. DESCRIPTION OF NQTL: NEGOTIATION SERVICES – FINANCIAL NEGOTIATION SERVICES AND CLINICAL NEGOTIATION SERVICES

MultiPlan offers two types of negotiation services which may be accessed jointly or individually by Clients: (i) Financial Negotiation Services, and (ii) Clinical Negotiation Services (collectively “Negotiation Services”). A more detailed description of each service is provided below. Negotiation Services offered to Clients were identified as NQTLs requiring a comparative analysis to ensure that the processes are applied no more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan utilizes a standard set of criteria for Financial Negotiation Services and Clinical Negotiation Services as part of the Negotiation Services, and does not differentiate in the application of those criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. Negotiations Services with MH/SUD providers are managed in the same fashion, using the same contract documents, rate methodologies, and processes as all other providers.

As supported by this comparative analysis, MultiPlan does not establish NQTLs on, or implied through, relationships with providers, as written and/or in operation, that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services. MultiPlan’s policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

FINANCIAL NEGOTIATION SERVICES

MultiPlan’s Financial Negotiation Services provide Clients with access to negotiated reductions on claims for health care services rendered to the Client’s members by out-of-network health care providers (“Financial Negotiation Services”). A provider may be considered “out-of-network” if the provider has not contractually agreed to participate in a MultiPlan network and/or a Client’s network. Financial Negotiation Services by MultiPlan may be initiated before or after the services are rendered, but typically occur prior to payment for such health care services. As part of Financial Negotiation Services, MultiPlan utilizes prevailing market reimbursement amounts to negotiate reductions with out-of-network providers, and in exchange, the out-of-network providers agree not to balance bill the Client’s members for the difference between the agreed upon negotiated reduction and the provider’s billed charges. Although many negotiations start with a “single case” negotiation agreement for health care services rendered to a specific member for a specific date of service, a provider may also agree to a reduction on all future claims for a single member or when billing for a specific service, or may agree to a reduction on

² Tim Clement, MPH, et al, *The “Six-Step” Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements*, the Kennedy Forum, Sep. 2017, https://s3.amazonaws.com/pjk-wpuploads/www.paritytrack.org/uploads/2017/09/six_step_issue_brief.pdf.



all future claims for all members when the provider bills with a specific tax identification number. Financial Negotiation Services apply to both MH/SUD and Medical/Surgical providers.

MultiPlan Financial Negotiation Services with out-of-network health care providers are based on comprehensive financial benchmarks, including publicly-available claim pricing data, MultiPlan's provider network performance with like claims, and MultiPlan's proprietary commercial benchmarks which are based on the amounts generally accepted by providers as payment in full ("MultiPlan's Proprietary Valuation Tool").

CLINICAL NEGOTIATION SERVICES

Similar to MultiPlan's Financial Negotiation Services, Clinical Negotiation Services:

- Take place after services have been rendered but prior to payment to providers for the services.
- Result in written agreements with providers where each agreement specifies reimbursement for an individual claim.
- Consider prevailing market reimbursement amounts when negotiating with providers.
- Include language in the agreements to help protect the Client's members from balance billing.
- Follow the same processes to seek agreement with MH/SUD providers and Medical/Surgical providers.

Clinical Negotiation Services differ from Financial Negotiation Services in that Clinical Negotiations involve an enhanced discussion between MultiPlan and the provider regarding potential billing waste, abuse, or errors identified on the individual claims. MultiPlan and providers often agree to lower reimbursement amounts to account for charge reductions related to the issues identified on claims. Since Clinical Negotiations attempt to correct for potential billing waste, abuse, or errors, negotiations are pursued with providers that have a MultiPlan network contract (where the contract allows) as well as out-of-network providers.

MultiPlan identifies billing issues on claims using a proprietary claims analytic system that evaluates the claims against industry-standard medical coding rules and clinical guidelines. The system then scores the claims to determine which claims should be resolved through Financial Negotiations versus Clinical Negotiations. The scoring process takes into account charges associated with the billing issues, confidence in the accuracy of the issues on the specific claim, and historical experience with the providers. A portion of the claims selected for Clinical Negotiations may be reviewed by certified medical coders, nurses and/or physicians to further evaluate the applicability of the system-identified issues. After analysis and expert evaluation of the claims, Clinical Negotiations are completed by negotiators who are specially trained in billing waste, abuse, and errors.

2. FACTORS USED IN NEGOTIATION SERVICES:

Financial Negotiation Services and Clinical Negotiation Services have been established by MultiPlan to ensure that: (i) Clients and their members have access to the greatest possible discount for health care services rendered to members which is based on prevailing market reimbursement data, while also offering members protection against balance billing for the difference between the agreed upon negotiated reduction and the provider's billed charges; (ii) MultiPlan applies consistent negotiation processes and standards throughout the organization when negotiating with MH/SUD and Medical/Surgical provider types for reductions on out of network health care services; and (iii) the



negotiated discounts offered to, and agreed upon by, out-of-network providers are offered, processed, and managed in the same manner for MH/SUD providers as for all other provider types.

“FINANCIAL NEGOTIATION SERVICES FACTORS” CONSIDERED FOR OUT-OF-NETWORK CLAIMS

As introduced above, the primary goal of Financial Negotiation Services is to provide the greatest possible savings to MultiPlan Clients and their members, which is agreed upon by the out-of-network provider, using a number of informational statistics and criteria as a baseline for negotiations (“Financial Negotiation Services Factors”). The grid below identifies the Financial Negotiation Services Factors used when negotiating a discount for health care services with an out-of-network provider on behalf of Clients who have purchased access to Financial Negotiation Services.

Financial Negotiation may vary depending on whether the negotiation is for a single case (i.e., single patient for specific date of service) or whether the provider agreed to a more global approach to a negotiated discount. The same process is used to negotiate with both MH/SUD and Medical/Surgical providers, even though outcomes may differ.

Factor	Description	Outpatient (Physician) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Allowed Amount	Clients may identify an Allowed Amount which Negotiation Services must negotiate below in order for the Client to elect to access the negotiated discount. The negotiated amount may differ from claim to claim, but the process produces the same target discount amount in the same market, and the Client determines if they will access the negotiated amount, based on their Allowed Amount determination.	✓	✓	✓	✓
Medicare Reimbursement Benchmark	The negotiation system captures Medicare rates for billed services which are used as a reference point for negotiations to compare billed charges to Medicare reimbursement. This information may be used in discussion or as a basis to generate an offer to a provider.	✓	✓	✓	✓
MultiPlan’s Proprietary Valuation Tool	The negotiation system captures the value established by MultiPlan’s Proprietary Valuation Tool which is used as a reference point for negotiations with a provider.	✓	✓	✓	✓

Factor	Description	Outpatient (Physician) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Negotiation Agreement	An agreement with a provider for an agreed upon rate for a claim. Financial Negotiation agreements may be for (i) a single case agreement; (ii) all claims submitted for all Clients and all patients; or (iii) all claims associated with a specific Client or specific patient.	✓	✓	✓	✓

“CLINICAL NEGOTIATION SERVICES FACTORS” CONSIDERED

Clinical Negotiation Services start with an automated computer analysis of claims used to identify potential billing waste, abuse, or errors. The analysis relies upon industry-standard medical coding rules and clinical guidelines that are publically available and sponsored by well-recognized entities such as Medicare and the American Medical Association. When applicable, the analysis may also incorporate billing rules and guidelines utilized by MultiPlan’s Clients. Common issues identified during the automated analysis include:

- billing a procedure that is inconsistent with the place of service (e.g. billing for a hospital emergency room visit in a doctor’s office)
- billing both a component procedure and a more comprehensive procedure that includes the component (e.g. billing an EKG and a cardiac stress test that includes an EKG)
- billing an incorrect number of services (e.g. can only bill one service per day when the service is defined as a per diem service)
- billing for incompatible procedures (repair an organ and remove an organ)

Note that MultiPlan does not create its own billing rules and guidelines. Instead, MultiPlan identifies billing waste, abuse, and errors based on the rules and guidelines published by reputable health care entities. MultiPlan also does not authorize services, deny services, perform utilization review, or determine the necessity of services. MultiPlan’s claims analysis focuses on the correctness of the procedure, diagnosis, and other codes reported on claims.

The grid below identifies the Clinical Negotiation Services Factors used by MultiPlan when reviewing and negotiating MultiPlan network claims and out-of-network claims with providers on behalf of Clients.

Factor	Description	Outpatient (Professional) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Billing waste, abuse, and errors analysis	Automated computerized analysis of claims data to identify potential billing situations that conflict with industry-standard coding rules and clinical guidelines. Expert review may occur on a portion of the claims to validate applicability of issues on the claims.	✓	✓	✓	✓

Factor	Description	Outpatient (Professional) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Allowed Amount	Clients may identify an Allowed Amount which Negotiation Services must negotiate below in order for Client to elect to access the Negotiation Services agreement.	✓	✓	✓	✓
Medicare Reimbursement Benchmark	The negotiation system captures Medicare rates for billed services which are used as a reference point for negotiations to compare billed charges to Medicare reimbursement.	✓	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	The negotiation system captures the value established by MultiPlan's Proprietary Valuation Tool which is used as a reference point for negotiations with a provider.	✓	✓	✓	✓
Negotiation Agreement	An agreement with a provider for an agreed upon rate for a claim. Clinical Negotiation agreements are for a single case agreement only.	✓	✓	✓	✓

3. EVIDENTIARY STANDARDS RELIED UPON TO FORMULATE THE NEGOTIATION SERVICES NQTL:

MultiPlan's established proprietary processes and policies, industry-standard analytics, and guidelines, as well as certain state and federal requirements, are used to formulate the criteria that establish the Negotiation Services Factors. These evidentiary standards support MultiPlan's determinations of what constitutes an effective Negotiation Services program.

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING FINANCIAL NEGOTIATION SERVICES FACTORS

The evidentiary standards for the Financial Negotiation Services Factors used in developing the processes for the review and negotiation of out-of-network MH/SUD and Medical/Surgical claims submitted to MultiPlan by Clients are detailed below:

Factor	Evidentiary Standard	MH/SUD		Medical Surgical Providers
		MH Providers	SUD Providers	
Allowed Amount	1. Client-Defined (Usual and Customary amount may vary depending on source used by Client). MultiPlan does not establish this target value.	✓	✓	✓
Medicare Reimbursement Benchmark	1. Reimbursement methods and rates published by CMS 2. Publically available fee schedules published by CMS	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	1. Relative Value Units (RVU) 2. Geographic Practice Cost Indices (GPCI) 3. Publicly Available Data Sets	✓	✓	✓

Factor	Evidentiary Standard	MH/SUD		Medical Surgical Providers
		MH Providers	SUD Providers	
Negotiation Agreement	1. The creation, negotiation criteria, processing and application of the Financial Negotiation agreements are standardized to ensure a consistent process.	✓	✓	✓

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING CLINICAL NEGOTIATION SERVICES FACTORS

The evidentiary standards for the Clinical Negotiation Services Factors used in developing the processes for the review and negotiation of MultiPlan network and out-of-network Medical/Surgical and MH/SUD claims submitted to MultiPlan by Clients are detailed below:

Factor	Evidentiary Standard	MH/SUD		Medical Surgical Providers
		MH Providers	SUD Providers	
Billing waste, abuse, and errors analysis	<ol style="list-style-type: none"> 1. CPT coding guidelines published by the American Medical Association 2. National Correct Coding Initiative (NCCI) publically available data files and manuals 3. Outpatient Code Editor (OCE) publically-available data files and manuals for outpatient facility services 4. Resource-Based Relative Value Scale (RBRVS) publically available data files and manuals for professional reimbursement 5. HCPCS coding guidelines published by the American Hospital Association 6. Health care billing instructions published by the National Uniform Billing Committee for facility billing 7. Standards and guidelines published by coding organizations (e.g. AAPC, American Health Information Management Association (AHIMA)) 8. Standards and guidelines published by Professional Medical Associations (e.g. American Society of Anesthesiologists) 9. State regulations related to state-specific workers' compensation programs 10. Client policies regarding reimbursement guidelines (applies only to specific Client's claims) 11. Provider-Specific – When industry standards are not met, indicates if the provider is a statistical outlier for frequency of billing inaccuracy 	✓	✓	✓

Factor	Evidentiary Standard	MH/SUD		Medical Surgical Providers
		MH Providers	SUD Providers	
Allowed Amount	1. Client-Defined (Usual and Customary amount may vary depending on source used by Client). MultiPlan does not have establish this target value.	✓	✓	✓
Medicare Benchmark	1. Reimbursement methods and rates published by CMS 2. Publically available fee schedules published by CMS	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	1. Relative Value Units (RVU) 2. Geographic Practice Cost Indices (GPCI) 3. Publicly Available Data Sets	✓	✓	✓
Negotiation Agreement	1. The creation, negotiation criteria, processing, and application of the Clinical Negotiation agreements are standardized to ensure a consistent process.	✓	✓	✓

4. WRITTEN POLICY AND PROCESS COMPARATIVE ANALYSIS:

This section includes the comparative analysis of MultiPlan's Negotiation Services processes to ensure that MultiPlan processes are applied no more stringently to MH/SUD providers than they would be to Medical/Surgical service providers. A summary of processes as outlined in MultiPlan proprietary policies and procedures is included.

DESCRIPTION OF THE NEGOTIATION SERVICES NQTL PROCESSES

For Clients utilizing Financial Negotiation Services, the Client will determine what types of claims should be considered (i.e., practitioner and/or facility), and may also establish a minimum claim threshold amount before a claim will be eligible for Negotiation Services (e.g., review claims over \$1,000.00 only). Once claim eligibility is established per the Client's criteria, MultiPlan will verify the provider's information to confirm whether the MH/SUD or Medical/Surgical provider has made a request not to be contacted or has a history of unsuccessful negotiations, in which case the claim will be returned to the Client without MultiPlan attempting to conduct a Financial Negotiation. For those claims deemed eligible for Financial Negotiation Services, MultiPlan will contact the provider to attempt to negotiate.

A similar claim eligibility process is followed for Clients that have purchased Clinical Negotiation Services as it relates to claim thresholds only, but eligibility is not limited based on Client defined claim type (i.e., practitioner or facility). However, using the Waste and Abuse Review Factors described in the table above, the claim may also be reviewed to determine whether industry-standard billing and coding practices were followed. If there is evidence of waste or abuse, then the claim becomes a Clinical Negotiation Services claim and clinical negotiations are attempted. All providers for Clinical Negotiation Services are contacted due to the identified irregularities in the claim. If a Client purchases access to both Financial Negotiation Services and Clinical Negotiation Services, unsuccessful Clinical Negotiations may be forwarded to Financial Negotiations Services if the provider has an existing Financial Negotiation Agreement.

Once MultiPlan contacts the provider to attempt a financial or clinical negotiation, the negotiation generally ends in the three possible outcomes: (1) signed agreement with a negotiated amount; (2) no



agreement is reached by time frame allowed by the Client to obtain an agreement; or (3) no agreement is reached because the provider has not agreed to terms consistent with negotiation criteria established by the Client. The same process is used to negotiate with both MH/SUD and Medical/Surgical providers, even though outcomes may differ. MultiPlan does not apply processes more stringently to MH/SUD providers that it does for Medical/Surgical providers.

NEGOTIATION SERVICES NQTL POLICY AUDIT RESULTS

The Negotiation Services policies and procedures are applied consistently for all claims and all provider types, which includes both MH/SUD and Medical/Surgical providers. Specific exceptions may be applied for a particular provider type (professional or facility), however, those exceptions are applied consistently for the applicable provider type (e.g., modifiers such as multiple procedures, bi-lateral, assistant surgeon, co-surgeon, and anesthesia that are applicable to professional providers but are not applicable to facility providers).

The previous subsections include a general overview of the content of the policies reviewed to ensure consistent application to all providers, MH/SUD or Medical/Surgical, equally. Therefore, the chart below includes an analysis of the content to support the findings of an internal review of MultiPlan's written policies.

POLICY DESCRIPTION	POLICY CONTENTS	APPLICABILITY		
		MH/SUD		MEDICAL/ SURGICAL PROVIDERS
		MH PROVIDERS	SUD PROVIDERS	
Negotiation Services Agreements Policy	1. Written agreement between MultiPlan and out-of-network providers for a predetermined discount amount. 2. Ambulatory Surgical Centers are eligible for a single case agreement but not for a global negotiated agreement.	✓ N/A	✓ N/A	✓ ✓
Assistant Surgeon and Co-Surgeon Claims Policy	1. Reduction in negotiated amount based on industry standard practices for Assistant Surgeons and Co-Surgeons.	N/A	N/A	✓
Unsuccessful Negotiation History Provider Policy	1. A provider with a history of unsuccessful negotiations may prefer not be contacted to negotiate a reduction in billed charges.	✓	✓	✓
Patient Benefits Policy	1. During negotiations, if a provider requests a copy of the patient's benefit plan, MultiPlan may request such information from the Client or refer the provider to the insurer for benefit information. MultiPlan's Clients are responsible for benefit requirements, benefit determinations, and payment for healthcare services.	✓	✓	✓
Stop Negotiation Policies	1. Negotiations for claims submitted with eligible charges that exceed the Client's Allowed Amount or payor liability, as determined by benefit plan design, may be	✓	✓	✓

POLICY DESCRIPTION	POLICY CONTENTS	APPLICABILITY		
		MH/SUD		MEDICAL/ SURGICAL PROVIDERS
		MH PROVIDERS	SUD PROVIDERS	
	discontinued. MultiPlan does not determine the Allowed Amount or make benefit determinations. The same Allowed Amount for an individual Client is used for both MH/SUD claims and Medical/Surgical claims.			
Claim Negotiation Timelines Policy	<ol style="list-style-type: none"> 1. Time frame established for contacting a provider after receipt of claim. 2. Automated reminders are sent on the specific dates following the initial contact. 3. Negotiations must close by the Client's claim due date identified on each claim, unless an extension is granted by the Client due to potential for high likelihood of a successful negotiation identified by MultiPlan. 	✓	✓	✓
Multiple Bilateral Surgery Claims Guide Policy	<ol style="list-style-type: none"> 1. Claims with surgical modifiers 50 and 51 require industry-standard reductions for procedures performed at the same time that share resources or are on identical opposing structures. 	N/A	N/A	✓
Anesthesia Claims Policy	<ol style="list-style-type: none"> 1. Claims with modifiers QK, QX, or QY require minimum reductions for anesthesiology services provided that (a) more than 1 anesthesia procedure is performed, (b) they are performed by a CRNA, or (c) they are directed by an anesthesiologist to a CRNA. 	N/A	N/A	✓

5. OPERATIONAL IMPLEMENTATION OF PROCESSES AND STRATEGIES COMPARATIVE ANALYSIS:

The grid below shows the percentage of claims that resulted in invalid, successful, and unsuccessful negotiations. These categories are defined as follows:

1. Invalid – A negotiation attempt could not be made due to claim-specific circumstances, including but not limited to the following: provider received reimbursement prior to negotiation attempt; Client already initiated direct negotiation with the provider; or the Allowed Amount was too low to attempt negotiation. Specific to mental health claims, for example, it is common that out-of-network mental health claims are paid to the provider by the member at the time the service is provided (i.e., up front) eliminating the opportunity for negotiation.
2. Successful – A successful negotiation is reached via an agreement with the provider.
3. Unsuccessful – Negotiation attempt was unsuccessful with provider.

For Financial Negotiations Services, 33.5% of MH/SUD claims and 52.37% of Medical/Surgical claims were determined to be invalid. These percentages are comparable given that MH/SUD claims were lower in



volume. Many Clients elect not to apply Financial Negotiation Services to MH/SUD services based on the their established criteria for claim review. MultiPlan does not have responsibility for claims that are not submitted for negotiation. A higher percentage of claims were successfully negotiated for MH/SUD claims (34.72%) as compared to Medical/Surgical claims (26.25%), however, the Medical/Surgical claims were significantly higher volume. Financial Negotiation Services received approximately 99 times more Medical/Surgical claims than MH/SUD in 2022. The percentage of successfully negotiated claims volume is within an acceptable standard deviation of 10%.

For Clinical Negotiations Services, 24.25% of MH/SUD claims and 33.45% of Medical/Surgical claims were determined to be invalid. These percentages are comparable with a deviation of less than 1%. Medical/Surgical claims are successfully negotiated at a rate of 33.26%, which is higher than the percentage of the successfully negotiated MH/SUD claims at 24.25%. This variance of 9.51% is likely due to the lower volume of MH/SUD claims selected for Clinical Negotiation Services for the reasons noted earlier (higher volume of MH/SUD claims that are paid up front and are never routed to MultiPlan for negotiation attempts). Claims with unsuccessful clinical negotiations are returned to the Client for repricing (or another MultiPlan product offering if purchased by the Client), and therefore, MultiPlan Negotiation Services policies no longer apply. A slightly higher percentage of unsuccessful clinical negotiations does not imply a disparity in application of Multiplan's Clinical Negotiation Services processes.

MH/SUD providers are treated equally and do not have different criteria or processes.

State specific detail can be found on Appendix A, attached hereto.

NEGOTIATION TYPE	CATEGORY	OUTCOME REASON	CLAIMS	% CLAIMS
FINANCIAL	MH/SUD	Invalid	614,214	33.55%%
		Successful	635,648	33.26%
		Unsuccessful	580,910	31.73%
	MH/SUD Total		1,830,772	1.16% of Total
	MEDICAL/ SURGICAL	Invalid	81,735,997	52.37%
		Successful	40,967,900	26.25%
		Unsuccessful	33,367,30	21.38%
	MEDICAL/ SURGICAL Total		156,071,213	98.84% of Total
CLINICAL	MH/SUD	Invalid	2,621	24.52%
		Successful	2,539	23.75%
		Unsuccessful	5,529	51.73%
	MH/SUD Total		10,689	0.54% of Total
	MEDICAL/ SURGICAL	Invalid	656,520	33.45%
		Successful	652,850	33.26%
		Unsuccessful	653,562	33.30%
	MEDICAL/ SURGICAL Total		1,962,932	99.46% of
Grand Total			159,875,606	100.00%



6. FINDINGS/COMPLIANCE DETERMINATION:

MultiPlan applies the criteria for Negotiation Services in the same manner to both MH/SUD and Medical/Surgical providers, and all aspects of the Negotiation Services process are subject to MultiPlan's policies and procedures. At no time have NQTLs been established or implied through MultiPlan's Financial Negotiation Services and Clinical Negotiation Services that are applied more stringently to MH/SUD providers than those applicable to Medical/Surgical providers.

The same set of policies and procedures are utilized for all providers, whether MH/SUD or Medical/Surgical, when initiating and providing Negotiation Services. The same staff members work with MH/SUD and Medical/Surgical providers when initiating a financial or clinical negotiation with a provider. No criteria are applied more stringently to MH/SUD than to Medical/Surgical providers.

MultiPlan Negotiation Services standards, as well as certain state and federally defined criteria, have been used to define the evidentiary standards used in this analysis. Review of the standards and reporting of the negotiation results from the last calendar year, as well as a comparison of historical negotiation practices provides evidentiary support that MultiPlan is not applying policies and procedures more stringently to MH/SUD than to Medical/Surgical providers.

In 2022, MH/SUD claims accounted for 1.16% of the Financial Negotiations Services and 0.54% of the Clinical Negotiations Services for MultiPlan's total Negotiation Services claims. This low volume of MH/SUD claims compared to the Medical/Surgical claims received likely accounts for the slight deviation in the number of successful negotiations as it relates to MH/SUD claims. Due to the low volume of claims submitted for MH/SUD claims, and the results being within an acceptable standard deviation, MultiPlan concludes that Negotiation Services processes for both Financial Negotiation Services and Clinical Negotiation Services, as applied in writing and operation, are not applied more stringently to MH/SUD claims than that of Medical/Surgical Claims even with slightly disparate results.

HISTORY:

Effective Date of Action	Description of Action
10/22/2021	Finalized Initial Analysis
4/1/2022	Annual Review and Data Update
3/1/2023	Annual Review and Data Update



Appendix A:

Included below are the percentage of Financial Negotiations Services and Clinical Negotiation Services claims by state. Some states, like California, show a larger percentage of MH/SUD claims in comparison to other states. However, all claims are treated the same. The number and types of claims received by MultiPlan are determined by the Client's criteria established for Negotiation Services.

PROVIDER STATE	MH/SUD CLAIMS	Medical/Surgical Claims	MH/SUD % Claims	Medical/Surgical % Claims
AK	20,744	2,315,064	1.13%	1.46%
AL	3,008	1,166,231	0.16%	0.74%
AR	7,161	657,544	0.39%	0.42%
AZ	16,894	3,818,681	0.92%	2.42%
CA	277,835	19,722,787	15.09%	12.48%
CO	30,616	2,428,791	1.66%	1.54%
CT	36,044	1,986,232	1.96%	1.26%
DC	14,299	555,147	0.78%	0.35%
DE	2,036	385,919	0.11%	0.24%
FL	85,122	11,520,343	4.62%	7.29%
GA	42,305	4,950,700	2.30%	3.13%
Guam	11	10,394	0.00%	0.01%
HI	531	121,849	0.03%	0.08%
IA	4,212	436,872	0.23%	0.28%
ID	4,236	398,168	0.23%	0.25%
IL	52,076	6,455,160	2.83%	4.08%
IN	34,925	1,516,259	1.90%	0.96%
KS	7,075	957,143	0.38%	0.61%
KY	9,723	1,110,914	0.53%	0.70%
LA	5,340	1,303,020	0.29%	0.82%
MA	67,336	2,365,387	3.66%	1.50%
MD	31,510	2,328,054	1.71%	1.47%
ME	8,893	587,374	0.48%	0.37%
MI	16,802	1,980,242	0.91%	1.25%
MN	25,686	1,188,384	1.39%	0.75%
MO	16,181	1,861,219	0.88%	1.18%
MS	3,051	761,456	0.17%	0.48%
MT	2,091	205,705	0.11%	0.13%
NC	25,294	2,991,568	1.37%	1.89%
ND	958	168,071	0.05%	0.11%
NE	4,224	579,745	0.23%	0.37%
NH	8,231	380,898	0.45%	0.24%

NJ	449,778	24,279,835	24.43%	15.36%
NM	3,137	270,859	0.17%	0.17%
NV	5,967	918,286	0.32%	0.58%
NY	194,058	19,052,977	10.54%	12.06%
OH	48,574	3,528,250	2.64%	2.23%
OK	6,445	1,788,182	0.35%	1.13%
OR	22,549	1,299,868	1.22%	0.82%
PA	30,345	3,117,269	1.65%	1.97%
Puerto Rico	25	38,508	0.00%	0.02%
RI	3,493	293,960	0.19%	0.19%
SC	7,778	1,207,944	0.42%	0.76%
SD	1,644	129,331	0.09%	0.08%
TN	23,895	2,340,823	1.30%	1.48%
TX	34,233	13,910,106	1.86%	8.80%
UT	16,206	893,209	0.88%	0.57%
VA	26,497	3,017,876	1.44%	1.91%
US Virgin Islands	105	34,495	0.01%	0.02%
VT	5,193	217,168	0.28%	0.14%
WA	62,990	2,235,086	3.42%	1.41%
WI	19,612	1,209,373	1.07%	0.77%
WV	2,397	292,284	0.13%	0.18%
WY	11,680	711,776	0.63%	0.45%
Provider Error in State Abbreviation Identification on Claim Submission	410	31,359	0.02%	0.02%
Grand Total	1,841,461	158,034,145	100.00%	100.00%



MENTAL HEALTH PARITY COMPARATIVE ANALYSIS

DATE PREPARED: June 8, 2023
SUBJECT MATTER: Network Services
PREPARED BY: Christy Brander, Vice President, Network Development

INTRODUCTION

This comparative analysis is intended to measure compliance with the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), as amended by the Consolidated Appropriations Act of 2021.

Effective February 10, 2021, group health plans must ensure that the financial requirements and treatment limitations on mental health or substance use disorder benefits they provide are no more restrictive than those on medical or surgical benefits. Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment.¹ NQTLs are processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Examples of NQTLs include, but are not limited to, medical management standards limiting benefits based on medical necessity, and network admission standards such as credentialing or reimbursement rates. Group health plans must perform an annual comparative analysis of NQTLs that apply to mental health and substance use disorder (“MH/SUD”) treatments to ensure that such NQTLs are comparable to, and no less restrictive than, those treatment limitations applicable for medical and/or surgical (“Medical/Surgical”) services. The law does not prohibit the use of NQTLs as long as they are not applied more stringently to MH/SUD benefits as compared to Medical/Surgical benefits. Disparate results do not necessarily indicate a violation of the MHPAEA, so long as comparable processes are followed.

MultiPlan, on behalf of itself and its subsidiaries (collectively “MultiPlan”), is neither a health care provider nor an insurance company, and does not reimburse physicians, hospitals, or other healthcare providers for their services. Rather, MultiPlan administers a network of healthcare providers that provide services to members of MultiPlan clients at negotiated contracted rates. MultiPlan does not pay claims, determine eligibility, or make benefit determinations; those responsibilities lie with MultiPlan clients, which include insurance companies, third-party administrators, health plans, HMOs, Taft-Hartley funds, and other organizations (“Clients”). The federal regulations prohibiting the imposition of a discriminatory NQTL for MH/SUD services does not directly apply to MultiPlan. However, Clients purchasing access to MultiPlan’s Network Services, as defined below, may require information from MultiPlan to assist with their compliance of these federal requirements. MultiPlan’s services include access to both MH/SUD and Medical/Surgical providers.

¹ See 29 CFR 2590.712(c)(2)-(3) for the test for financial requirements and QTLs and 29 CFR 2590.712(c)(4) for the requirements for NQTLs. 26 CFR 54.9812-1(c)(2)-(4); 29 CFR 2590.712(c)(2)-(4); 45 CFR 146.136(c)(2)-(4); and 147.160.



This comparative analysis is specific to MultiPlan’s Network Services, as defined below, including an analysis of MultiPlan’s network adequacy and network contract rate processes. Please note that although the regulation refers to the parity of “reimbursement,” this document will discuss the parity of the “network contract rates” negotiated with MultiPlan’s Network Providers, as defined below, since MultiPlan does not “reimburse” Network Providers. MultiPlan has adopted the six-step analysis outlined by the Kennedy Forum for conducting a comparative analysis.²

1. DESCRIPTION OF NQTL: NETWORK SERVICES - NETWORK ADEQUACY AND NETWORK CONTRACT RATES

“Network Providers” are health care providers contracted with MultiPlan for participation in MultiPlan networks which include, but are not limited to, the PHCS Network, the MultiPlan Network, the Beech Street Network, the HealthEOS Network, Rural Arizona Network, Health Management Network, and MultiPlan’s Government Program Networks (e.g. Medicare Advantage and Medicaid) (collectively “MultiPlan Networks” or “Network”), as applicable. Clients access Network Providers to offer health care services to their members at discounted rates (“Network Services”). MultiPlan has established processes to provide Clients’ members reasonable access to a sufficient number of Network Providers (“Network Adequacy”). In addition, MultiPlan has established processes to develop the negotiated contracted rates offered to, and agreed upon by, Network Providers (“Network Contract Rates”). Clients (or their customers) are responsible for payment of Network Contract Rates to Network Providers for covered services rendered to their members. Depending on the type of Network Services accessed (e.g., primary network, complementary network, etc.), Clients may pay for covered services at an in-network or out-of-network benefit level. The networks are used by clients based on their benefit plans and plan offerings. On occasion, not all providers who participate in the network(s) are used by all clients as part of their network offering. Clients may choose to offer a subset of the network depending on the repricing solutions chosen by the Client as part of their benefit plan or plan design.

Network Adequacy and Network Contract Rate processes are part of the Network Services offered to Clients and were identified as NQTLs requiring a comparative analysis to ensure that the processes are applied no more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan utilizes a standard set of criteria for Network Adequacy and Network Contract Rates as part of the Network Services offered by MultiPlan, and does not differentiate in the application of those criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. MH/SUD providers that request to join the MultiPlan Networks are managed in the same fashion, using the same contract documents, contract rate methodologies, and processes as all other providers.

As supported by this comparative analysis, MultiPlan does not establish NQTLs on, or implied through, relationships with providers, as written and/or in operation, that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services. MultiPlan’s policies, processes, and the operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

² Tim Clement, MPH, et al, *The “Six-Step” Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements*, the Kennedy Forum, Sep. 2017, https://s3.amazonaws.com/pjk-wp-uploads/www.paritytrack.org/uploads/2017/09/six_step_issue_brief.pdf.

2. FACTORS USED IN DEVELOPING PROCESSES FOR NETWORK SERVICES:

The Factors identified in this section have been established by MultiPlan to ensure that: (i) Clients' members accessing Network Services have access to an adequate number of hospitals, physicians, MH/SUD providers, and other providers based on applicable federal and/or state laws or regulations, as well as proprietary standards for network adequacy; (ii) MultiPlan applies consistent contracting processes and standards throughout the organization when contracting with MH/SUD and Medical/Surgical provider types for participation in the MultiPlan Network; and (iii) the Network Contract Rates offered to, and agreed upon by, Network Providers are offered, processed and managed in the same manner for MH/SUD providers as for all other provider types.

The below grid shows the rationale for applying the Network Services NQTL that were used in developing the Factors, as it relates to both Medical/Surgical providers and MH/SUD providers.

	MH/SUD Providers	Medical/Surgical Providers
MultiPlan uses standard contract documents to maintain consistency within the contracting process.	✓	✓
MultiPlan applies Policies and Procedures to maintain consistency in the contracting process.	✓	✓
MultiPlan applies proprietary network adequacy standards and state and federal regulatory agency standards to ensure adequate access to Network Providers for members.	✓	✓
MultiPlan applies Network Contract Rate methodologies agreed upon with Network Providers to maintain a competitive Network in the market.	✓	✓

“NETWORK SERVICES FACTORS” CONSIDERED WHEN ESTABLISHING NETWORK SERVICES

The grid below identifies the “Network Services Factors” used in developing Network Services processes for all providers applying to, or participating in, the MultiPlan Network(s).

Factor	Description	Outpatient (Physician) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Network Contract Documents	Network contract documents outline the definitions, terms, reimbursement, and obligations of each party related to Network Provider's participation in the network.	✓	✓	✓	✓

Factor	Description	Outpatient (Physician) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Network Contract Processing	The creation, negotiation criteria, processing and application of the provider network contracts are standardized to ensure a consistent process for professionals, facilities, health systems and ancillary providers, inclusive of mental health/substance use disorder providers. All Network Provider contracts, whether MH/SUD or Medical/Surgical, are entered, tracked, and managed in the MultiPlan contract management system.	✓	✓	✓	✓
Network Adequacy	MultiPlan's proprietary Network Adequacy standards are based on measurements for urban, suburban, and rural markets to provide Clients' members reasonable access to a sufficient number of Network Providers. In addition, MultiPlan applies the Network Adequacy standards established by state regulatory agencies, including geographic distribution of providers, provider ratios, and appointment wait times.	✓	✓	✓	✓
Network Contract Rate Methodologies	Network Contract Rates negotiated for all provider types is based on market dynamics, supply and demand, and geographic location.	✓	✓	✓	✓

3. EVIDENTIARY STANDARDS RELIED UPON TO FORMULATE THE NETWORK SERVICES NQTL:

MultiPlan's established processes and policies, as well as certain state and federal requirements, are used to formulate the criteria that establish the Network Services Factors. These evidentiary standards support MultiPlan's determinations of what constitutes an effective Network Services program.

The grid below identifies the various evidentiary standards for the Network Services Factors used in developing the processes for all providers applying to, or participating in, the MultiPlan Network(s) as applied to Medical/Surgical providers or to MH/SUD providers.

Factor	Documentation	MH/SUD Providers	Medical Surgical Providers
Network Contract Documents	1. Proprietary Contract Documents 2. State/Federal Contract Requirements, if applicable	✓	✓
Network Contract Processing	1. Provider Nominations Policy 2. Contracting using Provider Contract Policies 3. Access and Availability Policies	✓	✓
Network Adequacy	1. MultiPlan Proprietary Standards 2. Federal/State Laws for Network Adequacy	✓	✓

Factor	Documentation	MH/SUD Providers	Medical Surgical Providers
Reimbursement Methodologies	<ol style="list-style-type: none"> Centers for Medicare & Medicaid Services (“CMS”) physician pricing guidelines CMS HCPCS pricing guidelines CMS DRG classification 	✓	✓

4. WRITTEN POLICY AND PROCESS COMPARATIVE ANALYSIS:

This section includes a comparative analysis of MultiPlan Network Services processes to ensure that MultiPlan processes are applied no more stringently to MH/SUD providers than they would be to Medical/Surgical service providers. The information below includes a summary of processes as outlined in MultiPlan policies and procedures.

DESCRIPTION OF THE NETWORK SERVICES NQTL PROCESSES

Network Development. MultiPlan has established policies and procedures for all providers that participate or apply to participate in the MultiPlan Network(s), inclusive of MH/SUD and Medical/Surgical service provider types. All applicable MultiPlan policies and procedures are reviewed and approved annually for operational implementation of Network Services processes.

The network development process includes contracting with facilities, ancillaries, and professionals according to applicable state or federal law, MultiPlan policies, and client requests. During the network development process, the provider (inclusive of MH/SUD providers) receives information about MultiPlan, sample Network Contract Rate information, and contract documents for review and signature. Demographic information is also collected from the provider. During this process, the provider may ask questions about the contract terminology, Network Contract Rate methodology and other components of the contract.

Network Adequacy. MultiPlan develops, monitors, and maintains proprietary Network Adequacy Standards, except where state or federal law requires a specific standard. Network Adequacy Standards for MH/SUD and medical/surgical providers are applied consistently to determine whether a market provides appropriate levels of access to Network Providers. MH/SUD specialist geographic adequacy requirements defined in MultiPlan’s proprietary Network Adequacy Standards are the same criteria used for Medical/Surgical providers. MultiPlan requires a minimum of two providers by specialty category within a defined distance in Urban, Suburban, and Rural markets, regardless of whether the provider is a MH/SUD or Medical/Surgical provider. However, state or federal laws may dictate different standards; in those instances, the application of standards equitably between MH/SUD providers and Medical/Surgical providers is not determined by MultiPlan. MultiPlan’s Network Adequacy program is monitored annually, unless state or federal laws require a more frequent review. MultiPlan regularly reviews and analyzes information relating to Network Adequacy to determine if there are any markets that fail to comply with Network Adequacy standards. In such cases, corrective action is taken to correct the deficiency.

Below is a chart comparing MH/SUD Network Adequacy Standards to the Medical/Surgical Network Adequacy Standards used by MultiPlan:

Market	Standard	MH/SUD Providers	Medical/Surgical Providers
Urban	MultiPlan requires two providers within a proprietary distance for Urban markets. The same proprietary distance is required for MH/SUD and Medical/Surgical providers.	✓	✓
Suburban	MultiPlan requires two providers within a proprietary distance for Suburban markets. The same proprietary distance is required for MH/SUD and Medical/Surgical providers.	✓	✓
Rural	MultiPlan requires two providers within a proprietary distance for Rural markets. The same proprietary distance is required for MH/SUD and Medical/Surgical providers.	✓	✓
State/Federal Requirement	MultiPlan assists clients with meeting state/federal regulatory Network Adequacy Standards. State/federal Network Adequacy Standards may differ between MH/SUD and Medical/Surgical providers.	✓	✓

Provider Nomination & Recruitment. Provider nomination requests for individual professionals, small groups, and local ancillary providers, are managed by the Contracts and Development team at MultiPlan, inclusive of MH/SUD provider types and Medical/Surgical service provider types. Provider nominations and recruitment of large groups/Independent Practice Associations (“IPAs”), national ancillaries, facilities, and health systems are managed by the Network Development regional teams. Provider recruitment is initiated with the providers. Providers must meet MultiPlan’s credentialing requirements and contracting requirements to be eligible for participation in the MultiPlan Network. Provider nominations are closed if a provider is non-responsive or not interested in Network participation during the recruitment process.

Provider Contracting. The Individual Professional Agreement template is used when contracted with an individual professional provider. Individual professionals, whether MH/SUD or Medical/Surgical, are required to meet all MultiPlan credentialing criteria. All contracts are submitted through the contract submission process for execution and file storage.

The Professional Group/IPA Agreement template is used when contracting with a partnership, professional service corporation, limited liability company, or other legally constituted entity of licensed, registered, or certified health care professionals organized to provide health care services. All participating professionals within the Professional Group/IPA, whether MH/SUD or Medical/Surgical, are required to meet all MultiPlan credentialing criteria. All contracts are submitted with all required approvals and supporting documentation through the contract submission process for execution and file storage.

The Facility Agreement template is used for contracting with free standing health care facility providers. A Request for Information applicable to the facility provider is sent to the provider for completion. All facility providers, whether MH/SUD or Medical/Surgical, must meet the MultiPlan credentialing criteria. All contracts are submitted with all required approvals and supporting documentation through the contract submission process for execution and file storage.



The Health System Agreement or Health System IPA Agreement is used when contracting with both the Facility and an associated group/IPA of providers under one contract. All providers, whether MH/SUD or Medical/Surgical, must meet the MultiPlan credentialing criteria. All contracts are submitted with all required approvals and supporting documentation through the contract submission process for execution and file storage.

The Ancillary Agreement template is used for contracting with ancillary providers (e.g., free standing laboratory, free standing radiology, birthing center, urgent care center, etc.). In preparation for contracting, a Request for Information applicable to the Ancillary provider is sent to the provider for completion. All providers, whether MH/SUD or Medical/Surgical, must meet the MultiPlan credentialing criteria. All contracts are submitted with all required approvals and supporting documentation through the contract submission process for execution and file storage.

Network Contract Rates. The Fee Schedule Analysis and Implementation process ensures that a Network Contract Rate negotiated for professionals and ancillary providers billing on a Health Care Finance Administration (“HCFA”) form, inclusive of MH/SUD provider types and Medical/Surgical provider types, is analyzed and implemented consistently during the contracting process. During the contracting process, proposed contract rates for facilities, including MH/SUD and Medical Surgical provider types, that bill on the Uniform Medical Billing (“UB”) forms follow a similar analysis process. The process analyzes whether the negotiation is a new negotiation or renegotiation, the percent of CMS, if applicable, and market-specific considerations. The analysis, implementation, and approval process are managed through the contract submission process for execution and file storage.

Add new HST/PHCS NQTL – describe what specialties were excluded and how we came to that conclusion.

NETWORK SERVICES NQTL POLICY AUDIT RESULTS

The previous subsections include the general overview of the content of the policies reviewed to ensure consistent application to all providers, Medical/Surgical or MH/SUD, equally. The below chart includes the findings of an internal review of MultiPlan written policies.

POLICY NAME	COMPARISON	
	MH/SUD Providers	Medical/Surgical Providers
Network Development Process	Standards are the same for both MH/SUD providers and Medical/Surgical providers	
Access and Availability Standards	Standards are the same for both MH/SUD providers and Medical/Surgical providers	
Provider Recruitment from Provider Nomination Requests	Standards are the same for both MH/SUD providers and Medical/Surgical providers	
Contracting using the Professional Group Agreements	Standards are the same for both MH/SUD providers and Medical/Surgical providers	
Contracting using the Facility or Health System Agreement	Standards are the same for both MH/SUD providers and Medical/Surgical providers	
Contracting using the Ancillary Agreement	Standards are the same for both MH/SUD providers and Medical/Surgical providers	
Fee Schedule Analysis and Implementation	Standards are the same for both MH/SUD providers and Medical/Surgical providers	



5. OPERATIONAL IMPLEMENTATION OF PROCESSES AND STRATEGIES COMPARATIVE ANALYSIS:

The analysis for operational implementation of policies, procedures, and processes is based on data collected during 2022. MultiPlan analyzed the data collected for providers that received an invitation to participate in the MultiPlan Network as a result of self-nomination, client nomination, member nomination, or Network need. All providers that received an invitation to participate in the Network received the standard MultiPlan contract documents with the standard terms and conditions.

MultiPlan accepts nominations directly from providers, members, and clients to invite providers of all types into the MultiPlan Networks. The table below compares the Network Contract Rates offered to individual, small group, and ancillary providers across the United States that were nominated to participate in the MultiPlan Networks during 2022. The analysis shows that 73.14% of the Mental Health providers that were invited to participate in the MultiPlan Networks during 2022 received an invitation that included the standard Multiplan market fee schedule for the geographic market in which the provider is located. The MultiPlan market fee schedules are based on the CMS reimbursement methodologies. The remaining 26.86% of the Mental Health providers received an invitation that included an alternate fee schedule. An example of an alternate fee schedule would be a percent of charge arrangement.

The same analysis was performed for Mental Health-Substance Abuse providers that were invited to participate in the MultiPlan Networks during the same period. The analysis shows that 46.74% of the Mental Health-SUD providers that were invited to participate in the MultiPlan Networks during 2022 received an invitation that included the standard Multiplan market fee schedule for the geographic market in which the provider is located. The remaining 53.26% of the providers received an invitation that included an alternate fee schedule, like a percent of charge arrangement. The percentage of SUD providers that received an alternative fee schedule is higher than the percentage of Mental Health providers, as the services performed by the SUD providers may not always be represented in a CMS based reimbursement methodology, requiring an alternate fee schedule.

MultiPlan then compared the same information for the individual, small group, and ancillary Medical/Surgical providers who were invited to participate in the MultiPlan Networks during 2022. The analysis shows that 73.42% of Medical/Surgical providers received an invitation that included the standard MultiPlan market fee schedule for the geographic market in which the provider is located, while the remaining 26.58% received an invitation that included an alternate fee schedule.

Based on the analysis of the data, MultiPlan's contracting process, including the Network Contract Rates offered to providers, is applied consistently to MH providers, SUD providers, and Medical/Surgical providers based on market and client need. The results show that there is no disparity between the way MH providers, SUD providers, and Medical/Surgical providers are handled during the nomination and recruitment period.

PROVIDER RECRUITMENT ANALYSIS

	MH Providers	SUD Providers	Medical/Surgical Providers
Percentage of Contract Offers with Market Fee Schedules	73.14%	46.74%	73.42%

	MH Providers	SUD Providers	Medical/Surgical Providers
Percentage of Contract Offers with Alternative Fee Schedules	26.86%	53.26%	26.58%

Network Contract Rates offered to all provider types, including MH/SUD providers, are based on market dynamics, supply and demand, and geographic location. Values for procedure codes within a Network Contract Rate fee schedule do not vary by MH/SUD providers or other Medical/Surgical provider types. Contract documents establish the terms and obligations for providers who are offered participation in the Networks. The terms and obligations of the standard contracts applicable to the provider type (e.g., facility, group, ancillary, etc.) are consistently applied to all providers within that provider type category. For example, the standard group contract template for a group of professionals would contain the same contract terms and obligations whether offered to a MH/SUD group or to a Medical/Surgical group. The contract documents used to contract with providers who are MH/SUD providers are the same documents used to contract with Medical/Surgical provider types.

There is no provision in MultiPlan's contracting process for NQTLs whether in policy or operation that would be applied more stringently to MH/SUD providers, than those applicable to Medical/Surgical providers. The percentage of SUD providers that received an alternative fee schedule is higher than the percentage of Mental Health providers, as the services performed by the SUD providers may not always be represented in a CMS based reimbursement methodology, requiring an alternate fee schedule. At this point in the contracting process, MultiPlan relies upon the NPI taxonomy reported by the providers to categorize the providers during the initial contracting process. This means that we track providers based on either a Mental Health or SUD at the time of provider outreach and contracting. Based on this, MultiPlan cannot report on providers that offer both MH and SUD services until the credentialing stage, where verification of services is performed.

APPENDIX A contains the comparison between MH/SUD and Medical/Surgical contracting efforts on a state-by-state basis as it relates to Network Contract Rate offerings.

NETWORK PROVIDER CONTRACT RATE ANALYSIS – PROFESSIONAL PROVIDERS

To further validate the parity in the professional provider contracting process, MultiPlan also performed an analysis of contracts accepted by professional providers. The table below depicts a comparison of the Network Contract Rates for professional providers across the United States that participate in the MultiPlan Networks as of December 31, 2022. The analysis shows that 80.2% of the contracts for Mental Health professional providers contain the standard MultiPlan market fee schedule for the geographic market in which the provider is located. The MultiPlan market fee schedules are based on the CMS reimbursement methodologies. The contracts record for the remaining 19.8% of the Mental Health professional providers contain an alternate fee schedule. An example of an alternate fee schedule would be a percent of charge arrangement.

The analysis also shows that 82.6% of the contracts for SUD professional providers contain the standard MultiPlan market fee schedule for the geographic market in which the provider is located, while the remaining 17.4% contain an alternate fee schedule, like a percent of charge arrangement.



MultiPlan also analyzed the contracts for providers who render both Mental Health and SUD services. That analysis shows that 79.7% of the contracts for these professional providers contain the standard MultiPlan market fee schedule for the geographic market in which the provider is located, while the remaining 20.3% contain an alternate fee schedule.

Finally, MultiPlan compared the same information for the Medical/Surgical professional providers who participate in the MultiPlan Networks as of December 31, 2022. The analysis shows that 69.4% of the contracts for all Medical/Surgical professional providers contain the standard MultiPlan market fee schedule for the geographic market in which the provider is located, while the remaining 30.6% of contracts contain an alternate fee schedule.

As the above analysis shows, a slightly higher percentage of Medical/Surgical providers have negotiated an alternate fee schedule than MH/SUD providers. The volume of Medical/Surgical providers that negotiate an alternate fee schedule trends higher as a result of more contracted Medical/Surgical providers participating in the network. More Medical/Surgical specialties comprise the Medical/Surgical categorization than those included in the MH/SUD category, which contributes to the deviation. MultiPlan's policies and processes are not applied more stringently to MH/SUD providers as compared to Medical/Surgical providers.

	MH	SUD	Providers Who Are Both MH and SUD	Medical/Surgical
Percentage of Participating Providers with Alternate Fee Schedule	19.8%	17.4%	20.3%	30.6%
Percentage of Participating Providers with Market Fee Schedule	80.2%	82.6%	79.7%	69.4%

The table above compares the Network Contract Rates established in contracts with professionals participating in the MultiPlan Networks. These data demonstrate that once negotiations are completed and the provider has accepted a contract rate to be included in the Network arrangement, the percentage of providers who accept market fee schedules versus those who negotiate an alternate fee schedule is comparable among provider types, including MH providers, SUD providers, providers who perform both MH and SUD services, and Medical/Surgical providers. Medical/Surgical providers include a larger number of specialties and therefore constitute a larger percentage of the entire Network. This difference likely explains the differences in percentage of negotiated fee schedules between the Medical Surgical providers and the MH/SUD providers.

Appendix B contains a comparison among MH providers, SUD providers and Medical/Surgical professionals contracted in the Network on a state-by-state basis based on the contracted rate methodology.

NETWORK PROVIDER CONTRACT RATE ANALYSIS – FACILITIES

	MH	SUD	Providers Who Are Both MH and SUD	Medical/Surgical
Percentage of Participating Providers with Alternate Fee Schedule	47.2%	56.7%	47.9%	34.0%
Percentage of Participating Providers with Market Fee Schedule	52.8%	43.3 %	52.1%	66%

The table above compares the Network Contract Rates established in contracts with facilities participating in the MultiPlan Networks. These data show that once negotiations are completed and the provider has accepted a rate to be included in the Network, the percentage of providers who accept market fee schedules versus those who negotiate an alternate fee schedule is comparable among provider types, including MH providers, SUD providers, providers of both MH and SUD, and Medical/Surgical providers.

Appendix C contains a comparison among MH providers, SUD providers, and Medical/Surgical facilities contracted in the Network on a state-by-state basis based on the contracted rate methodology.

AUDIT OF NETWORK CONTRACT RATE METHODOLOGY FOR PROFESSIONAL PROVIDERS

The MultiPlan market fee schedules are generally based on CMS reimbursement methodologies for the geographic region in which the provider is located. Each market fee schedule establishes a Network Contract Rate amount for procedure codes potentially billed by a provider, which represent services provided to a patient. For example, the Evaluation and Management code 99203 is defined as “office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity.” This procedure code can be billed by an MH/SUD provider, such as a psychiatrist, or by a Medical/Surgical provider, such as a rheumatologist, to describe services rendered to a patient. Under the MultiPlan market fee schedule, the Network Contract Rate for both providers would be the same.

The table below represents the Network Contract Rate under the baseline market fee schedule for a specific geographic locale. The chart below identifies recommended reimbursement for a sampling of the reimbursement amounts for procedure codes commonly billed by providers in this specific geographic market for Evaluation and Management (E/M).

Specialty	CPT Code	MultiPlan 2023 S68 ABC Market Allowable (Non-Facility)	100% 2023 ABC Market RBRVS (Non-Facility)	ABC Market % of CMS Value
Orthopedic Surgery	99203	\$112.44	\$130.74	86%
	99213	\$89.73	\$104.34	86%
Cardiologists	99203	\$112.44	\$130.74	86%

Specialty	CPT Code	MultiPlan 2023 \$68 ABC Market Allowable (Non- Facility)	100% 2023 ABC Market RBRVS (Non-Facility)	ABC Market % of CMS Value
	99213	\$89.73	\$104.34	86%
Internists MD	99203	\$112.44	\$130.74	86%
	99213	\$89.73	\$104.34	86%
Endocrinologists	99203	\$112.44	\$130.74	86%
	99213	\$89.73	\$104.34	86%
Gastroenterologist	99203	\$112.44	\$130.74	86%
	99213	\$89.73	\$104.34	86%
Neurologists	99203	\$112.44	\$130.74	86%
	99213	\$89.73	\$104.34	86%
Pediatricians	99203	\$112.44	\$130.74	86%
	99213	\$89.73	\$104.34	86%
Dermatologists	99203	\$112.44	\$130.74	86%
	99213	\$89.73	\$104.34	86%
Psychiatrists	99203	\$112.44	\$130.74	86%
	99213	\$89.73	\$104.34	86%
Psychologists (85% of Fee Schedule)	90832 (based on 1 hr)	\$60.17	\$83.28	72.25%
	90791 (based on ½ hr)	\$139.63	\$193.26	72.25%
LCSW (75% of Fee Schedule)	90832 (based on 1 hr)	\$53.09	\$83.28	63.75%
	90791 (based on ½ hr)	\$123.20	\$193.26	63.75%
Nurse Practitioners (75% of Fee Schedule)	99203	\$84.33	\$130.74	64.50%
	99213	\$67.30	\$104.34	64.50%
	90832 (based on 1 hr)	\$53.09	\$83.28	63.75%
	90791 (based on ½ hr)	\$123.20	\$193.26	63.75%
Physician Assistants (75% of Fee Schedule)	99203	\$84.33	\$130.74	64.50%
	99213	\$67.30	\$104.34	64.50%
	90832 (based on 1 hr)	\$53.09	\$83.28	63.75%
	90791 (based on ½ hr)	\$123.20	\$193.26	63.75%
Podiatrists (90% of Fee Schedule)	99203	\$101.19	\$130.74	77.40%
	99213	\$80.76	\$104.34	77.40%
Chiropractors	99203	\$101.19	\$130.74	77.40%

Specialty	CPT Code	MultiPlan 2023 \$68 ABC Market Allowable (Non- Facility)	100% 2023 ABC Market RBRVS (Non-Facility)	ABC Market % of CMS Value
(90% of Fee Schedule)	99213	\$80.76	\$104.34	77.40%
Occupational Therapy (90% of Fee Schedule)	97165	\$87.85	\$114.84	76.50%
	97166	\$87.85	\$114.84	76.50%
	97167	\$87.85	\$114.84	76.50%
	97168	\$61.16	\$79.95	76.50%
Physical Therapy (90% of Fee Schedule)	97161	\$87.85	\$114.84	76.50%
	97162	\$87.85	\$114.84	76.50%
	97163	\$87.85	\$114.84	76.50%
	97164	\$61.47	\$80.35	76.50%
Septicemia	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%
Heart failure	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%
Osteoarthritis	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%
Complications specified during childbirth	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%
Pneumonia	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%
Diabetes mellitus with complication	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%
Acute myocardial infarction	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%
Cardiac dysrhythmias	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%
Chronic obstructive pulmonary disease and bronchiectasis	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%
Mood Disorder	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%
Alcohol Use Disorder	99221	\$82.50	\$95.93	86%
	99222	\$127.75	\$148.55	86%

This comparison shows the value of each procedure code based on CMS (RBRVS) values, the percentage of the CMS value assigned to the procedure code under the baseline market fee schedule, and the allowable for each procedure code under the baseline market fee schedule for this specific geographic



market. Under the MultiPlan market fee schedule, the Network Contract Rate is based on the services rendered by the providers. Standard procedure codes established by CMS are used to identify the services, and no distinction is made between MH providers, SUD providers, and Medical/Surgical providers.

The Network Contract Rate for professional providers who do not hold an MD/DO degree is based on industry standard reimbursement calculations for the providers. The Network Contract Rate is based, in part, on direct feedback from a number of multispecialty provider groups whose members included both medical and behavioral health practitioners. It was the consensus of the groups that reimbursement for “mid-level” providers should be based on a percentage of the physician reimbursement amounts. For example, psychiatrists within multispecialty groups requested that psychologists and social workers receive reimbursement based on a percentage of the psychiatrist reimbursement amount. This concept was further supported by the fact that CMS reimbursement for social workers is based on 75% of the reimbursement to physicians for the same services.

The percentage reduction established for psychologists took into consideration that social workers and psychologists bill using the same codes a majority of the time, but also that different educational requirements apply to psychologists versus a social worker. Social workers’ education level equates to the same education level of a nurse practitioner or physician assistant, which receive the same reduced percentage of seventy-five (75%) percent of the allowable amount. By contrast, psychiatrists have a Network Contract Rate amount equal to one-hundred (100%) percent of the allowable amount, which is the same as any other Medical/Surgical provider with the same education level. Psychologists have a Network Contract Rate amount equal to eighty-five (85%) of the allowable amount due to general education requirements that are somewhere between Social Workers and Psychiatrists. In the event state law requires payment parity between these non-MD/DO degree providers, the MultiPlan market fee schedule would be modified to reflect a Network Contract Rate at one-hundred (100%) percent of the allowable amount.

Other mid-level practitioners that are identified for the mid-level reduction percentage did not provide similar services at varying percentages like psychologists and social workers. Therefore, a direct comparison cannot be made in this regard. MultiPlan’s strategy for psychologists, based on the additional education requirements, increased the CMS reimbursement for social workers by 10% from the 75% CMS reimbursement percentage. Conversely, the mid-level Medical/Surgical providers were reduced by 10% from the equivalent 100% CMS reimbursement for MD/DOs. The 10% increase for psychologist is comparable to the 10% decrease applied to Medical/Surgical mid-level providers as a result of using CMS reimbursement practices as a basis.

If a state law or regulation prohibits the use of reimbursement rates based on a mid-level provider type, MultiPlan’s contracts in those states do not include a mid-level percentage reduction (i.e., mid-level practitioner would receive the same rate as an MD).

Finally, different geographic markets may be assigned different percentages of CMS values based on market need and other considerations. For example, the percentage of CMS value in the Los Angeles, CA market for the baseline market fee schedule may vary from the percentage of CMS value for the Manhattan, NY market. However, regardless of the percentage of CMS value assigned to a market, there



is no distinction made between MH providers, SUD providers, and Medical/Surgical providers in the market fee schedules.

6. FINDINGS/COMPLIANCE DETERMINATION:

MultiPlan applies the criteria for Network Services in the same manner to both MH/SUD and Medical/Surgical providers, and all aspects of the Network Services process are subject to MultiPlan's policies and procedures. MultiPlan's provider contract templates comply with all applicable state and federal regulations. The applicable provider contract templates are offered in the same manner to all providers, whether MH/SUD or Medical/Surgical providers. At no time have NQTLs been established or implied through MultiPlan provider contracts or relationships with providers that are applied more stringently to MH/SUD providers than those applicable to Medical/Surgical providers.

The same set of policies and procedures are utilized to process and make determinations regarding contract documents and contract language for all providers, whether MH/SUD or Medical/Surgical. The same staff members work with MH/SUD and Medical/Surgical providers when recruiting and contracting with providers for participation in MultiPlan's Network. No criteria are applied more stringently to MH/SUD over Medical/Surgical providers.

MultiPlan Network Services standards, as well as certain state and federally defined criteria, have been used to define the evidentiary standards used in this analysis. Review of the standards and reporting of the contracting results from the last calendar year as well as a comparison of historical contracting practices, provides evidentiary support that MultiPlan is not applying policies and procedures more stringently to MH/SUD than to Medical/Surgical providers.

MultiPlan's Network Adequacy policies and procedures are based on a proprietary standard, and incorporate state or federal requirements, as applicable. These proprietary Network Adequacy requirements are the same for MH/SUD and Medical/Surgical providers. Compliance with state or federal Network Adequacy requirements may impose different criteria on MH/SUD providers, however, these differences are not within MultiPlan's control. Provider recruitment is not limited to Network Adequacy standards, but also includes providers specifically requested by MultiPlan clients or their members. There is no provision in MultiPlan policies for NQTLs whether in policy or operation that would be applied more stringently to MH/SUD providers, than those applicable to Medical/Surgical providers.

The same staff members process MH/SUD provider files and Medical/Surgical provider files. As evidenced by the data and policy review depicted above, no criteria are applied more stringently to MH/SUD providers than to Medical/Surgical providers.

Based on the above analysis, MultiPlan's processes, as applied in writing and operation, are comparable to and no more stringently applied to MH/SUD providers than to Medical/Surgical providers.

HISTORY:

Effective Date of Action	Description of Action
9/1/2021	Finalized Initial Analysis
3/9/2022	Annual Review and Data Update Split out data for MH, SUD, and providers that offer both MH/SUD



Effective Date of Action	Description of Action
	Added clarification about mid-level providers Added additional codes for 99221 and 99222 for analysis
6/8/2023	Annual Review and Data Update Clarified that Clients have the option to use a subset of Network providers based on their Benefit Plan Design

APPENDIX A

PROVIDER RECRUITMENT FEE SCHEDULE OFFER ANALYSIS

State	Contract Count	Percentage
AK	188	0.36%
Mental Health	11	5.85%
Market Schedule	11	100.00%
Non-Mental Health	177	94.15%
Alternative Market Schedule	57	32.20%
Market Schedule	120	67.80%
AL	799	1.53%
Mental Health	31	3.88%
Alternative Market Schedule	2	6.45%
Market Schedule	29	93.55%
Mental Health-Substance Abuse	6	0.75%
Alternative Market Schedule	2	33.33%
Market Schedule	4	66.67%
Non-Mental Health	762	95.37%
Alternative Market Schedule	102	13.39%
Market Schedule	660	86.61%
AR	458	0.87%
Mental Health	42	9.17%
Alternative Market Schedule	2	4.76%
Market Schedule	40	95.24%
Mental Health-Substance Abuse	2	0.44%
Alternative Market Schedule	1	50.00%
Market Schedule	1	50.00%
Non-Mental Health	414	90.39%
Alternative Market Schedule	88	21.26%
Market Schedule	326	78.74%
AZ	1217	2.32%
Mental Health	115	9.45%
Alternative Market Schedule	11	9.57%
Market Schedule	104	90.43%
Mental Health-Substance Abuse	7	0.58%
Market Schedule	7	100.00%
Non-Mental Health	1095	89.98%
Alternative Market Schedule	163	14.89%
Market Schedule	932	85.11%
CA	3340	6.38%
Mental Health	529	15.84%
Alternative Market Schedule	376	71.08%
Market Schedule	153	28.92%

State	Contract Count	Percentage
Mental Health-Substance Abuse	50	1.50%
Alternative Market Schedule	26	52.00%
Market Schedule	24	48.00%
Non-Mental Health	2761	82.66%
Alternative Market Schedule	921	33.36%
Market Schedule	1840	66.64%
CO	668	1.28%
Mental Health	64	9.58%
Alternative Market Schedule	11	17.19%
Market Schedule	53	82.81%
Mental Health-Substance Abuse	11	1.65%
Market Schedule	11	100.00%
Non-Mental Health	593	88.77%
Alternative Market Schedule	138	23.27%
Market Schedule	455	76.73%
CT	508	0.97%
Mental Health	81	15.94%
Alternative Market Schedule	4	4.94%
Market Schedule	77	95.06%
Mental Health-Substance Abuse	6	1.18%
Market Schedule	6	100.00%
Non-Mental Health	421	82.87%
Alternative Market Schedule	70	16.63%
Market Schedule	351	83.37%
DC	67	0.13%
Mental Health	5	7.46%
Market Schedule	5	100.00%
Non-Mental Health	62	92.54%
Alternative Market Schedule	22	35.48%
Market Schedule	40	64.52%
DE	245	0.47%
Mental Health	29	11.84%
Alternative Market Schedule	1	3.45%
Market Schedule	28	96.55%
Mental Health-Substance Abuse	1	0.41%
Market Schedule	1	100.00%
Non-Mental Health	215	87.76%
Alternative Market Schedule	51	23.72%
Market Schedule	164	76.28%
FL	3367	6.43%
Mental Health	227	6.74%
Alternative Market Schedule	26	11.45%

State	Contract Count	Percentage
Market Schedule	201	88.55%
Mental Health-Substance Abuse	9	0.27%
Market Schedule	9	100.00%
Non-Mental Health	3131	92.99%
Alternative Market Schedule	428	13.67%
Market Schedule	2703	86.33%
GA	1749	3.34%
Mental Health	188	10.75%
Alternative Market Schedule	34	18.09%
Market Schedule	154	81.91%
Mental Health-Substance Abuse	3	0.17%
Market Schedule	3	100.00%
Non-Mental Health	1558	89.08%
Alternative Market Schedule	497	31.90%
Market Schedule	1061	68.10%
Hi	234	0.45%
Mental Health	21	8.97%
Alternative Market Schedule	1	4.76%
Market Schedule	20	95.24%
Mental Health-Substance Abuse	1	0.43%
Market Schedule	1	100.00%
Non-Mental Health	212	90.60%
Alternative Market Schedule	34	16.04%
Market Schedule	178	83.96%
IA	300	0.57%
Mental Health	20	6.67%
Alternative Market Schedule	1	5.00%
Market Schedule	19	95.00%
Non-Mental Health	280	93.33%
Alternative Market Schedule	77	27.50%
Market Schedule	203	72.50%
ID	916	1.75%
Mental Health	237	25.87%
Alternative Market Schedule	157	66.24%
Market Schedule	80	33.76%
Mental Health-Substance Abuse	8	0.87%
Alternative Market Schedule	4	50.00%
Market Schedule	4	50.00%
Non-Mental Health	671	73.25%
Alternative Market Schedule	324	48.29%
Market Schedule	347	51.71%
IL	1404	2.68%

State	Contract Count	Percentage
Mental Health	279	19.87%
Alternative Market Schedule	37	13.26%
Market Schedule	242	86.74%
Mental Health-Substance Abuse	13	0.93%
Alternative Market Schedule	1	7.69%
Market Schedule	12	92.31%
Non-Mental Health	1112	79.20%
Alternative Market Schedule	261	23.47%
Market Schedule	851	76.53%
IN	836	1.60%
Mental Health	118	14.11%
Alternative Market Schedule	12	10.17%
Market Schedule	106	89.83%
Mental Health-Substance Abuse	6	0.72%
Market Schedule	6	100.00%
Non-Mental Health	712	85.17%
Alternative Market Schedule	141	19.80%
Market Schedule	571	80.20%
KS	815	1.56%
Mental Health	72	8.83%
Alternative Market Schedule	11	15.28%
Market Schedule	61	84.72%
Mental Health-Substance Abuse	2	0.25%
Market Schedule	2	100.00%
Non-Mental Health	741	90.92%
Alternative Market Schedule	312	42.11%
Market Schedule	429	57.89%
KY	1052	2.01%
Mental Health	160	15.21%
Alternative Market Schedule	13	8.13%
Market Schedule	147	91.88%
Mental Health-Substance Abuse	11	1.05%
Alternative Market Schedule	3	27.27%
Market Schedule	8	72.73%
Non-Mental Health	881	83.75%
Alternative Market Schedule	167	18.96%
Market Schedule	714	81.04%
LA	756	1.44%
Mental Health	74	9.79%
Alternative Market Schedule	3	4.05%
Market Schedule	71	95.95%
Mental Health-Substance Abuse	5	0.66%

State	Contract Count	Percentage
Alternative Market Schedule	2	40.00%
Market Schedule	3	60.00%
Non-Mental Health	677	89.55%
Alternative Market Schedule	184	27.18%
Market Schedule	493	72.82%
MA	624	1.19%
Mental Health	72	11.54%
Alternative Market Schedule	6	8.33%
Market Schedule	66	91.67%
Mental Health-Substance Abuse	1	0.16%
Market Schedule	1	100.00%
Non-Mental Health	551	88.30%
Alternative Market Schedule	124	22.50%
Market Schedule	427	77.50%
MD	1075	2.05%
Mental Health	279	25.95%
Alternative Market Schedule	209	74.91%
Market Schedule	70	25.09%
Mental Health-Substance Abuse	10	0.93%
Alternative Market Schedule	9	90.00%
Market Schedule	1	10.00%
Non-Mental Health	786	73.12%
Alternative Market Schedule	354	45.04%
Market Schedule	432	54.96%
ME	285	0.54%
Mental Health	45	15.79%
Alternative Market Schedule	3	6.67%
Market Schedule	42	93.33%
Mental Health-Substance Abuse	1	0.35%
Alternative Market Schedule	1	100.00%
Non-Mental Health	239	83.86%
Alternative Market Schedule	35	14.64%
Market Schedule	204	85.36%
MI	2474	4.72%
Mental Health	335	13.54%
Alternative Market Schedule	134	40.00%
Market Schedule	201	60.00%
Mental Health-Substance Abuse	17	0.69%
Alternative Market Schedule	8	47.06%
Market Schedule	9	52.94%
Non-Mental Health	2122	85.77%
Alternative Market Schedule	322	15.17%

State	Contract Count	Percentage
Market Schedule	1800	84.83%
MN	430	0.82%
Mental Health	43	10.00%
Alternative Market Schedule	7	16.28%
Market Schedule	36	83.72%
Mental Health-Substance Abuse	4	0.93%
Market Schedule	4	100.00%
Non-Mental Health	383	89.07%
Alternative Market Schedule	109	28.46%
Market Schedule	274	71.54%
MO	750	1.43%
Mental Health	47	6.27%
Alternative Market Schedule	3	6.38%
Market Schedule	44	93.62%
Mental Health-Substance Abuse	1	0.13%
Market Schedule	1	100.00%
Non-Mental Health	702	93.60%
Alternative Market Schedule	166	23.65%
Market Schedule	536	76.35%
MS	284	0.54%
Mental Health	14	4.93%
Market Schedule	14	100.00%
Non-Mental Health	270	95.07%
Alternative Market Schedule	80	29.63%
Market Schedule	190	70.37%
MT	177	0.34%
Mental Health	18	10.17%
Alternative Market Schedule	2	11.11%
Market Schedule	16	88.89%
Mental Health-Substance Abuse	2	1.13%
Market Schedule	2	100.00%
Non-Mental Health	157	88.70%
Alternative Market Schedule	80	50.96%
Market Schedule	77	49.04%
NC	2725	5.20%
Mental Health	215	7.89%
Alternative Market Schedule	114	53.02%
Market Schedule	101	46.98%
Mental Health-Substance Abuse	221	8.11%
Alternative Market Schedule	210	95.02%
Market Schedule	11	4.98%
Non-Mental Health	2289	84.00%

State	Contract Count	Percentage
Alternative Market Schedule	1378	60.20%
Market Schedule	911	39.80%
ND	64	0.12%
Mental Health	3	4.69%
Market Schedule	3	100.00%
Non-Mental Health	61	95.31%
Alternative Market Schedule	18	29.51%
Market Schedule	43	70.49%
NE	257	0.49%
Mental Health	21	8.17%
Alternative Market Schedule	4	19.05%
Market Schedule	17	80.95%
Mental Health-Substance Abuse	5	1.95%
Market Schedule	5	100.00%
Non-Mental Health	231	89.88%
Alternative Market Schedule	83	35.93%
Market Schedule	148	64.07%
NH	162	0.31%
Mental Health	23	14.20%
Market Schedule	23	100.00%
Mental Health-Substance Abuse	3	1.85%
Market Schedule	3	100.00%
Non-Mental Health	136	83.95%
Alternative Market Schedule	52	38.24%
Market Schedule	84	61.76%
NJ	1770	3.38%
Mental Health	123	6.95%
Alternative Market Schedule	20	16.26%
Market Schedule	103	83.74%
Mental Health-Substance Abuse	4	0.23%
Market Schedule	4	100.00%
Non-Mental Health	1643	92.82%
Alternative Market Schedule	167	10.16%
Market Schedule	1476	89.84%
NM	364	0.70%
Mental Health	58	15.93%
Market Schedule	58	100.00%
Mental Health-Substance Abuse	3	0.82%
Alternative Market Schedule	1	33.33%
Market Schedule	2	66.67%
Non-Mental Health	303	83.24%
Alternative Market Schedule	58	19.14%

State	Contract Count	Percentage
Market Schedule	245	80.86%
NV	716	1.37%
Mental Health	53	7.40%
Alternative Market Schedule	2	3.77%
Market Schedule	51	96.23%
Mental Health-Substance Abuse	6	0.84%
Market Schedule	6	100.00%
Non-Mental Health	657	91.76%
Alternative Market Schedule	131	19.94%
Market Schedule	526	80.06%
NY	2784	5.32%
Mental Health	193	6.93%
Alternative Market Schedule	18	9.33%
Market Schedule	175	90.67%
Mental Health-Substance Abuse	13	0.47%
Alternative Market Schedule	3	23.08%
Market Schedule	10	76.92%
Non-Mental Health	2578	92.60%
Alternative Market Schedule	400	15.52%
Market Schedule	2178	84.48%
OH	1240	2.37%
Mental Health	148	11.94%
Alternative Market Schedule	10	6.76%
Market Schedule	138	93.24%
Mental Health-Substance Abuse	10	0.81%
Market Schedule	10	100.00%
Non-Mental Health	1082	87.26%
Alternative Market Schedule	242	22.37%
Market Schedule	840	77.63%
OK	525	1.00%
Mental Health	27	5.14%
Market Schedule	27	100.00%
Mental Health-Substance Abuse	3	0.57%
Market Schedule	3	100.00%
Non-Mental Health	495	94.29%
Alternative Market Schedule	113	22.83%
Market Schedule	382	77.17%
OR	391	0.75%
Mental Health	46	11.76%
Alternative Market Schedule	4	8.70%
Market Schedule	42	91.30%
Mental Health-Substance Abuse	1	0.26%

State	Contract Count	Percentage
Market Schedule	1	100.00%
Non-Mental Health	344	87.98%
Alternative Market Schedule	123	35.76%
Market Schedule	221	64.24%
PA	1380	2.64%
MentalHealth	116	8.41%
Alternative Market Schedule	9	7.76%
Market Schedule	107	92.24%
Mental Health-Substance Abuse	2	0.14%
Market Schedule	2	100.00%
Non-Mental Health	1262	91.45%
Alternative Market Schedule	294	23.30%
Market Schedule	968	76.70%
RI	401	0.77%
Mental Health	45	11.22%
Alternative Market Schedule	1	2.22%
Market Schedule	44	97.78%
Mental Health-Substance Abuse	3	0.75%
Alternative Market Schedule	1	33.33%
Market Schedule	2	66.67%
Non-Mental Health	353	88.03%
Alternative Market Schedule	49	13.88%
Market Schedule	304	86.12%
SC	585	1.12%
Mental Health	42	7.18%
Alternative Market Schedule	8	19.05%
Market Schedule	34	80.95%
Mental Health-Substance Abuse	2	0.34%
Market Schedule	2	100.00%
Non-Mental Health	541	92.48%
Alternative Market Schedule	100	18.48%
Market Schedule	441	81.52%
SD	163	0.31%
Mental Health	16	9.82%
Market Schedule	16	100.00%
Non-MentalHealth	147	90.18%
Alternative Market Schedule	40	27.21%
Market Schedule	107	72.79%
TN	1022	1.95%
Mental Health	45	4.40%
Alternative Market Schedule	1	2.22%
Market Schedule	44	97.78%

State	Contract Count	Percentage
MentalHealth-SubstanceAbuse	4	0.39%
Alternative Market Schedule	3	75.00%
Market Schedule	1	25.00%
Non-Mental Health	973	95.21%
Alternative Market Schedule	201	20.66%
Market Schedule	772	79.34%
TX	7001	13.37%
Mental Health	789	11.27%
Alternative Market Schedule	221	28.01%
Market Schedule	568	71.99%
Mental Health-Substance Abuse	33	0.47%
Alternative Market Schedule	8	24.24%
Market Schedule	25	75.76%
Non-Mental Health	6179	88.26%
Alternative Market Schedule	2460	39.81%
Market Schedule	3719	60.19%
UT	549	1.05%
Mental Health	99	18.03%
Alternative Market Schedule	6	6.06%
Market Schedule	93	93.94%
Mental Health-Substance Abuse	6	1.09%
Alternative Market Schedule	1	16.67%
Market Schedule	5	83.33%
Non-Mental Health	444	80.87%
Alternative Market Schedule	99	22.30%
Market Schedule	345	77.70%
VA	819	1.56%
Mental Health	76	9.28%
Alternative Market Schedule	4	5.26%
Market Schedule	72	94.74%
Mental Health-Substance Abuse	4	0.49%
Market Schedule	4	100.00%
Non-Mental Health	739	90.23%
Alternative Market Schedule	156	21.11%
Market Schedule	583	78.89%
VT	170	0.32%
Mental Health	28	16.47%
Market Schedule	28	100.00%
Non-Mental Health	142	83.53%
Alternative Market Schedule	40	28.17%
Market Schedule	102	71.83%
WA	2907	5.55%

State	Contract Count	Percentage
Mental Health	86	2.96%
Alternative Market Schedule	15	17.44%
Market Schedule	71	82.56%
Mental Health-Substance Abuse	5	0.17%
Market Schedule	5	100.00%
Non-Mental Health	2816	96.87%
Alternative Market Schedule	404	14.35%
Market Schedule	2412	85.65%
WI	899	1.72%
Mental Health	218	24.25%
Alternative Market Schedule	13	5.96%
Market Schedule	205	94.04%
Mental Health-Substance Abuse	31	3.45%
Alternative Market Schedule	2	6.45%
Market Schedule	29	93.55%
Non-Mental Health	650	72.30%
Alternative Market Schedule	170	26.15%
Market Schedule	480	73.85%
WV	340	0.65%
Mental Health	31	9.12%
Alternative Market Schedule	5	16.13%
Market Schedule	26	83.87%
Mental Health-Substance Abuse	1	0.29%
Market Schedule	1	100.00%
Non-Mental Health	308	90.59%
Alternative Market Schedule	136	44.16%
Market Schedule	172	55.84%
WY	117	0.22%
Mental Health	13	11.11%
Alternative Market Schedule	2	15.38%
Market Schedule	11	84.62%
Non-Mental Health	104	88.89%
Alternative Market Schedule	41	39.42%
Market Schedule	63	60.58%
Grand Total	52369	100.00%

APPENDIX B

CONTRACTED PROFESSIONAL FEE SCHEDULE CATEGORY ANALYSIS

STATE	Fee Schedule Type	MH/SUD	% Both MH/SUD By FS	MH	%MH Providers By FS	SUD	% SUD Providers By FS	MH/SUD/Both Total	% MH/SUD/Both Total Providers By FS	Non-MH	% Non-MH Provider By FS	Grand Total
Grand Total		52,817		74,280		3,537		130,634		1,571,375		1,702,009
AK	Alternate	81	61.8%	121	59.9%	2	25.0%	204	59.8%	1,967	67.6%	2,171
AK	Market	50	38.2%	81	40.1%	6	75.0%	137	40.2%	943	32.4%	1,080
AK Total		131		202		8		341		2,910		3,251
AL	Alternate	44	14.5%	105	14.8%	3	30.0%	152	14.9%	5,038	27.6%	5,190
AL	Market	259	85.5%	604	85.2%	7	70.0%	870	85.1%	13,202	72.4%	14,072
AL Total		303		709		10		1,022		18,240		19,262
AR	Alternate	9	1.8%	6	1.0%	2	7.4%	17	1.5%	1,482	10.2%	1,499
AR	Market	489	98.2%	607	99.0%	25	92.6%	1,121	98.5%	13,095	89.8%	14,216
AR Total		498		613		27		1,138		14,577		15,715
AZ	Alternate	106	11.1%	129	8.8%	4	6.9%	239	9.6%	8,141	22.9%	8,380
AZ	Market	847	88.9%	1,340	91.2%	54	93.1%	2,241	90.4%	27,401	77.1%	29,642
AZ Total		953		1,469		58		2,480		35,542		38,022
CA	Alternate	629	20.8%	1,036	21.3%	26	24.8%	1,691	21.1%	27,088	26.4%	28,779
CA	Market	2,392	79.2%	3,838	78.7%	79	75.2%	6,309	78.9%	75,332	73.6%	81,641
CA Total		3,021		4,874		105		8,000		102,420		110,420
CO	Alternate	395	28.8%	407	24.4%	47	39.5%	849	26.9%	10,714	34.3%	11,563
CO	Market	976	71.2%	1,260	75.6%	72	60.5%	2,308	73.1%	20,541	65.7%	22,849
CO Total		1,371		1,667		119		3,157		31,255		34,412
CT	Alternate	195	18.9%	194	15.5%	16	16.8%	405	17.0%	5,434	22.9%	5,839
CT	Market	838	81.1%	1,057	84.5%	79	83.2%	1,974	83.0%	18,316	77.1%	20,290
CT Total		1,033		1,251		95		2,379		23,750		26,129
DC	Alternate	94	28.6%	128	37.1%		0.0%	222	32.8%	3,371	38.4%	3,593
DC	Market	235	71.4%	217	62.9%	2	100.0%	454	67.2%	5,414	61.6%	5,868
DC Total		329		345		2		676		8,785		9,461
DE	Alternate	45	28.8%	14	8.9%		0.0%	59	18.6%	903	20.6%	962
DE	Market	111	71.2%	143	91.1%	5	100.0%	259	81.4%	3,489	79.4%	3,748
DE Total		156		157		5		318		4,392		4,710
FL	Alternate	440	24.7%	577	18.5%	29	18.5%	1,046	20.7%	35,757	39.0%	36,803

STATE	Fee Schedule Type	MH/SUD	% Both MH/SUD By FS	MH	%MH Providers By FS	SUD	% SUD Providers By FS	MH/SUD/Both Total	% MH/SUD/Both Total Providers By FS	Non-MH	% Non-MH Provider By FS	Grand Total
FL	Market	1,339	75.3%	2,541	81.5%	128	81.5%	4,008	79.3%	55,894	61.0%	59,902
FL Total		1,779		3,118		157		5,054		91,651		96,705
GA	Alternate	323	26.3%	365	16.1%	13	20.6%	701	19.7%	16,279	32.3%	16,980
GA	Market	904	73.7%	1,898	83.9%	50	79.4%	2,852	80.3%	34,088	67.7%	36,940
GA Total		1,227		2,263		63		3,553		50,367		53,920
HI	Alternate	24	23.5%	24	18.6%	2	28.6%	50	21.0%	1,257	28.7%	1,307
HI	Market	78	76.5%	105	81.4%	5	71.4%	188	79.0%	3,117	71.3%	3,305
HI Total		102		129		7		238		4,374		4,612
IA	Alternate	172	25.0%	211	25.7%	8	22.9%	391	25.3%	6,321	39.5%	6,712
IA	Market	516	75.0%	610	74.3%	27	77.1%	1,153	74.7%	9,673	60.5%	10,826
IA Total		688		821		35		1,544		15,994		17,538
ID	Alternate	23	5.4%	38	7.7%		0.0%	61	6.6%	1,609	23.4%	1,670
ID	Market	402	94.6%	453	92.3%	4	100.0%	859	93.4%	5,255	76.6%	6,114
ID Total		425		491		4		920		6,864		7,784
IL	Alternate	1,080	26.9%	1,334	26.3%	32	21.6%	2,446	26.5%	30,171	35.8%	32,617
IL	Market	2,941	73.1%	3,742	73.7%	116	78.4%	6,799	73.5%	54,111	64.2%	60,910
IL Total		4,021		5,076		148		9,245		84,282		93,527
IN	Alternate	283	14.1%	253	12.8%	6	5.4%	542	13.2%	9,950	24.6%	10,492
IN	Market	1,729	85.9%	1,724	87.2%	105	94.6%	3,558	86.8%	30,572	75.4%	34,130
IN Total		2,012		1,977		111		4,100		40,522		44,622
KS	Alternate	175	20.9%	130	18.1%	5	7.8%	310	19.1%	5,783	30.2%	6,093
KS	Market	664	79.1%	589	81.9%	59	92.2%	1,312	80.9%	13,397	69.8%	14,709
KS Total		839		719		64		1,622		19,180		20,802
KY	Alternate	102	13.6%	125	9.9%	15	21.1%	242	11.6%	6,225	24.4%	6,467
KY	Market	647	86.4%	1,134	90.1%	56	78.9%	1,837	88.4%	19,329	75.6%	21,166
KY Total		749		1,259		71		2,079		25,554		27,633
LA	Alternate	148	23.9%	149	15.3%	2	8.3%	299	18.5%	6,738	24.9%	7,037
LA	Market	472	76.1%	826	84.7%	22	91.7%	1,320	81.5%	20,339	75.1%	21,659
LA Total		620		975		24		1,619		27,077		28,696
MA	Alternate	818	30.1%	859	27.1%	24	17.9%	1,701	28.3%	15,272	28.3%	16,973
MA	Market	1,898	69.9%	2,307	72.9%	110	82.1%	4,315	71.7%	38,621	71.7%	42,936
MA Total		2,716		3,166		134		6,016		53,893		59,909
MD	Alternate	23	3.1%	132	11.4%	3	7.1%	158	8.2%	7,861	23.8%	8,019
MD	Market	712	96.9%	1,027	88.6%	39	92.9%	1,778	91.8%	25,233	76.2%	27,011

STATE	Fee Schedule Type	MH/SUD	% Both MH/SUD By FS	MH	%MH Providers By FS	SUD	% SUD Providers By FS	MH/SUD/Both Total	% MH/SUD/Both Total Providers By FS	Non-MH	% Non-MH Provider By FS	Grand Total
MD Total		735		1,159		42		1,936		33,094		35,030
ME	Alternate	89	18.3%	71	18.9%	1	4.5%	161	18.2%	1,779	28.7%	1,940
ME	Market	397	81.7%	304	81.1%	21	95.5%	722	81.8%	4,419	71.3%	5,141
ME Total		486		375		22		883		6,198		7,081
MI	Alternate	952	31.1%	480	22.4%	21	19.1%	1,453	27.3%	13,794	31.0%	15,247
MI	Market	2,114	68.9%	1,664	77.6%	89	80.9%	3,867	72.7%	30,723	69.0%	34,590
MI Total		3,066		2,144		110		5,320		44,517		49,837
MN	Alternate	739	60.3%	637	48.0%	27	42.9%	1,403	53.6%	17,231	68.8%	18,634
MN	Market	486	39.7%	691	52.0%	36	57.1%	1,213	46.4%	7,824	31.2%	9,037
MN Total		1,225		1,328		63		2,616		25,055		27,671
MO	Alternate	348	20.3%	509	21.3%	10	19.2%	867	20.9%	13,917	33.3%	14,784
MO	Market	1,365	79.7%	1,876	78.7%	42	80.8%	3,283	79.1%	27,847	66.7%	31,130
MO Total		1,713		2,385		52		4,150		41,764		45,914
MS	Alternate	2	1.5%	10	4.5%	1	33.3%	13	3.6%	1,568	15.7%	1,581
MS	Market	131	98.5%	211	95.5%	2	66.7%	344	96.4%	8,408	84.3%	8,752
MS Total		133		221		3		357		9,976		10,333
MT	Alternate	127	17.3%	266	22.4%	62	28.2%	455	21.3%	2,145	28.4%	2,600
MT	Market	609	82.7%	919	77.6%	158	71.8%	1,686	78.7%	5,421	71.6%	7,107
MT Total		736		1,185		220		2,141		7,566		9,707
NC	Alternate	442	42.3%	530	37.2%	29	34.5%	1,001	39.2%	18,798	48.0%	19,799
NC	Market	603	57.7%	893	62.8%	55	65.5%	1,551	60.8%	20,350	52.0%	21,901
NC Total		1,045		1,423		84		2,552		39,148		41,700
ND	Alternate	51	42.1%	146	46.1%	5	35.7%	202	44.7%	1,967	46.7%	2,169
ND	Market	70	57.9%	171	53.9%	9	64.3%	250	55.3%	2,243	53.3%	2,493
ND Total		121		317		14		452		4,210		4,662
NE	Alternate	183	42.8%	308	29.1%	7	17.9%	498	32.6%	4,279	40.0%	4,777
NE	Market	245	57.2%	751	70.9%	32	82.1%	1,028	67.4%	6,426	60.0%	7,454
NE Total		428		1,059		39		1,526		10,705		12,231
NH	Alternate	14	5.4%	29	6.1%	1	2.3%	44	5.6%	2,917	28.5%	2,961
NH	Market	247	94.6%	447	93.9%	42	97.7%	736	94.4%	7,311	71.5%	8,047
NH Total		261		476		43		780		10,228		11,008
NJ	Alternate	166	17.5%	298	25.8%	14	20.0%	478	22.0%	10,147	25.8%	10,625
NJ	Market	782	82.5%	855	74.2%	56	80.0%	1,693	78.0%	29,112	74.2%	30,805

STATE	Fee Schedule Type	MH/SUD	% Both MH/SUD By FS	MH	%MH Providers By FS	SUD	% SUD Providers By FS	MH/SUD/Both Total	% MH/SUD/Both Total Providers By FS	Non-MH	% Non-MH Provider By FS	Grand Total
NJ Total		948		1,153		70		2,171		39,259		41,430
NM	Alternate	15	3.7%	18	2.8%	2	7.7%	35	3.2%	1,714	17.6%	1,749
NM	Market	390	96.3%	632	97.2%	24	92.3%	1,046	96.8%	8,044	82.4%	9,090
NM Total		405		650		26		1,081		9,758		10,839
NV	Alternate	3	1.2%	12	3.0%	1	2.4%	16	2.3%	1,850	17.7%	1,866
NV	Market	242	98.8%	388	97.0%	40	97.6%	670	97.7%	8,622	82.3%	9,292
NV Total		245		400		41		686		10,472		11,158
NY	Alternate	375	11.0%	711	19.1%	23	16.3%	1,109	15.3%	27,724	24.5%	28,833
NY	Market	3,020	89.0%	3,013	80.9%	118	83.7%	6,151	84.7%	85,301	75.5%	91,452
NY Total		3,395		3,724		141		7,260		113,025		120,285
OH	Alternate	389	17.0%	428	14.4%	14	7.9%	831	15.3%	19,192	29.8%	20,023
OH	Market	1,897	83.0%	2,554	85.6%	164	92.1%	4,615	84.7%	45,128	70.2%	49,743
OH Total		2,286		2,982		178		5,446		64,320		69,766
OK	Alternate	38	12.0%	88	11.6%	3	6.1%	129	11.5%	2,530	16.1%	2,659
OK	Market	278	88.0%	669	88.4%	46	93.9%	993	88.5%	13,168	83.9%	14,161
OK Total		316		757		49		1,122		15,698		16,820
OR	Alternate	37	5.7%	78	10.7%		0.0%	115	8.1%	1,382	9.9%	1,497
OR	Market	617	94.3%	653	89.3%	37	100.0%	1,307	91.9%	12,566	90.1%	13,873
OR Total		654		731		37		1,422		13,948		15,370
PA	Alternate	436	24.0%	825	28.4%	50	35.7%	1,311	27.0%	25,803	37.6%	27,114
PA	Market	1,383	76.0%	2,080	71.6%	90	64.3%	3,553	73.0%	42,890	62.4%	46,443
PA Total		1,819		2,905		140		4,864		68,693		73,557
RI	Alternate		0.0%		0.0%		0.0%		0.0%	342	6.4%	342
RI	Market	398	100.0%	413	100.0%	22	100.0%	833	100.0%	5,015	93.6%	5,848
RI Total		398		413		22		833		5,357		6,190
SC	Alternate	33	13.7%	65	11.3%	5	16.1%	103	12.2%	7,043	31.7%	7,146
SC	Market	208	86.3%	510	88.7%	26	83.9%	744	87.8%	15,191	68.3%	15,935
SC Total		241		575		31		847		22,234		23,081
SD	Alternate	1	0.9%	1	0.5%		0.0%	2	0.6%	382	9.7%	384
SD	Market	109	99.1%	199	99.5%	11	100.0%	319	99.4%	3,549	90.3%	3,868
SD Total		110		200		11		321		3,931		4,252
TN	Alternate	43	5.0%	61	5.7%	4	9.3%	108	5.5%	7,578	20.8%	7,686
TN	Market	812	95.0%	1,007	94.3%	39	90.7%	1,858	94.5%	28,799	79.2%	30,657

STATE	Fee Schedule Type	MH/SUD	% Both MH/SUD By FS	MH	%MH Providers By FS	SUD	% SUD Providers By FS	MH/SUD/Both Total	% MH/SUD/Both Total Providers By FS	Non-MH	% Non-MH Provider By FS	Grand Total
TN Total		855		1,068		43		1,966		36,377		38,343
TX	Alternate	386	15.7%	553	8.2%	13	6.2%	952	10.1%	39,198	28.3%	40,150
TX	Market	2,070	84.3%	6,178	91.8%	198	93.8%	8,446	89.9%	99,434	71.7%	107,880
TX Total		2,456		6,731		211		9,398		138,632		148,030
UT	Alternate	210	28.3%	161	27.1%	3	21.4%	374	27.7%	4,395	37.8%	4,769
UT	Market	531	71.7%	433	72.9%	11	78.6%	975	72.3%	7,227	62.2%	8,202
UT Total		741		594		14		1,349		11,622		12,971
VA	Alternate	274	23.9%	616	27.7%	12	17.6%	902	26.3%	15,387	39.1%	16,289
VA	Market	873	76.1%	1,604	72.3%	56	82.4%	2,533	73.7%	23,931	60.9%	26,464
VA Total		1,147		2,220		68		3,435		39,318		42,753
VT	Alternate	11	11.3%	10	10.4%	1	6.3%	22	10.5%	441	32.2%	463
VT	Market	86	88.7%	86	89.6%	15	93.8%	187	89.5%	928	67.8%	1,115
VT Total		97		96		16		209		1,369		1,578
WA	Alternate	383	41.9%	440	30.9%	27	36.0%	850	35.2%	11,682	36.2%	12,532
WA	Market	532	58.1%	985	69.1%	48	64.0%	1,565	64.8%	20,581	63.8%	22,146
WA Total		915		1,425		75		2,415		32,263		34,678
WI	Alternate	1,104	45.4%	1,665	43.5%	143	36.7%	2,912	43.8%	27,642	69.7%	30,554
WI	Market	1,330	54.6%	2,164	56.5%	247	63.3%	3,741	56.2%	11,999	30.3%	15,740
WI Total		2,434		3,829		390		6,653		39,641		46,294
WV	Alternate	2	0.6%	1	0.3%	4	16.0%	7	1.1%	1,043	12.4%	1,050
WV	Market	329	99.4%	295	99.7%	21	84.0%	645	98.9%	7,389	87.6%	8,034
WV Total		331		296		25		652		8,432		9,084
WY	Alternate	74	72.5%	126	70.8%	6	60.0%	206	71.0%	1,874	63.8%	2,080
WY	Market	28	27.5%	52	29.2%	4	40.0%	84	29.0%	1,062	36.2%	1,146
WY Total		102		178		10		290		2,936		3,226

APPENDIX C

CONTRACTED FACILITY FEE SCHEDULE CATEGORY ANALYSIS

State Fee Schedule	Both (MH/SUD)	MH	SUD	Non-MH	Percentage Fee Schedule Both (MH/SUD)	Percentage Fee Schedule MH	Percentage Fee Schedule SUD	Percentage Fee Schedule Non-MH
AK	2	9	1	262				
Alternate	1	5	1	128	50.00%	55.56%	100.00%	48.85%
Market	1	4		134	50.00%	44.44%	0.00%	51.15%
AL	10	19	10	2,181				
Alternate	1	5		872	10.00%	26.32%	0.00%	39.98%
Market	9	14	10	1,309	90.00%	73.68%	100.00%	60.02%
AR	3	23	1	1,152				
Alternate	1	1		271	33.33%	4.35%	0.00%	23.52%
Market	2	22	1	881	66.67%	95.65%	100.00%	76.48%
AZ	59	59	18	4,133				
Alternate	11	21	5	1,310	18.64%	35.59%	27.78%	31.70%
Market	48	38	13	2,823	81.36%	64.41%	72.22%	68.30%
CA	326	372	167	12,594				
Alternate	106	126	92	4,232	32.52%	33.87%	55.09%	33.60%
Market	220	246	75	8,362	67.48%	66.13%	44.91%	66.40%
CO	23	72	8	2,839				
Alternate	10	27	2	771	43.48%	37.50%	25.00%	27.16%
Market	13	45	6	2,068	56.52%	62.50%	75.00%	72.84%
CT	47	53	6	1,380				
Alternate	23	30	2	432	48.94%	56.60%	33.33%	31.30%
Market	24	23	4	948	51.06%	43.40%	66.67%	68.70%
DC		2		149				
Alternate		1		41		50.00%		27.52%
Market		1		108		50.00%		72.48%
DE	1	4	2	360				
Alternate		1	1	97	0.00%	25.00%	50.00%	26.94%
Market	1	3	1	263	100.00%	75.00%	50.00%	73.06%
FL	169	224	46	12,343				
Alternate	77	123	10	4,788	45.56%	54.91%	21.74%	38.79%
Market	92	101	36	7,555	54.44%	45.09%	78.26%	61.21%
GA	29	51	14	5,382				
Alternate	18	30	8	2,152	62.07%	58.82%	57.14%	39.99%
Market	11	21	6	3,230	37.93%	41.18%	42.86%	60.01%
HI	3	1	2	265				
Alternate	3		1	75	100.00%	0.00%	50.00%	28.30%

State Fee Schedule	Both (MH/SUD)	MH	SUD	Non-MH	Percentage Fee Schedule Both (MH/SUD)	Percentage Fee Schedule MH	Percentage Fee Schedule SUD	Percentage Fee Schedule Non-MH
Market		1	1	190	0.00%	100.00%	50.00%	71.70%
IA	23	27	9	1,535				
Alternate	15	12	5	578	65.22%	44.44%	55.56%	37.65%
Market	8	15	4	957	34.78%	55.56%	44.44%	62.35%
ID	2	16	7	644				
Alternate	1	13		282	50.00%	81.25%	0.00%	43.79%
Market	1	3	7	362	50.00%	18.75%	100.00%	56.21%
IL	112	139	47	6,135				
Alternate	67	59	29	2,249	59.82%	42.45%	61.70%	36.66%
Market	45	80	18	3,886	40.18%	57.55%	38.30%	63.34%
IN	41	93	11	3,216				
Alternate	18	50	3	1,133	43.90%	53.76%	27.27%	35.23%
Market	23	43	8	2,083	56.10%	46.24%	72.73%	64.77%
KS	22	36	17	1,600				
Alternate	9	6	8	541	40.91%	16.67%	47.06%	33.81%
Market	13	30	9	1,059	59.09%	83.33%	52.94%	66.19%
KY	62	58	5	2,392				
Alternate	22	17	5	913	35.48%	29.31%	100.00%	38.17%
Market	40	41		1,479	64.52%	70.69%	0.00%	61.83%
LA	26	53	9	3,070				
Alternate	10	11	3	982	38.46%	20.75%	33.33%	31.99%
Market	16	42	6	2,088	61.54%	79.25%	66.67%	68.01%
MA	28	53	20	2,077				
Alternate	6	17	4	870	21.43%	32.08%	20.00%	41.89%
Market	22	36	16	1,207	78.57%	67.92%	80.00%	58.11%
MD	21	18	18	2,273				
Alternate	7	12	6	607	33.33%	66.67%	33.33%	26.70%
Market	14	6	12	1,666	66.67%	33.33%	66.67%	73.30%
ME	6	9	1	446				
Alternate	6	8	1	138	100.00%	88.89%	100.00%	30.94%
Market		1		308	0.00%	11.11%	0.00%	69.06%
MI	74	106	19	3,897				
Alternate	38	51	6	1,394	51.35%	48.11%	31.58%	35.77%
Market	36	55	13	2,503	48.65%	51.89%	68.42%	64.23%
MN	15	78	7	1,885				
Alternate	6	44	1	984	40.00%	56.41%	14.29%	52.20%
Market	9	34	6	901	60.00%	43.59%	85.71%	47.80%
MO	56	56	38	2,967				
Alternate	12	8	3	924	21.43%	14.29%	7.89%	31.14%

State Fee Schedule	Both (MH/SUD)	MH	SUD	Non-MH	Percentage Fee Schedule Both (MH/SUD)	Percentage Fee Schedule MH	Percentage Fee Schedule SUD	Percentage Fee Schedule Non-MH
Market	44	48	35	2,043	78.57%	85.71%	92.11%	68.86%
MS	8	13	1	1,303				
Alternate	4	6		356	50.00%	46.15%	0.00%	27.32%
Market	4	7	1	947	50.00%	53.85%	100.00%	72.68%
MT	5	16	1	533				
Alternate	5	16	1	294	100.00%	100.00%	100.00%	55.16%
Market				239	0.00%	0.00%	0.00%	44.84%
NC	23	42	14	3,483				
Alternate	11	23	1	1,253	47.83%	54.76%	7.14%	35.97%
Market	12	19	13	2,230	52.17%	45.24%	92.86%	64.03%
ND		15		248				
Alternate		7		129		46.67%		52.02%
Market		8		119		53.33%		47.98%
NE	14	17	1	840				
Alternate	11	13	1	353	78.57%	76.47%	100.00%	42.02%
Market	3	4		487	21.43%	23.53%	0.00%	57.98%
NH	3	5	1	380				
Alternate	1	2	1	153	33.33%	40.00%	100.00%	40.26%
Market	2	3		227	66.67%	60.00%	0.00%	59.74%
NJ	59	84	18	3,996				
Alternate	35	33	16	1,283	59.32%	39.29%	88.89%	32.11%
Market	24	51	2	2,713	40.68%	60.71%	11.11%	67.89%
NM	6	15	4	1,014				
Alternate		8		335	0.00%	53.33%	0.00%	33.04%
Market	6	7	4	679	100.00%	46.67%	100.00%	66.96%
NV	15	13		1,314				
Alternate	11	2		278	73.33%	15.38%		21.16%
Market	4	11		1,036	26.67%	84.62%		78.84%
NY	142	163	54	6,647				
Alternate	66	45	19	1,823	46.48%	27.61%	35.19%	27.43%
Market	76	118	35	4,824	53.52%	72.39%	64.81%	72.57%
OH	54	60	18	6,504				
Alternate	34	26	9	2,052	62.96%	43.33%	50.00%	31.55%
Market	20	34	9	4,452	37.04%	56.67%	50.00%	68.45%
OK	16	56	3	1,832				
Alternate	8	21		657	50.00%	37.50%	0.00%	35.86%
Market	8	35	3	1,175	50.00%	62.50%	100.00%	64.14%
OR	20	34	3	1,415				
Alternate	5	10	1	449	25.00%	29.41%	33.33%	31.73%

State Fee Schedule	Both (MH/SUD)	MH	SUD	Non-MH	Percentage Fee Schedule Both (MH/SUD)	Percentage Fee Schedule MH	Percentage Fee Schedule SUD	Percentage Fee Schedule Non-MH
Market	15	24	2	966	75.00%	70.59%	66.67%	68.27%
PA	70	99	42	5,611				
Alternate	29	57	22	1,781	41.43%	57.58%	52.38%	31.74%
Market	41	42	20	3,830	58.57%	42.42%	47.62%	68.26%
RI	7	3		304				
Alternate	2	2		79	28.57%	66.67%		25.99%
Market	5	1		225	71.43%	33.33%		74.01%
SC	13	22		2,292				
Alternate	6	11		845	46.15%	50.00%		36.87%
Market	7	11		1,447	53.85%	50.00%		63.13%
SD	6	6	1	443				
Alternate	3			83	50.00%	0.00%	0.00%	18.74%
Market	3	6	1	360	50.00%	100.00%	100.00%	81.26%
TN	95	101	22	3,923				
Alternate	58	35	13	1,149	61.05%	34.65%	59.09%	29.29%
Market	37	66	9	2,774	38.95%	65.35%	40.91%	70.71%
TX	136	227	62	13,641				
Alternate	45	61	13	4,577	33.09%	26.87%	20.97%	33.55%
Market	91	166	49	9,064	66.91%	73.13%	79.03%	66.45%
UT	36	23	6	908				
Alternate	14	18	5	345	38.89%	78.26%	83.33%	38.00%
Market	22	5	1	563	61.11%	21.74%	16.67%	62.00%
VA	22	51	13	2,735				
Alternate	7	25	8	1,080	31.82%	49.02%	61.54%	39.49%
Market	15	26	5	1,655	68.18%	50.98%	38.46%	60.51%
VT	5	11	1	125				
Alternate	2	5	1	42	40.00%	45.45%	100.00%	33.60%
Market	3	6		83	60.00%	54.55%	0.00%	66.40%
WA	37	45	24	2,139				
Alternate	13	31	11	676	35.14%	68.89%	45.83%	31.60%
Market	24	14	13	1,463	64.86%	31.11%	54.17%	68.40%
WI	34	154	11	2,995				
Alternate	24	138	10	1,911	70.59%	89.61%	90.91%	63.81%
Market	10	16	1	1,084	29.41%	10.39%	9.09%	36.19%
WV	3	7		654				
Alternate	3	3		200	100.00%	42.86%		30.58%
Market		4		454	0.00%	57.14%		69.42%
WY		3	1	256				
Alternate		2	1	99		66.67%	100.00%	38.67%

State Fee Schedule	Both (MH/SUD)	MH	SUD	Non-MH	Percentage Fee Schedule Both (MH/SUD)	Percentage Fee Schedule MH	Percentage Fee Schedule SUD	Percentage Fee Schedule Non-MH
Market		1		157		33.33%	0.00%	61.33%
Grand Total	1,989	2,916	784	140,712				

Nippon – Nonquantitative Treatment Limitation (NQTL) Submission Form

Instructions: This NQTL reporting submission form includes the required five elements as specified by 42 U.S.C. Section 300gg-26(a)(8)(A); 29 U.S.C. Section 1185a(a)(8)(A); and 26 U.S.C. Section 9812(a)(8)(A).

NQTL: Out-of-Network Reimbursement

Date Last Updated: December 2023

Applies to: Inpatient, Outpatient and Emergency (Out-of-Network) Classifications.

Comparative Analysis Performed by:

Name	Title	Position
Carrie Manniello	Second Vice President of Claims and Operations	VP over claims and operations at Nippon. Point of contact for MHPAEA compliance.
Phil Lavigne	Second Vice President and General Counsel	General Counsel for Nippon. Responsible for legal matters and point of contact for MHPAEA compliance.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q2, #'s 1 and 2) guidance stipulate that a sufficient analysis should include:

A clear description of the specific NQTL, plan terms, and policies at issue; and

Identification of the specific mental health or substance use disorder and medical or surgical benefits to which the NQTL applies

within each benefit classification, and a clear statement as to which benefits identified are treated as mental health or substance use disorder and which are treated as medical or surgical.

Issuer Response:

Nippon maintains a methodology for Out-of-Network (OON) reimbursement and rate setting for delivery of Inpatient, Outpatient, and Emergency Care Medical Surgical (“M/S”) and Mental Health Substance Use Disorder (“MH/SUD”) benefits.

Out-of-Network reimbursement rates are based upon the methodologies as set forth below and are client specific:

Provider OON Reimbursement

1. R&C rate
2. RBRVS
3. Billed Charges

For OON provider claims, OON services are priced based upon the R&C or RBRVS (e.g., 50-70%) of the claim, based upon the client’s choice. Nippon’s third-party administrator, Trustmark provides the R&C or RBRVS data based upon Fair Health standards and Medicare reimbursement rates. The claim then is provided to Exponent Health, Nippon’s OON pricing vendor for review and to negotiate with providers based on a discounted fee schedule. If Exponent Health is unable to provide a discounted rate below the Fair Health standard or Medicare reimbursement rate provided by Trustmark, then the OON reimbursement rate is based upon the Fair Health or Medicare reimbursement rate. If Exponent Health is able to negotiate and provide a better discounted rate, the provider claim is reimbursed based upon the negotiated fee provided by Exponent Health.

Facility OON Reimbursement

1. Billed Charges

For OON facility claims, the claims go to Trustmark, as a billed charge and are then provided to Exponent Health for review and to negotiate based on a discounted fee schedule. Exponent Health evaluates billed charges against reference-based pricing and provider history in order to obtain equal or comparable services with the geographic market. Exponent Health looks at the previous 12-month provider history to attempt to achieve the same discount across all claims for the same Tax Identification Number regardless of specialty. As for reference-based pricing, Exponent Health negotiators look at a range of percentiles in the FAIR Health allowable databases to understand what providers in the same geographic location for the same procedure code regardless of specialty, are paid for the same service. They also look at a range of percentiles in the FAIR Health UCR databases to understand what providers in the same geographic location for the same procedure code regardless of specialty charge for the same service.

They also look at Medicare pricing. All negotiations start at the same percentiles for the FAIR Health tables and at 100% of Medicare. Negotiators will then increase their offer based on counter offers from providers. FAIR Health databases do not separate mental health/substance abuse disorders and medical/surgical specialties from each other. The CPT codes have the same rate in these databases for the medical/surgical databases used. Given that there could be huge disparities in what Medicare may pay a provider in California compared to Kentucky, the additional references for FAIR Health allowable and UCR database rates provide the comparisons necessary to ensure objectivity in the negotiations. If Exponent Health is unable to provide a discounted rate that is lower than the billed charge, then the OON facility claim is process at the billed charge amount. If Exponent Health is able to negotiate a better discounted rate, the claim is processed using Exponent Health's OON reimbursement rate.

Nippon does not have OON reimbursement methodology specific to MH/SUD benefits but applies the OON reimbursement methodologies above to both M/S and MH/SUD OON benefits.

Policies:
Nippon Insurance Booklet

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both mental health or substance use disorder benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Issuer Response:

<u>Medical/Surgical:</u>	<u>MH/SUD:</u>
<u>Provider OON Reimbursement</u>	Same as M/S.

<ol style="list-style-type: none"> 1. R&C rate <ol style="list-style-type: none"> a. Factor: R&C rate as identified by the Trustmark process 2. RBRVS <ol style="list-style-type: none"> a. Factor: RBRVS rate as identified by the Trustmark process 3. Billed Charges <ol style="list-style-type: none"> a. Factor: Exponent Health process benchmark comparison process <p><u>Facility OON Reimbursement</u></p> <ol style="list-style-type: none"> 1. Billed Charges <ol style="list-style-type: none"> a. Factor: Exponent Health process benchmark comparison process 	
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Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q 2, # 4) guidance stipulates that a sufficient response includes:

To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

The FAQ 45 guidance (Q 3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

<u>Medical/Surgical:</u> <u>Provider OON Reimbursement</u> <ol style="list-style-type: none">1. R&C rate<ol style="list-style-type: none">a. Factor: R&C rate as identified by the Trustmark processb. Source: Fair Health standards and Medicare reimbursement rates2. RBRVS<ol style="list-style-type: none">a. Factor: RBRVS rate as identified by the Trustmark processb. Source: Fair Health standards and Medicare reimbursement rates3. Billed Charges<ol style="list-style-type: none">a. Factor: Exponent Health process benchmark comparison processb. Source: Reference-based pricing and provider history in order to obtain equal or comparable services with the geographic market. <u>Facility OON Reimbursement</u> <ol style="list-style-type: none">1. Billed Charges<ol style="list-style-type: none">a. Factor: Exponent Health process benchmark comparison processb. Source: Reference-based pricing and provider history in order to obtain equal or comparable services with the geographic market.	<u>MH/SUD:</u> Same as M/S.
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Step 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.

FAQ 45 Guidance: [The FAQ 45](#) guidance states that the following is necessary for a sufficient response:

(Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between mental health or substance use disorder and medical or surgical benefits and, if so, describe the process and factors used for establishing that variation.

(Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).

(Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both mental health or substance use disorder and medical or surgical benefits.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

(Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

(Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were

defined and applied in practice.

Issuer Response – As Written:

Nippon's process for OON reimbursement is the same for MH/SUD benefits as M/S benefits. The factors used and sources relied upon for provider OON reimbursement and facility OON reimbursement are the same for MH/SUD claims and M/S claims. For provider OON reimbursement, Nippon's OON provider claims are priced based upon the R&C, RBRVS, or billed charges. Trustmark provides the R&C and RBRVS data based upon Fair Health standards and Medicare reimbursement rates. The provider claim is then provided to Exponent Health for review and to negotiate based upon a discounted fee schedule. If Exponent Health is unable to provide a lower discounted rate before the Fair Health or Medicare reimbursement rate, then the OON reimbursement rate is based upon the Fair Health or Medicare reimbursement rate. If Exponent Health is able to negotiate and provide a better discounted rate, the provider claim is reimbursed based upon the negotiated fee provided by Exponent Health. For OON facility claims, the claims go to Trustmark, as a billed charge and are then provided to Exponent Health for review and to negotiate based on a discounted fee schedule. Exponent Health evaluates the billed charges against reference-based pricing and provider history. If Exponent Health is unable to provide a discounted rate that is lower than the billed charge, then the OON facility claim is process at the billed charge amount. If Exponent Health is able to negotiate a better discounted rate, the claim is processed using Exponent Health's OON reimbursement rate.

Issuer Response – In Operation:

Nippon reviews average plan rates nationwide for OON reimbursement as further detailed in the chart below. Providers performing services in a healthcare provider shortage area (HPSA) are eligible for 110% of the Medicare rates shown below. A physician assistant or nurse practitioner billing under their own NPI number will be paid 85% of the physician fee schedule for the rates below. For Nippon's OON reimbursement rates, Psychiatrists are reimbursed at 307.5% of the Medicare rate which is a higher reimbursement rate than M/S providers such as Gastroenterologist, reimbursed at 285.5% of the Medicare rate. Nippon's OON reimbursement rates for MH/SUD providers are applied comparable and no more stringently than M/S providers.

Specialty	CPT Code	Average Plan rate (Nationwide)	Medicare rate (Nationwide)	Plan rate as a percentage of Medicare
Orthopedic Surgery	99203	\$ 268.14	\$ 112.84	237.6%
	99213	\$ 146.52	\$ 90.82	161.3%
Cardiologists	99203	\$ 386.00	\$ 112.84	342.1%
	99213	\$ 171.92	\$ 90.82	189.3%
Internists MD	99203	\$ 229.15	\$ 112.84	203.1%
	99213	\$ 128.63	\$ 90.82	141.6%
Endocrinologists	99203	\$ 340.00	\$ 112.84	301.3%
	99213	\$ 95.06	\$ 90.82	104.7%
Gastroenterologist	99203	\$ 322.18	\$ 112.84	285.5%
	99213	\$ 66.76	\$ 90.82	73.5%
Neurologists	99203	\$ 458.00	\$ 112.84	405.9%
	99213	\$ 127.92	\$ 90.82	140.9%
Pediatrician	99203	\$ 125.89	\$ 112.84	111.6%
	99213	\$ 105.58	\$ 90.82	116.3%
Dermatologists	99203	\$ 212.64	\$ 112.84	188.4%
	99213	\$ 168.99	\$ 90.82	186.1%

Psychiatrists	99213	\$ 279.29	\$ 90.82	307.5%	
Psychologists	90832 (based on 1 hr) 90791 (based on ½ hour)	\$ 208.85 \$ 243.82	\$ 75.57 \$174.86	276.4% 139.4%	
LCSW	90832 (based on 1 hr) 90791 (based on ½ hour)	\$ 208.85 \$ 243.82	\$ 56.68 \$ 131.15	368.5% 185.9%	
Podiatrists	99203 99213	\$ 214.41 \$ 132.82	\$ 112.84 \$ 90.82	190.0% 146.2%	
Chiropractor	99203 99213	\$ 217.00 \$ 157.85	\$ 112.84 \$ 90.82	192.3% 173.8%	
Occupational Therapy	97165 97166 97167 97168	\$ 193.41 \$ 213.34 \$ 248.10 \$ 283.23	\$ 101.66 \$ 101.66 \$ 101.66 \$ 70.15	190.3% 209.9% 244.0% 403.8%	
Physical Therapy	97161 97162 97163 97164	\$ 171.96 \$ 167.96 \$ 206.21 \$ 127.90	\$ 101.66 \$ 101.66 \$ 101.66 \$ 70.49	169.2% 165.2% 202.8% 181.4%	
Speech Therapy	92507	\$188.91	\$ 77.26	244.5%	

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) guidance states that a sufficient response should include:

(Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusion:

Nippon has determined that OON reimbursement is applied to MH/SUD benefits in a manner that is comparable to and no more stringent than that of M/S benefits based on the information presented above that describes the processes used for OON reimbursement.

As Written: All processes, strategies, evidentiary standards and other factors used to apply OON reimbursement are the same processes, strategies, evidentiary standards and factors used to apply OON reimbursement to medical/surgical benefits as MH/SUD benefits.

In-Operation: Based upon the operational data for OON reimbursement above, Nippon has determined that OON reimbursement is

applied to MH/SUD benefits in a comparable and no more stringent way than M/S benefits.

Self-Compliance Tool for the
Mental Health Parity and Addiction Equity Act (MHPAEA)

About This Tool.....	2
Introduction.....	3
Definitions.....	4
SECTION A. APPLICABILITY.....	6
SECTION B. COVERAGE IN ALL CLASSIFICATIONS	8
SECTION C. LIFETIME AND ANNUAL LIMITS	13
SECTION D. FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS.....	14
SECTION E. CUMULATIVE FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.....	18
SECTION F. NONQUANTITATIVE TREATMENT LIMITATIONS	19
SECTION G. DISCLOSURE REQUIREMENTS	29
SECTION H. ESTABLISHING AN INTERNAL MHPAEA COMPLIANCE PLAN.....	33
APPENDIX I: ADDITIONAL ILLUSTRATIONS.....	35
APPENDIX II: PROVIDER REIMBURSEMENT RATE WARNING SIGNS	38

About This Tool

The goal of this self-compliance tool is to help group health plans, plan sponsors, plan administrators, group and individual market health insurance issuers, state regulators, and other parties determine whether a group health plan or health insurance issuer complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) and additional related requirements under the Employee Retirement Income Security Act of 1974 (ERISA) that apply to group health plans. The requirements described in this tool generally apply to group health plans, group health insurance issuers, and individual market health insurance issuers. However, requirements that do not apply as broadly are so noted.

This tool does not provide legal advice. Rather, it gives the user a basic understanding of MHPAEA to assist in evaluating compliance with its requirements. For more information on MHPAEA, or related guidance issued by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments), please visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

Furthermore, as directed by Section 13001(a) of the 21st Century Cures Act, this publicly available tool is a compliance program guidance document intended to improve compliance with MHPAEA. DOL will update the self-compliance tool biennially to provide additional guidance on MHPAEA's requirements, as appropriate.

MHPAEA, as a federal law, sets minimum standards for group health plans and issuers with respect to parity requirements. However, many states have enacted their own laws to advance parity between mental health and substance use disorder benefits and medical/surgical benefits by supplementing the requirements of MHPAEA. Insured group health plans and issuers should consult with their state regulators to understand the full scope of applicable parity requirements.

This tool provides a number of examples that demonstrate how the law applies in certain situations and how a plan or issuer might or might not comply with the law. Additional examples are included in the Appendix I. The fact patterns used as examples are intended to help group health plans and health insurance issuers identify and address important MHPAEA issues.

Examples of MHPAEA enforcement actions that the DOL has undertaken are included in the MHPAEA Enforcement Fact Sheets, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>. Examples of MHPAEA enforcement actions that HHS has taken are included in the Department of Health and Human Services' MHPAEA Reports at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#mental-health-parity>.

Introduction

MHPAEA, as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans and group and individual health insurance issuers that provide coverage for MH/SUD benefits in addition to medical/surgical benefits. DOL has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans, while HHS has primary enforcement authority over non-federal governmental group health plans, such as those sponsored by state and local government employers. HHS also has primary enforcement authority for MHPAEA over issuers selling products in the individual and fully insured group markets in states that have notified HHS' Centers for Medicare & Medicaid Services that they do not have the authority to enforce or are not otherwise enforcing MHPAEA. In all other states, generally the state is responsible for directly enforcing MHPAEA with respect to issuers.

Unless a plan is otherwise exempt, MHPAEA generally applies to both grandfathered and non-grandfathered group health plans and large group health insurance coverage. Also, the Affordable Care Act requires all issuers offering coverage in the individual and small group markets to cover certain essential health benefits (EHB), including MH/SUD benefits. Final rules issued by HHS implementing EHB requirements specify that MH/SUD benefits must be consistent with the requirements of the MHPAEA regulations. *See 45 CFR 156.115(a)(3).*

Under the MHPAEA regulations, if a plan or issuer provides MH/SUD benefits in any classification described in the MHPAEA final regulation, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. Under PHS Act section 2713, as added by the Affordable Care Act, non-grandfathered group health plans and group and individual health insurance coverage are required to cover certain preventive services with no cost-sharing, which include, among other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening. However, the MHPAEA regulations do not require a group health plan or a health insurance issuer that provides MH/SUD benefits only to the extent required under PHS Act section 2713, to provide additional MH/SUD benefits in any classification. *See 29 CFR 2590.712(e)(3)(ii), 45 CFR 146.136(e)(3)(ii), 26 CFR 54.9812-1(e)(3)(ii).*

Definitions

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on certain accumulated amounts, and they include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts, such as annual or lifetime day or visit limits.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but not including MH/SUD benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or state guidelines).

Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or state guidelines).

NOTE: If a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits for purposes of MHPAEA. For example, if a plan defines autism spectrum disorder (ASD) as a mental health condition, it must treat benefits for ASD as mental health benefits. Therefore, for example, any exclusion by the plan for experimental treatment that applies to ASD should be evaluated for compliance as a nonquantitative treatment limitation (NQTL) (and the processes, strategies, evidentiary standards, and other factors used by the plan to determine whether a particular treatment for ASD is experimental, as written and in operation, must be comparable to and no more stringently applied than those used for exclusions of experimental treatments of medical/surgical conditions in the same classification). *See FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century*

Cures Act Part 39, Q1, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>. Additionally, if a plan defines ASD as a mental health condition, any aggregate annual or lifetime dollar limit or any quantitative treatment limitation (QTL) imposed on benefits for ASD (for example, an annual dollar cap on benefits for Applied Behavioral Analysis (ABA) therapy for ASD of \$35,000, or a 50-visit annual limit for ABA therapy for ASD) should also be evaluated for compliance with MHPAEA.

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both QTLs, which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

SECTION A. APPLICABILITY

Question 1. Is the group health plan or group or individual health insurance coverage exempt from MHPAEA? If so, please indicate the reason (e.g. retiree-only plan, excepted benefits, small employer exception, increased cost exception, HIPAA opt-out).

Comments: Nippon Life Insurance is not exempt from MHPAEA.

If a group health plan or group or individual health insurance coverage provides either MH/SUD benefits, in addition to medical/surgical benefits, the plan may be subject to the MHPAEA parity requirements. However, **retiree-only group health plans**, self-insured non-federal governmental plans that have elected to exempt the plan from MHPAEA, and group health plans and group or individual health insurance coverage offering only **excepted benefits**, are generally not subject to the MHPAEA parity requirements. (*Note*: if under an arrangement(s) to provide medical care benefits by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and MH/SUD benefits, the MHPAEA parity requirements apply separately with respect to each combination of medical/surgical benefits and MH/SUD benefits and all such combinations are considered to be a single group health plan. *See 26 CFR 54.9812-1(e), 29 CFR 2590.712(e), 45 CFR 146.136(e).*)

Under ERISA, the MHPAEA requirements do not apply to **small employers**, defined as employers who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employ at least 1 employee on the first day of the plan year. *See 26 CFR 54.9812-1(f)(1), 29 CFR 2590.712(f)(1), 45 CFR 146.136(f)(1).* However, under HHS final rules governing the Affordable Care Act requirement to provide EHBs, non-grandfathered health insurance coverage in the individual and small group markets must provide all categories of EHBs, including MH/SUD benefits. The final EHB rules require that such benefits be provided in compliance with the requirements of the MHPAEA rules. *45 CFR 156.115(a)(3); see also ACA Implementation FAQs Part XVII, Q6, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xvii.pdf>.* In practice, this means that employees in group health plans offered by small employers who purchase non-grandfathered health insurance coverage in the small group market (within the meaning of section 2791 of the PHS Act) that must provide EHBs have coverage that is subject to the requirements of MHPAEA.

MHPAEA also contains an **increased cost exemption** available to group health plans and issuers that meet the requirements for the exemption. The MHPAEA regulations establish standards and procedures for claiming an increased cost exemption. *See 26 CFR 54.9812-1(g), 29 CFR 2590.712(g), 45 CFR 146.136(g).*

Sponsors of self-funded, non-federal governmental plans are permitted to elect to exempt those plans from certain provisions of the PHS Act, including MHPAEA. An exemption election is commonly called a “HIPAA opt-out.” The HIPAA opt-out election was authorized under section 2722(a)(2) of the PHS Act (42 USC § 300gg-21(a)(2)). *See also 45 CFR 146.180.* The

procedures and requirements for self-funded, non-federal governmental plans to opt out may be found at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#Self-Funded%20Non-Federal%20Governmental%20Plans>.

Question 2. If not exempt from MHPAEA, does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in addition to providing medical/surgical benefits?

Comments: Yes, Nippon Life Insurance provides MH/SUD benefits in addition to providing medical/surgical benefits.

Unless the group health plan or group or individual health insurance coverage is exempt from MHPAEA or does not provide MH/SUD benefits, continue to the following sections to examine compliance with requirements under MHPAEA.

SECTION B. COVERAGE IN ALL CLASSIFICATIONS

Question 3. Does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in every classification in which medical/surgical benefits are provided?

Comments: Yes, Nippon Life Insurance provides MH/SUD benefits in every classification in which medical/surgical benefits are provided.

Under the MHPAEA regulations, if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulation, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).*

Under the MHPAEA regulations, the six classifications* of benefits are:

- 1) inpatient, in-network;
- 2) inpatient, out-of-network;
- 3) outpatient, in-network;
- 4) outpatient, out-of-network;
- 5) emergency care; and
- 6) prescription drugs.

See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).

**See special rules related to the classifications discussed below.*

NOTE: If a plan or coverage generally excludes all benefits for a particular mental health condition or substance use disorder, but nevertheless includes prescription drugs for treatment of that condition or disorder on its formulary, the plan or coverage covers MH/SUD benefits in only one classification (prescription drugs). Therefore, the plan or coverage would generally be required to provide mental health or substance use disorder benefits with respect to that condition or disorder for each of the other five classifications for which the plan also provides medical/surgical benefits. However, if a prescription drug that may be used for a particular MH/SUD condition and may also be used for other unrelated conditions is included on a plan's or coverage's formulary, the drug's inclusion on the formulary alone would not be considered to override the plan or coverage's general exclusion for a particular mental health condition or substance use disorder unless the plan or coverage covers prescription drugs specifically to treat that condition.

ILLUSTRATION: A Plan provides for medically necessary medical/surgical benefits as well as MH/SUD benefits. While the Plan covers medical/surgical benefits in all benefit classifications, it does not cover outpatient services for MH/SUD benefits for either in-network or out-of-network providers. In this example, since the Plan fails to provide MH/SUD benefits in outpatient, in-network and outpatient, out-of-network classifications in which medical/surgical benefits are provided, the Plan fails to meet MHPAEA's parity requirements. The Plan could

come into compliance by covering outpatient services for MH/SUD benefits both in- and out-of-network in a manner comparable to covered medical/surgical outpatient in- and out-of-network services.

Classifying benefits. In determining the classification in which a particular benefit belongs, a group health plan or group or individual market health insurance issuer must apply the same standards to medical/surgical benefits as to MH/SUD benefits. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).* This rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must assign covered intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) to the existing six classifications in the same way that they assign intermediate medical/surgical benefits to these classifications. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well. A plan or issuer must also comply with MHPAEA's NQTL rules, discussed in Section F, in assigning any benefits to a particular classification. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4).*

Medication Assisted Treatment (MAT) is subject to MHPAEA

Plans and issuers that offer MAT benefits to treat opioid use disorder are subject to MHPAEA requirements, including the special rule for multi-tiered prescription drug benefits that applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as appropriate for purposes of MHPAEA. Plans and issuers should ensure there are NO impermissible QTLs, such as visit limits, or impermissible NQTLs, such as limits on treatment dosage and duration. For example, a limitation providing that coverage of medication for the treatment of opioid use disorder is contingent upon the availability of behavioral or psychosocial therapies or services or upon the patient's acceptance of such services would generally not be permissible unless a comparable process was used to determine limitations for the coverage of medications for the treatment of medical/surgical conditions.

ILLUSTRATION: An issuer did not cover methadone for opioid addiction, though it did cover methadone for pain management. The issuer failed to demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions. The issuer re-evaluated the medical necessity of methadone-maintenance treatment programs and developed medical-necessity criteria that mirrors federal guidelines (including the Substance Abuse and Mental Health Services Administration treatment improvement protocol 63 for medication for opioid use disorder) for opioid treatment programs to replace the methadone-maintenance treatment exclusion.

ILLUSTRATION: A plan uses nationally recognized clinical standards to determine coverage for prescription drugs to treat medical/surgical benefits based on the recommendations of a Pharmacy and Therapeutics (P&T) committee. However, the plan deviates from such standards

for buprenorphine/naloxone to treat opioid use disorder based on the P&T committee's recommendations. This deviation should be evaluated for compliance with MHPAEA's NQTL standard in practice, including the determination of (1) whether the P&T committee has comparable expertise in MH/SUD conditions as it has in medical/surgical conditions, and (2) whether the committee's evaluation of the nationally-recognized clinical standards and decision processes to deviate from those standards for MH/SUD conditions is comparable to and no more stringent than the processes it follows for medical/surgical conditions.

Treatment for eating disorders is subject to MHPAEA

Eating disorders are mental health conditions, and treatment of an eating disorder is a "mental health benefit" as that term is defined by MHPAEA. *See ACA Implementation FAQs Part 38, Q1, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf>.* Section 13007 of the 21st Century Cures Act provides that if a plan or an issuer provides coverage for eating disorders, including residential treatment, they must provide these benefits in accordance with MHPAEA requirements. For example, an exclusion under a plan of all inpatient, out-of-network treatment outside of a hospital setting for eating disorders would generally not be permissible if the plan did not employ a comparable process to determine if a similar limitation on treatment outside hospital settings for medical/surgical benefits warranted. *See FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q8, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>.*

Compliance Tips

- If the plan or issuer does not contract with a network of providers, all benefits are out-of-network. If a plan or issuer that has no network imposes a financial requirement or treatment limitation on inpatient or outpatient benefits, the plan or issuer is imposing the requirement or limitation within classifications (inpatient, out-of-network or outpatient, out-of-network), and the rules for parity will be applied separately for the different classifications. *See 26 CFR 54.9812-1(c)(2)(ii)(C), 29 CFR 2590.712(c)(2)(ii)(C), 45 CFR 146.136(c)(2)(ii)(C) Example 1.*
- If a plan or issuer covers the full range of medical/surgical benefits (in all classifications, both in-network and out-of-network), beware of exclusions on out-of-network MH/SUD benefits.
- Benefits for intermediate services (such as non-hospital inpatient and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

***NOTE: Special rules related to classifications**

1. Special rule for outpatient sub-classifications:

- For purposes of determining parity for outpatient benefits (in-network and out-of-network), a plan or issuer may divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules. *26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*
- After the sub-classifications are established, the plan or issuer may not impose any financial requirement or QTL on MH/SUD benefits in any sub-classification (*i.e.*, office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the MHPAEA regulations. *See 26 CFR 54.9812-1(c)(3)(i), 29 CFR 2590.712(c)(3)(i), 45 CFR 146.136(c)(3)(i), 45 CFR 146.136(c)(3)(iii).*
- Other than as explicitly permitted under the final rules, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, separate sub-classifications for generalists and specialists are not permitted.

2. Special rule for prescription drug benefits:

- There is a special rule for multi-tiered prescription drug benefits. Multi-tiered drug formularies involve different levels of drugs that are classified based primarily on cost, with the lowest-tier (Tier 1) drugs having the lowest cost-sharing. If a plan or issuer applies different levels of financial requirements to different tiers of prescription drug benefits, the plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for medical/surgical or MH/SUD benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. *See 26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*

3. Special rule for multiple network tiers:

- There is a special rule for multiple network tiers. If a plan or issuer provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan or issuer may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or MH/SUD

benefits. After the tiers are established, the plan or issuer may not impose any financial requirement or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

NOTE: As explained in the Introduction to this section, nothing in MHPAEA requires a non-grandfathered group health plan or health insurance coverage that provides MH/SUD benefits only to the extent required under PHS Act section 2713 to provide additional MH/SUD benefits in any classification.

SECTION C. LIFETIME AND ANNUAL LIMITS

Question 4. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding lifetime and annual dollar limits on MH/SUD benefits?

Comments: Yes, Nippon Life Insurance complies with mental health parity requirements regarding lifetime and annual dollar limits on MH/SUD benefits.

A plan or issuer generally may not impose a lifetime dollar limit or an annual dollar limit on MH/SUD benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. *See 26 CFR 9812-1(b), 29 CFR 2590.712(b), 45 CFR 146.136(b).* (This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged.) If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits, or it includes one that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. *26 CFR 54.9812-1(b)(2), 29 CFR 2590.712(b)(2), 45 CFR 146.136(b)(2).*

ILLUSTRATION: Plan Z limits outpatient substance use disorder treatments to a maximum of \$1,000,000 per calendar year. With the exception of a \$500,000 per year limit on chiropractic services (which applies to less than one-third of all medical/surgical benefits), Plan Z does not impose such annual dollar limits with respect to other outpatient medical/surgical benefits. In this example, Plan Z is in violation of MHPAEA since the outpatient substance use disorder dollar limit is not in parity with outpatient medical/surgical dollar limits.

Compliance Tip

- There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at **Question 6**. A plan or issuer may impose annual out-of-pocket dollar limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.

NOTE: These provisions are affected by section 2711 of the PHS Act, as amended by the Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime and annual dollar limits on EHB, which includes MH/SUD services. Accordingly, the parity requirements regarding lifetime and annual dollar limits apply only to the provision of MH/SUD benefits that are not EHBs.

Note also that, for plan years beginning in 2021, the annual limitation on an individual's maximum out-of-pocket (MOOP) costs in effect under the Affordable Care Act is \$8,550 for self-only coverage and \$17,100 for coverage other than self-only coverage. The annual limitation on out-of-pocket costs is increased annually by the premium adjustment percentage described under Affordable Care Act section 1302(c)(4), and this updated amount is detailed each year in regulations issued by the Department of Health and Human Services.

SECTION D. FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

Question 5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding financial requirements or QTLs on MH/SUD benefits?

Comments: Yes, Nippon Life Insurance complies with mental health parity requirements regarding financial requirements / QTLs on MH/SUD benefits.

- A plan or issuer may not impose a financial requirement or QTL applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of that type that is applied to substantially all medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(2), 29 CFR 2590.712(c)(2), 45 CFR 146.136(c)(2).*
- Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
- Types of QTLs include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
- The six classifications and the sub-classifications outlined in Section B, above, are the only classifications that may be used when determining the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits. *See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).* A plan or issuer may not use a separate sub-classification under these classifications for generalists and specialists. *See 26 CFR 54.9812-1(c)(3)(iii)(C), 29 CFR 2590.712(c)(3)(iii)(C), 45 CFR 146.136(c)(3)(iii)(C).*

Compliance Tips

- Ensure that the plan or issuer does not impose financial requirements or QTLs that are applicable only to MH/SUD benefits.
- Identify all benefit packages and health insurance coverage to which MHPAEA applies.

Detailed steps for applying this rule:

To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification. *See 26 CFR 54.9812-1(c)(2)(i), 29 CFR 2590.712(c)(2)(i), 45 CFR 146.136(c)(2)(i).* Coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions, for example, self-only, family, or employee plus spouse. *See 26 CFR 54.9812-1(c)(1)(iv), 29 CFR 2590.712(c)(1)(iv), 45 CFR 146.136(c)(1)(iv).* If a plan applies different levels of a financial requirement or QTL to different coverage units in a classification of medical/surgical benefits (for example, a \$15 copayment for self-only and a \$20 copayment for family coverage), the predominant level is determined separately for each coverage unit. *See 26 CFR 54.9812-1(c)(3)(ii), 29 CFR 2590.712(c)(3)(ii), 45 CFR 146.136(c)(3)(ii).*

- **STEP ONE (“substantially all” test):** First determine if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits.
 - Generally, a financial requirement or QTL is considered to apply to substantially all medical/surgical benefits if it applies to at least two-thirds of the medical/surgical benefits in the classification. *See 26 CFR 9812-1(c)(3)(i)(A), 29 CFR 2590.712(c)(3)(i)(A), 45 CFR 146.136(c)(3)(i)(A).* This two-thirds calculation is generally based on the dollar amount of plan payments expected to be paid for the plan year within the classification. *See 26 CFR 54.9812-1(c)(3)(i)(C), 29 CFR 2590.712(c)(3)(i)(C), 45 CFR 146.136(c)(3)(i)(C).* Any reasonable method can be used for this calculation. *See 26 CFR 54.9812-1(c)(3)(i)(E), 29 CFR 2590.712(c)(3)(i)(E), 45 CFR 146.136(c)(3)(i)(E).*
- **STEP TWO (“predominant” test):** If the type of financial requirement or QTL applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or QTL that applies to the medical/surgical benefits that are subject to that type of financial requirement or QTL in that classification of benefits. (**Note:** If the type of financial requirement or QTL does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to MH/SUD benefits in that classification.)
 - Generally, the level of a financial requirement or QTL that is considered the predominant level of that type is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or QTL. *See 26 CFR 54.9812-1(c)(3)(i)(B)(1), 29 CFR 2590.712(c)(3)(i)(B)(1), 45 CFR 146.136(c)(3)(i)(B)(1).* If there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or QTL in the classification. In that case, the least restrictive level within the combination is considered the predominant level. *See 26 CFR 54.9812-1(c)(3)(i)(B)(2), 29 CFR 2590.712(c)(3)(i)(B)(2), 45 CFR 146.136(c)(3)(i)(B)(2).* For a simpler method of compliance, a plan may treat the

least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.

Compliance Tip: Book of Business

- When performing the “substantially all” and “predominant” tests for financial requirements and QTLs, basing the analysis on an issuer’s entire book of business is generally not a reasonable method if a plan or issuer has sufficient claims data regarding a specific plan for a reasonable projection of future claims costs for the substantially all and predominant analysis. However, there may be insufficient reliable claims data for a group health plan, in which case the analyses will require utilizing reasonable data from outside the group health plan. A plan or issuer must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice. *See ACA Implementation FAQs Part 34, Q3, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf>.*

ILLUSTRATION: Plan Z requires copayments for out-patient, in-network MH/SUD benefits. In order to determine if the plan meets the parity requirements, take the following steps:

1. **STEP ONE: Determine if the particular type of financial requirement applies to substantially all (that is, 2/3 of) medical /surgical benefits in the relevant classification.**

Based on its prior claims experience, Plan Z expects \$1 million in medical/surgical benefits to be paid in the outpatient, in-network classification and \$700,000 of those benefits are expected to be subject to copayments. Because the amount of medical/surgical benefits expected to be subject to a copayment, which is \$700,000, is at least 2/3 of the \$1 million total medical/surgical benefits expected to be paid, a copayment can be applied to outpatient, in-network MH/SUD benefits.

2. **STEP TWO: Determine what level of the financial requirement is predominant (that is, the level that applies to more than half the medical/surgical benefits subject to the financial requirement in the relevant classification).**

In the outpatient, in-network classification where \$1 million in medical/surgical benefits is expected to be paid, \$700,000 of those benefits are expected to be subject to copayments. Out of the \$700,000, Plan Z expects that 25 percent will be subject to a \$15 copayment and 75 percent will be subject to a \$30 copayment. Since 75 percent is more than half, the \$30 copayment is the predominant level.

CONCLUSION: Plan Z cannot impose a copayment on MH/SUD benefits in this classification that is higher than \$30.

Warning Sign: If a plan or issuer applies a specialist copayment requirement for all MH/SUD benefits within a classification but applies a specialist copayment only for certain medical/surgical benefits within a classification, this may be indicative of noncompliance and warrant further review. See “Compliance Tips” below for further guidance on specialist copay requirements.

Compliance Tips

- Ensure that when conducting the predominant/substantially all tests, the dollar amount of all plan payments for medical/surgical benefits expected to be paid in that classification for the relevant plan year are analyzed.
- A plan may be able to impose the specialist level of a financial requirement or QTL to MH/SUD benefits in a classification (or an office visit sub-classification) if it is the predominant level that applies to substantially all medical/surgical benefits within the office visit sub-classification. For example, if the specialist level of copay is the predominant level of copay that applies to substantially all medical/surgical benefits in the office visit, in-network sub-classification, the plan may apply the specialist level copay to MH/SUD benefits in the office visit, in-network sub-classification. *See 26 CFR 54.9812-1(c)(3), 29 CFR 2590.712(c)(3).*

SECTION E. CUMULATIVE FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS

Question 6. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding cumulative financial requirements or cumulative QTLs for MH/SUD benefits?

Comments: Yes, Nippon Life Insurance complies with the mental health parity requirements regarding cumulative financial requirements / cumulative QTLs for MH/SUD benefits.

- A plan or issuer may not apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(3)(v), 29 CFR 2590.712(c)(3)(v), 45 CFR 146.136(c)(3)(v).* For example, a plan may not impose an annual \$250 deductible on medical/surgical benefits in a classification and a separate \$250 deductible on MH/SUD benefits in the same classification.
- Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements). *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*
- Cumulative QTLs are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*

ILLUSTRATION: A plan offers three benefit options, all of which provide medical/surgical as well as MH/SUD benefits. For all three benefit options, the plan provides for in-network treatment limitations of 30 days per year with respect to inpatient mental health services, and in-network treatment limitations of 20 visits per year with respect to outpatient mental health services. No such limitations are imposed on outpatient or inpatient, in-network medical/surgical benefits in any of the three benefit options.

In this example, the plan improperly imposes cumulative treatment limitations on the number of visits for outpatient and inpatient, in-network and out-of-network mental health benefits in all three benefit options. The plan could come into compliance by removing the day and visit limits for mental health services.

SECTION F. NONQUANTITATIVE TREATMENT LIMITATIONS

Question 7. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding NQTLs on MH/SUD benefits?

Comments: Yes, Nippon Life Insurance complies with mental health parity requirements regarding NQTLs on MH/SUD benefits.

An NQTL is generally a limitation on the scope or duration of benefits for treatment. The MHPAEA regulations prohibit a plan or an issuer from imposing NQTLs on MH/SUD benefits in any classification unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(4)(i), 29 CFR 2590.712(c)(4)(i), 45 CFR 146.136(c)(4)(i).*

The following is an illustrative, non-exhaustive list of NQTLs:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization or ongoing authorization requirements;
- Concurrent review standards;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or issuer methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “step therapy” protocols);
- Exclusions of specific treatments for certain conditions;
- Restrictions on applicable provider billing codes;
- Standards for providing access to out-of-network providers;
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

See 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), 45 CFR 146.136(c)(4)(ii). For additional examples of plan provisions that may operate as NQTLs see *Warning Signs*, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtl-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>.

While NQTLs are generally defined as treatment limitations that are not expressed numerically, the application of an NQTL in a numerical way does not modify its nonquantitative character. For example, standards for provider admission to participate in a network are NQTLs because such standards are treatment limitations that typically are not expressed numerically. *See 29 CFR 2590.712 (c)(4)(ii), 45 CFR 146.136(c)(4)(ii)*. Nevertheless, these standards sometimes rely on numerical standards, for example, numerical reimbursement rates. In this case, the numerical expression of reimbursement rates does not modify the nonquantitative character of the provider admission standards; accordingly, standards for provider admission, including associated reimbursement rates to which a participating provider must agree, are to be evaluated in accordance with the rules for NQTLs.

A group health plan or issuer may consider a wide array of factors in designing medical management techniques for both MH/SUD benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these or other factors in a comparable fashion, an NQTL, such as prior authorization, may be required for some (but not all) MH/SUD benefits, as well as for some (but not all) medical/ surgical benefits. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4), Example 8.*

NOTE – To comply with MHPAEA, a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network and out-of-network providers for both medical/surgical and MH/SUD benefits. For example, if reimbursement rates for medical/surgical benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule. Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, or market need or availability (demand) must be comparable and applied no more stringently to MH/SUD benefits than medical/surgical benefits.

NOTE - Plans and issuers may attempt to address shortages in medical/surgical specialist providers and ensure reasonable patient wait times for appointments by adjusting provider admission standards, through increasing reimbursement rates, and by developing a process for accelerating enrollment in their networks to improve network adequacy. To comply with MHPAEA, plans and issuers must take measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers, even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan's network. The Departments note that substantially disparate results—for example, a network that includes far fewer MH/SUD providers than medical/surgical providers—are a red flag that a plan or issuer may be imposing an impermissible NQTL. *See FAQs Part 39, Q6 and Q7, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>.*

Warning Signs: The following plan provisions related to provider reimbursements may be indicative of noncompliance and warrant further review:

1. *Inequitable reimbursement rates established via a comparison to Medicare:* A plan or issuer generally pays at or near Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for medical/surgical benefits. For assistance comparing a plan or coverage's reimbursement schedule to Medicare, see the PROVIDER REIMBURSEMENT RATE WARNING SIGNS in Appendix II.
2. *Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes:* A plan or issuer reimburses psychiatrists, on average, less than medical/surgical physicians for the same E&M codes.
3. *Consideration of different sets of factors to establish reimbursement rates:* A plan or issuer generally considers market dynamics, supply and demand, and geographic location to set reimbursement rates for medical/surgical benefits, but considers only quality measures and treatment outcomes in setting reimbursement rates for MH/SUD benefits.

In order to determine compliance with MHPAEA, the following analysis should be applied to each NQTL identified under the plan or coverage:

Step One:

- Identify the NQTL.

Comments:

Identify in the plan documents all the services (both MH/SUD and medical/surgical) to which the NQTL applies in each classification.

NOTE: NQTLs may also be included in other documents, such as internal guidelines or provider contracts.

Compliance Tips

- Ask for information about what medical/surgical benefits are also subject to these requirements or restrictions.
- If a benefit includes multiple components (*e.g.*, outpatient and prescription drug classifications), and each component is subject to a different type of NQTL (*e.g.*, prior authorization and limits on treatment dosage or duration), each NQTL must be analyzed separately.
- Find out how these requirements are implemented, who makes the decisions, and what the decision-maker's qualifications are.

Determine which benefits are treated as medical/surgical and which are treated as MH/SUD, and analyze the NQTLs under each benefit classification. Plans and issuers should clearly define which benefits are treated as medical/surgical and which benefits are treated as MH/SUD under the plan. Benefits (such as inpatient treatment at a skilled nursing facility or other non-hospital facility and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

Compliance Tip

- Any separate NQTL that applies to only the MH/SUD benefits within any particular classification does not comply with MHPAEA.

NOTE: If a plan classifies covered intermediate levels of care, such as skilled nursing care and residential treatment, as inpatient benefits, and covers room and board for all inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction only on MH/SUD benefits and therefore violates MHPAEA.¹ The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment.

¹ See 29 CFR 2590.712(c)(iii) Ex. 9.

Step Two:

- Identify the factors considered in the design of the NQTL.

Comments:

Examples of factors include but are not limited to the following:

- Excessive utilization;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- Lack of adherence to quality standards;
- Claim types with high percentage of fraud; and
- Current and projected demand for services.

Compliance Tips

- If only certain benefits are subject to an NQTL, such as meeting a fail-first protocol or requiring preauthorization, plans and issuers should have information available to substantiate how the applicable factors were used to apply the specific NQTL to medical/surgical and MH/SUD benefits.
- Determine whether any factors were given more weight than others and the reason(s) for doing so, including evaluating the specific data used in the determination (if any).

Step Three:

- Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified above to design the NQTL.

Comments:

Examples of sources of factors include, but are not limited to, the following:

- Internal claims analysis;
- Medical expert reviews;
- State and federal requirements;
- National accreditation standards;
- Internal market and competitive analysis;
- Medicare physician fee schedules; and
- Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

If these factors are utilized, they must be applied comparably to MH/SUD and medical/surgical benefits.

NOTE: Plans and issuers have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ a particular source or evidentiary standard), as long as they are applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits. For example, a plan utilizes a panel of medical experts, with equivalent expertise in both medical/surgical and MH/SUD benefits, to assess whether preauthorization (an NQTL) is appropriate to apply to certain services, based on the factors of cost and safety. The panel recommends that the plan require preauthorization for electroconvulsive therapy (ECT), because ECT is high cost and its use presents legitimate safety concerns. The plan does not require documentation or studies to support these concerns and instead relies on established medical best practices. As long as the plan similarly relies on established medical best practices to define high cost, identify legitimate safety concerns, and impose preauthorization requirements on medical/surgical benefits in the same classification, then the NQTL is applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits.

Compliance Tips

- Evidentiary standards and processes that a plan or issuer relies upon may include any evidence that a plan or issuer considers in developing its medical management techniques, including recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials), and published research studies.
- If there is any variation in the application of a guideline or standard being relied upon by the plan or issuer, the plan or issuer should explain the process and factors relied upon for establishing that variation.
- If the plan or issuer relies on any experts, the plan or issuer should assess the experts' qualifications and the extent to which the expert evaluations in setting recommendations are ultimately relied upon regarding both MH/SUD and medical/surgical benefits.

NOTE: When identifying the sources of the factors considered in designing the NQTL, also identify any threshold at which each factor will implicate the NQTL. For example, if high cost is identified as a factor used in designing a prior authorization requirement, the threshold dollar amount at which prior authorization will be required for any service should also be identified. You may also wish to consider the following:

- What data, if any, are used to determine if the benefit is “high cost”?
- How, if at all, is the amount that is to be considered “high cost” or the calculation for determining that amount different for MH/SUD benefits as compared to medical/surgical benefits, and how is the difference justified?

Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to, the following:

- Excessive utilization as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care.
- Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased 10 percent or more per year for two years.
- Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30 percent of the time based on clinical chart reviews.
- High level of variation in length of stay may be considered as a factor when claims data shows that 25 percent of patients stayed longer than the median length of stay for acute hospital episodes of care.
- High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period.
- Lack of clinical efficacy may be considered as a factor when more than 50 percent

of outpatient episodes of care for specific diseases are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12-month sample of claims data.

Step Four:

- Are the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical/surgical benefits, both as written and in operation?

Comments:

Plans and issuers should demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD services and medical/surgical services.

Compliance Tips

- If utilization review is conducted by different entities or individuals for medical/surgical and MH/SUD benefits provided under the plan or coverage, ensure that there are measures in place to ensure comparable application of utilization review policies.
- Determine what consequences or penalties apply to the benefits when the NQTL requirement is not met.

These are examples of methods/analyses substantiating that factors, evidentiary standards, and processes are comparable:

- Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and medical/surgical benefits subject to the NQTL.
- Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL.
- A consistent methodology for analyzing which MH/SUD and medical/surgical benefits had “high cost variability” and were therefore subject to the NQTL.
- Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and medical/surgical benefits were the same, both as developed and applied.
- Internal Quality Control Reports showing that the factors, evidentiary standards, and processes regarding MH/SUD and medical/surgical benefits are comparable and no more stringently applied to MH/SUD benefits.

- Summaries of research or peer-reviewed medical journal articles, if considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was utilized similarly for both MH/SUD and medical/surgical benefits.

Compliance Tips

- Look for compliance as written **AND IN OPERATION**.
- Determine whether there are exception processes available and when they may be applied.
- Determine how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and medical/surgical benefits claims.
- Determine who makes denial determinations and if the decision-makers have comparable expertise with respect to MH/SUD and medical/surgical benefits.
- Check sample claims to determine whether a particular NQTL warrants additional review. A plan may have written processes that are compliant on their face, but those processes may not be compliant in practice.
- Determine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/surgical benefits.
- Document your analysis, as a best practice.

NOTE: While outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational MHPAEA parity noncompliance. For example, if a plan has a 34 percent denial rate on concurrent reviews of psychiatric hospital stays in a 12-month period and a 5 percent denial rate on concurrent review for medical hospital stays in that same 12-month period, the concurrent review process for both psychiatric and medical hospital stays should be carefully examined to ensure that the concurrent review standard is not being applied more stringently to MH/SUD benefits than to medical/surgical benefits in operation.

Warning Signs: The following plan provisions related to NQTLs may be indicative of noncompliance and warrant further review:

1. *Prior authorization for medication for opioid use disorder:* A plan or issuer imposes prior authorization for medications for opioid use disorder but does not require prior authorization for comparable medications for medical/surgical conditions.
2. *Different medical necessity review requirements:* A plan or issuer imposes medical necessity review requirements on outpatient MH/SUD benefits after a certain number of visits, despite permitting a greater number of visits before requiring any such review for outpatient medical/surgical benefits.

Compliance Tip

- **Do not focus solely on results.** Look at the **underlying processes and strategies** used in applying NQTLs. Are there arbitrary or discriminatory differences in how the plan or issuer is applying those processes and strategies to medical/surgical benefits versus MH/SUD benefits? While results alone are not determinative of noncompliance, measuring and evaluating results and quantitative outcomes can be helpful to identify potential areas of noncompliance.

SECTION G. DISCLOSURE REQUIREMENTS

Question 8. Does the group health plan or group or individual health insurance issuer comply with the MHPAEA disclosure requirements?

Comments: Yes, Nippon Life Insurance complies with MHPAEA disclosure requirements.

- The plan administrator or health insurance issuer must make **available the criteria for medical necessity determinations** made under a group health plan or group or individual health insurance coverage with respect to MH/SUD benefits to any current or potential participant, beneficiary, enrollee, or contracting provider **upon request**. *See 29 CFR 2590.712(d)(1), 45 CFR 146.136 (d)(1).*

The plan administrator (or health insurance issuer) must make available **the reason for any denial** under a group health plan or group or individual health insurance coverage of reimbursement or payment for services with respect to MH/SUD benefits to any participant, beneficiary, or enrollee, and may do so in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the DOL claims procedure rule) and 29 CFR 2590.715-2719 (internal claims and appeals and external review processes).

- Pursuant to the internal claims and appeals and external review rules under the Affordable Care Act applicable to all non-grandfathered group health plans and to all non-grandfathered group and individual health insurance coverage, claims related to medical judgment (including MH/SUD) are eligible for external review. The **internal claims and appeals** rules include the right of claimants (or their authorized representatives) to be provided **upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits**. This includes documents with information about the **processes, strategies, evidentiary standards, and other factors used to apply an NQTL** with respect to medical/surgical benefits and MH/SUD benefits under the plan. *See 26 CFR 54.9812-1(d)(3), 29 CFR 2560.5301- 2590.712(d)(3), 45 CFR 146.136(d)(3), 147.136(b).*
- With respect to group health plans that are subject to ERISA, if coverage is denied based on medical necessity, **medical necessity criteria** for the MH/SUD benefits at issue and for medical/surgical benefits in the same classification must be provided **within 30 days of the request** to the participant, beneficiary, provider, or authorized representative of the beneficiary or participant. *See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).*
- If a plan or a plan administrator or health insurance issuer fails to provide these documents, a court may hold it liable for up to \$110 a day from the date of failure to provide these documents. *See ERISA Sec. 502(c)(1).*

Compliance Tips

- The reasons for benefit denials include applicable medical necessity criteria as applied to that participant, beneficiary, or enrollee.
- Under ERISA, plans and issuers cannot refuse to disclose information necessary for the parity analysis on the basis that the information is proprietary or has commercial value.
- Under ERISA, plans and issuers can provide summary descriptions of the medical necessity criteria in a layperson's terms.

Make Showing Compliance Simple

Documents or Plan Instruments Participants and Beneficiaries or DOL may Request Include the following:

Under ERISA section 104(b), participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with MHPAEA, and copies must be furnished within 30 days of the request. These documents and plan instruments may include documentation that illustrates how the health plan has determined that any financial requirement, QTL, or NQTL complies with MHPAEA. For example, participants and beneficiaries may request the following:

- An analysis showing that the plan meets the predominant/substantially all tests. The plan may need to provide information regarding the amount of medical/surgical claims subject to a certain type of financial requirement, such as a co-payment, in the prior year for a classification or the plan's basis for calculating claims expected to be subject to a certain type of QTL in the current plan year for a classification, for purposes of determining the plan's compliance with the predominant/substantially all tests;
- A description of an applicable requirement or limitation, such as preauthorization or concurrent review, that the plan applies for MH/SUD benefits and medical/surgical benefits within the relevant classification (for example, in- or out-of-network, or in- or outpatient). These might include references to specific plan documents: for example provisions as stated on specified pages of the summary plan description (SPD), or other underlying guidelines or criteria not included in the SPD that the plan has consulted or relied upon;
- Information regarding factors, such as cost or recommended standards of care, that are relied upon by a plan for determining which medical/surgical or MH/SUD benefits are subject to a specific requirement or limitation. These might include references to specific related factors or guidelines, such as applicable utilization review criteria;
- A description of the applicable requirement or limitation that the plan believes has been used in any given MH/SUD service adverse benefit determination (ABD) within the relevant classification; and
- Medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.

Compliance Tips

- Find out how the plan administrator handles general information requests about coverage limitations as well as specific information or disclosure requests with respect to denied benefit claims.
- Review a sample of appeals files and examine what was disclosed to participants, including the criteria for medical necessity determinations and reasons for claim denials.
- Determine how long it took the plan or the plan administrator to furnish requested documents to participants.

As directed by the 21st Century Cures Act, and in response to comments received from the regulated community, the Departments continue to issue additional guidance regarding disclosures, in particular with respect to NQTLs. Based on requests from various stakeholders for model MHPAEA disclosure forms and for guidance on processes for requesting disclosures in a more uniform, streamlined, or otherwise simplified way, the Departments issued a model disclosure request form (available at <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template.pdf>). For the most current version of the form please visit the DOL's dedicated MH/SUD parity webpage, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

This form can, but is not required to, be used to request MHPAEA-related information from group plans and group and individual health insurance issuers, including general information about coverage limitations or specific information that may have resulted in denial of MH/SUD benefit claims.

Compliance Tips

- Participants, beneficiaries, enrollees, dependents, and contracting providers may request information to determine whether benefits under a plan are being provided in parity even in the absence of any specific ABD.
- Group health plans may need to work with insurance issuers providing coverage on behalf of an insured group health plan or with third party administrators administering the plan to ensure that such service providers either directly or in coordination with the plan are providing participants and beneficiaries any documents or information to which they are entitled.
- If a group health plan or group or individual health insurance issuer uses MH/SUD vendors and carve-out service providers, the plan must ensure that all combinations of benefits comport with MHPAEA. Therefore, vendors and carve-out providers should provide documentation of the necessary information to the plan to ensure that all combinations of benefits comport with parity.

NOTE: Compliance with the disclosure requirements of MHPAEA is not determinative of compliance with any other provision of other applicable federal or state law. Be sure that the plan or issuer, in addition to these disclosure requirements, is disclosing all information relevant to medical/surgical, mental health, and substance use disorder benefits as required pursuant to other applicable provisions of law. For example, if a plan document states it covers benefits consistent with generally accepted standards of care (for both medical/surgical and MH/SUD benefits), and the plan has developed internal guidelines that are more restrictive than the generally accepted standards of care for both medical/surgical and MH/SUD benefits, the plan might comply with MHPAEA but fail to comply with Part 4 of ERISA, which requires that the plan be administered in accordance with its plan documents. Plans should be prepared to disclose their medical necessity criteria and should ensure that, to the extent the plan document specifies a specific treatment guideline, it follows that as well.

Compliance Tip

- Under ERISA, ERISA-covered plans must provide an SPD that describes plan provisions related to the use of network providers and describe the composition of the provider network (*i.e.*, a provider directory). The provider directory may be distributed as a separate document from the SPD and, in many circumstances, may be provided electronically. However, the provider directory must be up-to-date, accurate, and complete (using reasonable efforts). *See e.g.*, 29 CFR 2520.102-3; *FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q10*, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>; ERISA Secs. 102, 104, and 404(a).

SECTION H. ESTABLISHING AN INTERNAL MHPAEA COMPLIANCE PLAN

Although not required by MHPAEA, an internal compliance plan that promotes the prevention, detection, and resolution of potential MHPAEA violations can help plans and issuers improve compliance with the law. Compliance plans for group health plans or issuers may differ, but many successful compliance plans share the following characteristics:

1. **Conducting effective training and education.** Successful compliance programs provide ongoing training and education to all individuals responsible for ensuring MHPAEA compliance, including those who are responsible for making decisions related to medical/surgical and MH/SUD benefits on behalf of the plan or issuer (such as claims reviewers). EBSA provides many educational materials, webcasts, and in-person compliance assistance events that may assist in these trainings and can also be made available to participants and beneficiaries to inform them of their parity protections under MHPAEA.²
2. **Ensuring retention of records and information.** ERISA Section 107 requires the retention of certain documents. These documents should be retained for at least six years after the Form 5500 for the relevant plan year has been filed.
3. **Conducting internal monitoring and compliance reviews on a regular basis.** A plan or issuer may monitor compliance on an ongoing basis by conducting internal reviews for potential non-compliance and identification of problem areas related to MHPAEA and by auditing samples of adverse benefit determinations to assess the application of medical necessity criteria, the level of detail provided to claimants, and the correctness of determinations. Plans and issuers may wish to establish an internal consumer ombudsmen program to assist participants and beneficiaries in navigating their benefits and for elevating complaints of noncompliance. Plans and issuers that delegate management of MH/SUD benefits to another entity should have clear protocols to ensure that the service providers for both medical/surgical and MH/SUD benefits provide documentation of the necessary information to the plan or issuer (and to the entity that adjudicates MH/SUD benefit claims, if necessary) to ensure that all combinations of benefits that a participant or beneficiary can elect comport with MHPAEA and to ensure that plans and issuers are able to comply with disclosure requirements.
4. **Responding promptly to detected offenses and developing corrective action.** If a plan or issuer discovers a violation of MHPAEA, it should take steps to correct the violation promptly, including providing retroactive relief and notice to potentially affected participants and beneficiaries. EBSA Benefits Advisors may be able to assist plans and issuers in voluntarily complying with MHPAEA. They can be contacted at (866) 444-3272.

² See <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

If a group health plan is audited by DOL investigators for MHPAEA compliance, DOL may ask for at least the following, among other items:

1. Plan materials related to the plan's compliance with MHPAEA, including the following:
 - a) Information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the plan or coverage.
 - b) Records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under state law. Such records may also be helpful to plans and issuers in responding to inquiries from participants, beneficiaries, enrollees, and dependents regarding benefits under the plan or coverage.
 - c) Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer has relied upon as the basis for determining its compliance with the requirement that any NQTL applicable to MH/SUD benefits be comparable to and applied no more stringently than the NQTL as applied to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or issuer to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits. If the standards that are applied to MH/SUD benefits are more stringent than those in nationally recognized medical guidelines, but the standards that are applied to medical/surgical benefits are not, plans and issuers should include any applicable explanation of the reason(s) for the application of the more stringent standard for MH/SUD benefits.
 - d) Samples of covered and denied MH/SUD and medical/surgical benefit claims.
 - e) Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of MH/SUD benefits to another entity).
 - f) Any applicable MHPAEA testing completed by the plan or the issuer for financial requirements or QTLs applied to MH/SUD benefits.

In addition to this Self-Compliance Tool, the National Association of Insurance Commissioners (NAIC) has developed tools (such as a Data Collection Tool, which includes a Non-Quantitative Treatment Limitations Chart) to assist issuers in evaluating MHPAEA compliance. For more information regarding NAIC compliance assistance efforts, please visit its website at <https://content.naic.org/>.

APPENDIX I: ADDITIONAL ILLUSTRATIONS

ILLUSTRATION 1: A Plan covers neuropsychological testing but excludes such testing for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing, for example, clinical efficacy of such testing for different conditions and the degree to which such testing is used for educational purposes with regard to different conditions. Does the plan rely on criteria and evidence from comparable sources with respect to medical/surgical and mental health conditions? Does the plan have documentation indicating the criteria used and evidence supporting the plan's determination of the diagnoses for which the plan will cover this service and the rationale for excluding certain diagnoses? The result may be that the plan permissibly covers neuropsychological testing for some medical/surgical or mental health conditions, but not for all.

Conclusion: This outcome may be permissible to the extent the plan has based the exclusion of this testing for certain conditions on clinical efficacy and/or other factors if the factors are designed and applied in a comparable manner with respect to the conditions for which testing is covered and those for which it is excluded.

ILLUSTRATION 2: A Plan uses diagnosis related group (DRG) codes in their standard utilization review process to actively manage hospitalization utilization. For all non-DRG hospitalizations (whether due to an underlying medical/surgical condition or a MH/SUD condition), the plan requires precertification for hospital admission and incremental concurrent review. The precertification and concurrent review processes review unique clinical presentation, condition severity, expected course of recovery, quality, and efficiency. The evidentiary standards and other factors used in the development of the concurrent review process are comparable across medical/surgical benefits and MH/SUD benefits, and are well documented. These evidentiary standards and other factors are available to participants and beneficiaries free of charge upon request.

Conclusion: In this example, it appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its precertification and concurrent review of hospitalizations are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

ILLUSTRATION 3: A Plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical conditions as inpatient benefits and likewise treats any covered care in residential treatment facilities for MH/SUD as an inpatient benefit. In addition, the plan treats home health care as an outpatient benefit and treats intensive outpatient and partial hospitalization for MH/SUD services as outpatient benefits.

Conclusion: In this example, the plan assigns covered intermediate MH/SUD benefits to the six classifications in the same way that it assigns comparable intermediate medical/surgical benefits to the classifications.

ILLUSTRATION 4: Master's degree training and state licensing requirements often vary among provider types. The plan consistently applies its standard that any provider must meet the most

stringent licensing requirement standard in the applicable state related to supervised clinical experience requirements in order to participate in the network. Therefore, the plan requires master's-level therapists to have post-degree, supervised clinical experience in order to join its provider network. There is no parallel requirement for master's-level general medical providers because their licensing requires supervised clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD level psychologists since their licensing already requires supervised training.

Conclusion: The requirement that master's-level therapists must have supervised clinical experience to join the network is permissible, as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers whose state licensing does not require this experience.

ILLUSTRATION 5: A patient with chronic depression has not responded to five different anti-depressant medications and therefore was referred for outpatient treatment with repetitive transcranial magnetic stimulation (TMS). This specific treatment has been approved by the FDA and has been the subject of more than six randomized controlled trials published in peer reviewed journals. The plan denies the treatment as experimental. The plan states that it used the same criteria to deny TMS as it does to approve or deny any MH/SUD or medical/surgical benefits under the plan. The plan identifies its standard for both medical/surgical benefits and MH/SUD benefits as requiring that at least two randomized controlled trials showing efficacy of a treatment be published in peer reviewed journals for any new treatment. However, the plan indicates that while more than two randomized controlled trials regarding TMS have been published in peer reviewed journals, a committee of medical experts involved in plan utilization management reviews reviewed the journals and determined that only one of the articles provided sufficient evidence of efficacy. The plan did not identify what specific standards were used to assess whether a peer review had adequately evidenced efficacy and what the qualifications of the plan's experts are. Lastly, the plan does not impose this additional level of scrutiny with respect to reviewing medical/surgical treatments beyond the initial requirement that the treatment has been the subject of the requisite number and type of trials.

Conclusion: The plan's exclusion fails to comply with MHPAEA's NQTL requirements because, in practice, the plan applies an additional level of scrutiny with respect to MH/SUD benefits and therefore applies the NQTL more stringently to mental health benefits than to medical/surgical benefits without additional justification. To come into compliance, the plan could ensure that that any additional levels of scrutiny are imposed on both medical/surgical and MH/SUD benefits comparably, including by establishing standards for when a peer review has adequately evidenced efficacy, and that the qualifications of the plan's experts are similar for both MH/SUD and medical/surgical benefits.

ILLUSTRATION 6: A plan imposes prior authorization for certain MH/SUD and medical/surgical services. The medical/surgical outpatient services that require prior authorization include habilitative and rehabilitative services such as physical therapy. Physical therapy services were selected for prior authorization because of findings that physical therapists' documentation of medical necessity is often inadequate. In addition, there has been an increase in litigation regarding physical therapy claims. Prior authorization is conducted telephonically and authorization determinations are reviewed by a physician in consultation with

a licensed physical therapist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of sessions authorized is tailored to the specific medical/surgical condition treated, consistent with generally accepted national clinical guidelines. Determinations to approve or deny coverage are made by physicians with consultation from a licensed physical therapist.

Psychological testing also requires prior authorization. Psychological testing was selected for prior authorization because of recent Medicare fraud schemes and consistent with the Medicare Improper Payment Reports, which found improper payments with respect to psychological testing claims because of inadequate documentation from psychologists. Prior authorization is conducted telephonically and reviewed by a licensed psychologist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of hours authorized for psychological testing are tailored to the age of the client and type of evaluation requested and range from two to five hours for an average evaluation (on the basis of the average number of hours for evaluation as included in generally accepted national clinical guidelines). Determinations to approve or deny coverage are made by licensed psychologists with at least five years of experience in psychological testing.

Conclusion: In this example, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its preauthorization requirements, particularly the use of prior authorization to detect fraud and abuse, are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

APPENDIX II:

PROVIDER REIMBURSEMENT RATE WARNING SIGNS

The Departments have noted that, while outcomes are not determinative of a MHPAEA violation, they can often serve as red flags or warning signs to alert the plan or issuer that a particular provision may warrant further review. With respect to provider reimbursement, comparing a plan or issuer's average reimbursement rates for both medical/surgical and MH/SUD providers against an external benchmark of reimbursement rates, such as Medicare, may help identify whether the underlying methodology used to determine the plan's or issuer's reimbursement rates warrants additional review for compliance with MHPAEA. Furthermore, evaluating how medical/surgical and MH/SUD providers are reimbursed for the same or similar services may also help a plan or issuer determine if the plan's or issuer's underlying methodology for provider reimbursement warrants further review.

Accordingly, the following framework for comparison may assist plans and issuers in identifying information they might consider when comparing reimbursement rates for certain MH/SUD and medical/surgical services based on Current Procedural Terminology (CPT) codes. This is not the only framework for analyzing provider reimbursement rates, and it is not determinative of compliance. This framework utilizes Medicare reimbursement rates as its benchmark for comparison. If a plan's or issuer's comparison of reimbursement rates indicates that the reimbursement rate is lower for MH/SUD providers, either as compared to medical/surgical providers or as compared to an external benchmark, such as Medicare, the plan or issuer should consider further review to ensure that the processes, strategies, evidentiary standards, and other factors used with respect to provider reimbursement for MH/SUD benefits are comparable to, and applied no more stringently than, those used with respect to provider reimbursement for medical/surgical benefits. Please see Section F. Nonquantitative Treatment Limitations for information on how to further evaluate provider reimbursement rates for compliance with MHPAEA.

Specialty	CPT Code	Average Plan rate for [insert locality]	Medicare rate for [insert locality]	Plan rate as a percentage of Medicare
Orthopedic Surgery	99203 99213	\$ xx.xx \$	\$ xx.xx \$	xx.x%
Cardiologists	99203 99213	\$ \$	\$ \$	
Internists MD	99203 99213	\$ \$	\$ \$	
Endocrinologists	99203 99213	\$ \$	\$ \$	
Gastroenterologist	99203 99213	\$ \$	\$ \$	

Specialty	CPT Code	Average Plan rate for [insert locality]	Medicare rate for [insert locality]	Plan rate as a percentage of Medicare
Neurologists	99203 99213	\$ \$	\$ \$	
Pediatrician	99203 99213	\$ \$	\$ \$	
Dermatologists	99203 99213	\$ \$	\$ \$	
Psychiatrists	99203 99213	\$ \$	\$ \$	
Psychologists	90832 (based on 1 hr) 90791 (based on ½ hour)	\$ \$	\$ \$	
LCSW	90832 (based on 1 hr) 90791 (based on ½ hour)	\$ \$	\$ \$	
Podiatrists	99203 99213	\$ \$	\$ \$	
Chiropractor	99203 99213	\$ \$	\$ \$	
Occupational Therapy	97165 97166 97167 97168	\$ \$	\$ \$	
Physical Therapy	97161 97162 97163 97164	\$ \$	\$ \$	
Speech Therapy	Initial Office Visit Codes do not exist. Analysis of specific tests or follow- up may be useful to consider.			

Nippon – Georgia Nonquantitative Treatment Limitation (NQTL) Submission Form

Instructions: This NQTL reporting submission form includes the required five elements as specified by 42 U.S.C. Section 300gg-26(a)(8)(A); 29 U.S.C. Section 1185a(a)(8)(A); and 26 U.S.C. Section 9812(a)(8)(A).

NQTL: Concurrent Review

Date Last Updated: December 2023

Applies to: Inpatient (In-Network and Out-of-Network) Classifications. **Note: Nippon does not apply concurrent review to any MH/SUD benefits in the Outpatient (In-Network and Out-of-Network) Classification.**

Comparative Analysis Performed by:

Name	Title	Position
Carrie Manniello	Second Vice President of Claims and Operations	VP over claims and Operations at Nippon. Point of contact for MHPAEA compliance.
Phil Lavigne	Second Vice President and General Counsel	General Counsel for Nippon. Responsible for legal matters and point of contact for MHPAEA compliance

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q2, #'s 1 and 2) guidance stipulate that a sufficient analysis should include:

A clear description of the specific NQTL, plan terms, and policies at issue; and

Identification of the specific mental health or substance use disorder and medical or surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as mental health or substance use disorder and which are treated as medical or surgical.

Issuer Response:

Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:

Concurrent review is a utilization review service performed by licensed healthcare professionals to evaluate the patient's care while in the hospital. The intent is to determine medical necessity and appropriateness of treatment, assess appropriateness of level of care and treatment setting, determine benefits and eligibility identify the patient's discharge and continuing care plan, and identify and refer potential quality of care and patient safety concerns for additional review. Concurrent Review involves a review for continued medical necessity for dates of service beyond the initial prior authorization and occurs with subsequent coverage requests so that no gaps in the authorization exist.

Active Health Management ("AHM"), a subsidiary of Aetna, via contract with Nippon, is delegated to determine concurrent review.

Policies:

AHM BH Comparative Analysis

Nippon Insurance Booklet

Step 1(b): Identify the benefits/services for which the NQTL is required.

Concurrent review is performed for all inpatient in-network and out-of-network medical/surgical and MH/SUD benefits.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both mental health or substance use disorder benefits and medical or surgical

benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Issuer Response:

N/A: Concurrent review is performed for all inpatient in-network and out-of-network medical/surgical and MH/SUD benefits.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q 2, # 4) guidance stipulates that a sufficient response includes:

To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

The FAQ 45 guidance (Q 3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

N/A: Concurrent review is performed for all inpatient in-network and out-of-network medical/surgical and MH/SUD benefits.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) guidance states that the following is necessary for a sufficient response:

(Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between mental health or substance use disorder and medical or surgical benefits and, if so, describe the process and factors used for establishing that variation.

(Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).

(Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both mental health or substance use disorder and medical or surgical benefits.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

(Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

(Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response – As Written:

All inpatient in-network and out-of-network M/S and MH/SUD benefits are subject to Concurrent review, and all processes, timelines, reviewer qualifications, and other aspects of Concurrent review are the same for M/S and MH/SUD benefits unless Georgia state regulation has mandated a prohibition of Concurrent Review for MH/SUD benefits. Thus, as written, the processes, strategies, evidentiary standards, and other factors used to apply Concurrent Review to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Concurrent review to M/S benefits in the Inpatient In-Network and Out-of-Network classifications.

Medical/Surgical:**Process:**

Clinical information is sought upon request for Concurrent review.

Active Health accepts information both orally and in written form and only requests information that is current and clinically relevant.

If a patient or treating practitioner fails to submit necessary information to decide non-urgent cases, ActiveHealth may offer an extension that would specifically describe the required information and the patient or treating practitioner may be given at least 45 calendar days from receipt of notice to respond to the request for more information. If an extension is granted, the patient will be notified prior to the expiration of the initial 15 calendar day period of the circumstances requiring the extension and the date when ActiveHealth will make a decision. In most cases, the decision will be to deny the case for lack of medical information within the required timeframe for the type of review. A reconsideration will be conducted if additional

MH/SUD:**Process:**

Same as M/S with the following specific to MH/SUD services:

For MH services, AHM clinical staff will use either of the following guidelines to conduct MH Concurrent reviews:

1. The Level of Care Utilization Systems tool, (LOCUS) when the member is > 18 years old, or
2. The Child and Adolescent Level of Care Utilization System (CALOCUS) when the member is < 18 years old.

For SUD services, AHM clinical staff will use the following guidelines:

1. ASAM

<p>information is received.</p> <p>If the provider does not have the necessary information and requests more time than what is allotted to gather the information, they may be given the option of canceling the request.</p> <p>If the review nurse is unable to approve the request based on scant information that was provided, he/she follows the process for referring the request to a Medical Director or a clinical peer for review.</p> <p>Unless otherwise noted by a variance above, Active Health Management's clinical staff adhere to the following review criteria/guideline hierarchy when conducting UM reviews:</p> <p><i>UM Consultants and physicians utilize the following hierarchy when determining medical criteria usage:</i></p> <ol style="list-style-type: none"> 1. State or client-specific guideline 2. Active Health specific guideline 3. MCG Specific guideline 4. LOCUS or CALOCUS for all mental health reviews 5. If non-surgical, use MCG GRG 6. If surgical, consult with team leader about use of MCG GRG 7. In instances when a diagnosis or treatment-specific guideline is not available in the MCG CWQI, or the MCG indicates the "current role remains uncertain", the clinician will research the Aetna Clinical Policy Bulletins. 8. For cancer-related reviews, the licensed web-based NCCN Guidelines are used where Active Health and MCG do not have the necessary content. <p><u>Review and Revision of Criteria/Guidelines</u></p>	
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AHM's UM Clinical Policy Guidelines are consistent with Aetna's Clinical Policy Bulletins (CPBs). CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of the medical technologies addressed. If the Clinical Policy Unit determines that new evidence or other information has emerged to warrant a change in Aetna's clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in Aetna's position, the CPB may be updated with additional supporting background information and references. Each revised CPB is submitted to Aetna's Clinical Policy Council for review and approval by board-certified physicians with various specialties. Additional changes to the revised or updated draft CPB may be made upon the recommendations of the Clinical Policy Council. In addition, appropriate, actively participating physicians, pharmacists, and other providers with current knowledge relevant to the criteria under review are involved in the review process. AHM's SVP of Clinical Programs makes the determination for AHM to adopt the revised Aetna CPBs and brand them as AHM Clinical Policy Guidelines.

MCG

MCG reviews and updates their guidelines annually. The annual MCG release is reviewed by AHM Medical Directors to determine if MCG's guidelines meet AHM's business needs.

Professional Judgment used in Lieu of Utilization Review Criteria

Although clinical review criteria, as noted above, is used in every Utilization Review instance, there are times that Medical

Directors or clinical peers will take a member's atypical circumstances into consideration.

Staff Who Issue Denials

Active Health Management employs licensed (unrestricted), board certified physicians who provide support and oversight to UM staff for the purposes of consultation and clinical review of review requests for medical necessity. If the review nurse is unable to authorize a request because the clinical information received does not meet the review criteria, the nurse will send the request to a Medical Director for review.

The qualifications of the physician reviewer may vary based on state requirements. If mandated by state, federal, or accrediting agencies, this review physician will be a clinical peer of the treating provider. A clinical peer is a licensed physician who is in the same or similar specialty as the treating provider or the medical condition being treated.

Consultations with Expert Reviewers and Clinical Peers who Issue Adverse Determinations:

Telephonic consultation with attending providers is known as "peer-to-peer" conversations. Requests made by an attending provider to discuss the member's case with a clinical peer are returned within one business day. Peer-to-peer conversations are offered during the verbal notification of an adverse determination call to the provider and facility, as well as in the written notice of adverse determination.

Clinical Rationale Used in Issuing Denials:

The Medical Director (or if mandated by the state, a clinical peer reviewer of the same specialty as the treating provider), will write a note in the review database (ActiveAdvice) that includes the clinical rationale for all adverse determinations. The clinical rationale includes the medical and/or scientific basis on why the request is not found to be medical necessary, what parts of the cited guideline were not met, and the name of the guideline used to conduct the review. The clinical rationale for the adverse determination is given during the verbal notification calls, as well as included in the written notification to members, providers, facilities, or the member's authorized representative if applicable.

Issuer Response – In Operation:

Medical/Surgical:

Data: 1-1-2022 – 12-31-2022

In-Network Concurrent denial rates:

- Total Concurrent requests: 349
- Total Concurrent requests denied: 19
- % of Concurrent requests denied: 5.3%

Out-of-Network Concurrent denial rates:

- Total Concurrent requests: 271
- Total Concurrent requests denied: 15
- % of Concurrent requests denied: 5.5%

Inter-rater reliability scores:

- Average IRR score:
- Nurse Reviewers: 100%

MH/SUD:

Data: 1-1-2022 – 12-31-2022

In-Network Concurrent denial rates:

- Total Concurrent requests: 99
- Total Concurrent requests denied: 1
- % of Concurrent requests denied: 1%

Out-of-Network Concurrent denial rates:

- Total Concurrent requests: 85
- Total Concurrent requests denied: 6
- % of Concurrent requests denied: 7.1%

Inter-rater reliability scores:

- Average IRR score:
- Nurse Reviewers: 100%

<ul style="list-style-type: none"> Physician Reviewers: 100% 	<ul style="list-style-type: none"> Physician Reviewers: 100%
<p>In-Operation – Comparative Analysis:</p> <p>For Concurrent review In-Network there were 99 MH/SUD requests and 1 denial for a 1% denial rate in comparison to a 5.3% denial rate for M/S benefits. For Concurrent review Out-of-Network while the MH/SUD denial rate is slightly higher than the M/S denial rate, the number of Concurrent review Out-of-Network requests and denials were significantly lower for MH/SUD benefits than for M/S benefits. The interrater reliability scoring for both M/S and MH/SUD benefits was 100% for both nurse and physician reviewers.</p>	

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) guidance states that a sufficient response should include:

(Q 2, # 8) A reasoned discussion of the plan’s or issuer’s findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusion:

Nippon has determined that Concurrent review is applied to MH/SUD benefits in a manner that is comparable to and no more stringent than that of M/S services based on the information presented above that describes the processes used for Concurrent review.

As Written: All processes, strategies, evidentiary standards and other factors used to apply Concurrent Review are the same processes, strategies, evidentiary standards and factors used to apply Concurrent review to medical/surgical benefits in the Concurrent review Inpatient In-Network and Out-of-Network classifications.

In-Operation: Based upon the operational data for Concurrent review above, Nippon has determined that Concurrent review is applied to inpatient MH/SUD benefits in a comparable and no more stringent way than M/S benefits.

Nippon – Georgia Nonquantitative Treatment Limitation (NQTL) Submission Form

Instructions: This NQTL reporting submission form includes the required five elements as specified by 42 U.S.C. Section 300gg-26(a)(8)(A); 29 U.S.C. Section 1185a(a)(8)(A); and 26 U.S.C. Section 9812(a)(8)(A).

NQTL: Medical Necessity Criteria

Date Last Updated: December 2023

Applies to: Inpatient (In-Network and Out-of-Network) Classifications and Outpatient (In-Network and Out-of-Network) Classifications. For Pharmacy Classification, please see separate Pharmacy NQTL analyses.

Comparative Analysis Performed by:

Name	Title	Position
Carrie Manniello	Second Vice President of Claims and Operations	VP over claims and operations at Nippon. Point of contact for MHPAEA compliance
Phil Lavigne	Second Vice President and General Counsel	General Counsel for Nippon. Responsible for legal matters and point of contact for MHPAEA compliance.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q2, #'s 1 and 2) guidance stipulate that a sufficient analysis should include:

A clear description of the specific NQTL, plan terms, and policies at issue; and

Identification of the specific mental health or substance use disorder and medical or surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as mental health or substance use disorder and which are treated as medical or surgical.

Issuer Response:

Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:
Active Health Management (“Active Health” or “AHM”), a subsidiary of Aetna, via contract with Nippon, is delegated to determine medical

necessity reviews using established criteria, policies and procedures as described in this documentation.

Medically necessary means healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms that are all of the following as determined by the AHM/Aetna Claims Administrator or its designee, within the Aetna Claims Administrator's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The AHM/Aetna Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the AHM/Aetna Claims Administrator's sole discretion.

The AHM/Aetna Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies as developed by the AHM/Aetna Claims Administrator are reviewed annually and revised, when needed. Aetna publishes information concerning utilization review and our medical necessity criteria here: <https://www.aetna.com/health-care-professionals/utilization-management.html>

Within that site, there is a section dedicated specially to the criteria used for behavioral health conditions (i.e. LOCUS/CALOCUS, ABA and ASAM), which can be found here: <https://www.aetna.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html> We also publish clinical policy bulletins concerning services we may or may not cover, including behavioral health services that may be excluded on grounds that they are experimental and investigational, which detail the evidentiary bases for our coverage or exclusion determinations: <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>

Policies

Nippon Insurance Booklet

AHM BH Comparative Analysis

Aetna Mental Health Parity NQTL Analysis

Step 1(b): Identify the benefits/services for which the NQTL is required.

Medical necessity reviews are performed for all inpatient and all outpatient (in-network and out-of-network) benefits/services.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both mental health or substance use disorder benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Issuer Response:

Medical necessity applies to all medical/surgical and mental health/substance use disorder benefits in each MHPAEA category and is based on objective clinical criteria as further detailed herein.

In determining whether a medical technology is medically necessary and established, the Aetna Clinical Policy Council will consider whether the following five criteria are met:

- Whether the medical technology has final approval from the appropriate governmental regulatory bodies
- Whether the scientific evidence permits conclusions about the effect of the medical technology on health outcomes
- Whether the medical technology improves net health outcomes
- Whether the medical technology is at least as beneficial as any established alternatives
- Whether the medical technology is more costly (taking into account all health expenses incurred in connection with the medical technology) than any equally effective established alternatives

Medical/Surgical Benefits:

AHM/Aetna:

Medical/Surgical Benefits:

- For medical/surgical services, the review criteria appropriate to the member's diagnosis and/or procedure can be selected from Active Health Management's review database. In instances when a member has multiple conditions, the guideline selected to conduct the review would address the primary reason for the current episode of care. If, during continued stay reviews, the reasons for continuing treatment vary from the initial reason, the

MH/SUD Benefits:

AHM/Aetna:

Mental Health Benefits:

- Clinical staff will use either of the following guidelines to conduct UM reviews:
 - The Level of Care Utilization System tool, (LOCUS) when the member is >18 years old, or
 - The Child and Adolescent Level of Care Utilization System (CALOCUS) when the member is <18 years old.

<p>guideline selected to conduct the review would addresses the reason for the extended stay.</p>	<ul style="list-style-type: none"> • In instances when a member has multiple conditions, the guideline selected to conduct the review would address the primary reason for the current episode of care. <p>Substance Use Disorder Benefits:</p> <ul style="list-style-type: none"> • For SUD services, clinical staff will use the following guidelines. <ul style="list-style-type: none"> • ASAM <p>In instances when a member has multiple conditions, the guideline selected to conduct the review would address the primary reason for the current episode of care</p>
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Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q 2, # 4) guidance stipulates that a sufficient response includes:

To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

The FAQ 45 guidance (Q 3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

<p>Medical/Surgical Benefits:</p> <p><u>AHM/Aetna:</u> The processes, strategies, and evidentiary standards include:</p> <p>MHPAEA provides that a plan may develop medical policies that limit care for mental health/substance use disorder benefits based on medical necessity as long as it does so for medical/surgical benefits and the “evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition”. 45 CFR 146.136(c)(4)(iii) (Example 4)</p> <ul style="list-style-type: none">• Evidence in the peer-reviewed published medical literature• Evidence-based consensus statements, expert opinions of healthcare providers• Evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies.• Technology assessments and structured evidence reviews• Review of generally accepted national evidence-based guidelines from national medical professional organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations such as:<ul style="list-style-type: none">- Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and Medicare Benefit Policy Manual- MCG guidelines- American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition	<p>MH/SUD Benefits:</p> <p>Same as medical/surgical.</p>
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<ul style="list-style-type: none"> - Applied Behavior Analysis Medical Necessity Guide - Level of Care Utilization System (LOCUS) for adults 18 years old and above and the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS/CASII) <p>Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NQCA</p> <p>These processes, strategies, and evidentiary standards are represented in Aetna Clinical Policies and in our published Aetna Clinical Policy Bulletins (CPBs) (https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html)</p>	
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Step 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.

FAQ 45 Guidance: [The FAQ 45](#) guidance states that the following is necessary for a sufficient response:

(Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between mental health or substance use disorder and medical or surgical benefits and, if so, describe the process and factors used for establishing that variation.

(Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).

(Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both mental health or substance use disorder and medical or surgical benefits.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

(Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

(Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response – As Written:

AHM/Aetna:

Comparability Analysis:

Aetna's strategy regarding satisfaction of parity's NQTL requirements includes the utilization of an identical standard/definition of medical necessity. Medical and MH/SUD utilize appropriate, applicable and generally accepted standards of practice to guide clinician(s) with coverage determinations.

For substance use disorder treatments, Aetna utilizes criteria developed by the America Society of Addiction Medicine (or ASAM) as a guideline to determine medical necessity. Every individual MH/SUD medical necessity determination is afforded independent clinical consideration based on the member's presentation. This point is made clear to Aetna clinicians making medical necessity determinations in both the medical necessity tools utilized and in staff training. More information about LOCUS, CALOCUS/CASSII and ASAM criteria can be found on Aetna's website at <https://www.aetna.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html>

For medical treatments Aetna utilizes Milliman Care Guidelines (MCG) as a guideline to determine the medical necessity.

Stringency Analysis:

The definition of "medical necessity" for both MH/SUD and medical/surgical share the same definition in our standard Certificate of coverage. Additionally, the Aetna Clinical Policy Bulletins (CPB) and evidence-based guidelines used in the medical necessity review process have been found to be aligned to generally accepted practice standards. This validation is completed by Aetna's Clinical Policy Council and approval by Aetna's chief medical officer or their designee. This process involves annual review of generally accepted national evidence-based guidelines.

Issuer Response – In Operation:

AHM/Aetna:

Aetna monitors the application of medical necessity through several initiatives:

- Mental Health Parity (MHP) Task Force: Multi-disciplinary team that meets monthly to establish parity compliance protocols; clarify

interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care.

- Annual surveys: Comparative analysis of (Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, Qualified Health Plan Enrollee Experience Survey, Aetna BH Practitioner Experience Survey, Aetna BH Provider (Facility) Experience Survey, Aetna BH Member Experience Survey, Physician Practice Survey and surveys
- Review of NPL Committee Minutes

Further detail on the criteria:

LOCUS/CALOCUS

Aetna utilizes LOCUS and CALOCUS, which nationally is recognized (by several courts, regulators, and various external stakeholders) as a generally accepted standard of care tool, to guide clinicians in the making medically necessary level of care determinations.

The Level of Care Utilization System (LOCUS) assessment was developed to help determine the resource intensity needs of individuals who receive adult mental health services. The LOCUS was developed by the American Association of Community Psychiatrists (AACP) in 1996. The LOCUS provides a system for assessment of needs based on 6 evaluation parameters:

- Risk of harm
- Functional status
- Medical, addictive & psychiatric co-morbidity
- Recovery Environment
- Treatment and recovery history
- Engagement and recovery status

The LOCUS assessment is reviewed and updated annually. There are multiple venues for regular input from all users as well as processes for continuous review and update of the tools themselves based on this input. Venues include:

- National Council for Community Behavioral Healthcare/AACP LOCUS Advisory Committee
- Deerfield Solutions
- AACP/AACAP Committee for CALOCUS/CASII
- AACP Board of Directors Products and Service Plank

CALOCUS/CASII

The Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS/CASII) assessment provides a framework for defining the appropriate character and intensity of both services and resources to meet the needs of children and adolescents. CALOCUS/CASII was developed by the American Association of Community Psychiatrists in collaboration with the American Association of Child and Adolescent Psychiatry and closely mirrors the structure of the LOCUS.

The CALOCUS/CASI provides a system for assessment of needs based on 6 evaluation parameters:

- Risk of harm
- Functional status
- Co-Occurrence of Conditions: medical, substance use, developmental and psychiatric
- Environmental stress
- Environmental support
- Resilience and/or Response to Services
 - Child and Adolescent Engagement in Service
 - Parent/Primary Caregiver Engagement in Services

Similar to the LOCUS assessment, the CALOCUS/CASII assessment is reviewed and updated annually. There are multiple venues for regular input from all users as well as processes for continuous review and update of the tools themselves based on this input. Venues include:

- National Council for Community Behavioral Healthcare/AACP LOCUS Advisory Committee
- Deerfield Solutions
- AACP/AACAP Committee for CALOCUS/CASII
- AACP Board of Directors Products and Services Plank

ASAM

For members seeking treatment for substance use disorders, Aetna utilizes the American Society of Addiction Medicine Criteria. The ASAM Criteria provides guidelines for evaluating the medical necessity of levels and types of care for substance use disorders. Many Courts and regulators consider ASAM a generally accepted, national standard for SUD treatment decisions. ASAM revises its criteria from time to time in keeping with its established best practices. Such practices can be found at <https://www.asam.org/resources/the-asamcriteria/about>. Currently, Aetna is using the most recent version of the ASAM guidelines.

MCG

For medical/surgical health treatments, Aetna utilizes Milliman Care Guidelines, which nationally is a generally accepted standard of care tool, to guideline to clinicians in the making medically necessary level of care determinations.

Clinical Policy Bulletins (CPBs)

The Aetna Clinical Policy Council evaluates the safety, effectiveness and appropriateness of medical technologies (e.g., drugs, devices, medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided) that are covered under Aetna medical plans, or that may be eligible for coverage under Aetna medical plans. In making this determination, the Clinical Policy Council will review and evaluate evidence in the peer-reviewed published medical literature, information from the U.S. Food and Drug Administration and other Federal public health agencies, evidence-based guidelines from national medical professional organizations, and evidence-based evaluations by consensus panels and technology evaluation bodies. The Clinical Policy council is comprised of pharmacists and medical directors from the Medical Policy Administration (MPA) department, National Accounts department, Behavioral Health department, Clinical Pharmacy department and regional Patient Management units. The Clinical Policy council usually convenes twice monthly.

- Both new and revised CPB drafts undergo a comprehensive review process. This includes review by Aetna's Clinical Policy Council and external practicing clinicians, and approval by our chief medical officer or their designee.

- Drafts of new and revised CPBs are distributed for review to members of the Clinical Policy Council prior to each meeting. Each new and revised draft CPB is placed on the Clinical Policy Council agenda and is discussed during the meeting. The Clinical Policy Council votes whether or not to recommend approval of each draft CPB. In addition, the Clinical Policy Council may recommend other revisions to a draft CPB.
- The CPB draft may be revised based on the Clinical Policy Council's recommendations. CPB drafts are reviewed by our Legal department and the head of the Medical Policy Administration department, and further revisions to draft CPBs may be made based on their recommendations. Draft CPBs are sent to the chief medical officer or their designee for review and final approval. Draft CPBs that are approved by the chief medical officer or their designee will be published on our websites within 60 days of the Clinical Policy council's recommendations.
- CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of medical technologies addressed in each CPB. If the Clinical Policy unit determines that new evidence or other information has emerged to warrant consideration of a change in our clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in position, the CPB may be updated with additional supporting background information and references. Each revised and updated CPB is submitted to the Clinical Policy Council for review and approval.
- In developing our CPBs, for each medical technology selected for evaluation, the Clinical Policy unit conducts a comprehensive search of the peer reviewed published medical literature indexed in the National Library of Medicine PubMed Database, assesses the regulatory status of the technology, reviews relevant evidence-based clinical practice guidelines and related documents indexed in the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse Database, and reviews relevant technology assessments indexed in the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Database. Also, the opinions of relevant experts may be obtained where necessary.
- Each CPB includes a policy statement and references to the medical literature and other sources used in developing the clinical policy. In addition, the CPB may include a background section that describes the medical technology and provides the rationale for our policy.
- In addition, each CPB has a coding section that provides applicable International Classification of Diseases (ICD), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) guidance states that a sufficient response should include:

(Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as

applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusion:

<p>The definitions of medical necessity and processes to develop medical necessity criteria are the same for medical/surgical and MH/SUD benefits.</p> <p>AHM/Aetna's strategies regarding satisfaction of parity's NQTL requirements includes the utilization of an identical standard/definition of medical necessity. For both medical/surgical and MH/SUD AHM/Aetna utilize appropriately applicable and generally accepted standards of practice to guide clinician with coverage determinations.</p> <p>Based upon the as written and in-operation processes, Nippon has determined that the processes to develop medical necessity criteria is applied to MH/SUD benefits in a manner that is comparable to and no more stringent than the processes to develop medical necessity criteria applied to M/S benefits.</p>
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Appendix 1: Aetna Clinical Policy Council Composition

Role	Credentials	Job Title	Organization	Board Certified Specialty (if applicable)
Representing Chief Medical Officer (CMO)	MD	VP, Aetna Quality Management and Clinical Policy Development	Aetna Medical Affairs	Family Medicine
Council Chairman (only votes in case of a tie)	MD	Medical Director	Medical Policy & Operations (MPO)	Anesthesiology
Head of clinical policy research & development	MD	Senior Director of Clinical Policy Research & Development	Aetna Medical Affairs, Clinical Policy Unit	General Practice
Council Secretary; Clinical policy research & development support	APRN, NP-C, PCCN-K	Health Service Manager	Aetna Medical Affairs, Clinical Policy Unit	Adult-Gerontology
Council Secretary (alternate); Clinical policy research & development support	PharmD	Health Service Manager	Aetna Medical Affairs, Clinical Policy Unit	Pharmacy

Role	Credentials	Job Title	Organization	Board Certified Specialty (if applicable)
Council Secretary (alternate); Clinical policy research and development support	PhD	Lead Business Consultant	Aetna Medical Affairs, Clinical Policy Unit	
Representing Medical Policy & Operations (MPO)/Coding	MD, FAAP	Senior Director, Clinical Solutions	Medical Policy & Operations (MPO)	Pediatrics
Representing National Medical Excellence Program (NME)	MD, MBA	Senior Director, Clinical Solutions	Medical Policy & Operations (MPO), Special Case Precert Unit	Obstetrics & Gynecology
Representing National Accounts	MD	Senior Medical Director	National Accounts (NACMST)	Family Medicine
	MD	Medical Director		Occupational Medicine/Internal Medicine/Public Health & General Preventative
Representing Pharmacy	RPh	Director, Clinical Pharmacy	Aetna Pharmacy	Pharmacy
Representing Pharmacy	RN	Senior Director, Business Consultation	Aetna Pharmacy	
Representing West Territory	MD	Medical Director	Clinical Health Services – CA MD	Anatomic and Clinical Pathology
Representing North Central Territory	MD	Medical Director	Clinical Health Services – OH/KY MDs	Emergency Medicine
Representing South Central Territory	MD	Medical Director	MDA South Central MDs	Internal Medicine
Representing North Atlantic Territory	MD, MBA, FACS	Medical Director	Clinical Health Services - NJ MD	General Surgeon
	DO, FAAFP	Senior Medical Director, Clinical Solutions MD	Clinical Solutions CM MDs	Family Medicine
Representing North Atlantic Territory	MD, FCCP	Medical Director	Clinical Health Services – MD/DC/VA MDs	Pulmonary Medicine/Internal Medicine
	MD			

Role	Credentials	Job Title	Organization	Board Certified Specialty (if applicable)
		Medical Director & Team Lead	Clinical Health Services – PA/DE/WV MDs East; Keystone Market	Family Medicine
Representing Southeast Territory	MD, MHA	Senior Director, Clinical Solutions	Clinical Health Services Southwest MD	Internal Medicine/Pediatrics
Representing Compliance	MD	Senior Medical Director	Compliance	Internal Medicine
Representing Medicare	MD	Senior Director, Medical Health Service	Medicare Medical Operations	Internal Medicine
Representing Medicaid	DO	Deputy CMO	National Medical Management, Aetna Medicaid	Emergency Medicine
Representing Behavioral Health	MMM, MD, CPE, DFAPA	Senior Medical Director	Behavioral Health	Psychiatry
Representing Active Health	MD, MSc, CPE	Senior Director, Medical Health Service	Active Health Research and Development	Family Medicine
Representing Aetna Student Health	MD	Senior Medical Director	Clinical Solutions Transformation	Family Medicine
Representing Aetna International	MD	Senior Director, Clinical Solutions	Clinical Health Services CMO	Internal Medicine

Nippon – Georgia Nonquantitative Treatment Limitation (NQTL) Submission Form

Instructions: This NQTL reporting submission form includes the required five elements as specified by 42 U.S.C. Section 300gg-26(a)(8)(A); 29 U.S.C. Section 1185a(a)(8)(A); and 26 U.S.C. Section 9812(a)(8)(A).

NQTL: Precertification

Date Last Updated: December 2023

Applies to: Inpatient (In-Network and Out-of-Network) Classifications. For Pharmacy Classification, please see separate Pharmacy NQTL analyses. **Note: Nippon does not apply precertification to any MH/SUD benefits in the Outpatient (In-Network and Out-of-Network) Classification.**

Comparative Analysis Performed by:

Name	Title	Position
Carrie Manniello	Second Vice President of Claims and Operations	VP over claims and Operations at Nippon. Point of contact for MHPAEA compliance.
Phil Lavigne	Second Vice President and General Counsel	General Counsel for Nippon. Responsible for legal matters and point of contact for MHPAEA compliance.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q2, #'s 1 and 2) guidance stipulate that a sufficient analysis should include:

A clear description of the specific NQTL, plan terms, and policies at issue; and

Identification of the specific mental health or substance use disorder and medical or surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as mental health or substance use disorder and which are treated as medical or surgical.

Issuer Response:

Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:

Precertification is a decision that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Pre-Event Review is the review of a medical or surgical admission or procedure *in advance* of the actual admission or procedure date. “Prior Authorization” is synonymous with “precertification”, “pre-authorization” and “pre-event” are used interchangeably as referenced in Plan materials in some circumstances.

Active Health Management (“AHM”), a subsidiary of Aetna, via contract with Nippon, is delegated to determine precertification.

Policies:

AHM BH Comparative Analysis

Nippon Insurance Booklet

Step 1(b): Identify the benefits/services for which the NQTL is required.

Precertification is performed for all inpatient in-network and out-of-network medical/surgical and MH/SUD benefits.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both mental health or substance use disorder benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the

reason(s) for doing so, including an evaluation of any specific data used in the determination.

Issuer Response:

N/A: Precertification is performed for all inpatient in-network and out-of-network medical/surgical and MH/SUD benefits.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q 2, # 4) guidance stipulates that a sufficient response includes:

To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

The FAQ 45 guidance (Q 3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

N/A: Precertification is performed for all inpatient in-network and out-of-network medical/surgical and MH/SUD benefits.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) guidance states that the following is necessary for a sufficient response:

(Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between mental health or substance use disorder and medical or surgical benefits and, if so, describe the process and factors used for establishing that variation.

(Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).

(Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both mental health or substance use disorder and medical or surgical benefits.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

(Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

(Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response – As Written:

All inpatient in-network and out-of-network medical/surgical and MH/SUD benefits are subject to Precertification, and all processes, timelines, reviewer qualifications, and other aspects of Precertification are the same for M/S and MH/SUD benefits unless Georgia state regulation has mandated a prohibition of Precertification for SUD benefits. Thus, as written, the processes, strategies, evidentiary standards, and other factors used to apply Precertification to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Precertification to M/S benefits in the inpatient in-network and out-of-network classifications.

Medical/Surgical:**AHM UM Process:**

Clinical information is sought upon request for Prior Authorization.

Active Health accepts information both orally and in written form and only requests information that is current and clinically relevant.

If a patient or treating practitioner fails to submit necessary information to decide non-urgent cases, ActiveHealth may offer an extension that would specifically describe the required information and the patient or treating practitioner may be given at least 45 calendar days from receipt of notice to respond to the request for more information. If an extension is granted, the patient will be notified prior to the expiration of the initial 15 calendar day period of the circumstances requiring the extension and the date when ActiveHealth will make a decision. In most cases, the decision will be to deny the case for lack of medical information within the required timeframe for the type of review. A reconsideration will be conducted if additional information is received.

If the provider does not have the necessary information and

MH/SUD:**AHM UM Process:**

Same as M/S with the following specific to MH/SUD services:

For MH services, AHM clinical staff will use either of the following guidelines to conduct MH Precertification reviews:

1. The Level of Care Utilization Systems tool, (LOCUS) when the member is > 18 years old, or
2. The Child and Adolescent Level of Care Utilization System (CALOCUS) when the member is < 18 years old.

For SUD services, AHM clinical staff will use the following guidelines:

1. ASAM

requests more time than what is allotted to gather the information, they may be given the option of canceling the request.

If the review nurse is unable to approve the request based on scant information that was provided, he/she follows the process for referring the request to a Medical Director or a clinical peer for review.

Unless otherwise noted by a variance above, Active Health Management's clinical staff adhere to the following review criteria/guideline hierarchy when conducting UM reviews:

UM Consultants and physicians utilize the following hierarchy when determining medical criteria usage:

1. State or client-specific guideline
2. Active Health specific guideline
3. MCG Specific guideline
4. LOCUS or CALOCUS for all mental health reviews
5. If non-surgical, use MCG GRG
6. If surgical, consult with team leader about use of MCG GRG
7. In instances when a diagnosis or treatment-specific guideline is not available in the MCG CWQI, or the MCG indicates the "current role remains uncertain", the clinician will research the Aetna Clinical Policy Bulletins.
8. For cancer-related reviews, the licensed web-based NCCN Guidelines are used where Active Health and MCG do not have the necessary content.

Review and Revision of Criteria/Guidelines

AHM's UM Clinical Policy Guidelines are consistent with Aetna's Clinical Policy Bulletins (CPBs). CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory

actions, or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of the medical technologies addressed. If the Clinical Policy Unit determines that new evidence or other information has emerged to warrant a change in Aetna's clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in Aetna's position, the CPB may be updated with additional supporting background information and references. Each revised CPB is submitted to Aetna's Clinical Policy Council for review and approval by board-certified physicians with various specialties. Additional changes to the revised or updated draft CPB may be made upon the recommendations of the Clinical Policy Council. In addition, appropriate, actively participating physicians, pharmacists, and other providers with current knowledge relevant to the criteria under review are involved in the review process. AHM/s SVP of Clinical Programs makes the determination for AHM to adopt the revised Aetna CPBs and brand them as AHM Clinical Policy Guidelines.

MCG

MCG reviews and updates their guidelines annually. The annual MCG release is reviewed by AHM Medical Directors to determine if MCG's guidelines meet AHM's business needs.

Professional Judgment used in Lieu of Utilization Review Criteria

Although clinical review criteria, as noted above, is used in every Utilization Review instance, there are times that Medical Directors or clinical peers will take a member's atypical circumstances into consideration.

Staff Who Issue Denials

Active Health Management employs licensed (unrestricted), board certified physicians who provide support and oversight to UM staff for the purposes of consultation and clinical review of review requests for medical necessity. If the review nurse is unable to authorize a request because the clinical information received does not meet the review criteria, the nurse will send the request to a Medical Director for review.

The qualifications of the physician reviewer may vary based on state requirements. If mandated by state, federal, or accrediting agencies, this review physician will be a clinical peer of the treating provider. A clinical peer is a licensed physician who is in the same or similar specialty as the treating provider or the medical condition being treated.

Consultations with Expert Reviewers and Clinical Peers who Issue Adverse Determinations:

Telephonic consultation with attending providers is known as “peer-to-peer” conversations. Requests made by an attending provider to discuss the member’s case with a clinical peer are returned within one business day. Peer-to-peer conversations are offered during the verbal notification of an adverse determination call to the provider and facility, as well as in the written notice of adverse determination.

Clinical Rationale Used in Issuing Denials:

The Medical Director (or if mandated by the state, a clinical peer reviewer of the same specialty as the treating provider), will write a note in the review database (ActiveAdvice) that includes

the clinical rationale for all adverse determinations. The clinical rationale includes the medical and/or scientific basis on why the request is not found to be medical necessary, what parts of the cited guideline were not met, and the name of the guideline used to conduct the review. The clinical rationale for the adverse determination is given during the verbal notification calls, as well as included in the written notification to members, providers, facilities, or the member's authorized representative if applicable.	
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Issuer Response – In Operation:

<p>Medical/Surgical: Data: 1-1-2022 – 12-31-2022</p> <p>In-Network Precertification denial rates:</p> <ul style="list-style-type: none"> • Total # of Precertification requests: 76 • Total # of Precertification requests denied: 5 • % of Precertification denied: 6.6% <p>Out-of-Network Precertification denial rates:</p> <ul style="list-style-type: none"> • Total # of Precertification requests: 76 • Total # of Precertification requests denied: 5 • % of Precertification denied: 6.6% <p>Inter-rater reliability scores clinical reviewers:</p> <ul style="list-style-type: none"> • Average IRR score: • Nurse Reviewers: 100% • Physician Reviewers: 100% 	<p>MH/SUD: Data: 1-1-2022 – 12-31-2022</p> <p>In-Network Precertification denial rates:</p> <ul style="list-style-type: none"> • Total # of Precertification requests: 4 • Total # of Precertification requests denied: 0 • % of Precertification denied: 0 <p>Out-of-Network Precertification denial rates:</p> <ul style="list-style-type: none"> • Total # of Precertification requests: 5 • Total # of Precertification requests denied: 0 • % of Precertification denied: 0 <p>Inter-rater reliability scores clinical reviewers:</p> <ul style="list-style-type: none"> • Average IRR score: • Nurse Reviewers: 100% • Physician Reviewers: 100%
<p>In-Operation – Comparative Analysis:</p> <p>For Precertification In-Network requests and denials for MH/SUD benefits were four and zero respectively. The Precertufucatuib</p>	

Out-of-Network requests and denials for MH/SUD benefits were five and zero respectively. Both the Precertification In-Network and Out-of-Network denials for MH/SUD benefits were lower than the Precertification denial rates for In-Network and Out-of-Network M/S benefits.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) guidance states that a sufficient response should include:

(Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusion:

Nippon has determined that Precertification is applied to MH/SUD benefits in a manner that is comparable to and no more stringent than that of M/S services based on the information presented above that describes the processes used for Precertification.

As Written: All processes, strategies, evidentiary standards and other factors used to apply Precertification are the same and/or comparable processes, strategies, evidentiary standards and factors used to apply Precertification to medical/surgical benefits in

the Precertification inpatient in-network and out-of-network classifications as MH/SUD benefits.

In-Operation: Based upon the operational data for Precertification above, Nippon has determined that Precertification is applied to inpatient MH/SUD benefits in a comparable and no more stringent way than M/S benefits.

Nippon – Georgia Nonquantitative Treatment Limitation (NQTL) Submission Form

Instructions: This NQTL reporting submission form includes the required five elements as specified by 42 U.S.C. Section 300gg-26(a)(8)(A); 29 U.S.C. Section 1185a(a)(8)(A); and 26 U.S.C. Section 9812(a)(8)(A).

NQTL: Retrospective Review

Date Last Updated: December 2023

Applies to: Inpatient (In-Network and Out-of-Network) Classifications. **Note: Nippon does not apply retrospective review to any MH/SUD benefits in the Outpatient (In-Network and Out-of-Network) Classification**

Comparative Analysis Performed by:

Name	Title	Position
Carrie Manniello	Second Vice President of Claims and Operations	VP over claims and Operations at Nippon. Point of contact for MHPAEA compliance.
Phil Lavigne	Second Vice President and General Counsel	General Counsel for Nippon. Responsible for legal matters and point of contact for MHPAEA compliance

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q2, #'s 1 and 2) guidance stipulate that a sufficient analysis should include:

A clear description of the specific NQTL, plan terms, and policies at issue; and

Identification of the specific mental health or substance use disorder and medical or surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as mental health or substance use disorder and which are treated as medical or surgical.

Issuer Response:

Retrospective review is a utilization review service performed by licensed healthcare professionals to determine coverage after treatment has been given. The intent is to determine medical necessity, appropriateness of treatment, and determine benefits and eligibility.

Active Health Management, a subsidiary of Aetna, via contract with Nippon, is delegated to determine Retrospective Review.

Policies:

AHM BH Comparative Analysis

Nippon Insurance Booklet

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both mental health or substance use disorder benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Issuer Response:

N/A: Retrospective Review is performed for all inpatient in-network and out-of-network medical/surgical and MH/SUD benefits.

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) (Q 2, # 4) guidance stipulates that a sufficient response includes:

To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

The FAQ 45 guidance (Q 3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

N/A: Retrospective Review is performed for all inpatient in-network and out-of-network medical/surgical and MH/SUD benefits.
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Step 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.

FAQ 45 Guidance: [The FAQ 45](#) guidance states that the following is necessary for a sufficient response:

(Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between mental health or substance use disorder and medical or surgical benefits and, if so, describe the process and factors used for establishing that variation.

(Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).

(Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both mental health or substance use disorder and medical or surgical benefits.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

(Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

(Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response – As Written:

All inpatient in-network and out-of-network M/S and MH/SUD benefits are subject to Retrospective Review, and all processes, timelines, reviewer qualifications, and other aspects of Retrospective Review are the same for M/S and MH/SUD benefits unless Georgia state regulation has mandated a prohibition of Retrospective Review for MH/SUD benefits. Thus, as written, the processes, strategies, evidentiary standards, and other factors used to apply Retrospective Review to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used
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to apply Retrospective Review to M/S benefits in the Inpatient In-Network and Out-of-Network classifications.	
<p><u>Medical/Surgical:</u> Please also see Precertification and Concurrent Review NQTL Analyses. AHM conducts Retrospective Reviews via the same process for M/S and MH/SUD benefits.</p> <p><u>Process:</u> Clinical Information is sought upon request for Retrospective Review.</p> <p>Active Health accepts information both orally and in written form and only requests information that is current and clinically relevant.</p> <p><u>Staff Who Issue Denials</u> Active Health Management employs licensed (unrestricted), board certified physicians who provide support and oversight to UM staff for the purposes of consultation and clinical review of review requests for medical necessity. If the review nurse is unable to authorize a request because the clinical information received does not meet the review criteria, the nurse will send the request to a Medical Director for review.</p> <p>The qualifications of the physician reviewer may vary based on state requirements. If mandated by state, federal, or accrediting agencies, this review physician will be a clinical peer of the treating provider. A clinical peer is a licensed physician who is in the same or similar specialty as the treating provider or the medical condition being treated.</p> <p><u>Consultations with Expert Reviewers and Clinical Peers who</u></p>	<p><u>MH/SUD:</u> <u>Same as M/S.</u></p> <p><u>Process:</u></p> <p>Same as M/S.</p>

<p><u>Issue Adverse Determinations:</u></p> <p>Telephonic consultation with attending providers is known as “peer-to-peer” conversations. Requests made by an attending provider to discuss the member’s case with a clinical peer are returned within one business day. Peer-to-peer conversations are offered during the verbal notification of an adverse determination call to the provider and facility, as well as in the written notice of adverse determination.</p> <p><u>Clinical Rationale Used in Issuing Denials:</u></p> <p>The Medical Director (or if mandated by the state, a clinical peer reviewer of the same specialty as the treating provider), will write a note in the review database (ActiveAdvice) that includes the clinical rationale for all adverse determinations. The clinical rationale includes the medical and/or scientific basis on why the request is not found to be medical necessary, what parts of the cited guideline were not met, and the name of the guideline used to conduct the review. The clinical rationale for the adverse determination is given during the verbal notification calls, as well as included in the written notification to members, providers, facilities, or the member’s authorized representative if applicable.</p>	
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Issuer Response – In Operation:

<p>Medical/Surgical: Data 1-1-2022 – 12-31-2022</p> <p>In-Network Retrospective denial rates:</p> <ul style="list-style-type: none"> • Total Retrospective Review requests: 184 • Total Retrospective Review requests denied: 6 • % of Retrospective Review requests denied: 3.2% 	<p>MH/SUD: Data: 1-1-2022 – 12-31-2022</p> <p>In-Network Retrospective denial rates:</p> <ul style="list-style-type: none"> • Total Retrospective Review requests: 13 • Total Retrospective Review requests denied: 0 • % of Retrospective Review requests denied: 0%
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<p>Out-of-Network Retrospective denial rates:</p> <ul style="list-style-type: none"> • Total Retrospective Review requests: 163 • Total Retrospective Review requests denied: 7 • % of Retrospective Review requests denied: 4.3% <p>Inter-rater reliability scores clinical reviewers:</p> <ul style="list-style-type: none"> • Average IRR score: Nurse Reviewers: 100% Physician Reviewers: 100% 	<p>Out-of-Network Retrospective denial rates:</p> <ul style="list-style-type: none"> • Total Retrospective Review requests: 5 • Total Retrospective Review denied: 0 • % of Retrospective Review requests denied: 0% <p>Inter-rater reliability scores clinical reviewers:</p> <ul style="list-style-type: none"> • Average IRR score: Nurse Reviewers: 100% Physician Reviewers: 100%
<p>In-Operation – Comparative Analysis:</p> <p>For Retrospective Review In-Network and Out-of-Network there were zero denials for Retrospective Review of MH/SUD benefits. The interrater reliability scoring for both M/S and MH/SUD benefits was 100% for both nurse and physician reviewers.</p>	

Step 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.

FAQ 45 Guidance: [The FAQ 45](#) guidance states that a sufficient response should include:

(Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific

evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusion:

Nippon has determined that Retrospective Review is applied to MH/SUD benefits in a manner that is comparable to and no more stringent than that of M/S services based on the information presented above that describes the processes used to impose Retrospective Review.

As Written: All processes, strategies, evidentiary standards and other factors used to apply Retrospective Review are the same processes, strategies, evidentiary standards and factors used to apply Retrospective Review to medical/surgical benefits in the Retrospective Review Inpatient In-Network and Out-of-Network Classifications.

In-Operation: Based upon the operational data for Retrospective Review above, Nippon has determined that Retrospective Review is applied to inpatient MH/SUD benefits in a comparable and no more stringent way than M/S benefits.