

**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: No

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

**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

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

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

- 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

- 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

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: See attached NQTLs.

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.<sup>1</sup> 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.

---

<sup>1</sup> See 29 CFR 2590.712(c)(iii) Ex. 9.

## Step Two:

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

Comments: See attached NQTLs.

*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: See attached NQTLs.

*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: See attached NQTLs.

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

- 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.<sup>2</sup>
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.

---

<sup>2</sup> 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.			

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Provider Credentialing
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Provider Operations
Names of Person(s) Responsible for Analysis Formation	<p><b>Oscar:</b> Zeeshan Dawdani (Credentialing Operations Manager- four years experience)</p> <p><b>Optum:</b> Positions: NVP, Network Contracting and Provider Relations, Credentialing Specialist, Director, Provider Network Administration, Manager &amp; Director for Network Programs Provider Credentialing &amp; Performance, VP Benefits Integrity, Director MH Parity and Benefits, Out-of-Network Pricing and Policy</p> <p>Credentials: Licensed Psychologist, Licensed Nurse, Registered Health Information Technician, Certified Professional Coder, Certified Professional Medical Auditor, Certified Professional Compliance Officer, Certified Evaluation and Management Coder</p>
Last Update	3/31/2023
Reviewers	Alexandra Rubino, Associate Director, MHP (Five years experience in Mental Health Parity reporting and operational compliance)





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

### **Provider Credentialing**

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

<b>Purpose/Description of Provider Credentialing</b>
<p><b>MH/SUD:</b></p> <p>Strategy: Credentialing is performed to determine if a provider or facility meets standards to join (credential) or maintain (re-credential) their status in Optum Behavioral Health Solutions' (OBHS) network of participating providers. OBHS uses its credentialing and re-credentialing processes to validate that its network of contracted providers and facilities providing inpatient and outpatient services meet the baseline criteria, as applicable, to the State and practicing specialty.</p> <p><b>MED/SURG:</b></p> <p>Strategy: Credentialing is performed to determine if a provider or facility meets standards to join (credential) or maintain (re-credential) their status in Oscar's network of participating providers. Oscar uses its credentialing and re-credentialing processes to validate that its network of contracted providers and facilities providing inpatient and outpatient services meet the baseline criteria, as applicable, to the State and practicing specialty.</p>
<p><b>Coverage Terms (EOC language):</b></p> <p><b>Network Providers:</b></p> <p>To receive In-Network Benefits as indicated on Your Schedule of Benefits, You must choose Providers within the Network for all care (other than for Emergency Services). The Oscar Network consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Members throughout the Service Area. Refer to Your Provider Directory or Visit the Oscar website at <a href="http://www.hioscar.com">www.hioscar.com</a> to make Your selections. The list of Network Providers may change occasionally, so make sure the Providers You select are still Network Providers at the time of service. An updated directory will be available at least annually or You may access Our website at <a href="http://www.hioscar.com">www.hioscar.com</a> for the most current listing to assist You in locating a Provider. Our Member Services team is available to assist you in finding the Network Provider that will best suit Your needs at 1-855-672-2755, through our mobile application, or on our Member portal at <a href="http://www.hioscar.com">www.hioscar.com</a>.</p>

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

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

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
Inpatient In-Network	<ol style="list-style-type: none"> <li>1. The provider or facility completes and attests to the accuracy of the content of the application. The application includes, but is not limited to:               <ol style="list-style-type: none"> <li>a. Applicant's current professional license(s) or certification(s)</li> <li>b. Applicant's current Drug Enforcement Agency ("DEA") or Controlled Dangerous Substance ("CDS") certification(s)</li> <li>c. Applicant's professional liability claims history that resulted in settlements or judgments paid by</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. The provider or facility completes and attests to the accuracy of the content of the application. The application includes, but is not limited to:               <ol style="list-style-type: none"> <li>a. Applicant's current professional license(s) or certification(s)</li> <li>b. Applicant's current Drug Enforcement Agency ("DEA") or Controlled Dangerous Substance ("CDS") certification(s) (if applicable)</li> <li>c. Applicant's professional liability claims history</li> <li>d. Educational history and degrees received relevant to the Applicant's area of</li> </ol> </li> </ol>
Outpatient, In-Network		
Emergency		

	<p>or on behalf of the Applicant, and history of liability insurance coverage</p> <ul style="list-style-type: none"> <li>d. Educational history and degrees received relevant to the Applicant's area of practice, licensure or certification</li> <li>e. Any other documents or information that are necessary to review an applicant's qualifications</li> </ul> <p>2. Oscar delegates credentialing to a Credentialing Verification Organization ("CVO") that verifies certain information, i.e. primary source verification, in the application. The scope of the verification includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>a. Current valid license to practice or certification, as minimally required to engage in clinical practice</li> <li>b. Highest level of medical or professional education and training</li> <li>c. Board certification if the applicant states that he/she is board certified on application</li> <li>d. Data Bank Inquiry</li> <li>e. Sanctions Inquiry</li> </ul> <p>3. The provider or facility continues to meet the requirements set forth in the credentialing plan, such as having valid credentials (license, board certification,</p>	<p>practice, licensure, or certification</p> <ul style="list-style-type: none"> <li>e. Any other documents or information that are deemed necessary by OBHS to review an applicant's qualifications</li> </ul> <p>2. OBHS verifies certain information, i.e., primary source verification, in the application. The scope of the verification includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>a. Current valid license to practice or certification, as minimally required to engage in clinical practice</li> <li>b. Highest level of medical or professional education and training</li> <li>c. Board certification if the applicant states that he/she is board certified on application</li> <li>d. National Practitioner Data Bank (NPDB) Inquiry</li> <li>e. Sanctions Inquiry</li> </ul> <p>3. The provider or facility continues to meet the requirements set forth in the Credentialing Plan while they are contracted with OBHS.</p>
--	--	---

	etc.) while they are contracted with Oscar	
--	--	--

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

Benefit Classification	Evidentiary Standards: Medical/Surgical	Evidentiary Standards: MH/SUD
Inpatient In-Network	<ol style="list-style-type: none"> <li>1. Submission of application</li> <li>2. Oscar's Credentialing Policy Description describes the information that is required to complete the credentialing process (i.e. primary source verification). The scope of the verification includes, but is not limited to:               <ol style="list-style-type: none"> <li>a. Current valid license to practice or certification, as minimally required to engage in clinical practice</li> <li>b. Highest level of medical or professional education and training</li> <li>c. Board certification if the applicant states that he/she is board certified on application</li> <li>d. Data Bank Inquiry</li> <li>e. Sanctions Inquiry</li> </ol> </li> <li>3. State and federal regulatory requirements, National accreditation standards (e.g.</li> </ol>	<ul style="list-style-type: none"> <li>● Submission of application</li> </ul>
Outpatient, In-Network		<ul style="list-style-type: none"> <li>● The UBH Credentialing Pplan describes the information, i.e., primary source verification, that is required The scope of the verification includes, but is not limited to:               <ol style="list-style-type: none"> <li>a. Current valid license to practice or certification, as minimally required to engage in clinical practice</li> <li>b. Highest level of medical or professional education and training</li> <li>c. Board certification if the applicant states that he/she is board certified on application</li> <li>d. NPDB Inquiry</li> <li>e. Sanctions Inquiry</li> </ol> </li> </ul>
Emergency		<ol style="list-style-type: none"> <li>3.               <ul style="list-style-type: none"> <li>● State and federal regulatory requirements, including but not limited to:, for example, Medicare Managed Care Manual, Section 6                   <ol style="list-style-type: none"> <li>a. The requirements related to a completed application that has been attested to within state and/or federal regulatory requirements</li> </ol> </li> </ul> </li> </ol>

	<p>NCQA) and the Oscar Credentialing Policy, including but not limited to:</p> <ol style="list-style-type: none"> <li>The requirements related to a completed application that has been attested to within the standards of NCQA, state and/or federal regulatory requirements</li> <li>The minimum requirements as set by NCQA, state and/or federal regulatory requirements</li> </ol>	<ol style="list-style-type: none"> <li>The minimum requirements as set by state and/or federal regulatory requirements</li> </ol> <ul style="list-style-type: none"> <li>National accreditation standards, for example National Committee for Quality Assurance (NCQA) CR3 and CR4 credentialing standards, including but not limited to: <ol style="list-style-type: none"> <li>The requirements related to a completed application that has been attested to within the standards of NCQA</li> <li>The minimum requirements as set by NCQA</li> </ol> </li> </ul>
--	--	---

Benefit Classification	Sources: Medical/Surgical	Sources: MH/SUD
Inpatient In-Network	<ol style="list-style-type: none"> <li>Submission of application</li> <li>Oscar's Credentialing Policy Description describes the information that is required to complete the credentialing process (i.e. primary source verification). The scope of the verification includes, but is not limited to: <ol style="list-style-type: none"> <li>Current valid license to practice or certification, as minimally required to engage in clinical practice</li> <li>Highest level of medical or professional education and training</li> <li>Board certification if the applicant states that he/she is board certified on</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>Submission of application</li> <li>The UBH Credentialing Pplan describes the information, i.e., primary source verification, that is required. The scope of the verification includes, but is not limited to: <ol style="list-style-type: none"> <li>Current valid license to practice or certification, as minimally required to engage in clinical practice</li> <li>Highest level of medical or professional education and training</li> <li>Board certification if the applicant states that he/she is board certified on application</li> <li>NPDB) Inquiry</li> <li>Sanctions Inquiry</li> </ol> </li> <li></li> </ol>

	<p>application</p> <p>d. Data Bank Inquiry</p> <p>e. Sanctions Inquiry</p> <p>3. State and federal regulatory requirements, National accreditation standards (e.g. NCQA) and the Oscar Credentialing Policy on an ongoing basis, including but not limited to:</p> <p>a. The requirements related to a completed application that has been attested to within the standards of NCQA, state and/or federal regulatory requirements</p> <p>b. The minimum requirements as set by NCQA, state and/or federal regulatory requirements</p>	<ul style="list-style-type: none"> <li>● State and federal regulatory requirements, including but not limited to: , for example, Medicare Managed Care Manual, Section 6 <ul style="list-style-type: none"> <li>a. The requirements related to a completed application that has been attested to within state and/or federal regulatory requirements</li> <li>b. The minimum requirements as set by state and/or federal regulatory requirements</li> </ul> </li> <li>● National accreditation standards, for example NCQA credentialing standards, including but not limited to: <ul style="list-style-type: none"> <li>a. The requirements related to a completed application that has been attested to within the standards of NCQA</li> <li>b. The minimum requirements as set by NCQA</li> </ul> </li> </ul>
--	---	---

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

Benefit Classification	Comparative Analysis: Medical/Surgical	Comparative analysis: MH/SUD
Inpatient In-Network	<p>The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine network admission standards for medical/surgical providers and mental health/substance use disorder providers.</p> <p>The factors, sources, and evidentiary standards for network admission standards for mental health/substance use disorder providers and medical/surgical providers are the same.</p>	
Outpatient, In-Network		

Emergency	<p>The following factors apply to both M/S and MH/SUD:</p> <ol style="list-style-type: none"> <li>1. The provider or facility completes and attests to the accuracy of the content of the application</li> <li>2. The verification of certain information, i.e., primary source verification, in the application</li> <li>3. The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan</li> </ol> <p>The following sources and evidentiary standards apply to both M/S and MH/SUD:</p> <ol style="list-style-type: none"> <li>1. Submission of application</li> <li>2. Internal policies describing required primary source verification</li> <li>3. State and federal requirements, national accreditation standards, internal credentialing policies.</li> </ol> <p>Findings: The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information for MH/SUD network admissions strategy as-written is comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information for M/S network admissions strategy.</p> <p>Operationally, the Plan performs in-operation data assessments to make sure that factors, sources, and evidentiary standards are applied in a consistent manner. For a quantitative assessment of Provider Credentialing, the Plan compares Provider Admission to the Network for MH/SUD providers and M/S providers. The Plan measures % of providers credentialed within a 30-day period and sets a target of 90% credentialed within a 30-day period for both medical/surgical and mental health/substance use disorder providers.</p>	
	<p><b>M/S:</b></p> <p><b>Process:</b> The process is triggered by a provider or facility seeking to join or continue participation in Oscar's network to determine whether the provider or facility has the appropriate level of education/licensure/certification and satisfies additional qualifications (as applicable) to provide covered care to Plan members. Oscar uses credentialing processes and plans based on NCQA standards and</p>	<p><b>MH/SUD:</b></p> <p><b>Process:</b> The process is triggered by a provider or facility seeking to join or continue participation in the OBHS network to determine whether the provider or facility has the appropriate level of education/licensure/certification and satisfies additional qualifications (as applicable) to provide covered care to Plan members. OBHS uses credentialing processes and plans based on National Committee for Quality Assurance (NCQA) standards and</p>



	<p>applicable state or Federal regulatory requirements when determining whether to credential MED/SURG providers or facilities. To successfully complete the credentialing process, MED/SURG providers and facilities must meet the baseline criteria as applicable to the State and practicing specialty, which can be found in the Oscar Credentialing Policy or state addendum. Individual (and certain facility-based) providers must complete the CAQH application, or state-mandated application where applicable, and attestation.</p> <p><b>Ongoing Monitoring:</b></p> <p>Plan monitors compliance with turn-around times in real-time and on a retrospective basis.</p> <p>Following the initial credentialing process, providers are required to continually meet all credentialing requirements. To ensure this, Plan performs monthly monitoring with respect to provider credentialing requirements.</p> <p>Specific monitoring examples include, but are not limited to:          Medicare and Medicaid Sanctions          Licensure warnings, citations, probations, limitations, sanctions, restrictions, suspensions, terminations, or voluntary surrender          Member complaints regarding service and quality of care</p> <p>If an action and/or issue is discovered, it may result in the provider's credentialing information being sent to the Medical Director and/or Credentialing Committee for review.</p>	<p>applicable state or fFederal regulatory requirements when determining whether to credential MH/SUD providers or facilities. To successfully complete the credentialing process, MH/SUD providers and facilities must meet the baseline criteria as applicable to the sState and practicing specialty, which can be found in the Behavioral Health (UBH) d/b/a Optum Credentialing Plan or state addendum. Individual (and certain facility-based) providers must complete the Council for Affordable Quality Healthcare (CAQH®)CAQH application, or state-mandated application where applicable, and attestation.</p> <p><b>Ongoing Monitoring:</b></p> <p>Plan monitors compliance with turn-around times in real-time and on a retrospective basis.</p> <p>Following the initial credentialing process, providers are required to continually meet all credentialing requirements. To ensure this, Plan performs monthly monitoring with respect to provider credentialing requirements.</p> <p>Specific monitoring examples include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Medicare and Medicaid Sanctions</li> <li>• Licensure warnings, citations, probations, limitations, sanctions, restrictions, suspensions, terminations, or voluntary surrender</li> <li>• Member complaints regarding service and quality of care</li> </ul> <p>If an action and/or issue is discovered, it may result in the provider's credentialing information being sent to the Medical Director and/or Credentialing Committee for review. This review can lead to</p>
--	---	---



	<p>This review can lead to termination of the provider from Plan's credentialed networks. A resulting termination flag would then be entered into the Plan provider repository.</p> <p><b>Provider Directory</b> Insurance Ops conducts a quarterly phone outreach audit throughout the year to confirm the accuracy of five key pieces of provider information in our directory from our OHI networks. This methodology satisfies regulatory and quality requirements from NCQA and CMS. Providers are randomly selected based on varying methodologies which are based on a combination of geography, specialty or directory search data. The sample size is statistically significant based on the size of our overall network with a 95% confidence level. During the audit, when we receive intel on a discrepancy in the data we proactively initiate a process to update our production data using the information provided to them on the phone call.</p> <p><b>Appeal Information</b> If the Peer Review and Credentialing Committee makes a business, administrative or professional competence or conduct-related decision with regard to an applicant's participation status, the Peer Review and Credentialing Committee may offer such applicant an opportunity to dispute the recommendation.</p>	<p>termination of the provider from Plan's credentialed networks. A resulting termination flag would then be entered into the Plan provider repository.</p> <p><b>Provider Directory</b> Optum employs proactive outreach campaigns that use multiple channels throughout the year for all providers to attest to the accuracy of their demographic data every 90 to 180 days. Those channels include secure provider portal features, email, phone calls, faxes, in-person meetings, obtaining data from vendors and other sources, and the use of claims data. Our ongoing quality reviews occur throughout the year for a randomly selected auditing of our network via provider data attestations, phone call campaigns to providers, and other methods. This produces a statistically valid confidence level of 95% in the result (+/- 2%).</p> <p><b>Appeal Information</b> If the Credentialing Committee makes a business, administrative or professional competence or conduct-related decision with regard to an applicant's participation status, the Credentialing Committee may offer such applicant an opportunity to appeal the recommendation.</p>
--	--	--

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

Benefit Classification	Process Description
Inpatient In-Network	The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:
Outpatient, In-Network	<ol style="list-style-type: none"> <li>1. The factors are the same across MH/SUD and M/S network admissions standards.</li> <li>2. The sources and evidentiary standards are the same across MH/SUD and M/S network admission standards.</li> <li>3. Ongoing monitoring of network admission standards is aligned across MH/SUD and M/S.</li> </ol>
Emergency	<p>Findings/Conclusion:</p> <p>The findings of the comparative analysis reveal that the process and methodology to assess network admissions standards for MH/SUD as-written is comparable to, and applied no more stringently than, the process and methodology used to assess network admission standards for medical/surgical services.</p> <p>In-operation, the plan performs a variety of quantitative assessments to review the underlying methodologies for Provider Admission are aligned. When comparing the relative rate of providers credentialed and re-credentialed within a 30-day timeframe in 2022, MH/SUD providers consistently met targets above the 90% threshold for credentialing and re-credentialing.</p> <p>For M/S, 73% of providers were credentialed within a 30-day period and 98% of providers were re-credentialed within a 30 day period. For MH/SUD, 100% of providers were credentialed within a 30 day period, and 96% were re-credentialed within a 30-day period. These results meet the benchmark at 90% or above credentialing rate over a 30-day period for MH/SUD providers. This reveals that standards for Provider Admission to the Network are applied no more strictly to MH/SUD providers when compared to M/S providers.</p> <p>The findings of the comparative analysis reveal that the process and</p>

	methodology to assess network admissions standards in-operation for MH/SUD is comparable to, and applied no more stringently than, the process and methodology used to assess network admission standards for medical/surgical services.
--	--

<b>Non-Quantitative Treatment Limitation (NQTL) Analysis Index</b>	
<b>Non-Quantitative Treatment Limitation</b>	Quantity Limits
<b>Plan Type(s) Applicable</b>	<b>Oscar Health Plan of Georgia</b>
<b>Responsible Business Teams</b>	Formulary Design and Strategy
<b>Names of Person(s) Responsible for Analysis Formation</b>	<p>Jeenal Patel, PharmD, Senior Clinical Formulary Pharmacist (Nine years Pharmacy experience, two of which were dedicated to Pharmacy at a Health Plan)</p> <p>Kemper May, PharmD, Manager, Formulary Operations (seven years experience in Pharmacy at a Health Plan)</p>
<b>Last Update</b>	12/11/2023
<b>Reviewers</b>	Alexandra Rubino, MPH, Associate Director, MHP (Over five years experience in Mental Health Parity reporting and operational compliance for health plans)



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

### Quantity Limits

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

#### General Description/Explanation of the NQTL:

Quantity Limits (QL) establish a maximum quantity of certain medications that meets the plan's medical necessity standards and will be covered over a specified period of time. The limit is expressed in terms of dose or quantity dispensed per prescription, dose or quantity dispensed per time period, the amount covered for the drug, or the number of prescription claims for the drug over a period of time. Pharmacy quantity limits generally apply to both generic and brand drugs.

#### Plan/Coverage Terms:

##### Coverage Terms (Evidence of Coverage)

Some drugs have limits on the quantity dispensed. Some medications have limits, placed by Oscar, on the quantity that Your pharmacist can supply to You at a given time. These limits are based on clinical data from the FDA and from nationally recognized clinical guidelines. The limits apply regardless of the quantity prescribed by Your Healthcare Provider. You or Your Doctor can request an exception If You or Your Health Care Provider believes You require a higher quantity of medication than the limit, Your Health Care Provider can submit a request to Oscar for an exception. An Oscar clinician will review the request based on the submitted information. Any drugs dispensed by Your pharmacist in a manner intended to change or circumvent the maximum limits set by Oscar will be denied. A list of medications with quantity limits is available on our website at [www.hioscar.com](http://www.hioscar.com) or by contacting Member Services at 1-855-672-2755.

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
Pharmacy	All other drug classes on formulary which are not listed under the MH/SUD category.  A list of medications with a quantity limit may be found	A list of medications with a quantity limit may be found here:  <a href="https://www.hioscar.com/search-documents/drug-formularies/">https://www.hioscar.com/search-documents/drug-formularies/</a>

	<p>here:  <a href="https://www.hioscar.com/search-documents/drug-formularies/">https://www.hioscar.com/search-documents/drug-formularies/</a></p>	
--	---	--

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

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

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

Factor	Sources	Evidentiary Standards/Thresholds
Patient Safety	<p>Sources:</p> <ul style="list-style-type: none"> <li>● Oscar’s Clinical Guidelines</li> <li>● MCG</li> <li>● Hayes, Inc.</li> <li>● Up-to-Date</li> <li>● Authoritative peer-reviewed textbooks &amp; journals</li> <li>● National society guidelines</li> <li>● Agency for Healthcare Research and Quality</li> <li>● National Institutes of Health (“NIH”) Consensus Statements</li> <li>● CVS/Caremark Specialty Exceptions Criteria</li> <li>● CVS Prior Authorization Criteria</li> <li>● National Comprehensive Cancer Network</li> <li>● Clinical Pharmacology</li> </ul>	<ul style="list-style-type: none"> <li>● Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse. Example: Victoza is approved for the treatment of Type II Diabetes and in many cases it is NOT prescribed according to the package labeling and is requested for higher doses to treat obesity, instead.</li> <li>● Substantiated by nationally recognized guidelines (such as National institutes of health (NIH), American Academy of Dermatology, American Academy of Neurology, Infectious Diseases Society of America) to be safe and effective for the member’s illness, injury, or disease, taking into account factors such as</li> </ul>

		treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.
Fraud, Waste and Abuse potential	<ul style="list-style-type: none"> <li>• Medispan controlled substance flag</li> <li>• Internal claims data</li> </ul>	<p><b>Fraud:</b> Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347), including in violation of the federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)), the federal Physician Self-Referral (Stark) Law (42 U.S.C. § 1395nn), the False Claims Act (31 U.S.C. §§ 3729-3733), CMS Medicare Marketing Guidelines, and the federal Civil Monetary Penalties Law (42 U.S.C. § 1320a-7a).</p> <p><b>Waste:</b> Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and state healthcare programs. Waste is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.</p> <p><b>Abuse:</b> The result of practices that are inconsistent, or outside the bounds of generally accepted practices in the industry, which result in unnecessary services and payment. Abuse is also the payment for items or services when there is no legal entitlement to that payment and the individual or entity has knowingly and/or intentionally misrepresented facts to obtain payment.</p>

Risk Prioritization Scale (0-1000)	FWA Priority Level
750-1000	Urgent (5)
500-749	High (4)
250-499	Medium (3)
100-249	Low (2)
0-99*	Very low (1)
Total Points Possible:	1000

● Financial Exposure (Points: 0-250)

Criteria	Points
\$1,000,000 +	250
<\$1,000,000 >\$500,000	125
<\$500,000 >\$100,000	100
<\$100,000 >\$25,000	20
<\$25,000 \$0+	5
250	Exposure Total

● Prior History (Points: Cap at 100: 0-100)

Criteria	Points
Prior substantiated lead or criminal/License/exclusion issue	75
Prior unsubstantiated, inconclusive lead	25
Prior external flag (SIRIS, HFPP)	25
HCFS Alert	5
No prior leads	0
100	History Total

● Network Status (Points: 25-75)

Criteria	Points
INN	75
OON	25

● Line of Business(Points: 50-100)

Criteria	Points
IVL or SG	25
Platform	25
Medicare Advantage	50
100	LOB Total

● Target Type (Points: 5-50)

Criteria	Points
Provider (Med, Pharmacy, DME, lab etc)	50
Broker	25
Member/Other	5
50	Target Total



		<ul style="list-style-type: none"><li>● Specificity of Lead (Points: 5-25)</li></ul> <table><tr><th>Criteria</th><th>Points</th></tr><tr><td>Detailed report (dates, parties, locations, allegations)</td><td>25</td></tr><tr><td>Moderate detail</td><td>10</td></tr><tr><td>Minimal detail</td><td>5</td></tr><tr><td>25</td><td>Specificity Total</td></tr></table> <ul style="list-style-type: none"><li>● Member Volume (Points: 5-50)</li></ul> <table><tr><th>Criteria</th><th>Points</th></tr><tr><td>100+ Members</td><td>50</td></tr><tr><td>50-100 Members</td><td>25</td></tr><tr><td>10-50 Members</td><td>10</td></tr><tr><td>1-10 Members</td><td>5</td></tr><tr><td>50</td><td>Member Volume Total</td></tr></table> <ul style="list-style-type: none"><li>● Potential Member Harm (Points: 0-150)</li></ul> <table><tr><th>Criteria</th><th>Points</th></tr><tr><td>Physical</td><td>100</td></tr><tr><td>Financial</td><td>50</td></tr><tr><td>None apparent</td><td>0</td></tr><tr><td>150</td><td>Patient Harm Total</td></tr></table> <ul style="list-style-type: none"><li>● Access to Evidence (Points: 0-150)</li></ul> <table><tr><th>Criteria</th><th>Points</th></tr><tr><td>Minimal state, reg, contract limits</td><td>50</td></tr><tr><td>Members active</td><td>25</td></tr><tr><td>Claims within 3-6 months</td><td>25</td></tr><tr><td>100</td><td>Evidence total:</td></tr></table> <p>Example: Opioids and narcotics are classified as controlled substances and prone to misuse which can lead to addiction and/or substance use disorder. Therefore, dosing should not exceed FDA, CDC and/or The American Academy of Pain Medicine recommended quantities of opioids.</p> <p>Example: Compounded medications often require large amounts of a substance (i.e powders, creams, ointments), but compounds are not FDA approved products.</p>	Criteria	Points	Detailed report (dates, parties, locations, allegations)	25	Moderate detail	10	Minimal detail	5	25	Specificity Total	Criteria	Points	100+ Members	50	50-100 Members	25	10-50 Members	10	1-10 Members	5	50	Member Volume Total	Criteria	Points	Physical	100	Financial	50	None apparent	0	150	Patient Harm Total	Criteria	Points	Minimal state, reg, contract limits	50	Members active	25	Claims within 3-6 months	25	100	Evidence total:
Criteria	Points																																											
Detailed report (dates, parties, locations, allegations)	25																																											
Moderate detail	10																																											
Minimal detail	5																																											
25	Specificity Total																																											
Criteria	Points																																											
100+ Members	50																																											
50-100 Members	25																																											
10-50 Members	10																																											
1-10 Members	5																																											
50	Member Volume Total																																											
Criteria	Points																																											
Physical	100																																											
Financial	50																																											
None apparent	0																																											
150	Patient Harm Total																																											
Criteria	Points																																											
Minimal state, reg, contract limits	50																																											
Members active	25																																											
Claims within 3-6 months	25																																											
100	Evidence total:																																											
Cost	<ul style="list-style-type: none"><li>● Pharmacy Claims data</li></ul>	Thresholds:																																										

		<ul style="list-style-type: none"> <li>• For drugs with 30-day ingredient cost less than \$10, less than 25% of drugs have QL required.</li> <li>• For drugs with 30-day ingredient cost between \$100 - \$1000, less than 50% of drugs have QL required</li> <li>• For drugs with 30-day ingredient cost above \$1000, more than 50% of drugs have QL required</li> <li>• For drugs with 30-day ingredient cost above \$10,000, almost more than 75% drugs have QL required</li> </ul>
--	--	---

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

Benefit Classification	Comparative Analysis: Medical/Surgical and Mental Health/Substance Use Disorder
Pharmacy	<p><b>As-Written:</b></p> <p><b>Process:</b></p> <p><i>General:</i></p> <p>The quantity limit process is part of the Utilization Management (UM) activities and is an assessment performed to determine if the member has tried and failed, or has an intolerance or contraindication to the preferred formulary agent(s).</p> <p>The Plan maintains a list of services that require quantity limits. This list is available on request by phone, by provider portal, or via the published formularies online. Authorizations can be submitted via phone, fax, or online through Oscar's provider portal. If a request above the outlined plan quantity level limits is submitted, it is reviewed by licensed clinicians to determine if the request meets plan criteria.. Clinicians utilize the Plan's policies and established, evidence based clinical criteria to determine if the request meets coverage determinations and/or medical necessity. Licensed clinicians (e.g., physicians and pharmacists) review quantity limit requests; in most states, pharmacists can make adverse determinations. However, in all Oscar states,</p>

only appeals can be denied by a licensed physician.

The Plan requires the requesting provider to submit the following information when requesting a quantity level limit exceptions request:

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

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

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

***Purpose:***

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

***Structure:***

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

Voting Members	Qualifications
Chief Medical Officer	Licensure: Medical Doctor Specialty: Internal Medicine
External Member	Licensure: Medical Doctor Specialty: Rheumatology

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

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

*Internal oversight of the P&T Committee:*

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

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

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

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

***MHPAEA Summary***

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

The factors that determine whether a drug contains a quantity limit are the same for

	<p>both MH/SUD drugs and M/S drugs. The plan uses the following factors to determine whether a drug requires a quantity limit irrespective of whether the drug is classified as MH/SUD or M/S: patient safety, potential for fraud/waste/abuse, and cost. The plan also uses the same evidentiary standards and sources to determine the thresholds and supporting information for the aforementioned factors across all drug types (M/S and MH/SUD). There is no discrepancy between the factors, evidentiary standards, sources, and processes used to determine if a drug is subjected to quantity limits because all drugs, regardless of drug-type, are subject to the same underlying methodology. However, the Plan has conducted an in-operation quantitative analysis below to quantify the extent to which a discrepancy may exist for quantity limit application operationally.</p> <p>The methodology for quantity limits is applied consistently across all drugs and drug classes and does not discriminate against individuals based on medical/surgical condition, mental health/substance use disorder diagnosis, or other health conditions. Any pharmacy coverage factors, processes, development or implementation strategies, and evidentiary standards applied to drugs used to treat mental health or substance use disorder are comparable to, and are applied no more stringently than the coverage factors, processes, development or implementation strategies, evidentiary standards used in applying the limitations to drugs used to treat medical or surgical disorders as evidenced by the above as-written NQTL analysis.</p> <p><b>In-Operation:</b></p> <p><i>Overview:</i></p> <p>Operationally, the Plan performs in-operation data assessments for quantity limits to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across M/S and MH/SUD drugs.</p>
--	---

**Table 5 - Proportion of drugs\* subject to QL**

	Condition	Total # subject to QL	% subject to QL
controlled substance	MH	6206	78%
	SUD	305	100%
	M/S	6148	70%
not controlled substance	MH	2281	14%
	SUD	5	1%
	M/S	10793	11%

\*Individual NDCs

#### *Quantity Limit Analysis:*

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

##### Controlled Substance

- 70 % of the drugs in the Medical/Surgical category.
- 78 % of the drugs in the Mental Health category.
- 100% of the drugs in the Substance Use Disorder category.

##### Non-Controlled Substance

- 11% of the drugs in the Medical/Surgical category.
- 14 % of the drugs in the Mental Health category.
- 1 % of the drugs in the Substance Use Disorder category.

The development of quantity limits is based on comparable processes, strategies, evidentiary standards. Since mental health drugs have the highest proportion of drugs subject to a quantity limit, the Plan evaluated the categories of mental health drugs that comprise this proportion and assessed whether the Plan's methodology for imposing quantity limits is applied more stringently to mental health drugs.

	<i>Mental Health Drugs Subject to Quantity Limits:</i>	
	Amphetamines/Stimulants	Factors met: 1) Amphetamines are Controlled substances with FWA risk, 2) FDA and compendia supported max daily dosing to ensure patient safety
	Antianxiety Agents	Factors met: 1) benzodiazepines are Controlled substances with FWA risk, 2) FDA and compendia supported max daily dosing to ensure patient safety
	Antidepressants	Factors met: 1) FDA and compendia supported max daily dosing to ensure patient safety
	Antipsychotics/Antimanic Agents	Factors met: 1) FDA and compendia supported max daily dosing to ensure patient safety
	Hypnotics/Sedatives/Sleep Disorder Agents	Factors met: 1) benzodiazepines are Controlled substances with FWA risk, 2) FDA and compendia supported max daily dosing to ensure patient safety
	For amphetamines/stimulants, antianxiety agents, and hypnotics/sedatives/sleep disorder agents, two factors are met: patient safety and potential for fraud, waste, and abuse. For antidepressants and antipsychotics/antimanic agents, one factor is met: patient safety.	

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

Benefit Classification	Findings/Conclusions
Pharmacy	<p>The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:</p> <p>The Plan conducted a comparative analysis to determine whether quantity limits applied to Medical/Surgical (M/S) drugs and Mental Health/Substance Use Disorder (MH/SUD) drugs are</p>



	<p>comparable “as written.”</p> <p>The factors, evidentiary standards, sources, and processes for formulary design for medical/surgical drugs are the same as the factors, evidentiary standards, sources, and processes for mental health/substance use disorder drugs.</p> <p>The Plan’s quantity limits are applied consistently across all drugs and drug classes and does not discriminate against individuals based on age, expected length of life, disability, degree of medical dependency, quality of life, gender identity, medical or mental health diagnosis, or other health conditions. Any coverage factors, processes, development or implementation strategies, and evidentiary standards applied to drugs used to treat mental health or substance use disorder (MH/SUD) are comparable to, and are applied no more stringently than the coverage factors, processes, development or implementation strategies, evidentiary standards used in applying the limitations to drugs used to treat medical or surgical disorders (M/S).</p> <p>Operationally, the Plan performs in-operation data assessments for quantity limit procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across M/S and MH/SUD services. The Plan concludes that in-operation, its methodology for quantity limit application for mental health/substance use disorder drugs is comparable to and applied no more stringently than the methodology for quantity limit application for M/S drugs. While behavioral health drugs have the highest proportion of drugs subject to quantity limits, the plan evaluated whether this is consistent with the underlying methodology for imposing quantity limits. The plan concluded that the categories of BH drugs that comprise the proportion subject to quantity limits are aligned with the Plan’s methodology for the assignment of quantity limits. All categories of BH drugs subject to quantity limits raise patient safety concerns while most additionally raise concerns of potential fraud, waste, and abuse. While outcomes are not determinative of mental health parity compliance, outcomes can provide meaningful guidance to evaluate whether the Plan’s non-quantitative treatment limit application is sound. Since the BH drugs subject to quantity limits are aligned with the Plan’s quantity limit methodology, quantity limits are applied no more strictly toward MH drugs. Therefore, the application of quantity limits is consistent across all drugs irrespective of drug type.</p> <p>Conclusion: The findings of the comparative analysis reveal that the process and methodology for quantity limits as applied to MH/SUD drugs is comparable to, and applied no more stringently than, the process and methodology used for quantity limits for M/S drugs.</p>
--	--

<b>Non-Quantitative Treatment Limitation (NQTL) Analysis Index</b>	
<b>Non-Quantitative Treatment Limitation</b>	Medical Necessity Criteria Development Strategy
<b>Plan Type(s) Applicable</b>	Oscar Health Plan of Georgia
<b>Responsible Business Teams</b>	Clinical
<b>Names of Person(s) Responsible for Analysis Formation</b>	<p><b>Oscar:</b> Insiya Taj, MPH, Associate, UM Optimization, (Over 5 years experience in healthcare and clinical research) David Schaffzin, MD, Associate Medical Director, Utilization Management</p> <p><b>Optum Behavioral Health Solutions:</b> Positions: Chief Medical Officer, National Senior Behavioral Medical Directors (MD), VP Benefits Integrity, VP, Outpatient and Specialty Programs, Director MH Parity and Benefits, Legal Counsel, and Senior Director, National Policy and Standards. Credentials: Board Certified MDs, Licensed Psychologist, Licensed Nurse, Licensed Social Worker, and National Certified Counselor.</p>
<b>Last Update</b>	12/20/23
<b>Reviewers</b>	<p>Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance) Laura Barry MHA, RN, BSN, CCM, CPC, Manager, Clinical Policy</p>



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

### Medical Necessity Criteria Development Strategy

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

#### Medical/Surgical Definition of Medical Necessity:

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

- Generally accepted standards of medical practice in the United States;
- Specificity of clinical appropriateness unique to individual or circumstance (type, frequency and dosage of proposed intervention);
- Knowledge of scientifically-established effectiveness of proposed intervention Generally accepted standards of medical practice shall reflect:
- Evidence-based practice that is supported by clinical criteria and/or guidelines that have been established using scientific literature and peer-reviewed medical (or similar) journals;
- Expert opinions based on experiential history of Providers practicing in relevant clinical area;
- Clinical guidelines, compendia, and other nationally established Physician Specialty Societies recommendations and practice guidelines;
- Internal clinical guidelines that are established for Oscar Physicians with input from licensed participating Providers in Oscar's network
- Any other relevant factors

Generally accepted medical practices in light of conditions at the time of treatment are:

#### Mental Health/Substance Use Disorder Definition of Medical Necessity:

This term is variable and defined in the member's applicable Plan or Coverage document.

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

Prudent clinical judgment shall reflect:

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

Generally accepted standards of medical practice shall reflect:

- Evidence-based guidelines, including MCG (formerly Milliman Care Guidelines), that have been established in the scientific literature via their inclusion in peer-reviewed medical (or similar) journals.
- Expert opinions based on experiential history of Physicians practicing in relevant clinical area;
- Clinical guidelines established by Physician Specialty Societies, such as National Comprehensive Cancer Network (NCCN), and similar;
- Clinical guidelines that are established to Oscar Physicians with input from licensed participating

<ul style="list-style-type: none"> <li>• Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the Member's condition;</li> <li>• Compatible with the standards of acceptable, evidence-based medical practice in the United States;</li> <li>• Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;</li> <li>• Not provided solely for the convenience of the Member or Health Care Provider or Hospital;</li> <li>• Not primarily Custodial Care.</li> </ul>	<p>Providers in Oscar's network</p> <ul style="list-style-type: none"> <li>• Any other relevant factors.</li> </ul> <p>Medically Necessary services shall not be:</p> <ul style="list-style-type: none"> <li>• A reflection of convenience to Oscar Member, requesting Provider or Physician Reviewer.</li> <li>• Costlier than alternative services or clinical and/or treatment pathways that have been demonstrated to produce equivalent outcomes according to peer-reviewed medical literature are at least as likely to produce equivalent outcomes.</li> </ul> <p>Optum Behavioral Health Solutions (OBHS) covers services that are medically necessary. Medical necessity clinical determinations are made using externally developed, evidence-based clinical criteria (aka medical necessity criteria) such as American Society of Addiction Medicine (ASAM) Criteria<sup>®</sup><sup>[1]</sup>, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII) guidelines as well as internally developed, evidence-based, behavioral clinical policies. Application of clinical review criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination. OBHS publishes its medical necessity criteria, which are available through <a href="http://www.providerexpress.com">www.providerexpress.com</a>, unless they are proprietary.</p> <p><sup>[1]</sup> Only ASAM Criteria<sup>®</sup> are used to make substance use disorder (SUD) medical necessity coverage determinations, unless otherwise mandated by state law or contract.</p>
<p><b>Coverage Terms (EOC language):</b></p> <p><b>Medical Necessity or Medically Necessary</b> means services that a Physician (Medical Doctor (MD), Doctor of Osteopathy (DO), or similarly trained professional) would provide to a person in their care for the purpose of evaluating, diagnosing or treating an illness, Injury or disease, or associated symptoms, while exercising prudent clinical judgment. Prudent clinical judgment shall reflect:</p> <ul style="list-style-type: none"> <li>• Generally accepted standards of medical practice in the United States;</li> </ul>	

- Specificity of clinical appropriateness unique to individual or circumstance (type, frequency and dosage of proposed intervention);
- Knowledge of scientifically-established effectiveness of proposed intervention Generally accepted standards of medical practice shall reflect:
- Evidence-based practice that is supported by clinical criteria and/or guidelines that have been established using scientific literature and peer-reviewed medical (or similar) journals;
- Expert opinions based on experiential history of Providers practicing in relevant clinical area;
- Clinical guidelines, compendia, and other nationally established Physician Specialty Societies recommendations and practice guidelines;
- Internal clinical guidelines that are established for Oscar Physicians with input from licensed participating Providers in Oscar's network
- Any other relevant factors

Generally accepted medical practices in light of conditions at the time of treatment are:

- Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the Member's condition;
- Compatible with the standards of acceptable, evidence-based medical practice in the United States;
- Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the Member or Health Care Provider or Hospital;
- Not primarily Custodial Care.

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
In-Network Inpatient Services	<ul style="list-style-type: none"> <li>• All Medical/Surgical technologies subject to Utilization Management</li> </ul>	<ul style="list-style-type: none"> <li>• All MH/SUD technologies subject to Utilization Management</li> </ul>
In-Network Outpatient Services	<ul style="list-style-type: none"> <li>• All Medical/Surgical technologies subject to Utilization Management</li> </ul>	<ul style="list-style-type: none"> <li>• All MH/SUD technologies subject to Utilization Management</li> </ul>

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

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
In-Network Inpatient Services	<p><b>Factors for medical necessity criteria development:</b></p> <ol style="list-style-type: none"> <li>1. Clinical efficacy of the proposed treatment or service</li> <li>2. Safety Risk</li> <li>3. Appropriateness of the proposed technology</li> </ol> <p>The factors are not weighted.</p> <p><i>Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</i></p> <p><b>Factors used to determine whether to adopt a medical policy:</b></p> <ol style="list-style-type: none"> <li>1. Clinical Appropriateness</li> <li>2. Clinical Efficacy</li> <li>3. Safety Risk</li> <li>4. Adoption of new medical/surgical procedures</li> <li>5. Per Member Per Month Cost (PMPM)</li> <li>6. If the procedure is subject to utilization management review</li> </ol> <p><i>Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</i></p> <p><b>Factors used to determine which source to use for the medical</b></p>	<p>Committees consider the following factors when developing, assessing, and approving behavioral clinical policies/clinical criteria:</p> <ol style="list-style-type: none"> <li>1. Clinical effectiveness</li> <li>2. Safety of Services</li> <li>3. Appropriateness of the proposed technology</li> </ol> <p>The factors are not weighted.</p>

	<b>policy:</b> <ol style="list-style-type: none"> <li>1. The grade/rating of a particular medical guideline used to develop the Plan's internal medical policy</li> <li>2. Presence of Systematic Reviews and Randomized Control Trials</li> </ol>	
In-Network Outpatient Services	Same as Inpatient Analysis	Same as Inpatient Analysis

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

Benefit Classification	Evidentiary Standards and Sources: Medical/Surgical	Evidentiary Standards and Sources: MH/SUD
In-Network Inpatient Services	<p><i>Factors for medical necessity criteria development:</i></p> <ol style="list-style-type: none"> <li>1. <b>Clinical efficacy of the proposed treatment or service</b></li> </ol> <p>Clinical efficacy is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. Clinical effectiveness is based on the evidence of clinical trials that the interventions are considered to be effective for the general population.</p> <p><i>Evidentiary Standards:</i> The Plan rates efficacy by the</p>	<p><i>Factors for medical necessity criteria development:</i></p> <p>Evidentiary Standards and Sources:</p> <p>MH/SUD assesses evidence from the following when developing or approving behavioral clinical policies/clinical criteria:</p> <ul style="list-style-type: none"> <li>• Scientifically based clinical evidence</li> <li>• Peer-reviewed literature</li> <li>• Hierarchy of Clinical Evidence: <ul style="list-style-type: none"> <li>○ Systematic reviews and meta-analyses</li> <li>○ Randomized controlled trials</li> <li>○ Large non-randomized controlled trials</li> <li>○ Large prospective trials</li> <li>○ Comparative and cohort studies</li> <li>○ Cross sectional studies</li> <li>○ Retrospective studies</li> </ul> </li> </ul>



	<p>below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition. Class I, "Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective. Class IIa, "Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy."</p> <p>Or rating systems considering efficacy of regimen/agent is moderately effective or higher such as NCCN definition of "Modest impact on survival, but often provides control of disease,." or higher levels of efficacy.</p> <p>2. <b>Safety Risk</b> is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events.</p> <p><i>Evidentiary Standard:</i> Substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.</p>	<ul style="list-style-type: none"> <li>○ Surveillance studies</li> <li>○ Case Reviews/Case series</li> </ul> <ul style="list-style-type: none"> <li>● In the absence of strong and compelling scientific evidence, behavioral clinical policies may be based upon: <ul style="list-style-type: none"> <li>○ National consensus statements</li> <li>○ Publications by recognized authorities such as government sources and/or professional societies</li> </ul> </li> <li>● ASAM®, LOCUS, CALOCUS-CASII, and ECSII (for review of external medical necessity criteria)</li> </ul> <p>Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies/clinical criteria when no other source is available.</p> <p><b><i>Factors used to determine whether to adopt a behavioral clinical policy:</i></b></p> <p>Committees consider the following factors when developing or approving behavioral clinical policies/clinical criteria:</p> <ol style="list-style-type: none"> <li>1. Clinical effectiveness</li> <li>2. Safety of Services</li> <li>3. Appropriateness of the proposed technology</li> </ol> <p>The factors are not weighted.</p> <p>Evidentiary Standards and Sources:</p> <p>MH/SUD assesses evidence from the following when developing behavioral clinical policies/clinical criteria:</p> <ul style="list-style-type: none"> <li>● Scientifically based clinical evidence</li> </ul>
--	--	---



	<p>3. <b>Appropriateness</b> is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level of care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.</p> <p><b>Sources for Safety and Appropriateness:</b></p> <ul style="list-style-type: none"> <li>● Oscar's Clinical Guidelines (<i>see below for factors that determine development of Oscar Medical Policies</i>)</li> <li>● MCG</li> <li>● Hayes, Inc.</li> <li>● Up-to-Date</li> <li>● Authoritative peer-reviewed textbooks &amp; journals</li> <li>● National society guidelines</li> <li>● Agency for Healthcare Research and Quality</li> <li>● National Institutes of Health ("NIH") Consensus Statements</li> <li>● CVS/Caremark Specialty Exceptions Criteria</li> </ul>	<ul style="list-style-type: none"> <li>● Peer-reviewed literature</li> <li>● Hierarchy of Clinical Evidence: <ul style="list-style-type: none"> <li>○ Systematic reviews and meta-analyses</li> <li>○ Randomized controlled trials</li> <li>○ Large non-randomized controlled trials</li> <li>○ Large prospective trials</li> <li>○ Comparative and cohort studies</li> <li>○ Cross sectional studies</li> <li>○ Retrospective studies</li> <li>○ Surveillance studies</li> <li>○ Case Reviews/Case series</li> </ul> </li> <li>● In the absence of strong and compelling scientific evidence, behavioral clinical policies may be based upon: <ul style="list-style-type: none"> <li>○ National consensus statements</li> <li>○ Publications by recognized authorities such as government sources and/or professional societies</li> </ul> </li> <li>● ASAM®, LOCUS, CALOCUS-CASII, and ECSII (for review of external medical necessity criteria)</li> </ul> <p>Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies/clinical criteria when no other source is available.</p> <p><b><i>Factors used to determine which source to use for the behavioral clinical policy:</i></b></p> <p>For MH/SUD, the Clinical Technology Assessment Committee (CTAC) assesses externally developed clinical criteria and develops and approves behavioral clinical policies for MH/SUD services. CTAC uses scientifically based clinical evidence and the <i>Hierarchy of Clinical Evidence</i> in its</p>
--	---	--

	<ul style="list-style-type: none"> <li>● CVS Prior Authorization Criteria</li> <li>● National Comprehensive Cancer Network</li> </ul> <p>The Plan develops clinical guidelines internally that supplement adopted criteria to support Medical Necessity determinations. Additionally, clinical evidence, as defined by published standards and internal plan guidelines are used to support Medical Necessity determinations:</p> <ul style="list-style-type: none"> <li>● The US National Library of Medicine;</li> <li>● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> <li>● Published scientific evidence.</li> </ul> <p><b><i>Factors used to determine whether to adopt a medical policy:</i></b></p> <ol style="list-style-type: none"> <li>1. <b>Clinical Appropriateness</b> is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level of care, and (c) substantiated by nationally recognized</li> </ol>	<p>development, assessment, and approval processes. Scientifically based clinical evidence and the <i>Hierarchy of Clinical Evidence</i> are used to determine which MH/SUD services are safe and effective and, therefore, eligible for benefit coverage. The OBHS <i>Hierarchy of Clinical Evidence</i> details the order in which clinical evidence is preferred when assessing which health services are safe and effective. To be deemed safe and effective, a health service does not need to have evidence in every category.</p>
--	--	--

	<p>guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.</p> <p><i>Sources:</i></p> <ul style="list-style-type: none"> <li>● Oscar's Clinical Guidelines</li> <li>● MCG</li> <li>● Hayes, Inc.</li> <li>● Up-to-Date</li> <li>● Authoritative peer-reviewed textbooks &amp; journals</li> <li>● National society guidelines</li> <li>● Agency for Healthcare Research and Quality</li> <li>● National Institutes of Health ("NIH") Consensus Statements</li> <li>● CVS/Caremark Specialty Exceptions Criteria</li> <li>● CVS Prior Authorization Criteria</li> <li>● National Comprehensive Cancer Network</li> </ul> <p>The Plan develops clinical guidelines internally that supplement adopted criteria to support Medical Necessity determinations. Additionally, clinical evidence, as defined by published standards and internal plan guidelines are used to support Medical Necessity determinations:</p> <ul style="list-style-type: none"> <li>● The US National</li> </ul>	
--	--	--

	<p>Library of Medicine;</p> <ul style="list-style-type: none"> <li>• Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>• Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> <li>• Published scientific evidence.</li> </ul> <p>2. Clinical Efficacy</p> <p><b>Clinical efficacy</b> is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. <b>Clinical effectiveness</b> is based on the evidence of clinical trials that the interventions are considered to be effective for the general population.</p> <p><i>Evidentiary Standards:</i> The Plan rates efficacy by the below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition. Class I, "Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective. Class IIa, "Evidence and/or</p>	
--	--	--

	<p>expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy."</p> <p>Or rating systems considering efficacy of regimen/agent is moderately effective such as NCCN definition of "Modest impact on survival, but often provides control of disease," or higher levels of efficacy.</p> <p><i>Sources:</i> clinical or scientific peer-reviewed literature, Micromedex, NCCN, and national societies/national society guidelines</p> <p>3. <b>Safety Risk</b> is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events.</p> <p><i>Evidentiary Standard:</i> Substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.</p> <p><i>Sources:</i></p> <ul style="list-style-type: none"> <li>● Oscar's Clinical Guidelines</li> <li>● MCG</li> </ul>	
--	--	--

	<ul style="list-style-type: none"> <li>• Hayes, Inc.</li> <li>• Up-to-Date</li> <li>• Authoritative peer-reviewed textbooks &amp; journals</li> <li>• National society guidelines</li> <li>• Agency for Healthcare Research and Quality</li> <li>• National Institutes of Health (“NIH”) Consensus Statements</li> <li>• CVS/Caremark Specialty Exceptions Criteria</li> <li>• CVS Prior Authorization Criteria</li> <li>• National Comprehensive Cancer Network</li> </ul> <p>The Plan develops clinical guidelines internally that supplement adopted criteria to support Medical Necessity determinations. Additionally, clinical evidence, as defined by published standards and internal plan guidelines are used to support Medical Necessity determinations:</p> <ul style="list-style-type: none"> <li>• The US National Library of Medicine;</li> <li>• Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>• Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> </ul>	
--	--	--

	<ul style="list-style-type: none"> <li>Published scientific evidence.</li> </ul> <p><b>4. Adoption of new medical/surgical procedures</b></p> <p><i>Evidentiary Standard:</i> Medical/surgical procedures/drugs on the medical benefit that have the final approval of a licensing or regulatory agency (FDA), strong level of recommendation from consensus panels or national societies, and considered medically necessary by industry standards.</p> <p><i>Sources:</i> FDA, Consensus panels, national societies</p> <p><b>5. Per Member Per Month Cost (PMPM)- low, medium, high</b></p> <p><i>Evidentiary Standard:</i></p> <ul style="list-style-type: none"> <li>Low: &lt; \$0.20 pmpm</li> <li>Medium: &lt;\$0.5 pmpm</li> <li>High: &gt;=\$0.5 pmpm</li> </ul> <p><i>Source:</i> Claims Data</p> <p><b>6. If the procedure is subject to utilization management review</b></p> <p><i>Factors used to determine which source to use for the medical policy:</i></p>	
--	---	--

	<p>1. The grade/rating<sup>1</sup> of a particular medical guideline used to develop the Plan's internal medical policy</p> <p><i>Source:</i> United States Preventive Services Task Force  <i>Evidentiary Standard:</i> Add a guideline with Grade A or B.</p> <p><i>Source:</i> National Society Guidelines:  <i>Evidentiary Standard:</i> Add a guideline with Grade A or B. Add guideline B unless industry standard<sup>2</sup> reveals guidelines are not utilized.</p> <p><i>Source:</i> Hayes  <i>Evidentiary Standard:</i> Add a guideline with Rating A Add a guideline with Rating B, unless industry standard reveals this guideline is not utilized. Add a guideline with Rating C unless industry standard reveals this guideline is not utilized. Reject Rating D.</p>	
--	---	--

<sup>1</sup> Grade Definitions: USPSTF uses the following grading system: Grade A- "The USPSTF recommends the service. There is high certainty that the net benefit is substantial." Grade B- "The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial." Hayes uses the following grading system: Rating A - "Established benefit. Published evidence shows conclusively that safety and impact on health outcomes are comparable to or better than standard treatment/testing. Long-term safety and impact on health outcomes have been established, and other important questions concerning application of the technology have been answered." Rating B- "Some proven benefit. Published evidence indicates that safety and impact on health outcomes are at least comparable to standard treatment/testing. However, there are outstanding questions regarding long-term safety and impact on health outcomes, clinical indications, contraindications, optimal treatment/testing parameters, and/or effects in different patient subpopulations." Rating C - "Potential but unproven benefit. Some published evidence suggests that safety and impact on health outcomes are at least comparable to standard treatment/testing. However, substantial uncertainty remains about safety and/or impact on health outcomes because of poor-quality studies, sparse data, conflicting study results, and/or other concerns." Rating Hayes D1 - No proven benefit and/or not safe. Published evidence shows that the technology does not improve health outcomes or patient management for the reviewed application(s) or is unsafe. D2 - Insufficient evidence. There is insufficient published evidence to assess the safety and/or impact on health outcomes or patient management. For National Society Guidelines, ACC/AHA are examples used for grading guidelines.

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



	<p>2. Presence of Systematic Reviews and Randomized Controlled Trials</p> <p><i>Source:</i> Systematic Reviews/Meta-Analysis  <i>Evidentiary Standard:</i> At least 1 needed that shows level A evidence. Level B rejected if not industry standard.</p> <p><i>Source:</i> Randomized Controlled Trials  <i>Evidentiary Standard:</i> At least 2 or more randomized control trials with statistical significance and evaluated with the GRADE approach or other grading systems for quality of evidence and strength of recommendation that show “high” or “moderate” quality of evidence or “strong” or “moderate” recommendation</p>	
In-Network Outpatient Services	Same as Inpatient Analysis	○ Same as Inpatient Analysis

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

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

Benefit Classification	Committee Composition: Medical/Surgical	Committee Composition: MH/SUD
<p>In Network Inpatient Services/Outpatient Services</p>	<p><b>The following standard processes are used to develop and approve medical necessity criteria:</b></p> <p>Oscar develops clinical guidelines internally that supplement adopted criteria to support Medical Necessity determinations. Internal clinical guidelines are developed by Oscar clinicians, with input from licensed participating Providers in Oscar's Provider Network, or in cases where appropriate clinical expertise is not readily available within the Oscar Provider Network, from independent licensed specialists with the needed clinical expertise. Oscar's internal clinical guidelines require formal approval by the Clinical Advisory Subcommittee, which reports into the Quality Improvement Committee. Internal clinical guidelines are reviewed at least annually and updated as appropriate based on new medical evidence.</p> <p>Oscar Clinical Guidelines and adopted criteria are reviewed and preliminarily approved by the following stakeholders:</p> <ul style="list-style-type: none"> <li>• Vice President and National Medical Director, Clinical Operations (MD)</li> <li>• Senior Manager, Clinical Operations (RN)</li> <li>• Utilization Management Quality Nurse (RN)</li> <li>• Pharmacist, Clinical Policy and Performance (PharmD)</li> </ul>	<p><b>The following standard processes are used to develop and approve medical necessity criteria:</b></p> <p>For MH/SUD, the Clinical Technology Assessment Committee (CTAC) assesses externally developed clinical criteria and develops and approves behavioral clinical policies for MH/SUD services. CTAC uses scientifically based clinical evidence and the <i>Hierarchy of Clinical Evidence</i> in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective services for MH/SUD members.</p> <p>CTAC is comprised of, but is not limited to, behavioral health medical directors, senior leaders of clinical operations and representatives from the clinical quality improvement department, utilization management, clinical operations, appeals, legal, compliance, network strategy, and provider experience teams. The Clinical Quality and Operations Committee (CQOC) reviews and validates clinical policies/clinical criteria endorsed by CTAC.</p> <p>CQOC is comprised of, but is not limited to, Senior Behavioral Health Medical Directors, Senior Leaders of Clinical Operations and representatives from the following areas: Clinical Quality Improvement Department, Utilization Management, Clinical Operations, Appeals, Legal, Compliance, Network Strategy, and Provider Experience. All clinical policies are reviewed annually or more frequently if appropriate. Qualifications of committee members include but are not limited to board certified psychiatrists (MD/DO), Psychologists</p>

	<ul style="list-style-type: none"> <li>• Senior Medical Director, Clinical Review (MD)</li> <li>• State and Regional Medical Directors (MDs or DOs)</li> </ul> <p>Oscar adopted and developed clinical criteria are then presented to the Clinical Advisory Subcommittee for their approval. The Clinical Advisory Subcommittee is chaired by a Senior Medical Director and consists of the following:</p> <ul style="list-style-type: none"> <li>• Internal membership:</li> <li>• Clinical Operations Nurse (RN)</li> <li>• Senior Medical Director, Clinical Review (MD or DO)</li> <li>• State/Regional Medical Directors (MD or DO)</li> <li>• Designated Behavioral Health Physician (MD)</li> <li>• External membership <ul style="list-style-type: none"> <li>○ At least four network participating practitioners (e.g., MDs, DOs)</li> </ul> </li> </ul> <p>Finally, these updates are reported to the UM Subcommittee and ultimately through the Quality Improvement Committee.</p>	(PhD/PsyD), and behavioral health clinicians (graduate degrees and/or RN).
--	---	--

*Briefly describe the processes by which Medical Necessity is applied:*

Benefit Classification	Process Description: Medical/Surgical	Process Description: MH/SUD
In-Network Inpatient	<b>Description of IRR process:</b> All	<b>Description of IRR process:</b>

<p>Services/Outpatient Services</p>	<p>clinicians involved in clinical decision-making participate in annual inter-rater reliability (IRR) testing to ensure high quality, evidence-based decision making and consistent application of clinical criteria across its clinical UM staff. The IRR testing benchmark is 80%, and differences in determinations are used as the basis for quarterly clinical discussion and training. For cases where scores are below benchmark, the cases will be addressed in remediation discussions for continued quality improvement.</p> <p><b>Qualifications of those determining clinical criteria if applicable:</b></p> <p>The Clinical Advisory Subcommittee is chaired by a Senior Medical Director and consists of the following:</p> <ul style="list-style-type: none"> <li>• Internal membership: Clinical Operations Nurse (RN), Senior Medical Director, Clinical Review (MD or DO), State/Regional Medical Directors (MD or DO), Designated Behavioral Health Physician (MD)</li> <li>• External membership: At least four network participating practitioners (e.g., MDs, DOs)</li> </ul> <p>Finally, these changes are reported to the UM Subcommittee and ultimately through the Quality Improvement Committee of the Board.</p> <p><i>The selection and use of external or independent experts:</i></p> <p>All medical clinical guidelines, behavioral health clinical guidelines, and pharmaceutical clinical guidelines are reviewed and approved by OMC physicians, behavioral health practitioners, and pharmacists respectively with input from licensed</p>	<p>All MH/SUD clinical staff who make clinical coverage determinations utilizing behavioral clinical policies/clinical criteria are required to participate in annual Inter-Rater Reliability (IRR) assessment to ensure behavioral clinical policies/criteria are applied in a consistent and appropriate manner “in operation.” Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager.</p> <p><b>Qualifications of those determining clinical criteria if applicable:</b></p> <p>CQOC is comprised of, but is not limited to, Senior Behavioral Health Medical Directors, Senior Leaders of Clinical Operations and representatives from the following areas: Clinical Quality Improvement Department, Utilization Management, Clinical Operations, Appeals, Legal, Compliance, Network Strategy, and Provider Experience. Qualifications of committee members include but are not limited to board certified psychiatrists (MD/DO), Psychologists (PhD/PsyD), and licensed behavioral health clinicians (graduate degrees and/or RN).</p> <p><i>The selection and use of external or independent experts:</i></p> <p>All behavioral health clinical criteria are reviewed and approved by OBHS Medical Directors and behavioral health practitioners with input from licensed providers, or in cases where appropriate</p>
-------------------------------------	--	---

	Providers, or in cases where appropriate clinical expertise is not readily available, from independent licensed specialists with the needed clinical expertise.	clinical expertise is not readily available, from independent licensed specialists with the needed clinical expertise.
--	---	--

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

Benefit Classification	Comparative Analysis
In-Network Inpatient Services/Outpatient Services	<p>The Plan performs clinical inter-rater reliability testing and ensures processes for the development or adoption of medical necessity criteria and subsequent determinations are applied consistently across each benefit classification for mental health/substance use disorder services and medical/surgical services.</p> <p><b>Scheduled Policy Reviews:</b> All criteria are evaluated at least annually to ensure they reflect current scientific knowledge.</p> <p><b><u>Medical/Surgical:</u></b></p> <p>The Plan uses documented clinical review criteria based on sound clinical evidence to make utilization management decisions, including medical necessity coverage determinations. All clinicians involved in clinical decision-making participate in annual inter-rater reliability (IRR) testing to ensure high quality, evidence-based decision making and consistent application of clinical criteria across its clinical UM staff. The IRR testing benchmark is 80%, and differences in determinations are used as the basis for quarterly clinical discussion and training. For cases where scores are below benchmark, the cases will be addressed in remediation discussions for continued quality improvement.</p> <p><b><u>MH/SUD:</u></b></p> <p>M/S and MH/SUD utilize medical/clinical policies when making medical necessity coverage determinations related to M/S and MH/SUD technologies. All M/S and MH/SUD clinical staff who make coverage determinations utilizing medical/clinical policies are required to participate in annual Inter-Rater Reliability (IRR) audits to ensure policies/criteria are applied in a consistent and appropriate manner “in operation.” For clinical staff who do not achieve a passing score of 90%, remediation may include re-education, additional mentoring, additional chart audits and call monitoring to provide clinical education and guidance on the use and application of the relevant policies/criteria.</p>

	Inter-rater reliability scores clinical reviewers (M/S) 2022:	Inter-rater reliability scores clinical reviewers (MH/SUD) 2022:
	<ul style="list-style-type: none"> <li>Average IRR score: 92.0%</li> </ul>	<ul style="list-style-type: none"> <li>Average IRR score: 96%</li> </ul>

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

Benefit Classification	Findings/Conclusions
In-Network Inpatient Services/Out patient Services	<p>The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:</p> <ol style="list-style-type: none"> <li>1. The factors, sources, and evidentiary standards used to develop medical necessity criteria are aligned.</li> <li>2. As written, the Plan performs clinical inter-rater reliability testing and ensures processes for the development or adoption of medical necessity criteria and subsequent determinations are applied consistently across each benefit classification for mental health/substance use disorder services and medical/surgical services.</li> <li>3. In-operation, the Plan performs in-operation data assessments to ensure that the underlying methodology for developing medical necessity criteria is applied no more strictly to MH/SUD services when compared to M/S services.</li> </ol> <p>Findings/Conclusion: The findings of the comparative analysis reveal that the methodology for medical necessity criteria development for MH/SUD benefits is comparable to, and applied no more stringently than, the methodology for medical necessity criteria for M/S benefits. When reviewing the inter-rater reliability testing scores for clinical-decision making in 2021, medical reviewers' and behavioral health reviewers' average IRR scores met the relative benchmarks of 80% and 90% respectively. Medical clinical reviewers scored an average IRR score of 92% for 2022, while behavioral health clinical reviewers scored an average IRR score of 96%. Inter-rater reliability testing is employed to ensure high quality, evidence-based decision making and consistent application of clinical criteria across its clinical UM staff. Since behavioral health clinical reviewers achieved an average score of 96% and medical clinical reviewers achieved an</p>

	average score of 92%, there is evidence that reviewers apply consistent evidence-based decision-making when rendering medical necessity determinations. Thus, the underlying processes, strategies, evidentiary standards and other factors as-written and in-operation used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA.
--	---

Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Retrospective Review
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Clinical
Names of Person(s) Responsible for Analysis Formation	<p><b>Oscar:</b>  Insiya Taj, MPH, Associate, UM Optimization, (Over 5 years experience in healthcare and clinical research)  David Schaffzin, MD, Associate Medical Director, Utilization Management</p> <p><b>Optum Behavioral Health Solutions:</b>  Positions: Chief Medical Officer, National Senior Behavioral Medical Directors (MD), VP Benefits Integrity, VP, Outpatient and Specialty Programs, Director MH Parity and Benefits, Legal Counsel, and Senior Director, National Policy and Standards.  Credentials: Board Certified MDs, Licensed Psychologist, Licensed Nurse, Licensed Social Worker, and National Certified Counselor.</p>
Last Update	12/20/23
Reviewers	<p>Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)</p> <p>Laura Barry MHA, RN, BSN, CCM, CPC, Manager, Clinical Policy</p>





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

**Retrospective Review**

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

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

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
In-Network Inpatient Services	<ul style="list-style-type: none"> <li>● Acute/Elective Hospital</li> <li>● Hospice Long-Term Acute Care</li> <li>● Rehabilitation</li> <li>● Acute/Subacute</li> <li>● Skilled Nursing Facility</li> <li>● Procedures/Treatments/Surgeries, when place of service is inpatient</li> </ul>	<ul style="list-style-type: none"> <li>● MH Non-Emergent Acute Inpatient</li> <li>● MH Subacute Residential Treatment</li> <li>● SUD Acute Inpatient Detoxification</li> <li>● SUD Acute Inpatient Rehabilitation</li> <li>● SUD Subacute Residential Treatment</li> </ul> <p>Of note: MH/SUD conducts retrospective review when a service requires authorization, but the INN provider did not obtain authorization and the reason for lack of authorization meets criteria for an exception.</p> <p>MH/SUD may conduct retrospective review when the services indicated on a claim do not match an authorization that was previously provided.</p>
	<ul style="list-style-type: none"> <li>● Physician-Administered Drugs</li> <li>● Certain DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) such as oxygen, CPAP, and diabetic supplies</li> <li>● Home Health Care Services</li> <li>● Advanced Imaging</li> <li>● Home-Based Speech Therapy</li> <li>● Physical Therapy</li> <li>● Occupational Therapy</li> <li>● Diagnostic Tests &amp; Evaluations, Laboratory Procedures</li> <li>● Non-Emergency Transportation</li> <li>● Unlisted Procedures</li> </ul>	<ul style="list-style-type: none"> <li>● Applied Behavioral Analysis (ABA)</li> <li>● Psychological Testing</li> <li>● Partial Hospitalization (PHP)/Day Treatment</li> <li>● Intensive Outpatient (IOP)</li> <li>● Transcranial Magnetic Stimulation (TMS)</li> <li>● Electroconvulsive Therapy (ECT)</li> <li>● Physical Therapy<sup>1</sup></li> <li>● Occupational Therapy<sup>2</sup></li> </ul> <p>Of note: MH/SUD conducts retrospective review when a service requires authorization, but the INN provider did not obtain authorization and the reason</p>
In-Network Outpatient Services		

<sup>1</sup> Subject to MH/SUD benefit if contains MH/SUD diagnosis

<sup>2</sup> Subject to MH/SUD benefit if contains MH/SUD diagnosis

	<ul style="list-style-type: none"> <li>Procedures/Treatments/Surgeries, when place of service is outpatient</li> </ul>	for lack of authorization meets criteria for an exception.
--	--	--

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

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
In-Network Inpatient Services	<ol style="list-style-type: none"> <li>Safety risk</li> <li>Clinical appropriateness</li> <li>Cost</li> </ol> <p>Note: The factors are not weighted.</p>	<ol style="list-style-type: none"> <li>Clinical Appropriateness: OBHS has approved medical necessity criteria to be used in retrospective review and the application of retrospective review promotes optimal clinical outcomes</li> <li>Value: The cost of the service exceeds the costs of conducting a retrospective review</li> </ol> <p>Note: The factors are not weighted.</p>
In-Network Outpatient Services	<ol style="list-style-type: none"> <li>Cost variability</li> <li>Denial rate</li> <li>Cost percentile</li> <li>Safety risk</li> <li>New/emerging service/technology</li> <li>Clinical appropriateness</li> </ol>	<ol style="list-style-type: none"> <li>Clinical Appropriateness: OBHS has approved medical necessity criteria to be used in retrospective review and the application of retrospective review promotes optimal clinical outcomes</li> <li>Value: The cost of the service exceeds the costs of conducting a retrospective review</li> <li>Variation: Variability in cost per episode of service relative to other services within the classification of benefits.</li> </ol> <p>Note: The factors are not weighted.</p>

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

Benefit Classification	Evidentiary Standards and Sources: Medical/Surgical	Evidentiary Standards and Sources: MH/SUD
In-Network Inpatient Services	<p>1. <b>Clinical appropriateness</b> is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level of care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>As per World Professional Association for Transgender Health (WPATH) guidelines,</li> </ul>	<p>1. <b>Clinical Appropriateness: The application of retrospective review promotes optimal clinical outcomes</b> is defined as those inpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.</p> <p>This factor is utilized to determine which services may be subject to retrospective review. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the retrospective review list if there are objective, evidence-based clinical criteria to be used in the retrospective reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed</p>

	<p>prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines.</p> <ul style="list-style-type: none"> <li>● As per the American Psychological Association (APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder.</li> <li>● As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of cancer and individualized needs as documented in the medical record.</li> </ul> <p>Sources: Clinical criteria, Clinical evidence</p> <p>Evidentiary Standards:</p> <p>Clinical criteria</p> <ul style="list-style-type: none"> <li>● Plan Clinical Guidelines</li> <li>● MCG</li> <li>● ASAM (SUD only)</li> <li>● Hayes</li> <li>● UpToDate</li> <li>● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)</li> </ul> <p>Clinical evidence</p> <ul style="list-style-type: none"> <li>● The US National Library of Medicine;</li> <li>● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>● Guidance or regulatory status published by Government</li> </ul>	<p>technology are used to approve and develop Medical Necessity Criteria on which reviews are based.</p> <p>Evidentiary Standard and Sources:</p> <ul style="list-style-type: none"> <li>● Clinical criteria from nationally recognized third-party sources (e.g., ASAM®, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)</li> <li>● Clinical Technology and Assessment Committee (CTAC) review</li> <li>● Objective, evidence-based policies, and publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies</li> </ul> <p>Note: These standards are considered and used to define the Clinical Appropriateness factor. These standards are not defined in a quantitative manner.</p> <p>Clinical Evidence Used:</p> <ul style="list-style-type: none"> <li>● Systematic reviews and meta analyses</li> <li>● Randomized controlled trials</li> <li>● Large non-randomized controlled trials</li> <li>● Large prospective trials</li> <li>● Comparative and cohort studies</li> <li>● Cross sectional studies</li> <li>● Retrospective studies</li> <li>● Surveillance studies</li> <li>● Case Reviews/Case series</li> <li>● Anecdotal/editorial statements</li> <li>● Professional opinions</li> </ul> <p>In the absence of strong and compelling scientific evidence, clinical policies may be based upon:</p>
--	--	---

	<p>Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</p> <ul style="list-style-type: none"> <li>• Published scientific evidence;</li> <li>• In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Physical Therapy/Occupational Therapy</li> <li>• Gender affirming surgeries</li> <li>• Confirming member has undergone hormone therapy and counseling</li> <li>• Mastectomy - appropriate in most cases, but need to review for medical necessity</li> <li>• Physician-administered drugs</li> <li>• Level of care setting</li> </ul> <p>Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Public Health Service Act (PHS Act) section 2719A generally provides, among other things, that if a group health plan or health insurance coverage provides any benefits for emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without regard to whether a particular health care provider is an in-network provider with respect to the services, and generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network.</li> </ul>	<ul style="list-style-type: none"> <li>• National consensus statements</li> <li>• Publications by recognized authorities such as government sources and/or professional societies</li> </ul> <p><b>2. Value</b> is defined as the cost of subjecting the inpatient services to retrospective review meets or exceeds the administrative costs by at least 1:1. Consideration of this factor includes a review of national inpatient authorization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when retrospective review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering retrospective review to determine value.</p> <p>Sources: National internal claims data, national UM program operating costs, and national UM authorization data</p> <p>Evidentiary Standard: Value is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the service to retrospective review by at least 1:1</p>
--	---	---

	<ul style="list-style-type: none"> <li>• The Affordable Care Act mandates that health plans cover recommended preventive services without charging a deductible, copayment, or co-insurance.</li> </ul> <p><b>3. High Cost</b></p> <p>Evidentiary Standard: The mean cost of an inpatient episode of care is &gt;\$12,000</p> <p>Source: claims data</p> <p>2. <b>Safety Risk</b> is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The authorization process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered. If there is a less restrictive level of care available to meet the member's health needs, authorization may be applied to ensure the member receives the least restrictive level of care that is clinically appropriate.</p> <p>Sources: National societies and health agencies, Clinical criteria<sup>3</sup>, Clinical evidence<sup>4</sup></p>	
--	---	--

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

<sup>4</sup> Clinical evidence: The US National Library of Medicine; Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN); Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS,

	<ul style="list-style-type: none"> <li>● Centers for Medicare &amp; Medicaid Services</li> <li>● World Health Organization</li> <li>● Institute For Safe Medication Practices</li> <li>● U.S. Food and Drug Administration</li> <li>● Drug labeling / safety information</li> </ul> <p>Evidentiary Standards:</p> <ul style="list-style-type: none"> <li>● Treatments that increase the likelihood of adverse health effects</li> <li>● Services that increase the likelihood of perioperative morbidity and mortality</li> <li>● Procedures, such as high-risk operations, that carry a mortality rate of 5% or more.</li> <li>● Procedures with significant or major impact on hemodynamics, fluid shifts, possible major blood loss.</li> <li>● Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse.</li> </ul> <p><i>Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017 (<a href="http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf">http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf</a>).</i></p>	
--	--	--

---

FDA, NIH); Published scientific evidence;In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).



<p>In-Network Outpatient Services</p>	<p>1. <b>Clinical appropriateness</b> is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level of care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>● As per World Professional Association for Transgender Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines.</li> <li>● As per the American Psychological Association (APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder.</li> <li>● As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of</li> </ul>	<p>1. <b>Clinical Appropriateness</b> is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.</p> <p>This factor is utilized to determine which services may be subject to retrospective review. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the retrospective review list if there are objective, evidence-based clinical criteria to be used in the retrospective reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed technology are used to approve and develop Medical Necessity Criteria on which reviews are based.</p> <p>Evidentiary Standard and Sources:</p> <ul style="list-style-type: none"> <li>○ Clinical criteria from nationally recognized third-party sources (e.g., ASAM®, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)</li> <li>○ Clinical Technology and Assessment Committee (CTAC) review</li> <li>○ Objective, evidence-based policies, and publications and</li> </ul>
---------------------------------------	---	---

	<p>cancer and individualized needs as documented in the medical record.</p> <p>Evidentiary Standards:</p> <p>Clinical criteria</p> <ul style="list-style-type: none"> <li>● Plan Clinical Guidelines</li> <li>● MCG</li> <li>● ASAM (SUD only)</li> <li>● Hayes</li> <li>● UpToDate</li> <li>● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)</li> </ul> <p>Clinical evidence</p> <ul style="list-style-type: none"> <li>● The US National Library of Medicine;</li> <li>● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> <li>● Published scientific evidence;</li> <li>● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li>● Physical Therapy/Occupational Therapy</li> <li>● Gender affirming surgeries</li> <li>● Confirming member has undergone hormone therapy and counseling</li> <li>● Mastectomy - appropriate in most cases, but need to review for medical necessity</li> </ul>	<p>guidelines by nationally recognized authorities, such as government sources and/or professional societies</p> <p>Note: The evidentiary standards and sources are not defined in a quantitative manner.</p> <p>Clinical Evidence Used:</p> <ul style="list-style-type: none"> <li>● Systematic reviews and meta analyses</li> <li>● Randomized controlled trials</li> <li>● Large non-randomized controlled trials</li> <li>● Large prospective trials</li> <li>● Comparative and cohort studies</li> <li>● Cross sectional studies</li> <li>● Retrospective studies</li> <li>● Surveillance studies</li> <li>● Case Reviews/Case series</li> <li>● Anecdotal/editorial statements</li> <li>● Professional opinions</li> </ul> <p>In the absence of strong and compelling scientific evidence, clinical policies may be based upon:</p> <ul style="list-style-type: none"> <li>● National consensus statements</li> <li>● Publications by recognized authorities such as government sources and/or professional societies</li> </ul> <p>2. <b>Value</b> is defined as the cost of subjecting the outpatient services to retrospective review exceeds the administrative costs. Consideration of this factor includes a review of national outpatient authorization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when retrospective review is applied. The</p>
--	--	---

	<ul style="list-style-type: none"> <li>• Physician-administered drugs</li> <li>• Level of care setting</li> </ul> <p>Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Public Health Service Act (PHS Act) section 2719A generally provides, among other things, that if a group health plan or health insurance coverage provides any benefits for emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without regard to whether a particular health care provider is an in-network provider with respect to the services, and generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network.</li> <li>• The Affordable Care Act mandates that health plans cover recommended preventive services without charging a deductible, copayment, or co-insurance.</li> </ul> <p><b>2. Denial rate</b> is defined as the percentage of prior authorization requests that are denied by the Plan.</p> <p>Source: Prior authorization data Evidentiary Standard: &gt;10%</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Benefit: Medical/Surgical</li> </ul>	<p>projected benefit cost savings is reviewed relative to the operating cost of administering retrospective review to determine value.</p> <p>Sources: National internal claims data, national UM program operating costs, and national UM authorization data</p> <p>Evidentiary Standard: Value is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the service to retrospective review by at least 1:1</p> <p>3. <b>Variation</b> is defined as the cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services that are provided to a minimum of 50 unique plan members.</p> <p>Source: National internal claims data</p> <p>Evidentiary Standard: Variation is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services that are provided to a minimum of 50 unique members (the materiality threshold established for purposes of the variation analysis).</p>
--	---	--

	<p>Service: Outpatient  Services: Treatments &amp;  Procedures: Skin  Treatments &amp; Procedures    UV / Laser therapy  Denial rate applies to this  service category. Denial  rate is 70% for this  service category.</p> <ul style="list-style-type: none"> <li>Benefit: Mental  Health/Substance Use  Disorder  Service: Partial  Hospitalization  Denial rate applies to this  service category. Denial  rate is 60% for this  service category.</li> </ul> <p>3. <b>Cost variability</b> is defined as the cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members. Outpatient services are subject to variability in cost per episode of service relative to other services within the classification of benefits. For each service, the Plan calculates the Average Annual Allowed Amount per Unique Patient with Outpatient Claim Events for that Primary Service.</p> <p>Source: Claims data</p> <p>Evidentiary Standard: Cost per episode of service that triggers 2x the mean of other outpatient services.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>Benefit: Medical/Surgical  Service: Outpatient Services:  Treatments &amp; Procedures:  Musculoskeletal Surgery   Joint  arthroscopy / arthroplasty /</li> </ul>	
--	--	--

	<p>arthrodesis Cost variability applies to this service category. Cost variability is 5x the mean of other outpatient services.</p> <ul style="list-style-type: none"> <li>Benefit: Mental Health/Substance Use Disorder Service: Outpatient Psychiatric Testing Cost variability applies to this service category. Cost variability is 2.9x the mean of other outpatient services.</li> </ul> <p><b>4. Cost percentile</b> is defined as the average cost per claim event for a particular outpatient service relative to other services within the classification of benefits.</p> <p>Source: Claims data</p> <p><b>Evidentiary Standard: ≥ 85th Percentile</b></p> <p>Examples:</p> <ul style="list-style-type: none"> <li>Benefit: Medical/Surgical Service: Outpatient Services: Treatments &amp; Procedures: Digestive Treatments &amp; Procedures   Bariatric surgery Cost percentile applies to this service category. Cost is in the 100th percentile for this service category.</li> <li>Benefit: Mental Health/Substance Use Disorder Service: Outpatient psychiatric testing</li> </ul>	
--	---	--

	<p>Cost percentile applies to this service category. Cost is in the 100th percentile for this service category</p> <p><b>5. Safety risk</b> is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The authorization process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered.</p> <p>Sources: National societies and health agencies, Clinical criteria<sup>5</sup>, Clinical evidence<sup>6</sup></p> <ul style="list-style-type: none"> <li>● Centers for Medicare &amp; Medicaid Services</li> <li>● World Health Organization</li> <li>● Institute For Safe Medication Practices</li> <li>● U.S. Food and Drug Administration</li> <li>● Drug labeling / safety information</li> </ul> <p>Evidentiary Standards:</p> <ul style="list-style-type: none"> <li>● Treatments that increase the likelihood of adverse health effects</li> <li>● Services that increase the likelihood of perioperative morbidity and mortality</li> <li>● Procedures, such as high-risk operations, that carry a mortality rate of 5% or more.</li> <li>● Procedures with significant or major impact on hemodynamics, fluid</li> </ul>	
--	--	--

	<p>shifts, possible major blood loss.</p> <ul style="list-style-type: none"> <li>• Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse.</li> </ul> <p><i>Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017 (<a href="http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf">http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf</a>).</i></p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Surgical procedures at risk for infection and complications (e.g., gastrectomy, hip replacement)</li> <li>• Advanced radiology procedures with exposure to radiation (e.g., CT, MRI, nuclear medicine)</li> <li>• Physician-administered drugs due to the risk for adverse effects and contraindications (e.g., chemotherapeutic agents)</li> </ul> <p><b>6. New/ Emerging Service/ Technology</b> is defined as any health care service, testing, procedure, treatment, device or prescription drug for which safety and efficacy has not been established and proven is considered experimental, investigational, or unproven. Services that are not accepted as the standard medical treatment of the condition being treated are considered “new and</p>	
--	---	--

	<p>emerging services and technologies.” This includes any health care service, testing, procedure, treatment, device, or prescription drug that:</p> <ul style="list-style-type: none"> <li>● Is not accepted as standard medical treatment of the condition; or</li> <li>● Has not been approved by the U.S. Food and Drug Administration (FDA) to be lawfully used; or</li> <li>● Has not been identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or</li> <li>● Requires review and approval by any institutional review board (IRB) for the proposed use or are subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations; or</li> <li>● Requires any Federal or other governmental agency approval not listed above that has not been and will not be granted at the time services will be provided.</li> </ul> <p>Sources: Clinical criteria, Clinical evidence</p> <p>Evidentiary Standards:</p> <p>Clinical criteria</p> <ul style="list-style-type: none"> <li>● Plan Clinical Guidelines</li> <li>● MCG</li> <li>● ASAM (SUD only)</li> <li>● Hayes</li> <li>● UpToDate</li> <li>● National Society Guidelines (e.g., ACOG, APA, NCCN,</li> </ul>	
--	---	--



	<p>WPATH)</p> <p>Clinical evidence</p> <ul style="list-style-type: none"> <li>● The US National Library of Medicine;</li> <li>● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> <li>● Published scientific evidence;</li> <li>● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li>● Genetic, biomarker and molecular tests</li> <li>● Medical devices and implants</li> <li>● Novel therapies (e.g., gene therapy, CAR T-Cell therapy)</li> </ul>	
--	--	--

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

### **Inpatient M/S**

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

### **Outpatient M/S**

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

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

### **Inpatient MH/SUD**

	Clinical Appropriateness	Value
Inpatient, MH	<b>X</b>	<b>X</b>
Inpatient, SUD	<b>X</b>	<b>X</b>
Residential, MH	<b>X</b>	<b>X</b>
Residential, MH	<b>X</b>	<b>X</b>

### **Outpatient MH/SUD**

	Clinical Appropriateness	Value	Variation
Partial Hospitalization/Day Treatment	<b>X</b>	<b>X</b>	<b>X</b>
Intensive Outpatient	<b>X</b>	<b>X</b>	<b>X</b>

Applied Behavior Analysis (ABA)	<b>X</b>	<b>X</b>	<b>X</b>
Transcranial Magnetic Stimulation (TMS)	<b>X</b>	<b>X</b>	<b>X</b>
Electroconvulsive Therapy (ECT)	<b>X</b>		<b>X</b>
Psychological Testing	<b>X</b>	<b>X</b>	

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

<b>Retro Process M/S</b>	<b>Retro Review Process MH/SUD</b>
<p>A retrospective review is conducted when the Plan receives a request for coverage of medical care or services that have already been received, or when prior authorization was required but not obtained and a claim was submitted for the service. A written notification is issued to the member and provider within state, federal, or accreditation required timeframes; the written notification includes information on appeal rights. The Plan follows all state, federal, and accreditation timeframe requirements. After an adverse determination has been issued, the Plan offers the opportunity for the provider to discuss the request with a Plan physician. This peer to peer discussion is not considered part of a grievance or appeal process.</p>	<p>OBHS may approve services that do not require clinical evaluation or interpretation. If OBHS cannot approve the services because they require clinical evaluation or interpretation, the case is referred to a clinical reviewer. The services will receive a medical necessity review based on the clinical records provided. OBHS may gather more clinical information. The clinical reviewer uses applicable member clinical information, benefit plan documents, and medical necessity criteria in the case reviews.</p> <p>If OBHS cannot approve the services after clinical review, then the adverse determination is communicated to the member and provider consistent with state, federal and accreditation requirements, including appeal rights.</p> <p><b>**Note:</b> Optum Behavioral Health (OBH) generally structures UM processes to comply with Federal ERISA requirements, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.</p>

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

Committee Information M/S	Committee Information MH/SUD
<p>The OMC Board of Directors has the ultimate authority and responsibility for the quality of care and services delivered to its members. The Board of Directors provides strategic planning and direction, budget approval, and staff allocation for the UM Department. The Board of Directors assigns day-to-day responsibility for implementation of the UM Program to the UM Subcommittee, which is a subcommittee of the Quality Improvement Committee. The Board of Directors oversees the implementation of and adherence to the UM Program through the UM Subcommittee. The UM Subcommittee reports to the Quality Improvement Committee at a minimum of once per quarter, per year. The UM Program and Annual Program Evaluation are approved at the UM Subcommittee portion of the Quality Improvement Committee meeting. Minutes conveying this approval are submitted to the Board of Directors, who approve the actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical).</p> <p>As noted above, the UM Subcommittee is a subcommittee to the Quality Improvement Committee. A senior-level physician chairs the UM Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary.</p>	<p>OBHS monitors its retrospective review program performance through its clinical business performance oversight functions. In addition, OBHS national committees review overall UM program performance, including retrospective review, at least annually. This process is overseen by the Clinical Quality and Operations Committee (CQOC). CQOC receives oversight from the Quality Improvement Committee (QIC). Appointed by the Chief Medical Officer, a senior-level licensed psychiatrist (MD) Medical Director Chairs the CQOC along with a Vice Chair (PhD, MBA) who is a senior leader of clinical operations responsible for UM activities. Voting membership includes representation from licensed and board-certified psychiatrists (MDs), licensed Psychologists (PhDs) and a licensed nurse (RN). Committee voting membership includes participants from the following areas: Clinical Technology Assessment Committee (MDs), Clinical Criteria (LCSW, MSN, RN, PMHNP-BC), Clinical Operations of Direct Sites (MBA), Utilization Management (PhD), Senior Leader Quality Improvement (PhD), Appeals, Care Engagement Medical Operations (MD) and Medical Operations for UM (MD). Additional internal department representatives attend as non-voting membership, including Legal Counsel, Compliance, Accreditation, the Operational Policy and Standards Committee, Network Strategy and Benefits Integrity. The CQOC meets monthly and ad hoc, as necessary.</p> <p>The CQOC undertakes, but is not limited to, the following ongoing activities:</p> <ul style="list-style-type: none"> <li>● Oversees the development and implementation of a National Utilization Management (UM) Program (NUMP) with the Utilization Management Program Description (UMPD) serving as the source document for the NUMP</li> </ul>

<p>The UM Subcommittee undertakes, but is not limited to, the following ongoing activities:</p> <ul style="list-style-type: none"> <li>• Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated.</li> <li>• Reviews and approves modifications to the UM Program as indicated by operational needs and/or to meet regulatory and accreditation compliance.</li> <li>• Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services.</li> <li>• Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.</li> </ul>	<ul style="list-style-type: none"> <li>• Proposes and evaluates UM-related Clinical QIAs</li> <li>• Evaluates the effectiveness and efficiency of our UM program across all business operation sites</li> <li>• Ensures the standardization of our UM program across all business operation sites</li> <li>• Reviews Operational Policy and Standards Committee policies related to UM management as necessary</li> <li>• Reviews, recommends, and votes on Clinical Criteria</li> <li>• Review and approval of prior authorization requirements</li> </ul>
--	---

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

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

	<table border="1" data-bbox="407 205 1404 415"> <tr> <th data-bbox="407 205 870 310">Inter-rater reliability scores clinical reviewers (M/S) 2022:</th><th data-bbox="870 205 1404 310">Inter-rater reliability scores clinical reviewers (MH/SUD) 2022:</th></tr> <tr> <td data-bbox="407 310 870 415"> <ul style="list-style-type: none"> <li>Average IRR score: 92%</li> </ul> </td><td data-bbox="870 310 1404 415"> <ul style="list-style-type: none"> <li>Average IRR score: 96%</li> </ul> </td></tr> </table> <p data-bbox="407 493 1502 709">In completing its annual MHPAEA filings in many states, the Plan performs a variety of self-assessments and mandatory in-operation analyses as required by each regulatory recipient. Because the Plan's benefit designs and internal practices are consistent across markets, the findings of these self-assessments and analyses are largely consistent across markets and serve as a validation mechanism for MHPAEA compliance more broadly.</p> <p data-bbox="407 745 1502 1075">Operationally, the Plan performs in-operation data assessments to make sure that factors, sources, and evidentiary standards are applied in a consistent manner. The Plan reviews denial rates, informal reconsideration statistics, and overturned appeal rates for retrospective review across all commercial plans and compares these metrics for med/surg benefits against MH/SUD benefits. While data outcomes are not determinative of mental health parity compliance, the Plan uses these metrics to guide if investigations into UM processes are necessary to ensure that underlying methodology for UM procedures are not more stringent toward behavioral health services.</p> <p data-bbox="407 1113 527 1150">Findings:</p> <table border="1" data-bbox="407 1186 1481 1711"> <tr> <th data-bbox="407 1186 922 1291"><u>Medical/Surgical: Retrospective Review</u></th><th data-bbox="922 1186 1481 1291"><u>MH/SUD: Retrospective Review</u></th></tr> <tr> <td data-bbox="407 1291 922 1711"> <p data-bbox="407 1312 738 1350">Post service denial rates:</p> <ul style="list-style-type: none"> <li>Total # of requests: <b>9,507</b></li> <li>Total # of requests denied: <b>4,005</b></li> <li>% of requests denied: <b>42%</b></li> </ul> <p data-bbox="407 1543 852 1623">Overturned appeal rates (includes partially overturned):</p> <ul style="list-style-type: none"> <li>Total # overturned: <b>671</b></li> <li>Overturn rate (%): <b>38%</b></li> </ul> </td><td data-bbox="922 1291 1481 1711"> <p data-bbox="922 1270 1258 1308">Post service denial rates:</p> <ul style="list-style-type: none"> <li>Total # of requests: <b>1,441</b></li> <li>Total # of requests denied: <b>43</b></li> <li>% of requests denied: <b>3%</b></li> </ul> <p data-bbox="922 1470 1372 1549">Overturned appeal rates (includes partially overturned):</p> <ul style="list-style-type: none"> <li>Total # overturned: <b>521</b></li> <li>Overturn rate (%): <b>56.8%</b></li> </ul> </td></tr> </table>	Inter-rater reliability scores clinical reviewers (M/S) 2022:	Inter-rater reliability scores clinical reviewers (MH/SUD) 2022:	<ul style="list-style-type: none"> <li>Average IRR score: 92%</li> </ul>	<ul style="list-style-type: none"> <li>Average IRR score: 96%</li> </ul>	<u>Medical/Surgical: Retrospective Review</u>	<u>MH/SUD: Retrospective Review</u>	<p data-bbox="407 1312 738 1350">Post service denial rates:</p> <ul style="list-style-type: none"> <li>Total # of requests: <b>9,507</b></li> <li>Total # of requests denied: <b>4,005</b></li> <li>% of requests denied: <b>42%</b></li> </ul> <p data-bbox="407 1543 852 1623">Overturned appeal rates (includes partially overturned):</p> <ul style="list-style-type: none"> <li>Total # overturned: <b>671</b></li> <li>Overturn rate (%): <b>38%</b></li> </ul>	<p data-bbox="922 1270 1258 1308">Post service denial rates:</p> <ul style="list-style-type: none"> <li>Total # of requests: <b>1,441</b></li> <li>Total # of requests denied: <b>43</b></li> <li>% of requests denied: <b>3%</b></li> </ul> <p data-bbox="922 1470 1372 1549">Overturned appeal rates (includes partially overturned):</p> <ul style="list-style-type: none"> <li>Total # overturned: <b>521</b></li> <li>Overturn rate (%): <b>56.8%</b></li> </ul>
Inter-rater reliability scores clinical reviewers (M/S) 2022:	Inter-rater reliability scores clinical reviewers (MH/SUD) 2022:								
<ul style="list-style-type: none"> <li>Average IRR score: 92%</li> </ul>	<ul style="list-style-type: none"> <li>Average IRR score: 96%</li> </ul>								
<u>Medical/Surgical: Retrospective Review</u>	<u>MH/SUD: Retrospective Review</u>								
<p data-bbox="407 1312 738 1350">Post service denial rates:</p> <ul style="list-style-type: none"> <li>Total # of requests: <b>9,507</b></li> <li>Total # of requests denied: <b>4,005</b></li> <li>% of requests denied: <b>42%</b></li> </ul> <p data-bbox="407 1543 852 1623">Overturned appeal rates (includes partially overturned):</p> <ul style="list-style-type: none"> <li>Total # overturned: <b>671</b></li> <li>Overturn rate (%): <b>38%</b></li> </ul>	<p data-bbox="922 1270 1258 1308">Post service denial rates:</p> <ul style="list-style-type: none"> <li>Total # of requests: <b>1,441</b></li> <li>Total # of requests denied: <b>43</b></li> <li>% of requests denied: <b>3%</b></li> </ul> <p data-bbox="922 1470 1372 1549">Overturned appeal rates (includes partially overturned):</p> <ul style="list-style-type: none"> <li>Total # overturned: <b>521</b></li> <li>Overturn rate (%): <b>56.8%</b></li> </ul>								

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

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



One factor, new/emerging services, is considered for medical/surgical services but not for mental health services. The Plan has concluded that this does not result in more stringency towards mental health/substance use disorder benefits because this factor could trigger additional services becoming subject to retrospective review for medical/surgical benefits.

Operationally, the Plan performs in-operation data assessments for retrospective review procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across M/S and MH/SUD services. The Plan concludes that in-operation, its methodology for retrospective review for mental health/substance use disorder services is comparable to and applied no more stringently than the methodology for retrospective review applied to medical/surgical services. A comparison of denial rates (including partial denials) reveals that retrospective review denial rates for M/S services are higher compared to denial rates of MH/SUD services indicating higher approval rates for MH/SUD benefits (42% v. 3%). This reveals that more services are denied when they are M/S services compared to MH/SUD services. Finally, overturned appeals are higher for MH/SUD services when compared to M/S services (56.8% v. 38%) indicating that more appealed services are approved for MH/SUD benefits. The outcome measures show comparability (or in this case are more favorable to behavioral health benefits) in processes for retrospective review because the metrics reveal more favorable outcomes for MH/SUD benefits with higher rates of approval for services overall.

The Plan is responsible for coordinating responses to non-quantitative treatment limitations (NQTLs) with its Behavioral Health Vendor (Optum Behavioral Health Solutions) on an annual basis or as needed when there is a change to a current methodology or process directly related to the NQTL. The Plan conducts non-quantitative treatment limitations to review that factors, sources, evidentiary standards, and processes are applied no more stringently to Mental Health/Substance Use Disorder services when compared to Medical/Surgical services. If a discrepancy is identified, the Plan coordinates with Optum Behavioral Health Solutions to investigate if there is a risk of non-compliance to perform necessary remediation.

The retrospective review non-quantitative treatment limitation is approved on an annual basis by the Clinical Advisory Committee which reports to the Utilization Management Subcommittee, in quarter three of each year. The Associate of UM Optimization is responsible for conveying annual updates to the committee for review and formal sign-off. Non-quantitative treatment limitation changes and modifications, including factors or other modifications to the non-quantitative treatment limitation methodology, are determined during the next quarterly Clinical Advisory Subcommittee session or can be voted on by CAS committee members off-cycle

**Conclusion:** The findings of the comparative analysis reveal that the process and methodology to apply retrospective review to mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and

	methodology used to apply retrospective review to medical/surgical services.
--	--

<b>Non-Quantitative Treatment Limitation (NQTL) Analysis Index</b>	
<b>Non-Quantitative Treatment Limitation</b>	Service Coding
<b>Plan Type(s) Applicable</b>	<b>Oscar Health Plan of Georgia</b>
<b>Responsible Business Teams</b>	Edits Configuration Payment Integrity
<b>Names of Person(s) Responsible for Analysis Formation</b>	<p><b>Oscar:</b> Joanna Sun- Manager, Claims Platform Reimbursement- Edits (2+ years of edit configuration in adherence with reimbursement policy)</p> <p>CJ Wisecarver - Manager, Reimbursement Policy (7+ years experience in Policy work, both Medical and Reimbursement, 6+ years as a CPC, and Registered Nurse)</p> <p><b>Optum Behavioral Health Solutions:</b> Positions/Titles: Optum Reimbursement Policy Product Research Consultant, VP Benefits Integrity, Director MH Parity and Benefits Credentials: MS Health Administration, Licensed Psychologist, Licensed Nurse</p>
<b>Last Update</b>	12/20/2023
<b>Reviewers</b>	Alexandra Rubino, Associate Director, MHP (Over five years experience in Mental Health Parity reporting and operational compliance)



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

### Service Coding

1. **The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification:**

Medical/Surgical:	Mental Health/Substance Use Disorder:
<p>Reimbursement policies are meant to provide payment methodology guidelines based on generally accepted coding practices. These are typically provider, contract, and/or payer agnostic determinations. The goal of our policies is to provide clarity on how Oscar may process and ultimately reimburse based on claim-specific information. The basis of these policies are generally derived from the external medical community with insight from our internal teams.</p> <p>Some of the guidelines referenced are:</p> <p>Centers for Medicare and Medicaid Services (CMS) Publication 100-04 Claims Processing Manual CMS National Correct Coding Initiative (NCCI) Current Procedural Technology (CPT) guidance by American Medical Association (AMA)</p> <p>Additionally, we also have policies based on state-specific guidelines as well as appropriateness of health care and medical necessity. The latter use cases tend to be more for specific scenarios rather than the norm. These coding methodologies impact the following but are not limited to: CPT coding, diagnosis codes, modifiers, bundling, frequency, and number of units.</p> <p>Process: The development of reimbursement policies are driven by a number of factors such as industry standards, external expert medical panels, internal data for potential fraud, waste, and abuse, and internal medical expertise.</p> <p>Please see below for the more detailed approach:</p> <p>Identification: Through data analysis, competitive analysis,</p>	<p>Reimbursement policies describe how physicians and health care professionals should code for the covered services they provide to members. Coding edits ensure claims are administered in accordance with industry standards (e.g., Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), American Psychiatric Association (APA), etc.). The strategy to apply coding edits is to ensure the procedure codes referenced on the claim are current (not expired), supported by the diagnosis codes, and consistent with industry standards and the reimbursement policies. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design, and other factors are considered in developing reimbursement policies.</p> <p>Reimbursement policies are developed to ensure accurate coding and billing and claim administration for services rendered for MH/SUD conditions, based on industry standards as described in third-party sources. Coding edits are programmed within claims systems, as a way to ensure proper billing practices and reimbursement according to reimbursement policies.</p> <p>Optum Behavioral Health Solutions (OBHS) has developed reimbursement policies to ensure accurate coding, billing, and claim administration for MH/SUD conditions. OBHS considers various elements including industry-standard reimbursement logic, regulatory requirements, and benefit design when developing the reimbursement policies.</p> <p>MH/SUD reimbursement policies are publicly</p>

and internal expertise, identify the policy gaps to support new or revised reimbursement policies.

**Analysis and Prioritization:** Gather both quantitative and qualitative input from relevant stakeholders to ensure the proper logic. All reimbursement policies are then prioritized based on the business needs.

**Governance:** The reimbursement policies are reviewed and approved by Legal and other relevant stakeholders to ensure alignment across other policies and benefits

**Communication:** Providers are notified of new policies in accordance with both state and federal regulations

**Publication:** The policy will go live along with the proper coding edits. Applicable claims will then be subject to guidelines of the policy.

Oscar's reimbursement policies are publicly available on the provider portals.

Prior to any new policy, revision of policy, or deletion of a policy, Oscar will follow the above processes to ensure proper procedures and governance.

The above process results in the development of reimbursement policies and claim system coding edits implemented to ensure the accurate coding, billing, and claims administration of healthcare services in accordance with industry standards. Reimbursement policies apply to participating and non-participating providers for both fully insured and self-funded plans.

Reimbursement policies are reviewed at least annually. Policies may be reviewed and updated more frequently when there is new information relevant to reimbursement of a service, to provide clarification, and/or based on provider feedback.

available on the provider portal: [Reimbursement Policies \(providerexpress.com\)](https://providerexpress.com).

OBHS uses industry standards and third-party sources (e.g., AMA's Current Procedural Terminology (CPT®), CMS's Healthcare Common Procedure Coding System (HCPCS), CMS's CCI publications, etc.) in drafting reimbursement policy content. MH/SUD reimbursement policies are supported by third-party external sources for policy creation and implementation using five phases of development in order to be approved for use:

- **Triage/Prioritization:** Triaging consists of confirming the criteria and elements are available to support a reimbursement policy.
- **Research/Analysis:** The Team will request input from other Medical/Surgical (M/S) and Mental Health/Substance Use Disorders (MH/SUD) business areas related to potential provider and/or member impact concerns.
- **Governance:** The reimbursement policies are reviewed and approved by governance committees.
- **Communication:** Providers are notified of new policies through external provider portals, according to regulatory requirements. Additional provider communication may be released based on provider impact.
- **Deployment:** MH/SUD develops the system programming to support the published reimbursement policy. Based upon the applicable regulatory requirements, claims may be paid upon auto-adjudication; pended to request additional information from the provider; or administratively denied for various reasons such as unbundling code combinations, incorrect or missing modifiers, exceeding daily frequency limitations, etc.

The above process results in the development of reimbursement policies and claim system coding edits implemented to ensure the accurate coding, billing, and claims administration of healthcare services are in

accordance with industry standards. Reimbursement policies apply to participating and non-participating providers for both fully insured and self-funded plans.

OBHS reviews MH/SUD reimbursement policies on a quarterly basis for coding updates and on an annual basis to validate sourcing. Reimbursement policies may be reviewed and updated more frequently when there is new information relevant to reimbursement of the service or to provide clarification.

MH/SUD Payment Integrity Oversight and Governance Committee oversees the development of and provides approval for reimbursement policies. The Payment Integrity Oversight and Governance Committee is comprised of voting members representing areas such as Program and Network Integrity, Clinical Services, Benefits and Services, Network Pricing Team, Claims, Value and Healthcare Optimization.

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
In-Network Inpatient Services	<ul style="list-style-type: none"> <li>All covered M/S services in the inpatient classification are subject to the provider reimbursement policies/coding edits as described in reimbursement policies</li> </ul>	<ul style="list-style-type: none"> <li>All covered MH/SUD services in the inpatient classification are subject to reimbursement policies as described in the reimbursement policies</li> </ul>
In-Network Outpatient Services	<ul style="list-style-type: none"> <li>All covered M/S services in the outpatient classification are subject to the provider reimbursement policies/coding edits as described in reimbursement policies</li> </ul>	<ul style="list-style-type: none"> <li>All covered MH/SUD services in the outpatient classification are subject to reimbursement policies as described in the reimbursement policies</li> </ul>

Emergency	<ul style="list-style-type: none"> <li>All covered M/S services in the emergency classification are subject to the provider reimbursement policies/coding edits as described in reimbursement policies</li> </ul>	<ul style="list-style-type: none"> <li>All covered MH/SUD services in the emergency classification are subject to reimbursement policies as described in the reimbursement policies</li> </ul>

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

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
In-Network Inpatient Services	<ol style="list-style-type: none"> <li>State and Federal Regulatory Requirements <ul style="list-style-type: none"> <li>The State and Federal rules established as the standards for healthcare transactions</li> </ul> </li> <li>Benefit Design <ul style="list-style-type: none"> <li>Rules that structure how members access plan benefits</li> </ul> </li> <li>Industry-standard reimbursement logic</li> <li>Valid CPT®/HCPCS Coding <ul style="list-style-type: none"> <li>Identifies all the items and services included within certain designated health services (DHS) categories or that may qualify for certain exceptions</li> </ul> </li> <li>Correct Coding <ul style="list-style-type: none"> <li>Promotes national correct coding methodologies and reduces improper coding, with the overall goal of reducing improper payments</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>State and Federal Regulatory Requirements <ul style="list-style-type: none"> <li>The State and Federal rules established as the standards for healthcare transactions</li> </ul> </li> <li>Benefit Design <ul style="list-style-type: none"> <li>Rules that structure how members access plan benefits</li> </ul> </li> <li>Industry-standard reimbursement logic</li> <li>Valid CPT®/HCPCS Coding <ul style="list-style-type: none"> <li>Identifies all the items and services included within certain designated health services (DHS) categories or that may qualify for certain exceptions</li> </ul> </li> <li>Correct Coding <ul style="list-style-type: none"> <li>Promotes national correct coding methodologies and reduces improper coding, with the overall goal of reducing improper payments</li> </ul> </li> </ol>
In-Network Outpatient Services	Same as Inpatient Analysis	Same as Inpatient Analysis

Emergency	Same as Inpatient Analysis	Same as Inpatient Analysis

4. Identify the evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical or surgical benefits:

Benefit Classification	Evidentiary Standards and Sources: Medical/Surgical	Evidentiary Standards and Sources: MH/SUD
In-Network Inpatient Services	<p><b>Evidentiary Standards:</b></p> <ol style="list-style-type: none"> <li><b>State and Federal Regulatory Requirements</b> is defined as a set of rules to establish standards for healthcare transactions.</li> </ol> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>Relevant federal and state laws govern proper claims coding and reimbursement</li> </ul> <ol style="list-style-type: none"> <li><b>Benefit Design</b> is defined as rules that structure how members access plan benefits.</li> </ol> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>Governing plan document</li> </ul> <ol style="list-style-type: none"> <li><b>Industry Standard Reimbursement Logic</b> is defined as standard reimbursement terminology that appears in managed care plan requirements (e.g., the administrative guide).</li> </ol> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>CMS</li> </ul>	<p><b>Evidentiary Standards and Sources:</b></p> <ol style="list-style-type: none"> <li><b>State and Federal Regulatory Requirements</b> is defined as a set of rules to establish standards for healthcare transactions.</li> </ol> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>Relevant federal and state laws govern proper claims coding and reimbursement</li> </ul> <ol style="list-style-type: none"> <li><b>Benefit Design</b> is defined as rules that structure how members access plan benefits.</li> </ol> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>Governing plan document</li> </ul> <ol style="list-style-type: none"> <li><b>Industry Standard Reimbursement Logic</b> is defined as standard reimbursement terminology that appears in managed care plan requirements (e.g., the administrative guide).</li> </ol> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>CMS</li> </ul>



	<ul style="list-style-type: none"> <li>○ Clinical Laboratory Fee Schedule (CLFS)</li> <li>○ Medicare Administrative Contractors (MACs)</li> </ul> <p>4. <b>Valid CPT Coding</b> is defined as the items and services included within certain DHS categories or that may qualify for certain exceptions.</p> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>○ AMA</li> <li>○ CPT®</li> <li>○ Associated publications and services</li> </ul> <p><b>Valid HCPCS Coding</b> is defined as the items and services included within certain DHS categories or that may qualify for certain exceptions.</p> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>○ CMS</li> <li>○ HCPCS</li> <li>○ HCPCS Release and Code Sets</li> </ul> <p>5. <b>Correct Coding</b> is defined as national correct coding methodologies to reduce improper coding, with the overall goal of reducing improper payments.</p> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>○ CMS</li> <li>○ NCCI publications</li> </ul> <p>The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.</p>	<ul style="list-style-type: none"> <li>○ Clinical Laboratory Fee Schedule (CLFS)</li> <li>○ Medicare Administrative Contractors (MACs)</li> </ul> <p>4. <b>Valid CPT Coding</b> is defined as the items and services included within certain DHS categories or that may qualify for certain exceptions.</p> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>○ AMA</li> <li>○ CPT®</li> <li>○ Associated publications and services</li> </ul> <p><b>Valid HCPCS Coding</b> is defined as the items and services included within certain DHS categories or that may qualify for certain exceptions.</p> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>○ CMS</li> <li>○ HCPCS</li> <li>○ HCPCS Release and Code Sets</li> </ul> <p>5. <b>Correct Coding</b> is defined as national correct coding methodologies to reduce improper coding, with the overall goal of reducing improper payments.</p> <p>Evidentiary Standards and Sources:</p> <ul style="list-style-type: none"> <li>○ CMS</li> <li>○ NCCI publications</li> </ul> <p>The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.</p>
In-Network Outpatient	Same as Inpatient Analysis	Same as Inpatient Analysis

Services		
Emergency	Same as Inpatient analysis	Same as Inpatient analysis

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

Benefit Classification	Comparative Analysis	
	Medical/Surgical	Mental Health/Substance Use Disorder
In-Network Inpatient Services/Outpatient Services and Emergency Services	<p>Process: The development of reimbursement policies are driven by a number of factors such as industry standards, external expert medical panels, internal data for potential fraud, waste, and abuse, and internal medical expertise.</p> <p>Please see below for the more detailed approach:</p> <p>Identification: Through data analysis, competitive analysis, and internal expertise, identify the policy gaps to support new or revised reimbursement policies.</p> <p>Analysis and Prioritization: Gather both quantitative and qualitative input from relevant stakeholders to ensure the proper logic. All reimbursement policies are then prioritized based on the business needs.</p>	<p>The processes for the development of reimbursement policies for MH/SUD services are driven by industry standards as described in third-party resources.</p> <p>Reimbursement policies must be supported by third-party external sourcing for policy creation and implementation using five phases of development in order to be approved for use:</p> <ul style="list-style-type: none"> <li>● Triage/Prioritization: Triaging consists of confirming the criteria and elements are available to support a reimbursement policy.</li> <li>● Research/Analysis: The Team will request input from other Medical/Surgical (M/S) and Mental Health/Substance Use Disorders (MH/SUD) business areas related to potential provider and/or member</li> </ul>

	<p>Governance: The reimbursement policies are reviewed and approved by Legal and other relevant stakeholders to ensure alignment across other policies and benefits</p> <p>Communication: Providers are notified of new policies in accordance with both state and federal regulations</p> <p>Publication: The policy will go live along with the proper coding edits. Applicable claims will then be subject to guidelines of the policy.</p> <p>Oscar's reimbursement policies are publicly available on the provider portals.</p> <p>Prior to any new policy, revision of policy, or deletion of a policy, Oscar will follow the above processes to ensure proper procedures and governance.</p> <p>The above process results in the development of reimbursement policies and claim system coding edits implemented to ensure the accurate coding, billing, and claims administration of healthcare services in accordance with industry standards. Reimbursement policies apply to participating and non-participating providers for both fully insured and self-funded plans.</p> <p>Medical/Surgical reimbursement policies are available on the provider portal: <a href="https://provider.hioscar.com/resources/medicare-advantage/appendix/">https://provider.hioscar.com/resources/medicare-advantage/appendix/</a></p> <p>Reimbursement policies are reviewed at least annually. Policies may be reviewed and updated more frequently when there is new information relevant to reimbursement of a service, to provide</p>	<p>impact concerns.</p> <ul style="list-style-type: none"> <li>● Governance: The reimbursement policies are reviewed and approved by governance committees.</li> <li>● Communication: Providers are notified of new policies through external provider portals, according to regulatory requirements. Additional provider communication may be released based on provider impact.</li> <li>● Deployment: MH/SUD develops the system programming to support the published reimbursement policy. Based upon the reimbursement policy and applicable regulatory requirements, claims may be paid upon auto-adjudication; pending to request additional information from the provider; or administratively denied for various reasons such as unbundling code combinations, incorrect or missing modifiers, exceeding daily frequency limitations, etc.</li> </ul> <p>The above process results in the development of reimbursement policies and claim system coding edits implemented to ensure the accurate coding, billing, and claims administration of healthcare services are in accordance with industry standards. Reimbursement policies apply to participating and non-participating providers for both fully insured and self-funded plans.</p> <p>MH/SUD reimbursement policies are publicly available on the provider portal: <a href="https://providerexpress.com/Reimbursement-Policies">Reimbursement Policies (providerexpress.com)</a>.</p> <p>OBHS reviews MH/SUD reimbursement policies on a quarterly basis for coding updates and on an annual basis to validate</p>
--	--	--

	<p>clarification, and/or based on provider feedback.</p>	<p>sourcing. Reimbursement policies may be reviewed and updated more frequently when there is new information relevant to reimbursement of the service or to provide clarification.</p> <p>MH/SUD Payment Integrity Oversight and Governance Committee oversees the development of and provides approval for reimbursement policies. The Payment Integrity Oversight and Governance Committee is comprised of voting members representing areas such as Program and Network Integrity, Clinical Services, Benefits and Services, Network Pricing Team, Claims, Value and Healthcare Optimization.</p>
<p>In-Network Inpatient Services/Outpatient Services and Emergency Services</p>	<p>As-written and in-operation, the methodologies used to apply service coding to mental health/substance use disorder services are the same methodologies used to apply service coding to medical/surgical services.</p> <p>For both medical/surgical and mental health/substance use disorder services, the Plan walks through the same phases of development of reimbursement policies which includes: identification/prioritization, analysis, governance, communication, and publication.</p> <p>Additionally, for medical/surgical services and mental health/substance use disorder services similar factors, evidentiary standards, and sources are used to guide the development of these standards.</p> <p>Therefore, as-written and in-operation, the processes, strategies, evidentiary standards, and factors used to demonstrate comparability are aligned.</p>	

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

Benefit Classification	Findings/Conclusions
In-Network	The underlying processes, strategies, evidentiary standards and other factors

<p>Inpatient Services/Out patient Services and Emergency Services</p>	<p>used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:</p> <ol style="list-style-type: none"> <li>1. Service Coding methodologies for both medical/surgical and mental health/substance use disorder considers the following same factors: <ol style="list-style-type: none"> <li>1) State and Federal Regulatory Requirements <ul style="list-style-type: none"> <li>○ The State and Federal rules established as the standards for healthcare transactions</li> </ul> </li> <li>2) Benefit Design <ul style="list-style-type: none"> <li>○ Rules that structure how members access plan benefits</li> </ul> </li> <li>3) Industry-standard reimbursement logic</li> <li>4) Valid CPT®/HCPCS Coding <ul style="list-style-type: none"> <li>○ Identifies all the items and services included within certain designated health services (DHS) categories or that may qualify for certain exceptions</li> </ul> </li> <li>5) Correct Coding <ul style="list-style-type: none"> <li>○ Promotes national correct coding methodologies and reduces improper coding, with the overall goal of reducing improper payments</li> </ul> </li> </ol> </li> <li>2. The same evidentiary standards and sources are considered which include: <ol style="list-style-type: none"> <li>1) Relevant federal and state laws govern proper claims coding and reimbursement</li> <li>2) Governing plan document</li> <li>3) <ul style="list-style-type: none"> <li>○ CMS</li> <li>○ Clinical Laboratory Fee Schedule (CLFS)</li> <li>○ Medicare Administrative Contractors (MACs)</li> </ul> </li> <li>4) <ul style="list-style-type: none"> <li>○ AMA</li> <li>○ CPT®</li> <li>○ Associated publications and services</li> <li>○ CMS</li> <li>○ HCPCS</li> <li>○ HCPCS Release and Code Sets</li> </ul> </li> <li>5) <ul style="list-style-type: none"> <li>○ NCCI publications</li> <li>○ CMS</li> </ul> </li> </ol> </li> <li>3. Operationally, both MH/SUD and M/S perform routine updates to reimbursement policies in accordance with the factors, evidentiary standards, and sources provided in the analysis. For both medical/surgical and mental health/substance use disorder services, the Plan walks through the same phases of development of reimbursement policies which includes: identification/prioritization, analysis, governance, communication, and publication.</li> </ol>
---	---

	<p>Findings/Conclusion: The findings of the comparative analysis reveal that the process and methodology to assess service coding for mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology used to assess service coding for medical/surgical services.</p>
--	--

<b>Non-Quantitative Treatment Limitation (NQTL) Analysis Index</b>	
<b>Non-Quantitative Treatment Limitation</b>	Concurrent Review
<b>Plan Type(s) Applicable</b>	<b>Oscar Health Plan of Georgia</b>
<b>Responsible Business Teams</b>	Clinical
<b>Names of Person(s) Responsible for Analysis Formation</b>	<p><b>Oscar:</b>  Insiya Taj, MPH, Associate, UM Optimization, (Over 5 years experience in healthcare and clinical research)  David Schaffzin, MD, Associate Medical Director, Utilization Management</p> <p><b>Optum Behavioral Health Solutions:</b>  Positions: Chief Medical Officer, National Senior Behavioral Medical Directors (MD), VP Benefits Integrity, VP, Outpatient and Specialty Programs, Director MH Parity and Benefits, Legal Counsel, and Senior Director, National Policy and Standards.  Credentials: Board Certified MDs, Licensed Psychologist, Licensed Nurse, Licensed Social Worker, and National Certified Counselor.</p>
<b>Last Update</b>	12/20/23
<b>Reviewers</b>	Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)



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

**Concurrent Review**

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

Medical/Surgical Terms	Mental Health/Substance Use Disorder Terms
<b>Definition:</b> Concurrent review is a review of services when the member is actively receiving services or review for an extension of a previously approved number of treatments or ongoing course of treatment over a period of time.	<b>Definition:</b> A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.
<p><b>Coverage Terms (EOC language):</b></p> <p>Managed Care means the determination of availability of coverage under a Health Insurance Policy through the use of clinical standards to determine the Medical Necessity of an admission or treatment, and the level and type of treatment, and 25 OSC-GA-IVL-EOC-2023 appropriate setting for treatment, with required authorization on a prospective, <b>concurrent</b> or retrospective basis, sometimes involving case management.</p> <p><b>Utilization Review Decisions and Procedures</b></p> <p>For initial determinations, Oscar will make our determinations within the following timeframes:</p> <ul style="list-style-type: none"><li>• For pre-service urgent requests: within 3 calendar days</li><li>• For pre-service non-urgent requests: within 15 calendar days</li><li>• For <b>concurrent</b> urgent requests (submitted in a timely manner -- for an extension of care approved previously, where the request is received &gt;24 hours before the expiration of the urgent authorization): within 1 calendar day</li><li>• For complete post-service requests: within 30 days</li></ul> <p>For approvals, Oscar will provide written notification of our decision within 2 business days of our decision. For denials (Adverse Determinations), we will provide verbal and written notification within 1 business day of our determination.</p> <p>In any case where NCQA or federal authorization time frames conflict with Georgia standards, Oscar will adhere to the stricter of all relevant time frames.</p>	



Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
In-Network Inpatient Services	<p>All inpatient services are subject to this NQTL.</p> <ul style="list-style-type: none"> <li>Acute/Elective Hospital</li> <li>Hospice, Long-Term Acute Care</li> <li>Rehabilitation</li> <li>Acute/Subacute</li> <li>Skilled Nursing Facility</li> <li>Procedures/Treatments/Surgeries when place of service is inpatient</li> </ul>	<ul style="list-style-type: none"> <li>MH Non-Emergent Acute Inpatient</li> <li>MH Subacute Residential Treatment</li> <li>SUD Acute Inpatient Detoxification</li> <li>SUD Acute Inpatient Rehabilitation</li> <li>SUD Subacute Residential Treatment</li> </ul> <p>Applies to all inpatient services for facilities reimbursed on a per diem basis.</p>
In-Network Outpatient Services	<ul style="list-style-type: none"> <li>Physician-Administered Drugs</li> <li>Certain DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) such as oxygen, CPAP, and diabetic supplies</li> <li>Home Health Care Services</li> <li>Advanced Imaging</li> <li>Home-Based Speech Therapy</li> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Diagnostic Tests &amp; Evaluations, Laboratory Procedures</li> <li>Non-Emergency Transportation</li> <li>Unlisted Procedures</li> <li>Procedures/Treatments/Surgeries, when place of service is outpatient</li> </ul>	<ul style="list-style-type: none"> <li>Partial Hospitalization (PHP)/Day Treatment</li> <li>Intensive Outpatient (IOP)</li> <li>Physical Therapy<sup>1</sup></li> <li>Occupational Therapy<sup>2</sup></li> <li>Home-Based Speech Therapy<sup>3</sup></li> </ul>

**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:**

<sup>1</sup> Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)

<sup>2</sup> Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)

<sup>3</sup> Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/A analysis)

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
In-Network Inpatient Services	1. Safety risk 2. Clinical appropriateness 3. Cost  The factors are not weighted.	1. Clinical Appropriateness: The application of Concurrent Review promotes optimal clinical outcomes 2. Value: The cost of the service exceeds the associated costs of conducting a concurrent review  The factors are not weighted.
In-Network Outpatient Services	1. Cost variability 2. Denial rate 3. Cost percentile 4. Safety risk 5. New/emerging service/technology 6. Clinical appropriateness  The factors are not weighted.	1. Clinical Appropriateness: The application of Concurrent Review promotes optimal clinical outcomes 2. Value: The cost of the service exceeds the associated costs of conducting a concurrent review 3. Variation: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits  The factors are not weighted.

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

Benefit Classification	Evidentiary Standards and Sources: Medical/Surgical	Evidentiary Standards and Sources: MH/SUD
------------------------	--	--

<p>In-Network Inpatient Services</p>	<p>1. <b>Clinical appropriateness</b> is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level of care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>● As per World Professional Association for Transgender Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines.</li> <li>● As per the American Psychological Association (APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder.</li> <li>● As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of</li> </ul>	<p>1. <b>Clinical Appropriateness:</b> is defined as those inpatient services that as determined by internal medical experts are in accordance with objective, evidenced-based clinical criteria and nationally recognized guidelines.</p> <p>This factor is utilized to determine which services may be subject to concurrent review. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the concurrent review list if there are objective, evidence-based clinical criteria to be used in the concurrent reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed technology are used to approve and develop Medical Necessity Criteria on which reviews are based.</p> <p>Evidentiary Standard and Sources:</p> <ul style="list-style-type: none"> <li>○ Clinical criteria from nationally recognized third-party sources (e.g., ASAM®, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)</li> <li>○ Clinical Technology and Assessment Committee (CTAC) review</li> <li>○ Objective, evidence-based policies, and publications and guidelines by nationally recognized authorities, such as</li> </ul>
--------------------------------------	---	--

	<p>cancer and individualized needs as documented in the medical record.</p> <p>Sources: Clinical criteria, Clinical evidence</p> <p>Evidentiary Standards:</p> <p>Clinical criteria</p> <ul style="list-style-type: none"> <li>● Plan Clinical Guidelines</li> <li>● MCG</li> <li>● ASAM (SUD only)</li> <li>● Hayes</li> <li>● UpToDate</li> <li>● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)</li> </ul> <p>Clinical evidence</p> <ul style="list-style-type: none"> <li>● The US National Library of Medicine;</li> <li>● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> <li>● Published scientific evidence;</li> <li>● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li>● Physical Therapy/Occupational Therapy</li> <li>● Gender affirming surgeries</li> <li>● Confirming member has undergone hormone therapy and counseling</li> </ul>	<p>government sources and/or professional societies</p> <p>Note: The evidentiary standards and sources are not defined in a quantitative manner.</p> <p>Clinical Evidence Used:</p> <ul style="list-style-type: none"> <li>● Systematic reviews and meta analyses</li> <li>● Randomized controlled trials</li> <li>● Large non-randomized controlled trials</li> <li>● Large prospective trials</li> <li>● Comparative and cohort studies</li> <li>● Cross sectional studies</li> <li>● Retrospective studies</li> <li>● Surveillance studies</li> <li>● Case Reviews/Case series</li> <li>● Anecdotal/editorial statements</li> <li>● Professional opinions</li> </ul> <p>In the absence of strong and compelling scientific evidence, clinical policies may be based upon:</p> <ul style="list-style-type: none"> <li>● National consensus statements</li> <li>● Publications by recognized authorities such as government sources and/or professional societies</li> </ul> <p>2. <b>Value:</b> is defined as the cost of the inpatient services exceeding the administrative costs of subjecting the inpatient services to concurrent review by at least 1:1. Consideration of this factor includes a review of national inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce</p>
--	---	--

	<ul style="list-style-type: none"> <li>● Mastectomy - appropriate in most cases, but need to review for medical necessity</li> <li>● Physician-administered drugs</li> <li>● Level of care setting</li> </ul> <p>Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</p> <p><b>2. High Cost</b></p> <p>Evidentiary Standard: The mean cost of an inpatient episode of care is &gt;\$12,000</p> <p>Source: claims data</p> <p><b>3. Safety risk</b> is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The concurrent review process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered. If there is a less restrictive level of care available to meet the member's health needs, concurrent review may be applied to ensure the member receives the least restrictive level of care that is clinically appropriate.</p> <p>Sources: National societies and health agencies, Clinical criteria<sup>4</sup>, Clinical</p>	<p>unnecessary costs when concurrent review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering concurrent review to determine value.</p> <p>Sources: Facility / service per diem reimbursement model, National internal claims data, National UM program operating costs, National UM authorization data</p> <p>Evidentiary Standard: Value is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the service to concurrent review by at least 1:1</p>
--	---	---

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

	<p>evidence<sup>5</sup></p> <ul style="list-style-type: none"> <li>• Centers for Medicare &amp; Medicaid Services</li> <li>• World Health Organization</li> <li>• Institute For Safe Medication Practices</li> <li>• U.S. Food and Drug Administration</li> <li>• Drug labeling / safety information</li> </ul> <p>Evidentiary Standards:</p> <ul style="list-style-type: none"> <li>• Treatments that increase the likelihood of adverse health effects</li> <li>• Services that increase the likelihood of perioperative morbidity and mortality</li> <li>• Procedures, such as high-risk operations, that carry a mortality rate of 5% or more.</li> <li>• Procedures with significant or major impact on hemodynamics, fluid shifts, possible major blood loss.</li> <li>• Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse.</li> </ul> <p><i>Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017 (<a href="http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf">http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf</a>).</i></p>	
--	--	--

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

<p>In-Network Outpatient Services</p>	<p>1. <b>Clinical appropriateness</b> is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level of care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>● As per World Professional Association for Transgender Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines.</li> <li>● As per the American Psychological Association (APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder.</li> <li>● As per the National Comprehensive Cancer Network</li> </ul>	<p>1. <b>Clinical Appropriateness</b> is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, nationally recognized clinical criteria and evidence-based policies.</p> <p>This factor is utilized to determine which services may be subject to concurrent review. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the concurrent review list if there are objective, evidence-based clinical criteria to be used in the concurrent reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed technology are used to approve and develop Medical Necessity Criteria on which reviews are based.</p> <p>Evidentiary Standard and Sources:</p> <ul style="list-style-type: none"> <li>○ Clinical criteria from nationally recognized third-party sources (e.g., ASAM®, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)</li> <li>○ Clinical Technology and Assessment Committee (CTAC) review</li> <li>○ Objective, evidence-based policies, and publications and</li> </ul>

	<p>(NCCN), radiation and chemotherapy requires confirmation of certain types of cancer and individualized needs as documented in the medical record.</p> <p>Sources: Clinical criteria, Clinical evidence</p> <p>Evidentiary Standards:</p> <p>Clinical criteria</p> <ul style="list-style-type: none"> <li>● Plan Clinical Guidelines</li> <li>● MCG</li> <li>● ASAM (SUD only)</li> <li>● Hayes</li> <li>● UpToDate</li> <li>● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)</li> </ul> <p>Clinical evidence</p> <ul style="list-style-type: none"> <li>● The US National Library of Medicine;</li> <li>● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> <li>● Published scientific evidence;</li> <li>● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li>● Physical Therapy/Occupational Therapy</li> <li>● Gender affirming surgeries</li> <li>● Confirming member has</li> </ul>	<p>guidelines by nationally recognized authorities, such as government sources and/or professional societies</p> <p>Note: The evidentiary standards are not defined in a quantitative manner.</p> <p>Clinical Evidence Used:</p> <ul style="list-style-type: none"> <li>● Systematic reviews and meta analyses</li> <li>● Randomized controlled trials</li> <li>● Large non-randomized controlled trials</li> <li>● Large prospective trials</li> <li>● Comparative and cohort studies</li> <li>● Cross sectional studies</li> <li>● Retrospective studies</li> <li>● Surveillance studies</li> <li>● Case Reviews/Case series</li> <li>● Anecdotal/editorial statements</li> <li>● Professional opinions</li> </ul> <p>In the absence of strong and compelling scientific evidence, clinical policies may be based upon:</p> <ul style="list-style-type: none"> <li>● National consensus statements</li> <li>● Publications by recognized authorities such as government sources and/or professional societies.</li> </ul> <p>2. <b>Value:</b> is defined as the cost of the outpatient services exceeding the administrative costs of subjecting the outpatient services to concurrent review by at least 1:1. Consideration of this factor includes a review of national outpatient utilization or claims data to identify if there is opportunity to improve quality and reduce</p>
--	---	---



	<p>undergone hormone therapy and counseling</p> <ul style="list-style-type: none"> <li>● Mastectomy - appropriate in most cases, but need to review for medical necessity</li> <li>● Physician-administered drugs</li> <li>● Level of care setting</li> </ul> <p>Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</p> <p>2. <b>Denial rate</b> is defined as the percentage of authorization requests that are denied by the Plan.</p> <p>Source: Authorization data Evidentiary Standard: &gt;10%</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>● Benefit: Medical/Surgical Service: Outpatient Services: Treatments &amp; Procedures: Skin Treatments &amp; Procedures   UV / Laser therapy Denial rate applies to this service category. Denial rate is 70% for this service category.</li> <li>● Benefit: Mental Health/Substance Use Disorder Service: Partial Hospitalization Denial rate applies to this service category. Denial rate is 60% for this service category.</li> </ul> <p>3. <b>Cost variability</b> is defined as the cost per episode of service (service units X unit cost) that</p>	<p>unnecessary costs when concurrent review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering concurrent review to determine value.</p> <p>Sources: National internal claims data, National UM program operating costs, National UM authorization data</p> <p>Evidentiary Standard: Value is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the service to concurrent review by at least 1:1</p> <p>3. <b>Variation Identified:</b> is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of the costs of other outpatient services and provided to a minimum of 50 unique members (the materiality threshold established by MH/SUD for purposes of the variation analysis). Consideration of this factor includes a review of national internal claims data for service-specific costs and calculating for an overall mean of the service-specific average cost per patient. For any given MH/SUD service, if the average allowed cost per patient's episode of care is twice the average cost per patient's episode of care across all other MH/SUD outpatient services, concurrent review is applied.</p>
--	--	--

	<p>trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members. Outpatient services are subject to variability in cost per episode of service relative to other services within the classification of benefits. For each service, the Plan calculates the Average Annual Allowed Amount per Unique Patient with Outpatient Claim Events for that Primary Service.</p> <p>Source: Claims data</p> <p>Evidentiary Standard: Cost per episode of service that triggers 2x the mean of other outpatient services.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>Benefit: Medical/Surgical Service: Outpatient Services: Treatments &amp; Procedures: Musculoskeletal Surgery   Joint arthroscopy / arthroplasty / arthrodesis Cost variability applies to this service category. Cost variability is 5x the mean of other outpatient services.</li> <li>Benefit: Mental Health/Substance Use Disorder Service: Outpatient Psychiatric Testing Cost variability applies to this service category. Cost variability is 2.9x the mean of other outpatient services.</li> </ul> <p>4. <b>Cost percentile</b> is defined as the average cost per claim event for a particular outpatient service relative to other services within</p>	<p>Source: National internal claims data</p> <p>Evidentiary Standard: Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of 50 unique members</p>
--	--	--

	<p>the classification of benefits.</p> <p>Source: Claims data</p> <p>Evidentiary Standard: <math>\geq</math> 85th Percentile</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Benefit: Medical/Surgical Service: Outpatient Services: Treatments &amp; Procedures: Digestive Treatments &amp; Procedures   Bariatric surgery Cost percentile applies to this service category. Cost is in the 100th percentile for this service category.</li> <li>• Benefit: Mental Health/Substance Use Disorder Service: Outpatient psychiatric testing Cost percentile applies to this service category. Cost is in the 100th percentile for this service category</li> </ul> <p>5. <b>Safety risk</b> is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The authorization process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered.</p> <p>Sources: National societies and</p>	
--	--	--

	<p>health agencies, Clinical criteria<sup>6</sup>, Clinical evidence<sup>7</sup></p> <ul style="list-style-type: none"> <li>○ Centers for Medicare &amp; Medicaid Services</li> <li>○ World Health Organization</li> <li>○ Institute For Safe Medication Practices</li> <li>○ U.S. Food and Drug Administration</li> <li>○ Drug labeling / safety information</li> </ul> <p>Evidentiary Standards:</p> <ul style="list-style-type: none"> <li>● Treatments that increase the likelihood of adverse health effects</li> <li>● Services that increase the likelihood of perioperative morbidity and mortality</li> <li>● Procedures, such as high-risk operations, that carry a mortality rate of 5% or more.</li> <li>● Procedures with significant or major impact on hemodynamics, fluid shifts, possible major blood loss.</li> <li>● Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions,</li> </ul>	
--	---	--

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

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

	<p>medication errors, and/or risks for abuse or misuse.</p> <p><i>Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017</i>  <a href="http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf">(<a href="http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf">http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf</a>).</a></p> <p>Examples:</p> <ul style="list-style-type: none"> <li>● Surgical procedures at risk for infection and complications (e.g., gastrectomy, hip replacement)</li> <li>● Advanced radiology procedures with exposure to radiation (e.g., CT, MRI, nuclear medicine)</li> <li>● Physician-administered drugs due to the risk for adverse effects and contraindications (e.g., chemotherapeutic agents)</li> </ul> <p>6. <b>New/ Emerging Service/ Technology</b> is defined as any health care service, testing, procedure, treatment, device or prescription drug for which safety and efficacy has not been established and proven is considered experimental, investigational, or unproven. Services that are not accepted as the standard medical treatment of the condition being treated are considered “new and emerging services and technologies.” This includes any health care service, testing, procedure, treatment, device, or prescription drug that:</p> <ul style="list-style-type: none"> <li>○ Is not accepted as standard medical treatment of the</li> </ul>	
--	---	--

	<p>condition; or</p> <ul style="list-style-type: none"> <li>○ Has not been approved by the U.S. Food and Drug Administration (FDA) to be lawfully used; or</li> <li>○ Has not been identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or</li> <li>○ Requires review and approval by any institutional review board (IRB) for the proposed use or are subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations; or</li> <li>○ Requires any Federal or other governmental agency approval not listed above that has not been and will not be granted at the time services will be provided.</li> </ul> <p>Sources: Clinical criteria, Clinical evidence</p> <p>Evidentiary Standards:</p> <p>Clinical criteria</p> <ul style="list-style-type: none"> <li>● Plan Clinical Guidelines</li> <li>● MCG</li> <li>● ASAM (SUD only)</li> <li>● Hayes</li> <li>● UpToDate</li> <li>● National Society Guidelines</li> </ul>	
--	---	--

	<p>(e.g., ACOG, APA, NCCN, WPATH)</p> <p>Clinical evidence</p> <ul style="list-style-type: none"> <li>• The US National Library of Medicine;</li> <li>• Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>• Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> <li>• Published scientific evidence;</li> <li>• In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Genetic, biomarker and molecular tests</li> <li>• Medical devices and implants</li> <li>• Novel therapies (e.g., gene therapy, CAR T-Cell therapy)</li> </ul>	
--	--	--

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

**Inpatient M/S**

	Clinical Appropriateness	Safety	High Cost
Acute/Elective Hospital Rehabilitation	<b>X</b>	<b>X</b>	<b>X</b>

Hospice Long-Term Acute Care	<b>X</b>	<b>X</b>	<b>X</b>
Acute/Subacute	<b>X</b>	<b>X</b>	<b>X</b>
Skilled Nursing Facility	<b>X</b>	<b>X</b>	<b>X</b>
Procedures/Treatment s/Surgeries, when place of service is inpatient	<b>X</b>	<b>X</b>	<b>X</b>

### Outpatient M/S

<b>Service</b>	<b>Cost variability</b>	<b>Denial rate</b>	<b>Cost percentile</b>	<b>Safety risk</b>	<b>New/ Emerging Service/ Technology</b>	<b>Clinical Appropriateness</b>
Physician- Administered Drugs		<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>
DMEPOS		<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
Home Health Care Services		<b>X</b>				<b>X</b>
Advanced Imaging		<b>X</b>		<b>X</b>		
Diagnostic Tests & Evaluations, Laboratory Procedures		<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
Treatments/ Procedures	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
Non- Emergency Transportation		<b>X</b>	<b>X</b>			



Unlisted Procedures	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>	
---------------------	----------	----------	--	----------	----------	--

#### **Inpatient MH/SUD**

	Clinical Appropriateness	Value
Inpatient, MH	<b>X</b>	<b>X</b>
Inpatient, SUD	<b>X</b>	<b>X</b>
Residential, MH	<b>X</b>	<b>X</b>
Residential, MH	<b>X</b>	<b>X</b>

#### **Outpatient MH/SUD**

	Clinical Appropriateness	Value	Variation
Partial Hospitalization/ Day Treatment	<b>X</b>	<b>X</b>	<b>X</b>
Intensive Outpatient	<b>X</b>	<b>X</b>	<b>X</b>

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

<b>Concurrent Review Process M/S</b>	<b>Concurrent Review Process MH/SUD</b>
<b>Description and Application of Concurrent Review:</b> Concurrent review is a review of services when the member is actively receiving services or review for an extension of a previously approved number of treatments or ongoing course of treatment over a period of time.	<b>Description and Application of Concurrent Review:</b> When OBHS approves an inpatient admission to an INN facility for MH/SUD services that are reimbursed on a per diem basis, OBHS will review the medical necessity or level of care (LOC) at the INN facility. Clinical reviewers will contact the INN provider and request clinical information. Reviewers will apply plan benefit terms and applicable behavioral clinical

**Application of Concurrent Review:** A concurrent review is conducted when the Plan receives a request for coverage for medical care or services made while the member is in the process of receiving the requested medical care or services.

**Concurrent Review Submissions:** Requests for authorization for procedures and services, including Prospective, Concurrent, and Retrospective Reviews, are made by contacting Oscar directly, either by phone, fax, or electronically through the Provider Web Portal. Additionally, in cases where a UM delegate is used to review a specific service type or service area, Oscar provides direction on its web site or through customer service for contacting the vendor for authorization requests.

**Concurrent Review Process:** During concurrent reviews, only the necessary and relevant sections of medical records are requested, i.e., those needed to verify medical necessity. In cases where the Plan does not receive the specific information requested, or if the information is not complete by the timeframe in which a notification of determination must be made, a determination will be made based upon the information available at that time. All reviews are conducted by licensed clinicians; the clinicians assess if the services being requested meet medical necessity based on established clinical criteria.

**Guidelines/Criteria used:** Clinicians make determinations based on plan benefits and established evidence-based clinical criteria.

**Staff qualifications:** Concurrent reviews are conducted by licensed clinicians (nurses and physicians); only board certified physicians make adverse determinations.

policies to determine if the LOC is a covered benefit.

Outpatient concurrent review includes requests to extend a course of treatment beyond the previously approved time period or number of treatments previously approved by OBHS.

**Concurrent Review Submissions:** Concurrent review requests may be submitted via fax, phone, or electronically via portal.

**Concurrent Review Process:** OBHS first confirms member eligibility and plan benefits.

For inpatient services, an initial review is conducted by clinical staff to determine whether the provider has submitted sufficient information to support medical necessity of the inpatient service as set forth in the clinical guidelines and behavioral clinical policies (criteria). The authorization request can be approved if the submitted clinical information from the facility appears to meet the criteria for a continued stay. If the authorization request is not approved, then, additional clinical information may be requested, or the request is elevated for secondary review. For outpatient services, OBHS consults clinical criteria to make benefit coverage determinations. OBHS may approve requests for additional numbers of treatments or extensions of time if the reviews do not require clinical evaluation or interpretation.

If OBHS cannot approve requests for additional numbers of treatments or extensions of time, the case is referred to a clinical reviewer for further research and evaluation. OBHS may gather more clinical information that may include, but is not limited to consultations, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, and history of related treatment and services. The clinical reviewer uses applicable member clinical information, benefit plan documents, clinical criteria in their case reviews.

For both inpatient and outpatient services, if the requested clinical information is not received or if the

**Notification of Determination:** A written notification is issued to the member and provider within state, federal, or accreditation required timeframes; the written notification includes information on appeal rights.

**Timeframe for the Plan to respond:** The Plan follows all state, federal, and accreditation timeframe requirements.

**Peer to Peer:** After an adverse determination has been issued, the Plan offers the opportunity for the provider to discuss the request with a Plan physician.

case cannot be approved, the case is referred to a peer clinical reviewer. Peer-to-peer conversations are offered as required. If a peer clinical reviewer issues an adverse benefit determination (e.g., that numbers of treatments or extensions of time are not authorized), then the adverse determination is communicated to the member and provider consistent with state, federal and accreditation requirements, including appeal rights, as applicable.

As stated above, applicable state and federal requirements include clinical reviewer qualification requirements, timeframe requirements, provider/member adverse benefit determination notification requirements (e.g., timeframe and appeal requirements), and the process for seeking an external appeal for adverse benefit determinations, as applicable.

OBHS monitors concurrent review program performance through its clinical performance oversight functions. In addition, the UM program performance, including concurrent review, is reviewed at least annually.

**Guidelines/Criteria used:** Clinical reviewers base medical necessity determinations on the objective, evidence-based behavioral clinical policies and use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM®), Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.

**Staff qualifications:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are made by clinical staff (i.e., physicians, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors (MD) or Psychologists.

**Notification of Determination:** The member, facility and the physician will be notified consistent

	<p>with state, federal or accreditation requirements and applicable appeal rights are provided.</p> <p><b>Timeframe for the Plan to respond:</b> Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements.</p> <p><b>Peer to Peer:</b> A practitioner/facility may request an opportunity to discuss reconsideration of a non-coverage determination with the Peer Reviewer who made the decision within 24 hours of the verbal notification of the non-coverage determination.</p>
--	---

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

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

<p>submitted to the Board of Directors, who approve the actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical).</p> <p>As noted above, the UM Subcommittee is a sub-committee to the Quality Improvement Committee. A senior-level physician chairs the UM Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary.</p> <p>The UM Subcommittee undertakes, but is not limited to, the following ongoing activities:</p> <ul style="list-style-type: none"> <li>• Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated.</li> <li>• Reviews and approves modifications to the UM Program as indicated by operational needs and/or to meet regulatory and accreditation compliance.</li> <li>• Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services.</li> <li>• Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.</li> </ul>	<p>Management (PhD), Senior Leader Quality Improvement (PhD), Appeals, Care Engagement Medical Operations (MD) and Medical Operations for UM (MD). Additional internal department representatives attend as non-voting membership, including Legal Counsel, Compliance, Accreditation, the Operational Policy and Standards Committee, Network Strategy and Benefits Integrity. The Clinical Quality and Operations Committee meets monthly and ad hoc, as necessary.</p> <p>The CQOC undertakes, but is not limited to, the following ongoing activities:</p> <ul style="list-style-type: none"> <li>• Oversees the development and implementation of a National Utilization Management (UM) Program (NUMP) with the Utilization Management Program Description (UMPD) serving as the source document for the NUMP</li> <li>• Proposes and evaluates UM-related Clinical QIAs</li> <li>• Evaluates the effectiveness and efficiency of our UM program across all business operation sites</li> <li>• Ensures the standardization of our UM program across all business operation sites</li> <li>• Reviews Operational Policy and Standards Committee policies related to UM management as necessary</li> <li>• Reviews, recommends, and votes on Clinical Criteria</li> <li>• Review and approval of prior authorization requirements</li> </ul>
--	---

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

Benefit	Process Description:	Process Description: MH/SUD
---------	----------------------	-----------------------------

Classification	Medical/Surgical	
In-Network Inpatient Services/Outpatient Services	Where Oscar delegates utilization review services, Oscar audits clinical decisions made for our members on behalf of the Plan. Clinical audits may be driven by utilization trends or by known or hypothesized compliance risks. The clinical audit is conducted by a group of clinicians either at Oscar or by an independent expert in this field. The process includes a review of decision-making, criteria or formulary application, and documentation. Review of clinical decision-making ensures our members receive high quality, cost-effective care at the right place at the right time by supporting and making consistent and evidence-based clinical decisions regarding the appropriateness of healthcare services. Oscar additionally audits clinical decisions internally to ensure members receive high quality, cost-effective care at the right place at the right time by supporting and making consistent and evidence-based clinical decisions regarding the appropriateness of healthcare services. The audits test for appropriate criteria selection and application, decision-making, internal documentation, and denial language (where applicable).	
	<b>Inter-rater reliability scores clinical reviewers (M/S) 2022:</b>	<b>Inter-rater reliability scores clinical reviewers (MH/SUD) 2022:</b>
	<ul style="list-style-type: none"><li>Average IRR score: 92.0%</li></ul>	<ul style="list-style-type: none"><li>Average IRR score: 96%</li></ul>
In completing its annual MHPAEA filings in many states, the Plan performs a variety of self-assessments and mandatory in-operation analyses as required by each regulatory recipient. Because the Plan's benefit designs and internal practices are consistent across markets, the findings of these self-assessments and analyses are largely consistent across markets and serve as a validation mechanism for MHPAEA compliance more broadly.		
Operationally, the Plan performs in-operation data assessments to make sure that factors, sources, and evidentiary standards are applied in a consistent manner. For UM, the Plan reviews denial rates, informal reconsideration statistics, out-of-network statistics, and overturned appeal rates for pre-service across all commercial plans and compares these metrics for med/surg benefits against MH/SUD benefits. While data outcomes are not determinative of mental health parity compliance, the Plan uses these results to guide if investigations into UM processes are necessary to ensure that underlying methodology for UM procedures are not more stringent toward behavioral health benefits.		
Findings:		

	<p><i>Identify and define the factors and processes that are used to monitor and evaluate the application of CR for M/S services:</i></p> <p><b><u>Medical/Surgical: Concurrent Review</u></b></p> <p>Concurrent Review denial rates:</p> <ul style="list-style-type: none"> <li>• Total # of CR requests: <b>118,671</b></li> <li>• Total # of CR requests denied: <b>38,070</b></li> <li>• % of CR requests denied: <b>32%</b></li> </ul> <p>OON stats:</p> <ul style="list-style-type: none"> <li>• Total # OON requests: <b>18,236</b></li> <li>• Percentage (from total # of requests): <b>15%</b></li> <li>• Total # denied: <b>6,836</b></li> <li>• Percentage of denied (from total OON requests): <b>37%</b></li> </ul> <p>Overturned appeal rates (includes partially overturned):</p> <ul style="list-style-type: none"> <li>• Total # overturned: <b>113</b></li> <li>• Overturn rate (%): <b>49%</b></li> </ul>	<p><i>Identify and define the factors and processes that are used to monitor and evaluate the application of CR MH/SUD services:</i></p> <p><b><u>MH/SUD: Concurrent Review</u></b></p> <p>Concurrent Review denial rates:</p> <ul style="list-style-type: none"> <li>• Total # of CR requests: <b>8,295</b></li> <li>• Total # of CR requests denied: <b>129</b></li> <li>• % of CR requests denied: <b>1.6%</b></li> </ul> <p>OON stats:</p> <ul style="list-style-type: none"> <li>• Total # OON requests: <b>222</b></li> <li>• Percentage (from total # of requests): <b>2.7%</b></li> <li>• Total # denied: <b>27</b></li> <li>• Percentage of denied (from total OON requests): <b>12.2%</b></li> </ul> <p>Overturned appeal rates (includes partially overturned):</p> <ul style="list-style-type: none"> <li>• Total # overturned: <b>11</b></li> <li>• Overturn rate (%): <b>22.9%</b></li> </ul>
<p>*Data is based on 2022 authorization data across Oscar commercial plans (excluding MA)</p>		

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

<p>In-Network Inpatient Services/Outpatient Services</p>	<p>The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to mental health/substance use disorder (MH/SUD) benefits and to medical/surgical (M/S) benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:</p> <p>The Plan conducted a comparative analysis to determine which Medical/Surgical</p>
--	---



(M/S) and Mental Health/Substance Use Disorder (MH/SUD) services are subject to concurrent review “as written.”

The factors that demonstrate whether inpatient benefits require Concurrent Review are aligned for MH/SUD services and M/S services. For both MH/SUD and M/S services, clinical appropriateness is a factor. Additionally, safety is a factor considered for M/S services which is also considered under medical necessity as described in the clinical appropriateness factor for MH/SUD services. One difference is that mental health/substance use disorder benefits use value as a factor while medical/surgical benefits use cost as a factor. For inpatient factors, objective, evidence-based clinical guidelines, medical experts, and national guidelines are used as evidentiary standards and sources for factors such as clinical appropriateness and safety. Claims data is used to evaluate cost for medical/surgical benefits, while value for mental health/substance use disorder benefits is defined as the value of applying concurrent review reduces unnecessary variation in inpatient utilization. While cost and value are measured differently, these factors are still aligned as both factors take into consideration measures to optimize the value of applying concurrent review by providing oversight for the utilization of inpatient services which is the highest/most restrictive level of care.

The factors that demonstrate whether an outpatient benefit requires Concurrent Review are aligned for MH/SUD services and M/S services. The factors clinical appropriateness (MH/SUD and M/S) and safety (M/S) are aligned as they both take into consideration the appropriateness of a service and rely on objective, evidence-based clinical guidelines, medical experts, and national guidelines as an evidentiary standard and source. Safety is considered as an element under medical necessity as described in the clinical appropriateness factor for MH/SUD benefits and thus is aligned with the safety factor for M/S benefits.

For the MH/SUD outpatient factor "value," this factor closely aligns with M/S factors such as cost and denial rate. This is because the calculation of value takes into account the costs of rendered services compared to the administrative burden of reviewing a case which considers denial rates (e.g. considerably low denial rates might signal there is an unnecessary administrative burden of review). For these factors, authorization data and claims data is used as a source to derive the evidentiary standards to support these factors.

Additionally, for both MH/SUD benefits and M/S benefits, variability in cost is considered as a factor that determines whether a service requires concurrent review. Variability for both MH/SUD and M/S benefits is evaluated by using a threshold of 2x the mean of other services and uses claims data as a source.

One factor, new/emerging services, is considered for medical/surgical services but not for mental health services. The Plan has concluded that this does not result in more stringency towards mental health/substance use disorder benefits because this factor could result in additional services becoming subject to concurrent review for



	<p>medical/surgical benefits.</p> <p>Operationally, the Plan performs in-operation data assessments for concurrent review procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across med/surg and MH/SUD services. The Plan concludes that in-operation, its methodology for concurrent review for mental health/substance use disorder services is comparable to and applied no more stringently than the methodology for concurrent review applied to medical/surgical services. A comparison of denial rates (including partial denials) reveals that concurrent review denial rates for M/S services are higher compared to denial rates of MH/SUD services indicating higher approval rates for MH/SUD benefits (32% v. 1.6%). This reveals that more services are denied when they are M/S services compared to MH/SUD services. Out-of-network (OON) denial rates (including partial denials) similarly reveal higher rates of denial for M/S services (37% v. 12.2%). This reveals that more OON services are denied when they are M/S services compared to MH/SUD services. Finally, the rate of overturned appeals is lower for M/S services when compared to MH/SUD services with (49% v. 22.9%) indicating that more appealed services are approved for MH/SUD benefits. The outcome measures show comparability (or in this case are more favorable to behavioral health benefits) in processes for concurrent review because the metrics reveal more favorable outcomes for MH/SUD benefits with higher rates of approval for services overall.</p> <p>The Plan is responsible for coordinating responses to non-quantitative treatment limitations (NQTLs) with its Behavioral Health Vendor (Optum Behavioral Health Solutions) on an annual basis or as needed when there is a change to a current methodology or process directly related to the NQTL. The Plan conducts non-quantitative treatment limitations to review that factors, sources, evidentiary standards, and processes are applied no more stringently to Mental Health/Substance Use Disorder services when compared to Medical/Surgical services. If a discrepancy is identified, the Plan coordinates with Optum Behavioral Health Solutions to investigate if there is a risk of non-compliance to perform necessary remediation.</p> <p>The concurrent review non-quantitative treatment limitation is approved on an annual basis by the Clinical Advisory Committee, which reports to the Utilization Management Subcommittee, in quarter three of each year. The Associate of UM Optimization is responsible for conveying annual updates to the committee for review and formal sign-off. Non-quantitative treatment limitation changes and modifications, including factors or other modifications to the non-quantitative treatment limitation methodology, are determined during the most subsequent quarterly Clinical Advisory Subcommittee session or can be voted on by CAS committee members off-cycle</p> <p>Conclusion: The findings of the comparative analysis reveal that the process and methodology to apply concurrent review to mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology used to apply concurrent review to medical/surgical services.</p>
--	---

<b>Non-Quantitative Treatment Limitation (NQTL) Analysis Index</b>	
<b>Non-Quantitative Treatment Limitation</b>	Experimental/Investigational Determinations
<b>Plan Type(s) Applicable</b>	<b>Oscar Health Plan of Georgia</b>
<b>Responsible Business Teams</b>	Clinical
<b>Names of Person(s) Responsible for Analysis Formation</b>	<p><b>Oscar:</b>  Insiya Taj, MPH, Associate, UM Optimization, (Over 5 years experience in healthcare and clinical research)  David Schaffzin, MD, Associate Medical Director, Utilization Management</p> <p><b>Optum Behavioral Health Solutions:</b>  Positions: Chief Medical Officer, National Senior Behavioral Medical Directors (MD), VP Benefits Integrity, VP, Outpatient and Specialty Programs, Director MH Parity and Benefits, Legal Counsel, and Senior Director, National Policy and Standards.  Credentials: Board Certified MDs, Licensed Psychologist, Licensed Nurse, Licensed Social Worker, and National Certified Counselor.</p>
<b>Last Update</b>	12/17/23
<b>Reviewers</b>	Alexandra Rubino, Associate Director, MHP (Over five years experience in Mental Health Parity reporting and operational compliance) Laura Barry MHA, RN, BSN, CCM, CPC, Manager, Clinical Policy



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

### Experimental/Investigational Determinations

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

Medical/Surgical Terms	Mental Health/Substance Use Disorder Terms
<p><b>Definition:</b> Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition for which one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought:</p> <ol style="list-style-type: none"><li>1. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (“FDA”), or other licensing or regulatory agency, and such final approval has not been granted;</li><li>2. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply has been determined by the FDA to be contraindicated for the specific use;</li><li>3. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, supply is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;</li><li>4. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function;</li><li>5. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is provided pursuant to informed consent documents that</li></ol>	<p><b>Definition:</b> Experimental/Investigational means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition for which one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought:</p> <ul style="list-style-type: none"><li>● The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the FDA or other licensing or regulatory agency, and such final approval has not been granted;</li><li>● The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply has been determined by the FDA to be contraindicated for the specific use;</li><li>● The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is provided as part of a clinical research protocol or Clinical Trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;</li><li>● The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is</li></ul>

describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigational based on the criteria above may still be deemed Experimental/Investigational by Oscar based on assessment as to whether;

1. The scientific evidence is conclusory concerning the effect of the service on health outcomes;
2. The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
3. The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
4. The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Oscar to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigational under the above criteria may include one or more items from the following list, which is not all inclusive:

1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
2. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
3. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
4. Documents of an IRB or other similar body performing substantially the same function; or
5. Consent document(s) and/or the written protocol(s)

subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function

- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

6. Medical records; or

7. The opinions of consulting providers and other experts in the field.

### Coverage Terms (EOC language):

**Experimental / Investigational** means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition for which one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought:

- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the FDA or other licensing or regulatory agency, and such final approval has not been granted;
- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply has been determined by the FDA to be contraindicated for the specific use;
- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is provided as part of a clinical research protocol or Clinical Trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function;
- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

**Any service not deemed Experimental/Investigational** based on the criteria above may still be deemed Experimental/Investigational by Oscar based on assessment as to whether;

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical

investigatory settings.

The information considered or evaluated by Oscar to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigational under the above criteria may include one or more items from the following list, which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, Commonwealth, or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
In-Network Inpatient Services	<ul style="list-style-type: none"> <li>● All Medical/Surgical technologies determined to be Experimental/Investigational</li> </ul>	<ul style="list-style-type: none"> <li>● All technologies determined to be Experimental/Investigational</li> </ul>
In-Network Outpatient Services	<ul style="list-style-type: none"> <li>● All Medical/Surgical technologies determined to be Experimental/Investigational</li> </ul>	<ul style="list-style-type: none"> <li>● All technologies determined to be Experimental/Investigational</li> </ul>

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

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
In-Network Inpatient Services	<ul style="list-style-type: none"> <li>• Clinical Efficacy</li> <li>• Clinical Safety</li> <li>• Appropriateness of the proposed technology for the underlying condition</li> </ul> <p><b>**Note:</b> State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</p>	<p>1. Exclusions for EIU technologies and EIU definitions as outlined in plan documents</p> <p>2. Committees also consider the following factors when assessment whether a technology is EIU:</p> <p>Clinical efficacy</p> <ul style="list-style-type: none"> <li>• Safety</li> <li>• Appropriateness of the proposed technology</li> <li>• Whether the technology is an unproven treatment for a specific diagnosis</li> </ul> <p>The factors are not weighted.</p>
In-Network Outpatient Services	Same as Inpatient Analysis	Same as Inpatient Analysis

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

Benefit Classification	Evidentiary Standards and Sources: Medical/Surgical	Evidentiary Standards and Sources: MH/SUD
In-Network Inpatient Services	<p><b><u>Evidentiary Standards and Sources:</u></b></p> <p>Overall, Clinical Criteria are:</p> <ul style="list-style-type: none"> <li>• Based on nationally-recognized standards;</li> </ul>	<p><b><u>Evidentiary Standards and Sources</u></b></p> <p>1. Plan documents</p> <p>2. MH/SUD assesses the following categories of evidence when determining whether a</p>



	<ul style="list-style-type: none"> <li>● Developed in accordance with the current standards of national accreditation entities;</li> <li>● Developed to ensure quality of care and access to needed healthcare services;</li> <li>● Evidence-based; and</li> <li>● Evaluated and updated at least annually.</li> </ul> <p>Any health care service, testing, procedure, treatment, device or prescription drug for which safety and efficacy has not been established and proven is considered experimental, investigational, or unproven. Services that are not accepted as the standard medical treatment of the condition being treated are considered “new and emerging services and technologies.”</p> <p>To determine whether a service, device, treatment or procedure has proven safety and efficacy, the available reliable evidence is reviewed, which may include but is not limited to (listed in order of decreasing reliability):</p> <ol style="list-style-type: none"> <li>1. Published technology assessments and/or high quality meta analyses</li> <li>2. Randomized, controlled trials</li> <li>3. Other controlled studies or cohort studies</li> <li>4. Case reports or case series</li> <li>5. Reports of expert opinion</li> </ol> <p><b>**Note:</b> State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards</p>	<p>technology is EIU</p> <ul style="list-style-type: none"> <li>● Plan documents</li> <li>● Scientifically based clinical evidence</li> <li>● Peer-reviewed literature</li> <li>● Hierarchy of Clinical Evidence: <ul style="list-style-type: none"> <li>○ Systematic reviews and meta-analyses</li> <li>○ Randomized controlled trials</li> <li>○ Large non-randomized controlled trials</li> <li>○ Large prospective trials</li> <li>○ Comparative and cohort studies</li> <li>○ Cross sectional studies</li> <li>○ Retrospective studies</li> <li>○ Surveillance studies</li> <li>○ Case Reviews/Case series</li> <li>○ Anecdotal/editorial statements</li> <li>○ Professional opinions</li> </ul> </li> </ul> <p>No MH/SUD service is deemed unproven solely on the basis of a lack of randomized controlled trials particularly for new and emerging behavioral health technologies.</p> <p>In the absence of strong and compelling scientific evidence, clinical policies may be based upon:</p> <ul style="list-style-type: none"> <li>● National consensus statements</li> <li>● Publications by recognized authorities such as government sources and/or professional societies</li> </ul>
--	--	---



In-Network Outpatient Services	Same as Inpatient Analysis	<p><b><u>Evidentiary Standards and Sources</u></b></p> <p>1. Plan documents</p> <p>2. MH/SUD assesses the following categories of evidence when determining whether a technology is EIU</p> <ul style="list-style-type: none"> <li>● Plan documents</li> <li>● Scientifically based clinical evidence</li> <li>● Peer-reviewed literature</li> <li>● Hierarchy of Clinical Evidence: <ul style="list-style-type: none"> <li>○ Systematic reviews and meta-analyses</li> <li>○ Randomized controlled trials</li> <li>○ Large non-randomized controlled trials</li> <li>○ Large prospective trials</li> <li>○ Comparative and cohort studies</li> <li>○ Cross sectional studies</li> <li>○ Retrospective studies</li> <li>○ Surveillance studies</li> <li>○ Case Reviews/Case series</li> <li>○ Anecdotal/editorial statements</li> <li>○ Professional opinions</li> </ul> </li> </ul> <p>No MH/SUD service is deemed unproven solely on the basis of a lack of randomized controlled trials particularly for new and emerging behavioral health technologies.</p> <p>In the absence of strong and compelling scientific evidence, clinical policies may be based upon:</p> <ul style="list-style-type: none"> <li>● National consensus statements</li> <li>● Publications by recognized authorities such as government sources and/or professional societies</li> </ul>
--------------------------------	----------------------------	--

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

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

Benefit Classification	Committee Composition: Medical/Surgical	Committee Composition: MH/SUD
In Network Inpatient Services/Outpatient Services	The OMC Board of Directors has the ultimate authority and responsibility for the quality of care and services delivered to its members. The Board of Directors provides strategic planning and direction, budget approval, and staff allocation for the UM Department. The Board of Directors assigns day-to-day responsibility for implementation of the UM Program to the UM Subcommittee, which is a subcommittee of the Quality Improvement Committee. The Board of Directors oversees the implementation of and adherence to the UM Program through the UM Subcommittee. The UM Subcommittee reports to the Quality Improvement Committee at a minimum of once per quarter, per year. The UM Program and Annual Program Evaluation are approved at the UM Subcommittee portion of the Quality Improvement Committee meeting. Minutes	The Clinical Technology Assessment Committee (CTAC) is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies. CTAC obtains approval from the Clinical Quality and Operations Committee (CQOC). CTAC is Co-Chaired by two licensed and board-certified psychiatrists (MDs) who are Medical Directors. Voting membership includes licensed and board-certified psychiatrists (MDs) and Medical Directors whose specialties includes General Psychiatry, Addiction Medicine, Research, Geriatrics, Child/Adolescent Psychiatry, Adult Psychiatry, Forensic Psychiatry as well as a PhD, VP of Research and Evaluation. Additional representatives attend as non-voting membership, including Legal Counsel, Compliance, Clinical Review (MD and RN) and Clinical Policy (MSN, RN, LCSW, MBA, M.A, N.C.C). CTAC meets three times annually and ad hoc, as necessary.  Once a technology has been assessed, a behavioral clinical policy is updated or

	<p>conveying this approval are submitted to the Board of Directors, who approve the actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical).</p> <p>As noted above, the UM Subcommittee is a sub-committee to the Quality Improvement Committee. A senior-level physician chairs the UM Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary.</p> <p>The UM Subcommittee undertakes, but is not limited to, the following ongoing activities:</p> <ul style="list-style-type: none"> <li>● Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated.</li> <li>● Reviews and approves modifications to the UM</li> </ul>	<p>developed which outlines CTAC's findings. The behavioral clinical policies are reviewed and voted upon by CTAC's oversight Committee, the Clinical Quality and Operations Committee (CQOC). All behavioral clinical policies are reviewed and/or updated at least once annually.</p> <p>The CTAC undertakes, but is not limited to, the following ongoing activities:</p> <ul style="list-style-type: none"> <li>● Evaluating new behavioral health technologies/services and new applications of existing behavioral health technologies/services as per the policy, Clinical Technology Assessments.</li> <li>● Reviewing requests for evaluation of new technologies/services received from any of the organization's business units or directly from contracted health plans as appropriate.</li> <li>● Providing parameters, when available, to inform implementation of the technology.</li> </ul>
--	--	---

	<p>Program as indicated by operational needs and/or to meet regulatory and accreditation compliance.</p> <ul style="list-style-type: none"> <li>• Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services.</li> <li>• Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.</li> </ul>	
--	---	--

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

<b>Benefit Classification</b>	<b>Process Description: Medical/Surgical</b>	<b>Process Description: MH/SUD</b>
In-Network Inpatient Services/Outpatient Services	<p><b>Process for E/I determination:</b></p> <p>A senior-level physician chairs the Utilization Management Subcommittee with representation from licensed physicians (MD, DO) and licensed nurses (RN). Key health plan functions are represented at the meeting, including participation of the behavioral health designated physician (MD, clinical PhD, PsyD). Additional internal department representatives attend based on identified needs. The UM Subcommittee meets quarterly, or more frequently as necessary. The Utilization Management Subcommittee is a sub-committee to the Quality Improvement Committee, which ultimately</p>	<p><b>Process for E/I determination:</b></p> <p>OBHS uses committees to assess technologies and conduct a thorough review of the scientifically based clinical evidence and peer-reviewed literature in accordance with the Hierarchy of Clinical Evidence in order to develop medical/clinical policies that apply to the technologies. The Clinical Technology Assessment Committee (CTAC) is responsible for developing evidence-based Behavioral Clinical Policies for select behavioral health technologies and obtains approval from the Clinical Quality and Operations Committee (CQOC). CTAC is comprised of board-certified psychiatrists, addictionologists, behavioral health professionals and clinical representatives from Optum's Research &amp; Evaluation organization. MH/SUD technologies assessed</p>

	<p>determines whether a service, device, treatment or procedure has proven safety and efficacy, the available reliable evidence<sup>1</sup> is reviewed, which may include but is not limited to (listed in order of decreasing reliability):</p> <ol style="list-style-type: none"> <li>1. Published technology assessments and/or high quality meta analyses</li> <li>2. Randomized, controlled trials</li> <li>3. Other controlled studies or cohort studies</li> </ol> <p><b>IRR Process:</b> All clinicians (nurses, pharmacists, physicians, behavioral health practitioners) involved in clinical decision-making participate in IRR testing to ensure high quality, evidence-based decision-making and the consistent application of clinical criteria across its clinical UM staff. In IRR testing, clinicians are given the same clinical scenario cases. The IRR cases include hypothetical cases designed by OMC or complex cases where a learning opportunity has been identified. The IRR testing benchmark is 80%, and differences in determinations are used as the basis for quarterly clinical discussion and training. For cases where scores are below benchmark, the cases will be addressed in remediation discussions for continued quality improvement.</p> <p><b>Qualifications of E/I reviewers:</b> The Clinical Advisory Subcommittee is chaired by a Senior</p>	<p>by the CTAC committee as NOT being safe, clinically effective and/or appropriate are determined to be EIU. Once a technology has been assessed, a medical/clinical policy is developed which outlines CTAC's findings. All medical/clinical policies are reviewed and/or updated at least once annually.</p> <p><b>IRR Process:</b> All MH/SUD clinical staff utilize behavioral clinical policies when making coverage determinations of EIU technology services. All MH/SUD clinical staff who make coverage determinations utilizing behavioral clinical policies are required to participate in annual Inter-Rater Reliability (IRR) assessments to ensure policies are applied in a consistent and appropriate manner "in operation." Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff and provides additional training on the use and application of the relevant policies to those who do not achieve a passing score. If necessary, remediation planning and training will be directed by a Supervisor/Manager.</p> <p><b>Qualifications of E/I reviewers:</b> CTAC is board-certified psychiatrists, addictionologists, behavioral health professionals and clinical representatives from Optum's Research &amp; Evaluation organization. In addition to board certified psychiatrists (MD/DO), committee qualifications also include Psychologists (PhD/PsyD) and behavioral health clinicians (graduate degrees and/or RN).</p>
--	--	--

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

	<p>Medical Director and consists of the following:</p> <ul style="list-style-type: none"> <li>• Internal membership: Clinical Operations Nurse (RN), Senior Medical Director, Clinical Review (MD or DO), State/Regional Medical Directors (MD or DO), Designated Behavioral Health Physician (MD)</li> <li>• External membership: At least four network participating practitioners (e.g., MDs, DOs)</li> </ul> <p>Finally, these changes are reported to the UM Subcommittee and ultimately through the Quality Improvement Committee of the Board.</p>	
--	---	--

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

Benefit Classification	Comparative Analysis
In-Network Inpatient Services/Out patient Services	<p><b>Monitoring and Oversight:</b></p> <p>The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) services are subject to experimental/investigational determinations “as written.”</p> <p>The Plan ensures that the criteria and processes used for medical necessity are no more stringently applied to MH/SUD than medical/surgical benefits in operation, whether utilization review is conducted by the same or different entities. The Plan maintains a clinical criteria hierarchy crosswalk between the M/S and MH/SUD benefits, performs clinical interrater reliability testing, and ensures processes are applied consistently across each benefit classification.</p> <p>Medical/Surgical:</p> <p>The Plan uses documented clinical review criteria based on sound clinical evidence to make utilization management decisions, including medical necessity coverage determinations. All clinicians involved in clinical decision-making participate in annual inter-rater reliability (IRR)</p>

	<p>testing to ensure high quality, evidence-based decision making and consistent application of clinical criteria across its clinical UM staff. The IRR testing benchmark is 80%, and differences in determinations are used as the basis for quarterly clinical discussion and training. For cases where scores are below benchmark, the cases will be addressed in remediation discussions for continued quality improvement.</p> <p>MH/SUD:</p> <p>M/S and MH/SUD utilize medical/clinical policies when making medical necessity coverage determinations related to M/S and MH/SUD technologies. All M/S and MH/SUD clinical staff who make coverage determinations utilizing medical/clinical policies are required to participate in annual Inter-Rater Reliability (IRR) audits to ensure policies/criteria are applied in a consistent and appropriate manner “in operation.” For clinical staff who do not achieve a passing score of 90%, remediation may include re-education, additional mentoring, additional chart audits and call monitoring to provide clinical education and guidance on the use and application of the relevant policies/criteria.</p> <p><b>In-Operation Metrics:</b></p> <table border="1" data-bbox="326 894 1567 1066"> <tr> <th data-bbox="326 894 946 995">Inter-rater reliability scores clinical reviewers (M/S) 2021:</th><th data-bbox="946 894 1567 995">Inter-rater reliability scores clinical reviewers (MH/SUD) 2021:</th></tr> <tr> <td data-bbox="326 995 946 1066"> <ul style="list-style-type: none"> <li>• Average IRR score: 92%</li> </ul> </td><td data-bbox="946 995 1567 1066"> <ul style="list-style-type: none"> <li>• Average IRR score: 96%</li> </ul> </td></tr> </table>	Inter-rater reliability scores clinical reviewers (M/S) 2021:	Inter-rater reliability scores clinical reviewers (MH/SUD) 2021:	<ul style="list-style-type: none"> <li>• Average IRR score: 92%</li> </ul>	<ul style="list-style-type: none"> <li>• Average IRR score: 96%</li> </ul>
Inter-rater reliability scores clinical reviewers (M/S) 2021:	Inter-rater reliability scores clinical reviewers (MH/SUD) 2021:				
<ul style="list-style-type: none"> <li>• Average IRR score: 92%</li> </ul>	<ul style="list-style-type: none"> <li>• Average IRR score: 96%</li> </ul>				

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

Benefit Classification	Findings and Conclusions
In-Network Inpatient Services/Outpatient Services	<p>The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:</p> <p>The factors are aligned for experimental/investigational across M/S and MH/SUD. The same factors are used to determine whether a service is experimental/investigational for M/S and MH/SUD and include:</p>

1. Clinical efficacy
2. Clinical safety
3. Appropriateness of the proposed technology

Additionally, For sources and evidentiary standards, both M/S and MH/SUD rely on the source and evidentiary standard information for medical necessity criteria to support whether services are experimental/investigational.

One difference in the analysis is that for MH/SUD benefits, an additional factor is listed in step 2. This factor is “whether the technology is an unproven treatment for a specific diagnosis.” The Plan has concluded that this difference does not result in more stringency for MH/SUD benefits when compared to M/S benefits because this factor is closely aligned with the M/S factor “appropriateness of the proposed technology **for the underlying condition.**” Experimental/Investigational determinations for M/S and MH/SUD benefits both rely on whether the technology is appropriate for the treatment of a specific condition and therefore are aligned in methodology for such determinations.

For both MH/SUD and M/S, IRR testing is commenced to ensure that clinical criteria is closely adhered to. MH/SUD requires a higher passing score of 90% which is more beneficial for MH/SUD services as it ensures that clinical criteria are applied as consistently and accurately as possible when applying medical necessity criteria.

**Findings:** Both M/S and MH/SUD clinical reviewers are required to successfully complete an annual IRR assessment. The same standards are used; clinical reviewers are expected to pass the IRR assessment with a score of 80% or better for M/S and 90% or better for MH/SUD. The average IRR score for MH/SUD clinicians was slightly higher in 2022 compared to the IRR score for M/S providers. Both MH/SUD clinicians and M/S clinicians on average meet the appropriate benchmarks for rendering appropriate medical necessity determinations revealing that this NQTL is applied no more stringently to MH/SUD benefits. These results show that clinical reviewers appropriately applied medical/behavioral clinical policies when making utilization review determinations.

The findings of the comparative analysis reveal that the process and methodology for experimental/investigational determinations for mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology for experimental/investigational determinations for medical/surgical services.



<b>Non-Quantitative Treatment Limitation (NQTL) Analysis Index</b>	
<b>Non-Quantitative Treatment Limitation</b>	Formulary Design/Formulary Tiering
<b>Plan Type(s) Applicable</b>	<b>Oscar Health Plan of Georgia</b>
<b>Responsible Business Teams</b>	Pharmacy
<b>Names of Person(s) Responsible for Analysis Formation</b>	<p>Kemper May, PharmD, Manager, Formulary Operations (Seven years experience in Pharmacy at a Health Plan)</p> <p>Jeenal Patel, PharmD, Senior Clinical Formulary Pharmacist (Nine years Pharmacy experience, two of which were dedicated to Pharmacy at a Health Plan)</p>
<b>Last Update</b>	12/11/23
<b>Reviewers</b>	<p>Alexandra Rubino, MPH, Associate Director, MHP</p> <p>(Over 5 years experience in Mental Health Parity reporting and operational compliance)</p>



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

#### **General Description/Explanation of the NQTL:**

A formulary is a list of prescription drugs covered by a drug plan offering prescription drug benefit. A formulary is sometimes referred to as a covered drug list.

The copay tiers on a formulary determine the amount that the member pays for coverage of a prescription. The copay tiers are based on whether the drug is formulary-eligible, included as covered on the formulary, available as a generic or a brand product, and whether the brand or generic drug product is considered preferred, non-preferred, or formulary-excluded.

The classification of specialty drug status typically includes higher-cost drugs that require special handling, special storage, or close clinical monitoring of the member. Due to the special handling of the drug or the drug's limited distribution, the prescription may need to be dispensed from a specialty pharmacy. The applicable copay for a specialty drug would apply.

#### **For Oscar 4-tier formularies (Standard Plans):**

Tier 0: The prescription drug tier which consists of select generics and brand products at no cost-share to the member.

Tier 1: The prescription drug tier which consists of generic drugs are generally the least expensive option for prescriptions. They are approved by the Food and Drug Administration (FDA) for the same safety and effectiveness as their brand name equivalent.

Tier 2: The prescription drug tier which consists of typically brand medications that generally have lower prices and copays than non-preferred brands.

Tier 3: The prescription drug tier which consists typically of brand medications that generally have higher prices and copays than preferred brands.

Tier 4: The prescription drug tier which consists of specialty drugs which are typically the highest cost drugs on the formulary and are limited by the Food and Drug Administration (FDA) or drug manufacturer to specialty pharmacies. These drugs also may require clinical monitoring or training for self-administration.

#### **For Oscar 6-tier formularies (Non-standard Plans):**

Tier 0: The prescription drug tier which consists of select generics and brand products at no cost-share to the member.

Tier 1: The prescription drug tier which consists of preferred generic drugs are typically the least expensive option for prescriptions - and generally more affordable than other generics. They are approved by the Food and Drug Administration (FDA) for the same safety and effectiveness as their brand name equivalent..

Tier 2: The prescription drug tier which consists of non- preferred generic drugs are typically higher cost generic medications but are generally less expensive than brand name medications.

Tier 3: The prescription drug tier which consists of typically brand medications that generally have lower prices and copays than non-preferred brands.

Tier 4: The prescription drug tier which consists typically of brand medications that generally have higher prices and copays than preferred brands.

Tier 5: Preferred Specialty drugs are typically the high cost drugs on the formulary and are limited by the Food and Drug Administration (FDA) or drug manufacturer to specialty pharmacies. These drugs also may require clinical monitoring or training for self-administration..

Tier 6: The prescription drug tier which consists of non-preferred Specialty drugs are typically the highest cost drugs on the formulary and are limited by the Food and Drug Administration (FDA) or drug manufacturer to specialty pharmacies. These drugs also may require clinical monitoring or training for self-administration.

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

## Plan/Coverage Terms:

### Coverage Terms (Evidence of Coverage):

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

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

**Cost-Sharing Amounts:** The Formulary tier determines how much You pay. The cost-sharing amount for Your medications is determined by the Formulary tier of the drug being dispensed. Please see Your Schedule of Benefits for more details about Your plan's specific cost-sharing amounts.

**Formulary Exception Process:** You can request that Oscar cover a drug that isn't listed on our Formulary. If You or Your Health Care Provider believe Your treatment needs require a medication not on the Oscar Formulary, Your Health Care Provider can submit an exception Request. The necessary form can be found on our website at [www.hioscar.com](http://www.hioscar.com). Once submitted, the exception request will be reviewed by a Clinician in accordance with state specific timeframes. Your Provider can request either an expedited or standard review.

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
Pharmacy	<p>Please see:  <a href="https://www.hioscar.com/forms/2022/ny">https://www.hioscar.com/forms/2022/ny</a></p> <p>All other drug classes not listed under MH/SUD</p>	<p>Please see:  <a href="https://www.hioscar.com/forms/2022/ny">https://www.hioscar.com/forms/2022/ny</a></p> <ul style="list-style-type: none"> <li>• Attention Deficit/Hyperactivity Disorder (ADHD) agents/stimulants</li> <li>• Antianxiety agents</li> <li>• Antidepressants</li> </ul>

		<ul style="list-style-type: none"> <li>• Antipsychotics</li> <li>• Hypnotics</li> <li>• Mood Stabilizers (specifically Lamotrigine)</li> <li>• Substance Use Disorder (SUD) agents</li> </ul>
--	--	---

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

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

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

Factor	Sources	Evidentiary Standards/Thresholds
Brand or generic status of the drug (including generic releases upcoming)	Medispan MONY code designation of MON = Brand; Y = Generic; Rx/OTC designation where MediSpan qualifier O/P = OTC and R/S = Rx	<p>The P&amp;T Committee reviews the brand/generic status of the drug. AB rated Generic drugs are typically assigned to tiers 1 and 2.</p> <p>Non specialty brand drugs are typically assigned to tier 3 or 4. Speciality drugs are typically assigned to tier 4 or 5</p>
Availability of therapeutic alternatives	<p>Consensus documents and nationally sanctioned guidelines: Milliman Care Guidelines (MCG), Hayes, Inc., Up-To-Date</p> <p>Recognized drug compendia: US Pharmacopeia, Clinical Pharmacology, Lexicomp, Micromedex</p>	The P&T Committee will review the category/class to determine if a FDA approved AB-rated drug with similar therapeutic efficacy and safety exists or if there is a unique indication or population that may benefit from the addition of the comparator product based on standards of practice, clinical guideline recommendation, and evidence-based

	<p>Publications of the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), and other organizations or government agencies</p> <p>Evidence-based reviews of peer-reviewed medical literature and relevant clinical information: American Journal of Medicine, SAMHSA, American Journal of Psychiatry, Journal of Clinical Oncology, NCCN etc.</p> <p>Standards of care recommended by clinical literature, medical or pharmacy societies, standard clinical drug references: Nexis, Orange Book, PubMed, UpToDate, JAMA, NCCN, American Heart Association, American Academy of Neurology</p> <p>Appropriate clinical drug information from other sources as applicable: FDA.gov, Clinicaltrial.gov, ASHP (American Society of Health-System Pharmacists)</p>	<p>reviews.</p> <p>Availability of therapeutic alternatives is assessed by evaluating clinical efficacy. <b>Clinical efficacy</b> is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. <b>Clinical effectiveness</b> is based on the evidence of clinical trials that the interventions are considered to be effective for the general population.</p> <p>The Plan measures efficacy by the below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition.</p> <p>Class I: "Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective. Class IIa: "Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy."</p> <p>Clinical Pharmacology Rating:</p> <ul style="list-style-type: none"> <li>• Strength of Recommendation of "strong".</li> <li>• Level of evidence rating of "High, Moderate"</li> </ul> <p>Or rating systems considering efficacy of regimen/agent is moderately effective such as NCCN definition of 2b evidence "Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate" or higher levels of efficacy.</p>
Average daily drug cost	Pharmacy Claims Data	<ul style="list-style-type: none"> <li>• The generic tier includes all generic drugs under \$360.00 (on</li> </ul>

		<p>average) for 30-day ingredient costs (Tier 1)</p> <ul style="list-style-type: none"> <li>• The brand tier includes generic drugs over \$360.00 (on avg) and any brand drugs with a cost</li> <li>• between \$360.00 and \$3700.00 (on average) (Tiers 3 and Tier 4)</li> <li>• The specialty tier includes all drugs above \$3700.00 dollars (on average) regardless of generic status (Tier 5 and Tier 6)</li> </ul>
Applicable manufacturer agreement	CVS CFC Team - Proprietary Trade Agreements	<p>Manufacturers may offer competitive rebates in order for the Health Plan to employ the lowest net cost strategy for both the plan and members. As a result, manufacturers in certain instances may dictate which tier a drug needs to fall on.</p> <p>Example: 2023 Pfizer trade agreement states Norditropin must be placed on the preferred specialty tier in order to offer a low net cost growth hormone strategy.</p>
Regulatory requirements - certain prescription drugs are mandated to be covered as essential health benefits; drug formularies are often regulated at the state level regarding formulary design (e.g., limitations with select drugs needing to be on certain tiers).	Government regulations/state legislation websites, memos, bulletins	<p>Examples include but are not limited to:</p> <ol style="list-style-type: none"> <li>1) ACA: The Affordable Care Act mandates that health plans cover recommended preventive services without charging a deductible, copayment, or co-insurance (at the lowest tier: Tier 0)</li> <li>2) Perphenazine-Amitriptyline tablet required to be covered to meet state filing benchmarks</li> </ol>

**4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are**



applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits:

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

changes are reported to CMS during the contract year. Members complete a Conflict of Interest and Non-Disclosure Agreement, annually.

Voting Members	Qualifications
Chief Medical Officer	Licensure: Medical Doctor Specialty: Internal Medicine
External Member	Licensure: Medical Doctor Specialty: Rheumatology
External Member	Licensure: PharmD
External Member	Licensure: Pharm D Specialty: Infectious disease
External Member	Licensure: Medical Doctor Specialty: Family Practice
External Member	Licensure: Medical Doctor Specialty: Psychiatry
External Member	Licensure: PharmD Specialty: Oncology
Managing Medical Director	Licensure: Medical Doctor Specialty: Pediatric
Medical Director	Licensure: Medical Doctor Specialty: Surgery
Medical Director	Licensure: Medical Doctor Specialty: Hematology-Oncology
Medical Director	Licensure: Medical Doctor Specialty: Neurology
Medical Director	Licensure: Medical Doctor Specialty: Family Practice
Medical Director	Licensure: Medical Doctor Specialty: Family Practice

*Responsibilities:*



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

*Internal oversight of the P&T Committee:*

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

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

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

- Evaluates and refines the UM Program through analysis of curated objective metrics and subjective feedback from members and Providers, making recommendations for intervention when indicated.
- Reviews and approves modifications to the UM Program as indicated by operational needs and/or to meet regulatory and accreditation compliance.

- Reviews and approves written Clinical Criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services.
- Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.

FDA-approved drug products are reviewed and considered for inclusion on the formulary by the P&T Committee. In evaluating new drugs for formulary inclusion, the P&T Committee reviews the individual drug monographs, pivotal clinical trials accompanying the drug monographs, and therapeutic class reviews. The Committee members share insights based on their clinical practice and the quality of published literature. Additionally, the P&T members are tasked with reviewing and approving all utilization management (UM) criteria (i.e., prior authorization, step therapy and quantity limits outside of FDA-approved labeling). The P&T Committee reviews all formulary additions and removals as well as all tier changes and the formulary is reviewed annually.

#### ***MHPAEA Summary***

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

The factors that determine the formulary design are the same for both MH/SUD drugs and M/S drugs. Formulary design is determined by brand or generic status of the drug (including generic releases upcoming), availability of therapeutic alternatives, average daily drug cost, applicable manufacturer agreement, and regulatory requirements. The plan also uses the same evidentiary standards and sources to determine the thresholds and supporting information for the aforementioned factors across all drug types (M/S and MH/SUD). There is no discrepancy between the factors, evidentiary standards, sources, and processes used to determine formulary design because all drugs, regardless of drug-type, are subject to the same underlying methodology. However, the Plan has conducted an in-operation quantitative analysis below to quantify the extent to which a discrepancy may exist for formulary design operationally.

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

## In-Operation:

### Overview:

Operationally, the Plan performs in-operation data assessments for formulary design to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across M/S and MH/SUD drugs.

**Table 1 - Number and proportion of MH, SUD, and M/S drugs placed in each tier**

Tier	Condition		Total Drugs in Tier	Proportion of drugs in tier by condition
Tier 0	ACA	MH	0	0%
		SUD	395	26%
		M/S	1113	74%
Tier 1a	Generic - preferred	MH	8310	18%
		SUD	0	0%
		M/S	39108	82%
Tier 1b	Generic - non-preferred	MH	14641	21%
		SUD	340	0%
		M/S	55852	79%
Tier 2	Brand - preferred	MH	1121	19%
		SUD	6	0%
		M/S	4702	81%
Tier 3	Brand - non-preferred	MH	372	11%
		SUD	0	0%
		M/S	3120	89%
Tier 4	Specialty - preferred	MH	4	0%
		SUD	0	0%
		M/S	2205	100%
Tier 5	Specialty - non-preferred	MH	0	0%
		SUD	0	0%
		M/S	137	100%

For tiering, we use the decision tree<sup>1</sup> and logistic regression together to model the probability that an on-formulary drug is assigned to a certain tier. Based on the output of the decision tree model, we assessed that if a drug has worse than expected formulary status and if the being MH/SUD contributed to the discrepancy.

The reasoning for this framework is as follows:

1. The tiering is not a simple binary outcome as the case for UM. While it's possible to use one single complex model, this two-step modeling approach makes it easier to frame the analysis with more explainable/interpretable models.
2. The tiers are grouped into three main tiers in the decision tree step because the formularies in certain states do not have preferred and non-preferred. This grouping makes it possible to apply a general approach to all states.
3. Tier zero (Preventative drugs and Contraceptives) is omitted because it is largely determined by regulatory rules, and not driven by cost and drug type.

The first step is to use a decision tree to estimate the three major tiers including generic, brand, and specialty. We treat the output of this step as the expected tiers.

This decision tree model can be summarized as below:

- The generic tier includes all generic drugs under \$360.00 for 30-day ingredient cost
- The brand tier includes non-generic drugs over \$360.00 and any drugs with a cost between \$360.00 and \$3700.00
- The specialty tier includes all drugs above \$3700.00 dollars regardless of generic status

Based on the expected tiers, in the second step, the Plan uses three logistic regression models to assess the three hypotheses independently:

- If BH drugs have higher than expected tiers
- If BH drugs are more likely to be non-preferred generic than preferred generic

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

- If BH drugs are more likely to be non-preferred brand than preferred brand

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

***Regression Analysis:***

	Formulary Status	
State	p_value	coef
GA	0.00	-0.77

Findings: The coefficient is negative in GA and the P value < 0.05. This indicates that: MH/SUD are less likely to be off-formulary compared to similar M/S drugs

	Tiering	
State	p_value	coef
GA	0.00	-0.67

Findings: The coefficient is negative in GA and the P value < 0.05. This indicates MH/SUD drugs are less likely to be put on higher tiers compared to similar M/S drugs

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

Benefit Classification	Findings and Conclusions
Pharmacy	The underlying processes, strategies, evidentiary standards and other factors used to

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

<b>Non-Quantitative Treatment Limitation (NQTL) Analysis Index</b>	
<b>Non-Quantitative Treatment Limitation</b>	Fraud, Waste, and Abuse
<b>Plan Type(s) Applicable</b>	<b>Oscar Health Plan of Georgia</b>
<b>Responsible Business Teams</b>	Special Investigations Unit
<b>Names of Person(s) Responsible for Analysis Formation</b>	<p>Nicole Matty Associate Director, SIU Attorney with over ten years experience conducting insurance fraud investigations.</p> <p>Michael Hermosillo Process Optimization Associate, SIU Two years experience in Special Investigations at Oscar Health</p>
<b>Last Update</b>	12/11/2023
<b>Reviewers</b>	Alexandra Rubino, Associate Director, MHP (Over five years experience in Mental Health Parity reporting and operational compliance)



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

### Fraud, Waste, and Abuse

1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQL, 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 NQL applies or for which it does not apply:

General Description/Explanation of the NQL:
<p><b>Fraud:</b> Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program. Fraud has both civil and criminal implications (<i>18 U.S. Code § 1347</i>).</p> <p><b>Waste:</b> Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and state healthcare programs. Waste is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.</p> <p><b>Abuse:</b> Improper behaviors or billing practices that may, directly or indirectly, result in unnecessary costs to healthcare programs. It involves practices that are inconsistent with generally accepted business or medical practices and it may result in an unnecessary spend. Some examples are misusing codes on claims, not complying with national or local coding guidelines or inappropriately allocating costs on a cost report.</p>

Benefit Classification	Medical/Surgical Services to which the NQL applies	Mental Health/SUD Services to which the NQL applies
Inpatient In-Network	Oscar employs an in-house Special Investigations Unit (SIU) responsible for carrying out Oscar's Antifraud Program. As part of its investigations, pre-payment or post-payment reviews may be applied to claims of a provider or member for whom there is a basis to suggest inappropriate billing or services. Antifraud	Oscar employs an in-house Special Investigations Unit (SIU) responsible for carrying out Oscar's Antifraud Program. As part of its investigations, pre-payment or post-payment reviews may be applied to claims of a provider or member for whom there is a basis to suggest inappropriate billing or services. Antifraud detection and
Inpatient, Out-of-Network		



Outpatient, In-Network	detection and investigations are applied across all claim and service types and are applied no more stringently to MH/SUD than to Med/Surg benefits.	investigations are applied across all claim and service types and are applied no more stringently to MH/SUD than to Med/Surg benefits. Additionally, Oscar delegates Optum Payment and Integrity as the dedicated group responsible for reducing Fraud, Waste, Abuse, and Error (FWAE) for behavioral health services. Oscar consistently reviews and monitors its processes and technologies to ensure that detection systems, tools, and goals are aligned to meet the business needs and effectively prevent FWAE. Oscar meets with our delegate on a periodic and consistent basis to ensure all operating FWA metrics are properly reported, to discuss active investigations and other applicable FWA metrics specific to the MH/SUD claims.
Outpatient, Out-of-Network		
Emergency		
Prescription Drugs	Oscar employs an in-house Special Investigations Unit (SIU) responsible for carrying out Oscar's Antifraud Program. As part of its investigations, reviews may be applied to RX claims of a referring provider, member, or pharmacy for whom there is a basis to suggest inappropriate billing or services. Antifraud detection and investigations are applied across claims and are applied no more stringently to MH/SUH than to Med/Surg benefits	Oscar employs an in-house Special Investigations Unit (SIU) responsible for carrying out Oscar's Antifraud Program. As part of its investigations, reviews may be applied to RX claims of a referring provider, member, or pharmacy for whom there is a basis to suggest inappropriate billing or services. Antifraud detection and investigations are applied across claim and service types and are applied no more stringently to MH/SUH than to Med/Surg benefits. Additionally, Oscar delegates Optum PNI as the dedicated group responsible for reducing Fraud, Waste, Abuse, and Error (FWAE) for behavioral health services. Oscar consistently reviews and monitors its processes and technologies to ensure that detection systems, tools, and goals are aligned to meet the business needs and effectively prevent FWAE. Oscar meets with our delegate on a periodic and consistent basis to ensure all operating FWA metrics are properly reported, to discuss active investigations and other

		applicable FWA metrics specific to the MH/SUD claims.
--	--	---

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

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

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

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD														
Inpatient In-Network	<table><tr><th>Risk Prioritization Scale (0-1000)</th><th>FWA Priority Level</th></tr><tr><td>750-1000</td><td>Urgent (5)</td></tr><tr><td>500-749</td><td>High (4)</td></tr><tr><td>250-499</td><td>Medium (3)</td></tr><tr><td>100-249</td><td>Low (2)</td></tr><tr><td>0-99*</td><td>Very low (1)</td></tr><tr><td colspan="2">Total Points Possible: 1000</td></tr></table>		Risk Prioritization Scale (0-1000)	FWA Priority Level	750-1000	Urgent (5)	500-749	High (4)	250-499	Medium (3)	100-249	Low (2)	0-99*	Very low (1)	Total Points Possible: 1000	
Risk Prioritization Scale (0-1000)	FWA Priority Level															
750-1000	Urgent (5)															
500-749	High (4)															
250-499	Medium (3)															
100-249	Low (2)															
0-99*	Very low (1)															
Total Points Possible: 1000																
Inpatient, Out-of-Network																
Outpatient, In-Network																
Outpatient, Out-of-Network	<table><tr><th>Factors Considered:</th></tr><tr><td><b>Factor:</b><ul style="list-style-type: none"><li>Financial Exposure; referring to the dollar amount at potential risk.</li></ul></td></tr></table>		Factors Considered:	<b>Factor:</b> <ul style="list-style-type: none"><li>Financial Exposure; referring to the dollar amount at potential risk.</li></ul>												
Factors Considered:																
<b>Factor:</b> <ul style="list-style-type: none"><li>Financial Exposure; referring to the dollar amount at potential risk.</li></ul>																
Emergency																

## Prescription Drugs

- **Evidentiary Standard:**

**Financial Exposure**  
(Points: 0-250)

Criteria	Points
\$1,000,000 +	250
<\$1,000,000	
>\$500,000	125
<\$500,000	100

>\$100,000	
<\$100,000	
>\$25,000	20
<\$25,000	
\$0+	5
250	<b>Exposure Total</b>

**Source:**

- Provider Claims History

● **Factor:**

- Prior History: previous PFWA related incidents, alerts, or flags.

●

● **Evidentiary Standard:**

**Prior History**  
(Points: **Cap at 100: 0-100**)

Criteria	Points
Prior substantiated lead or criminal/License/exclusion issue	75
Prior unsubstantiated, inconclusive lead	25
Prior external flag (SIRIS, HFPP)	25
HCFS Alert	5
No prior leads	0
100	<b>History Total</b>

● **Source:**

- PFWA escalations, as recorded in the JIRA task management system
- FWA industry information sharing agencies (NHCAA/SIRIS, HFPP, HPMS/CMS, NPPES etc.)
- Healthcare Fraud Shield
- State medical licensing board verification

- Network Status; the facilities, providers, and suppliers, our plan has contra

● **Evidentiary Standard:**

**Network Status**  
(Points: 25-75)

Criteria	Points
INN	75
OON	25
75	<b>Network Total</b>

**Source:**

- Platform Directory / Provider Contract

● **Factor:**

- Line of Business; the general classification of an insurance industry product

●

● **Evidentiary Standard:**

**Line of Business**  
(Points: 50-100)  
Choose All

Criteria	Points
IVL or SG	25
Platform	25
Medicare Advantage	50
100	<b>LOB Total</b>

● **Source:**

- Directory / Provider Contract
- Provider Claims History

● **Factor:**

- Target Type; or targeted category.

●

● **Evidentiary Standard:**

**Target Type**  
(Points: 5-50)

Criteria	Points
Provider (Med, Pharmacy, DME, lab etc)	50

--	--

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

Benefit Classification	Process Description: Medical/Surgical	Process Description: MH/SUD
Inpatient In-Network	Oscar’s SIU is responsible for reviewing all referrals related to suspected FWA, and for determining whether opening an investigation is appropriate. The SIU is made aware of potential instances of FWA through several channels not limited to: internal escalation, data analysis, or external referral from law enforcement, regulatory	
Inpatient, Out-of-Network		

Outpatient, In-Network	agencies, other SIUs, National HealthCare Anti-Fraud Association (NHCAA) or the Healthcare Fraud Prevention Partnership (HFPP).
Outpatient, Out-of-Network	<p>When reports of potential FWA are received, the SIU makes best efforts to review them in a timely manner. For any reports related to Medicare beneficiaries, a reasonable inquiry is initiated as quickly as possible, but not later than 2 weeks after the date the potential FWA incident was identified in compliance with CMS Managed Care Manual Chapters 21 &amp; 9. Considerations include, but are not limited to, the risk of patient harm, the volume of claims or members affected, the potential financial exposure of the affected claims, the likelihood the case will resolve with a finding and substantiation. All potential FWA reports are entered into Oscar's case management systems, JIRA and Health Care Fraud Shield (HCFS), and maintained by the SIU. All information received or discovered by the SIU will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, or Oscar's Legal Department, Compliance Department, Regional Medical Directors or senior management). If an investigation is opened, a case file is created, along with a case report, and the assigned investigator enters updates in HCFS as the investigation proceeds. If appropriate, the referring party is informed of developments and may be further involved in the investigation. The investigator makes best efforts to close any investigation, within six (6) months of the receipt date, but more time may be necessary due to complexity, caseload and ongoing monitoring efforts.</p> <p>The SIU's investigation process may vary depending on the allegation, however the assigned investigator takes steps for evidence gathering that include the following:</p> <ul style="list-style-type: none"> <li>• <b>Contact with relevant parties:</b> This may include contacting members, providers, or agents to get a better understanding of the issue, e.g., contacting a member to ask about a visit with his or her physician, providing a description of the services rendered, who provided the care, how long the member was at the office, etc.</li> <li>• <b>Documentation Requests:</b> This may include requests for medical records, patient and provider attestations, copies of receipt of payments or consent.</li> </ul> <p><b>Data analysis of members claims data, financial data</b></p>
Emergency	
Prescription Drugs	

- **Pre-payment Review:** This includes notifying a provider or group that claims will be reviewed pre-payment and to submit medical records for SIU's auditors to review for coding accuracy and/or medical necessity.
- **Performance of post-payment claims audit:** This involves the support of coding and/or clinical review staff who review records to determine if the billing of the claims were supported.
- **When and where appropriate, referring suspected FWA to law enforcement,** CMS, Medicare Drug Integrity Contractor (MEDIC), licensing boards, state attorney general offices, and any other applicable state and/or federal agencies.

Outcomes of an investigation can vary. An investigation may find that an allegation is substantiated, unsubstantiated or inconclusive, where despite best efforts the available facts were insufficient to conclude FWA likely occurred. Any outcome, whether substantiated or not, may provide potential leads for future investigations or provide supporting information that could be linked to future investigations.

It is important to note that Oscar's SIU and Delegated Oversight teams review the written policies of delegates that may perform detection or investigative functions on Oscar's behalf. These are compared to Oscar's internal policies to determine that they are no more stringently applied to MH/SUD as written. Oscar's SIU and Delegated Oversight team performs ongoing monitoring of delegates' processes to ensure their policies are carried out and applied no more stringently to MH/SUD than medical/surgical benefits. Oscar employs a delegate, Optum, to assist in its MH/SUD FWA compliance and Oscar has ultimate control and oversight over its delegate to align Oscar's business practices to be in parity under state and federal laws.

Upon validating allegations or suspicions of FWA, SIU will document and formally communicate any corrective action recommendations or plans (CAP) appropriately through the necessary company channels or directly to the individual and/or provider. Company channels include, but are not limited to: Audit and Compliance Committees, FWA Committee, SIU, Credentialing Committee, Compliance, and Legal Departments. Corrective actions may include but are not limited to: re-education, overpayment recovery, refining existing policy, procedures and processes. Additional auditing and monitoring may be scheduled to ensure that corrective actions were implemented to mitigate the findings of FWA, to prevent future recurrence of FWA,



or to determine the fate of any formal CAPs issued. Formal Corrective Action Plans issued by the SIU will be owned and monitored by the SIU. Failure to adhere to, or any non-compliance with, any formal CAPs issued will be reported to the Compliance Officer and/or the FWA Committee for determinations of next steps.

***Identify and define the factors and processes that are used to monitor and evaluate the application of FWA management to M/S services:***

***Identify and define the factors and processes that are used to monitor and evaluate the application of FWA management to MH/SUD services:***

Medical/Surgical:

Services subject to outlier claims/high dollar review:

- Total # of M/S services subject to review: 31,995
- % of M/S services subject to review: 0.26%
- # of overpayments identified

MH/SUD:

Services subject to outlier claims/high dollar review:

- Total # of MH/SUD services subject to review: 55,512
- % of MH/SUD services subject to review: 4.98%
- # of overpay

	<p>d: 10,241</p> <ul style="list-style-type: none"> <li>• Amount of overpayments identified (\$): \$41,544,788.08</li> </ul> <p>Services subject to <i>[other FWA management review]</i>:</p> <ul style="list-style-type: none"> <li>• Total # of M/S services subject to review: 172,441</li> <li>• % of M/S services subject to review: 1.39%</li> <li>• # of overpayments identified: 478</li> <li>• Amount of overpayments identified (\$): \$267,100.94</li> </ul>	<p>ments identified: 54,448</p> <ul style="list-style-type: none"> <li>• Amount of overpayments identified (\$): \$20,459,135.90</li> </ul> <p>Services subject to <i>[other FWA management review]</i>:</p> <ul style="list-style-type: none"> <li>• Total # of MH/SU D services subject to review: 2,045</li> <li>• % of MH/SU D services subject to review: 100% of all Oscar claims with claim benefit of \$5,000.00 or higher</li> <li>• # of overpay</li> </ul>
--	---	---

	<p>Providers subject to prepayment review:</p> <ul style="list-style-type: none"> <li>○ Total # of M/S providers subject to prepayment review: 471</li> <li>○ % of M/S providers subject to prepayment review: 0.16%</li> </ul> <p>SIU cases<sup>1</sup>:</p> <ul style="list-style-type: none"> <li>○ # of SIU cases opened in the past year from referrals related to M/S claims: 37 cases opened regarding M/S claims</li> <li>○ # of SIU cases closed in the past</li> </ul>	<p>ments identified: 6</p> <ul style="list-style-type: none"> <li>● Amount of overpayments identified (\$): \$24,437.11</li> </ul> <p>Providers subject to prepayment review:</p> <ul style="list-style-type: none"> <li>○ Total # of MH/SUD providers subject to prepayment review: 1,407</li> <li>○ % of MH/SUD providers subject to prepayment review: 8.81%</li> </ul> <p>SIU cases:</p> <ul style="list-style-type: none"> <li>○ # of SIU cases opened in the</li> </ul>
--	--	---

<sup>1</sup> Reflects number of opened and closed “leads”

	<div> <div> year from referrals related to M/S claims: 8 cases closed regardin g M/S claims </div> <div> ○ # of SIU cases ongoing, from referrals related to M/S claims: 29 ongoing cases regardin g M/S claims. </div> </div>	<div> <div> past year from referrals related to MH/SU D claims: 552 </div> <div> ○ # of SIU cases closed in the past year from referrals related to MH/SU D claims: 408 </div> <div> ○ # of SIU cases ongoing, from referrals related to MH/SU D claims: 444 </div> </div>
--	--	--

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

Benefit Classification	Findings and Conclusions
All	<p>The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:</p> <ol style="list-style-type: none"> <li>1. The factors, sources, and evidentiary standards applied in FWA are the same.</li> <li>2. Oscar's SIU and Delegated Oversight team performs ongoing monitoring and has ultimate control and oversight over its delegate to align Oscar's business practices for FWA and applies investigation strategies consistently across all services.</li> </ol> <p>Operationally, the Plan performs in-operation data assessments for fraud, waste, and abuse procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across med/surg and MH/SUD services. The Plan concludes that in-operation, its methodology for fraud, waste, and abuse for mental health/substance use disorder services is comparable to and applied no more stringently than the methodology for fraud, waste, and abuse applied to medical/surgical services. The Plan analyzed services subject to outlier claims/high dollar reviews, number of services subject to FWA review, providers subject to prepayment review, and total SIU leads/cases in 2022. For services subject to outlier claims/high dollar review, the total number of services subject to review was lower for M/S services compared to MH/SUD services (31,995 v. 55,512). For providers subject to prepayment review, 471 providers were subject to review for M/S services while 1,407 providers were subject to review for MH/SUD services. However, the amount of overpayments identified for M/S was over \$41 million (\$41,544,788.08), while the amount of overpayments identified for MH/SUD was \$20,459,135.90. For overpayments related to fraud, waste, and abuse, there was \$267,100.94 worth of overpayments for M/S services compared to \$24,437.11 for MH/SUD services. Outcomes are not determinative of parity non-compliance, but may act as a warning sign to review underlying processes for comparability. Operationally, the Plan adheres to the same methodology and processes for fraud, waste, and abuse investigations across M/S benefits and MH/SUD benefits.</p>

	<p>Findings/Conclusion: The findings of the comparative analysis reveal that the process and methodology to assess fraud, waste, and abuse for mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology used to assess fraud, waste, and abuse for medical/surgical services.</p>
--	--



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

<b>Non-Quantitative Treatment Limitation (NQTL) Analysis Index</b>	
<b>Non-Quantitative Treatment Limitation</b>	Network Adequacy Standards
<b>Plan Type(s) Applicable</b>	<b>Oscar Health Plan of Georgia</b>
<b>Responsible Business Teams</b>	Network
<b>Names of Person(s) Responsible for Analysis Formation</b>	<b>Oscar:</b> John Amy, Director, Network Optimization (10 years experience in provider network development)  <b>Optum:</b> Positions: Director, Policy and Process Provider Network Administration, VP Benefits Integrity, Director MH Parity and Benefits Credentials: Licensed Psychologist, Licensed Nurse
<b>Last Update</b>	4/15/2023
<b>Reviewers</b>	Alexandra Rubino, MPH, Associate Director, MHP (Over four years experience in Mental Health Parity reporting and operational compliance for health plans)



## Network Management - Network Adequacy

1. **The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification;**

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

### Definitions

**Access or Accessibility:** The extent to which a member can obtain timely covered services from a contracted provider at the appropriate level of care, and appropriate location.

**Available or Availability:** The extent to which the plan has contracted providers of the appropriate type and numbers at geographic locations to afford members access to timely covered services.

**Network exception:** A member receives covered services from a non-contracted provider either:

- Because there is no contracted provider accessible or available that can provide the enrollee timely covered services, or
- For any reason the HCSO determines it is in the enrollee's best interests to receive care from a non-contracted provider.

### Plan/Coverage Terms

**In-Network Benefits:** This Plan only covers In-Network Benefits. To receive In-Network Benefits, You must make sure Your care is received exclusively from Network Providers in Our Network. You're responsible for paying the cost of all care that is provided by Out-of-Network Providers, unless the care is for an Emergency Medical Condition or if the services you need aren't available from Network Providers. Neither Oscar nor a Network Provider shall act in a manner that restricts your access to the entire Network.

**Health Maintenance Organization (HMO) Provisions Oscar Network** The Network for this Plan is the Oscar Network. The Oscar Network has been specially curated to contain the best Providers that we're confident will serve all of Your needs. You can access up-to date lists of Our Network Providers and other Oscar Network information at [www.hioscar.com](http://www.hioscar.com). Printed directories are available upon request, without charge. Except in the case of Emergency Services and Care or Urgent Care services received while outside of the Service Area, a Member must obtain Covered Services and supplies from Oscar Network Providers to receive benefits under this Plan. Services and supplies obtained from Providers that are not Oscar Network Providers will generally not be covered, unless Oscar, at its discretion, determines coverage to be warranted due to extenuating circumstances such as significant barriers to a Member's ability to select a Network Provider.





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

**2. Factors Used to Determine the Adequacy of the Network: The Plan's methodology used to assess the adequacy of the network is based on the following factors:**

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
Inpatient In-Network and Outpatient In-Network	<ol style="list-style-type: none"><li>1. State regulations defining quantifiable network adequacy measurement for geographic, appointment and numeric availability</li><li>2. Centers for Medicare &amp; Medicaid Services (CMS)/ Network Adequacy Criteria Guidance</li></ol> <p>The factors are not weighted.</p>	<ol style="list-style-type: none"><li>1. State-specific standards when state regulations identify a quantifiable network adequacy measurement for geographic and numeric availability</li><li>2. Centers for Medicare &amp; Medicaid Services (CMS)/ Health Services Deliver (HSD) Table</li></ol> <p>The factors are not weighted.</p>

**3. The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical or surgical benefits:**

<b>Benefit Classification</b>	<b>Evidentiary Standards: Medical/Surgical</b>	<b>Evidentiary Standards: MH/SUD</b>
Inpatient In-Network and Outpatient In-Network	<ol style="list-style-type: none"> <li>1. Applicable state regulatory requirements</li> <li>2. State/CMS/CCIIO (Marketplace) Network Adequacy Criteria Guidance<sup>1</sup></li> </ol>	<ol style="list-style-type: none"> <li>1. Applicable state regulatory requirements</li> <li>2. CMS/ Health Services Deliver (HSD) Table (located under downloads in the following website: cms.gov/medicare/medicare-advantage/medicareadvantageapps )</li> </ol>

<b>Benefit Classification</b>	<b>Sources: Medical/Surgical</b>	<b>Sources: MH/SUD</b>
Inpatient In-Network and Outpatient In-Network	<ol style="list-style-type: none"> <li>1. Applicable state regulatory requirements</li> <li>2. CMS/Medicare Advantage Network Adequacy Criteria Guidance</li> </ol>	<ol style="list-style-type: none"> <li>1. Applicable state regulatory requirements</li> <li>2. CMS/ Health Services Deliver (HSD) Table (located under downloads in the following website: cms.gov/medicare/medicare-advantage/medicareadvantageapps)</li> </ol>

<sup>1</sup> <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

--	--	--

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

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

	<p>standards are based by the Centers for Medicare &amp; Medicaid Services. Network adequacy and access reports are prepared on a regular basis (no less than quarterly) and shared with the Plan's network teams for recruitment purposes to ensure regulatory network access requirements are met.</p> <p>If the Plan determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by stated or federal requirements, the Plan will actively seek to add providers to the network in that specialty or provider type. If there is a supply gap, we allow members to seek an exception and receive services from an out-of-network provider at the in-network benefit level via Single Case Agreements.</p> <p>Access to out-of-network provider at the in-network benefit level (Single Case Agreement) is determined by the availability of an in-network provider within the geographic standards (time or distance) and appointment availability of an in-network provider within the time standards.</p> <p>If a Member obtains Prior Authorization for Covered Services from an Out-of-Network Provider due to an access gap, OMC will approve the Covered Services at the same Member cost-sharing as if the services were rendered by an In-Network Provider.</p> <p>When an In-Network Provider cannot meet the Member's health care needs, the Member should contact the Member's Concierge team. The Concierge team Care Guide will verify that there is no available In-Network</p>	<p>Key steps in the network management process for MH/SUD services include:</p> <ul style="list-style-type: none"> <li>· OBHS determines Time, Distance, and Provider Threshold requirements based on state/federal requirements</li> <li>· OBHS conducts MH/SUD network adequacy reporting (by state/county) to determine if Time, Distance, and Provider Threshold requirements are met</li> <li>· If network adequacy requirements are not met, the OBHS actively seeks to add providers to the network in that specialty or provider type</li> </ul> <p>Network adequacy and access reports are prepared on a regular basis (no less than quarterly) and shared with OBHS network teams for recruitment purposes to ensure regulatory network access requirements are met.</p> <p>If OBHS determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by stated or federal requirements, OBHS will actively seek to add providers to the network in that specialty or provider type. If there is a supply gap, plan language allows members to seek an exception and receives services from an out-of-network provider at the in-network benefit level via a Single Case Agreement.</p> <p>Access to out-of-network provider at the in-network benefit level (Single Case Agreement) is determined by the availability of an in-network provider within the geographic standards (time or distance) and appointment availability of an in-network provider within the time standards.</p>
--	---	---

	<p>Provider that can meet the Member's needs. Once the Care Guide has confirmed that the In-Network Provider cannot meet the Member's needs, the Care Guide will escalate the Member's request to the Navigation team. The Navigation team will verify whether In-Network Providers are available to meet the Member's needs within the access standards. If there is no In-Network Provider available, the Navigation team will refer to the Member's request for Out-of-Network approval.</p> <p>The Plan also considers Single Case Agreement volume and out-of-network utilization to identify and prioritize areas where we can attempt to contract with these providers or other providers in the area or that provide the items or services. The Plan's Sales team may also notify the network team about a customer requests to contract with a specific provider. In response, the network team will review adequacy and access reports and determine whether there are available in-network alternatives, whether it's necessary to expand or enhance the network panel and pursue a contract with the provider, as appropriate.</p> <p><b>The following include strategies for provider recruitment:</b></p> <p><i>Claims Data Outlier Analysis</i></p> <p>Review of out-of-network utilization is performed monthly and presented to a</p>	<p>If a Member obtains Prior Authorization for Covered Services from an Out-of-Network Provider due to an access gap, OHBS will approve the Covered Services at the same Member cost-sharing as if the services were rendered by an In-Network Provider.</p> <p>If a member is unable to identify an In-Network provider to meet their needs, OBHS will assist the Member in finding a Network Provider. If it is confirmed that an In-Network provider is unavailable, OBHS will assist the Member in obtaining services from an out-of-network provider at the in-network benefit level via a Single Case Agreement.</p> <p>The OBHS Sales team may also notify the network team about a customer request to contract with a specific provider. In response, the network team will review adequacy and access reports and determine whether there are available in-network alternatives, whether it's necessary to expand or enhance the network panel and pursue a contract with the provider, as appropriate.</p> <p><b>The following include strategies for provider recruitment:</b></p> <p><i>Claims Data Outlier Analysis</i></p> <p>Review of out-of-network utilization is performed monthly and presented to a monthly committee for review.<sup>4</sup> When reviewing historical out-of-network claims utilization per 1k members, <b>a series of 3 or more points above the mean will prompt a root cause analysis and potential improvement plan.</b> A rolling 12 or 24 month</p>
--	--	---

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

	<p>monthly committee for review.<sup>2</sup> When reviewing historical out-of-network claims utilization per 1k members, <b>a series of 3 or more points above the mean will prompt a root cause analysis and potential improvement plan.</b> A rolling 12 or 24 month control chart is used to make these determinations. Out-of-Network utilization is assessed by product and state and is analyzed at the specialty level by member counties when an issue is identified.</p> <p><i>Single Case Agreement (SCA) and/or Gap Exception reports</i> Single-Case Agreements are reviewed under the out-of-network utilization analysis described above. Review of out-of-network utilization is performed monthly and presented to a monthly committee for review.<sup>3</sup> When reviewing historical out-of-network claims utilization per 1k members, a series of 3 or more points above the mean will prompt a root cause analysis and potential improvement plan. A rolling 12 or 24 month control chart is used to make these determinations. Out-of-Network utilization is assessed by product and state and is analyzed at the specialty level by member counties when an issue is identified.</p> <p><i>Member access complaint data</i> The member access complaint is documented with one of the following</p>	<p>control chart is used to make these determinations. Out-of-Network utilization is assessed by product and state and is analyzed at the specialty level by member counties when an issue is identified.</p> <p><i>Single Case Agreement (SCA) and/or Gap Exception reports</i> Single-Case Agreements are reviewed under the out-of-network utilization analysis described above. Review of out-of-network utilization is performed monthly and presented to a monthly committee for review.<sup>5</sup> When reviewing historical out-of-network claims utilization per 1k members, a series of 3 or more points above the mean will prompt a root cause analysis and potential improvement plan. A rolling 12 or 24 month control chart is used to make these determinations. Out-of-Network utilization is assessed by product and state and is analyzed at the specialty level by member counties when an issue is identified.</p> <p><i>Member access complaint data</i> The member access complaint is documented with one of the following subtags dependant upon the provider type:</p> <ul style="list-style-type: none"> <li>• Insufficient in-network PCP options (excl. BH)</li> <li>• Insufficient in-network specialist options (excl. BH)</li> <li>• Insufficient in-network DME options</li> <li>• Insufficient in-network Hospital / Facility options</li> <li>• Insufficient in-network Behavioral Health provider options</li> </ul>
--	---	---

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

<sup>3</sup>

	<p>subtags dependant upon the provider type:</p> <ul style="list-style-type: none"> <li>• Insufficient in-network PCP options (excl. BH)</li> <li>• Insufficient in-network specialist options (excl. BH)</li> <li>• Insufficient in-network DME options</li> <li>• Insufficient in-network Hospital / Facility options</li> <li>• Insufficient in-network Behavioral Health provider options</li> <li>• Insufficient in-network Pharmacies</li> </ul> <p>When member access complaints are identified, they are escalated to the network team to identify opportunities for recruitment.</p>	<ul style="list-style-type: none"> <li>• Insufficient in-network Pharmacies</li> </ul> <p>When member access complaints are identified, they are escalated to the network team to identify opportunities for recruitment.</p>
	<p>Oscar's Quality of Member Experience Subcommittee reviews network adequacy data inclusive of mental health and medical/surgical providers, no less than quarterly, including GeoAccess Reports, out-of-network utilization trends, gap exceptions, enrollee access complaints, and/or enrollee satisfaction with access survey results. This review pertains to network adequacy assessments for both medical/surgical services and mental health/substance use disorder services.</p> <p>Oscar's Quality of Member Experience Subcommittee's includes representatives (Director level and above) from:</p> <ul style="list-style-type: none"> <li>• Care Delivery and Clinical Concierge Services</li> <li>• Claims Production</li> <li>• Clinical Review Team Operations</li> <li>• Configuration and Support</li> <li>• Complaints, Grievances and Appeals</li> <li>• Quality Improvement</li> <li>• Member Services Operations, esp. Concierge Services</li> <li>• Network Strategy and Growth</li> <li>• Insurance Operations</li> <li>• Operational Compliance</li> <li>• Regulatory Operations</li> <li>• Product &amp; Design</li> <li>• Marketing</li> <li>• Pharmacy</li> </ul>	

- Regional Medical Directors

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

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

### **Network Adequacy Monitoring results**

State	BH gaps	M/S gaps	Total
GA	1	77	78

The plan takes the following steps address network adequacy gaps:



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

**Valuation:** Network deficiencies are prioritized and assigned.

**Planning:** The provider network team defines the network strategy and identifies contracting or operational opportunities within network design parameters for remediating deficiencies.

**Contracting:** The provider network team negotiates mutually agreeable contracts with providers as necessary.



	<p><b>Onboarding: Providers are onboarded into Oscar’s system and network by Provider Relations.</b></p> <p>Oscar has allocated resources to the re-mediation of network adequacy gaps through provider recruitment and network development activities. Oscar's leadership team meets monthly to review and prioritize existing gaps and progress towards gap closure and Oscar's network management teams meet bi-weekly to discuss blockers and tactical opportunities to address gaps and improve access to high quality, low cost care.</p>
--	---

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

Benefit Classification	Process Description
Inpatient In-Network and Outpatient In-Network	<p>The network adequacy process for MH/SUD benefits and M/S benefits are aligned. The Plan and OBHS assess network adequacy based on access standards that are in accordance with Centers for Medicare &amp; Medicaid Services and/or applicable state laws. Further, network adequacy reports are prepared on a quarterly basis to inform recruitment practices. For both MH/SUD and M/S benefits, if there is a supply gap, members may seek an exception and receive services from an out-of-network provider at the in-network benefit level via Single Case Agreements. The availability of an in-network provider is evaluated the same and takes into account time/distance standards and appointment availability standards.</p> <p>The Plan and OBHS employ the same strategies which consists of:</p> <ol style="list-style-type: none"> <li>1. Claims data outlier analysis;</li> <li>2. Gap exception analysis reports; and</li> <li>3. Member access complaint data analysis</li> </ol> <p>to inform provider recruitment.</p> <p>A comparison of the factors, evidentiary standards and source information used to determine network adequacy for medical/surgical services and mental health/substance use disorder reveals that the underlying methodology by which network adequacy is established is comparable and applied no more strictly to mental health/substance use disorder benefits.</p>

	<p>For network adequacy for both medical/surgical and mental health/substance use disorder benefits, the same factors are considered which include state specific standards and CMS.</p> <p>Additionally, similar evidentiary standards and sources are used to support the factors which include state regulatory requirements and CMS Network Adequacy criteria guidance.</p> <p>Operationally, the plan performs data analysis to compare network adequacy gaps for each state by reviewing network adequacy gaps for MH/SUD providers and M/S providers. Network Adequacy gaps are defined as a county or specialty that does not meet regulatory adequacy standards. For Georgia , there were 77 gaps reported for M/S providers and 1 gap reported for MH/SUD providers in 2022. When measured in the same exact manner, there are more gaps identified for M/S providers when compared to MH/SUD providers. For gaps identified, the Plan follows the steps described in Step 4 above which include an assessment of the gap, valuation, planning, contracting, and onboarding. This methodology is utilized for both M/S network gaps and MH/SUD network gaps. Therefore, in-operation, network adequacy methodology for mental health/substance use disorder providers is comparable to, and applied no more stringently than network adequacy methodology for medical/surgical providers.</p> <p><b>Findings/Conclusion:</b> The findings of the comparative analysis reveal that the process and methodology to assess network adequacy for mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology used to assess network adequacy for medical/surgical services.</p>
--	---



Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Medical Necessity Criteria Development Pharmacy
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Pharmacy
Names of Person(s) Responsible for Analysis Formation	<p>Jeenal Patel, PharmD, Senior Clinical Formulary Pharmacist (Nine years Pharmacy experience, two of which were dedicated to Pharmacy at a Health Plan)</p> <p>Kemper May, PharmD, Manager, Formulary Operations (Seven years experience in Pharmacy at a Health Plan)</p>
Last Update	12/11/2023
Reviewers	Alexandra Rubino, MPH, Associate Director, MHP (Over five years experience in Mental Health Parity reporting and operational compliance for health plans)



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

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

### General Description of the NQTL:

**Definition:** Medical Necessity Criteria Development Strategy is defined as: The process of developing or adopting medical necessity criteria to guide the application and implementation of the Plan's general definition of Medical Necessity to authorization requests and benefit determinations for specific healthcare services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.

Medical Necessity reviews are employed when the requested drug is being used for an FDA approved indication or an "off-label" indication supported by compendia.

Experimental/investigation reviews are employed when the requested drug is not being used for an FDA approved indication that treats the members condition/diagnosis, is part of a clinical trial, or being used off-label without any compendia support.

Clinical criteria are developed and used in these reviews. Clinical Criteria are developed based upon published clinical evidence supporting the different uses of a drug and coverage conditions are not affected or altered by the medication's intended area of utilization.

### Plan/Coverage Terms:

#### **Coverage Terms (Evidence of Coverage):**

The Plan covers benefits described in this Policy as long as services are such that a Physician (Medical Doctor (MD), Doctor of Osteopathy (DO), or similarly trained professional) would provide to a person in their care for the purpose of evaluating, diagnosing or treating an illness, Injury or disease, or associated symptoms, while exercising prudent clinical Judgment.

Prudent clinical judgment shall reflect:



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

Generally accepted standards of medical practice shall reflect:

- Evidence-based practice that is supported by clinical criteria and/or guidelines that have been established using scientific literature and peer-reviewed medical (or similar) Journals; expert opinions based on experiential history of Providers practicing in relevant clinical area;
- Clinical guidelines, compendia, and other nationally established Physician Specialty Societies recommendations and practice guidelines;
- Internal clinical guidelines that are established for Oscar Physicians with input from licensed participating Providers in Oscar's network
- Any other relevant factors.

Generally accepted medical practices in light of conditions at the time of treatment are:

- Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the Member's condition;
- Compatible with the standards of acceptable, evidence-based medical practice in the United States;
- Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the Member or Health Care Provider or Hospital;
- Not primarily Custodial Care

With the respect to the treatment of Mental Health or Substance Use Disorder, a service or product addressing the specific needs of the Member for the purpose of screening, preventing, diagnosing, managing or treating an illness injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is:

- In accordance with the generally accepted standards of Mental Health or Substance Use Disorder care;
- Clinically appropriate in terms of type, frequency, extent, site, and duration; and
- Not primarily for the economic benefit of Oscar, or for the convenience of the Member, treating Physician, or other Health Care Provider. Medically Necessary services shall not be:
  - A reflection of convenience to Oscar Member, requesting Provider or PhysicianReviewer.
  - Costlier than alternative services or clinical and/or treatment pathways that have been demonstrated to produce equivalent outcomes according to peer-reviewed medical literature are at least as likely to produce equivalent outcomes.

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies	Rationale/Comparability
------------------------	---	--	-------------------------

Pharmacy	All medications on our formulary at: <a href="https://www.hioscar.com/search-documents/drug-formularies/">https://www.hioscar.com/search-documents/drug-formularies/</a>	
----------	---	--

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

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
Pharmacy	<p>Factors that determine medical necessity criteria development and adoption of a medical necessity policy:</p> <p>The medication is FDA approved and the following are considered:</p> <ol style="list-style-type: none"> <li>1. Clinical Efficacy <ul style="list-style-type: none"> <li>○ Guidelines and publications from professional societies</li> </ul> </li> <li>2. Safety Risk</li> <li>3. Manufacturer prescribing information</li> <li>4. PBM contracting with pharmaceutical manufacturers</li> </ol> <p>Experimental/Investigation review: Review would occur when a medication is being requested that is not an FDA approved medication and/or is being requested to use to participate in an active ongoing clinical trial. Please note, a drug that is FDA approved but is experimental in any given diagnosis will be reviewed for medical necessity.</p>	

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

Benefit Classification	Sources/Evidentiary Standards: Medical/Surgical	Sources/Evidentiary Standards: MH/SUD
Pharmacy	<ol style="list-style-type: none"> <li>1. Clinical Efficacy</li> </ol> <p><b>Clinical efficacy</b> is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. <b>Clinical effectiveness</b> is based on the evidence of clinical</p>	

trials that the interventions are considered to be effective for the general population.

*Evidentiary Standards:* The Plan rates efficacy by the below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition.

Class I: "Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective.

Class IIa: "Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy."

Clinical Pharmacology Rating:

- Strength of Recommendation of "strong".
- Level of evidence rating of "High, Moderate"

Or rating systems considering efficacy of regimen/agent is moderately effective such as NCCN definition of 2b evidence "Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate" or higher levels of efficacy.

*Sources:* Clinical or Scientific Peer-Reviewed Literature, Clinical Pharmacology, Micromedex, NCCN, National Societies/National Society Guidelines (such as National institutes of health (NIH), American Academy of Dermatology, American Academy of Neurology, Infectious Diseases Society of America)

## 2. Safety Risk

*Evidentiary Standard:*

- Substantiated by nationally recognized guidelines (such as National institutes of health (NIH), American Academy of Dermatology, American Academy of Neurology, Infectious Diseases Society of America) to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.
- Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse.

Example: Victoza is approved for the treatment of Type II Diabetes and in many cases it is NOT prescribed according to the package labeling and is requested for higher doses to treat obesity, instead.

*Sources:*

- Oscar's Clinical Guidelines
- MCG
- Hayes, Inc.
- Up-to-Date
- Authoritative peer-reviewed textbooks & journals
- National society guidelines
- Agency for Healthcare Research and Quality
- National Institutes of Health ("NIH") Consensus Statements
- CVS/Caremark Specialty Exceptions Criteria
- CVS Prior Authorization Criteria
- National Comprehensive Cancer Network
- Clinical Pharmacology

3. Manufacturer prescribing information

*Evidentiary Standards:*

Created by manufacturers and approved by the FDA before the drug is approved for market release to provide guidance to clinicians on how to prescribe the medication with key administration, safety, and clinical effectiveness information. Information from manufacturer prescribing information is included in clinical criteria for a drug.

*Sources:* Food and Drug Administration (FDA)

<https://www.accessdata.fda.gov/scripts/cder/daf/>

4. PBM contracting with pharmaceutical manufacturers

*Evidentiary Standards:* Pharmacy Benefit Manager (e.g CVS, Magellan, Express Scripts) contract with pharmaceutical manufacturers and the type of utilization management the health plan implements on the medication is a consideration of these contract terms. Pharmacy Benefit Managers negotiate rebates and discounts from drug manufacturers on behalf of the health plan. Contract terms of these agreements can dictate step therapy requirements, prior authorization requirements, and clinical criteria requirements for a drug or drug class



*Sources:*

- CVS Caremark

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

Benefit Classification	Comparative Analysis: Medical/Surgical and Mental Health/Substance Use Disorder
Pharmacy	<p><b>As-Written:</b></p> <p><b>Process:</b>  Oscar Pharmacy Clinical Guidelines are developed or adopted to establish evidence-based clinical criteria for utilization management decisions, alongside the terms, conditions, limitations of a member's policy and applicable state and federal law. The Clinical Guideline development process ensures that policies are quality-driven, evidenced-based using efficient and transparent methodology for action-ready recommendations with multi-disciplinary applicability.</p> <ol style="list-style-type: none"> <li>1. Oscar's P&amp;T Committee is responsible for developing and approving all new and revised medical policies. Clinical policies are developed to assist UM staff in accurately reviewing requests for coverage of FDA-approved or cleared products within the context of the Plan's benefit.</li> <li>2. Selection of drug products for Clinical Guidelines development is guided by, but not limited to: <ol style="list-style-type: none"> <li>a. Federal and/or State mandates</li> <li>b. The member's COC, EOC or summary plan description</li> <li>c. Medicare products CMS NCDs and LCDs</li> <li>d. Plan's benefit and Formulary</li> <li>e. PBM contracting with pharmaceutical manufacturers</li> </ol> </li> </ol>

- f. Claims data analysis (e.g., using Oscar or PBM's available data to estimate potential utilization based on disease prevalence or incidence)
- 3. Pharmacy clinical criteria are developed based on manufacturer prescribing information, clinical efficacy, safety risks, and contract terms with pharmaceutical manufacturers:
  - a. Manufacturer Prescribing Information:
    - i. Food and Drug Administration (FDA) approved indications and limits
    - ii. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions
    - iii. The risks, benefits and potential member outcomes
    - iv. The likely impact of a drug product on patient compliance when compared to alternative products
  - b. Clinical efficacy:
    - i. Clinical Pharmacology
    - ii. Micromedex
    - iii. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
    - iv. Published practice guidelines and treatment protocols from national societies (such as National Comprehensive Cancer Network (NCCN), National institutes of health (NIH), American Academy of Dermatology, American Academy of Neurology, Infectious Diseases Society of America)
    - v. UpToDate
  - c. Safety risks:
    - i. Substantiated by evidence from:
      - 1. Manufacturer Prescribing Information (3.a. - *above*)
      - 2. Clinical efficacy sources (3.b. - *above*)
    - ii. Taking into account factors such as treatment type, frequency, extent, site, and duration
    - iii. Ensuring that products or services are provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.
  - d. Contract terms with pharmaceutical manufacturers:
    - i. Specific contract terms may guide step therapy, prior authorization or clinical criteria requirements for a drug or drug class.

- ii. Reviewed and considered alongside, but not as a replacement for:
  1. Applicable Plan or Benefit considerations (as noted under 2. Selection of drug products for Clinical Guidelines development - *above*)
  2. Manufacturer Prescribing Information (3.a. - *above*)
  3. Clinical efficacy sources (3.b. - *above*)
  4. Safety risks (3.c. - *above*)
4. The Clinical Guideline is then sent to a licensed physician specialist with subject-matter-expertise within Oscar or at an Independent Review Organization (IRO) - A panel of medical and benefit experts intended to provide unbiased, independent, clinical, evidence-based reviews of the proposed Clinical Guideline.
5. The clinical pharmacist takes into consideration feedback from the physician specialist reviewer(s) and incorporates their recommendation(s) based on its validity and weight of medical evidence, including the nature and source of the evidence.
6. The clinical pharmacist(s) responsible for Clinical Guideline development present the proposed clinical criteria to the P&T Committee. The P&T Committee reviews, evaluates and approves of clinical review criteria annually or more frequently as appropriate.
  - a. All criteria are reviewed by the P&T Committee before implemented.
  - b. At least annually, medical literature is reviewed to determine if criteria need to be modified based on new evidence for medications with clinical review criteria.
  - c. Ad hoc reviews may be performed at any time when questions concerning any indication are raised by internal or external stakeholders.
7. Clinical Guidelines are uploaded to <https://www.hioscar.com/clinical-guidelines/pharmacy> for public review and updates are communicated to all UM staff through various means of communication (e.g., Team Sync, Confluence, and other appropriate methods).

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

***Purpose:***

Oscar's Pharmacy and Therapeutics (P&T) Committee promotes the safe and appropriate use of cost-effective pharmaceuticals for members. The committee

operates in compliance with NCQA standards and state/federal regulations for Oscar's individual, small group, and self-insured drug formularies in all states. The committee regularly reviews new drugs, drug classes, new drug indications, and new safety information. Policies & Procedures for pharmaceutical management and all formularies are reviewed at least annually.

*Structure:*

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

<b>Voting Members</b>	<b>Qualifications</b>
Chief Medical Officer	Licensure: Medical Doctor Specialty: Internal Medicine
External Member	Licensure: Medical Doctor Specialty: Rheumatology
External Member	Licensure: PharmD
External Member	Licensure: Pharm D Specialty:

		Infectious disease
	External Member	Licensure: Medical Doctor Specialty: Family Practice
	External Member	Licensure: Medical Doctor Specialty: Psychiatry
	External Member	Licensure: PharmD Specialty: Oncology
	Managing Medical Director	Licensure: Medical Doctor Specialty: Pediatric
	Medical Director	Licensure: Medical Doctor Specialty: Surgery
	Medical Director	Licensure: Medical Doctor Specialty: Hematology-Oncology
	Medical Director	Licensure: Medical Doctor Specialty: Neurology

Medical Director	Licensure: Medical Doctor Speciality: Family Practice
Medical Director	Licensure: Medical Doctor Speciality: Family Practice

*Responsibilities:*

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

*Internal oversight of the P&T Committee:*

The Board of Directors oversees the implementation of and adherence to the UM Program through the UM Subcommittee. The UM Subcommittee reports to the Quality Improvement Committee at a minimum of once per quarter, per year. The P&T minutes are approved at the UM Subcommittee portion of the Quality Improvement Committee meeting. Minutes conveying this approval are submitted to the Board of Directors, who approve the actions of the Quality Improvement Committee. The Board of Directors delegates the responsibility for the oversight and operations of the UM Program to the Chief Medical

Director (CMO). The CMO oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical).

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

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

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

### ***MHPAEA Summary***

The medical necessity clinical criteria development, review and approval process through the P&T committee is applied consistently across all drugs and drug classes and applies fairly to all members. Oscar ensures the clinical criteria used for UM reviews are developed and approved by the P&T committee and are evaluated at least annually and updated, if necessary, by appropriately actively practicing physicians, pharmacists and nurses with current knowledge relevant to the criteria, clinical principles, and processes. All changes are captured in meeting minutes and voted on by the P&T Committee. The medical necessity process is applied consistently across all drugs and drug classes and applies fairly to all members.

The factors that determine medical necessity development criteria are the same across all drug types. The plan uses the following factors to determine medical necessity guidelines: clinical efficacy, safety risk, manufacturer prescribing information, and PBM contracting with pharmaceutical manufacturers. The

plan also uses the same evidentiary standards and sources to determine the thresholds and supporting information for the aforementioned factors. There is no discrepancy between the factors, evidentiary standards, sources, and processes used to determine medical necessity criteria development because all drugs, regardless of drug-type, are subject to the same underlying medical necessity criteria development methodology. However, the Plan has conducted an in-operation quantitative analysis below to quantify the extent to which a discrepancy may exist for medical necessity criteria application.

Any pharmacy coverage factors, processes, development or implementation strategies, and evidentiary standards applied to drugs used to treat mental health or substance use disorder are comparable to, and are applied no more stringently than the coverage factors, processes, development or implementation strategies, evidentiary standards used in applying the limitations to drugs used to treat medical or surgical disorders that are not associated with mental health or substance use disorder.

### **In-Operation**

#### ***Inter Rater Reliability Scores:***

All clinicians involved in clinical decision-making within the utilization management (UM) team participate in inter-rater reliability (“IRR”) testing to ensure the following:

- a) high quality, evidence-based clinical decision-making
- b) consistent, accurate application of clinical criteria

In IRR testing, clinicians are given 15 clinical scenario cases relevant to their clinical review case type per year. Cases include hypothetical cases designed by the Plan or clinically complex cases where a learning opportunity has been or can be identified. IRR testing requires that clinicians demonstrate consistency with decision-making, criteria selection and application. The IRR testing benchmark is 80%, and differences in determinations are used as the basis for annual clinical discussion and training. Performance and quality improvement initiatives are reported annually to the UM Subcommittee.

**The overall team avg for the 2023 pharmacy IRR was 92.5%**





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

Benefit Classification	Findings and Conclusions
Pharmacy	<p>The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to mental health/substance use disorder (MH/SUD) benefits and to medical/surgical (M/S) benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:</p> <ol style="list-style-type: none"><li>1. The factors are the same.</li><li>2. The evidentiary standards and sources are the same.</li><li>3. As-written and in-operation, clinical criteria for MH/SUD and M/S drugs are developed and approved by the P&amp;T committee and are evaluated at least annually and updated when necessary.</li></ol> <p>The Plan's UM criteria, which includes medical necessity reviews, is applied consistently across all drugs and drug classes and does not discriminate against individuals based on age, expected length of life, disability, degree of medical dependency, quality of life, gender identity, medical or mental health diagnosis, or other health conditions. Any coverage factors, processes, development or implementation strategies, evidentiary standards applied to drugs used to treat mental health or substance use disorder are comparable to, and are applied no more stringently than the coverage factors, processes, development or implementation strategies, evidentiary standards used in applying the limitations to drugs used to treat medical or surgical disorders.</p> <p>Operationally, all clinicians involved in clinical decision-making are required to participate in inter-rater reliability testing to make sure that clinical criteria is applied consistently across M/S and MH/SUD drugs. This testing is to evaluate the consistency of clinical decision-making across all drug types. The inter-rater reliability testing score for 2023 was 92.5% for clinical criteria decision-making for pharmacy drugs which is above the 80% benchmark.</p> <p>Conclusion: The findings of the comparative analysis reveal that the process and methodology for medical necessity criteria development as applied to MH/SUD drugs is comparable to, and applied no more stringently than, the process and methodology for medical necessity criteria development for M/S drugs.</p>



Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Prior Authorization Pharmacy
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Formulary Design and Strategy
Names of Person(s) Responsible for Analysis Formation	Kemper May, PharmD, Manager, Formulary Operations (Seven years experience in Pharmacy at a Health Plan)  Jeenal Patel, PharmD, Senior Clinical Formulary Pharmacist (Nine years Pharmacy experience, two of which were dedicated to Pharmacy at a Health Plan)
Last Update	12/11/2023
Reviewers	Alexandra Rubino, MPH, Associate Director, MHP (Over 5 years experience in Mental Health Parity reporting and operational compliance)



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

### Prior Authorization

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

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

### Plan/Coverage Terms:

#### **Coverage Terms (Evidence of Coverage):**

Some medications, despite being prescribed by Your Healthcare Provider, require an additional review by a Clinician before You can fill the prescription. This process is called Prior Authorization. A Clinician performs a Prior Authorization review to ensure the prescribed drug is safe, effective, and appropriate for Your specific



treatment plan. A list of the medications which require a Prior Authorization and the required forms are available on our website at [www.hioscar.com](http://www.hioscar.com) or by contacting Member Services at 1-855-672-2755. We will review all Prior Authorization requests and make a decision to approve or deny coverage for the requested medication based on established clinical criteria. A decision will be made within the time limits specified by the State or the applicable Quality Standard Regulations.

If You or Your Health Care Provider do not agree with the decision made by Oscar, You have the ability to contest the decision (see section 'What if You Disagree'). You can request either an expedited or standard review Timeframe. We may request Medical Records from Your Provider as part of our Clinical Review. A Provider's failure to supply all the information necessary to make a determination may result in a denial. Should Your review be denied our "Rights of Appeal" section provides more detail. If Your Health Care Provider does not obtain a Prior Authorization, the pharmacy will be alerted when they are attempting to submit a claim to Oscar and You will not be able to receive Your medication as a covered benefit. In certain cases at Oscar's discretion, Oscar may review medicines for medical necessity even though they are not subject to our Prior Authorization requirements. If so, Your prescribing doctor will be asked for clinical information to support the medical necessity of Your use of the drug. If the determination is unfavorable, future claims for this medication will be denied; if this occurs You will be eligible for an appeal or exceptions process.

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

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

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



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

Factor	Sources	Evidentiary Standards/Thresholds
Average ingredient cost for a 30 day supply for generics vs brand drugs	Pharmacy claims data	Thresholds: <ul style="list-style-type: none"><li>• For drugs with 30-day ingredient cost less than \$10, almost no drugs have PA required.</li><li>• For drugs with 30-day ingredient cost less than \$100, less than 25% of drugs have PA required</li><li>• For drugs with 30-day ingredient cost between \$100 to \$1000, less than 50% of drugs have PA required</li><li>• For drugs with 30-day ingredient cost above \$1000, more than 50% of drugs have PA required</li><li>• For drugs with 30-day ingredient cost above \$10,000, almost all drugs have PA required</li></ul>
Clinical Appropriateness	<p>Clinical criteria</p> <ul style="list-style-type: none"><li>• Plan Clinical Guidelines</li><li>• CVS Caremark Clinical Guidelines</li><li>• MCG</li></ul> <p>Clinical evidence</p> <ol style="list-style-type: none"><li>1) The US National Library of Medicine;</li><li>2) Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN)</li><li>3) UpToDate</li><li>4) National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)</li></ol>	<p>Clinical Appropriateness is applicable when evidence-based criteria is required to confirm the drug is (a) medically necessary, (b) delivered in the appropriate setting or level of care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as diagnosis, specialist care, and duration.</p> <p>Examples:</p> <ol style="list-style-type: none"><li>1) As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires</li></ol>

		<p>confirmation of certain types of cancer and individualized needs as documented in the medical record.</p> <p>2) As per the American Psychological Association (APA), concurrent or planned course of therapy or counseling [e.g., interpersonal psychotherapy, cognitive-behavioral therapy, dialectical behavior therapy] is appropriate prior to requesting pharmacological treatment in binge eating disorder</p>
Regulatory Requirements - Certain prescription drugs are mandated to be covered as essential health benefits; drug formularies are often regulated at the state level regarding utilization management edits such as prior authorization	Government regulations/state legislation websites, memos, bulletins	<p>Examples include but are not limited to:</p> <ol style="list-style-type: none"> <li>1) ACA: The Affordable Care Act mandates that health plans cover recommended preventive services without charging a deductible, copayment, or co-insurance (at the lowest tier: Tier 0)</li> <li>2) Perphenazine-Amitriptyline tablet required to be covered to meet state filing benchmarks</li> </ol> <p><i>**Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</i></p>
Manufacturer Trade Agreements	CVS CFC Team - Proprietary Trade Agreements	<p>Manufacturers may offer competitive rebates in order for the Health Plan to employ the lowest net cost strategy for both the plan and members. As a result, manufacturers in certain instances may dictate if a prior authorization is allowed in order to offer competitive pricing.</p> <p>Example A: GLP-1s, DPP-IVs, and SGLT-2 inhibitors are <u>not</u> allowed to have prior authorization edits.</p> <p>Example B: The Hepatitis C category</p>

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

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

Prior Authorization Process M/S	Prior Authorization Process MH/SUD
<p><b>Process:</b></p> <p>The prior-authorization process is part of the Utilization Management (UM) activities and is an assessment performed to determine if the request for the prescription drug meets the plan's criteria for coverage.</p> <p>The Plan maintains a list of services that require prior authorization. This list is available on request by phone, by provider portal, or via the published formularies online. Authorizations can be submitted via phone, fax, or online through Oscar's provider portal. When a prior authorization request is submitted, it is reviewed by licensed clinicians to determine if the request meets medical necessity. Clinicians utilize the Plan's policies and established, evidence based clinical criteria to determine if the request meets coverage determinations and/or medical necessity. Licensed clinicians (e.g., physicians and pharmacists) review authorization requests; in Georgia pharmacists can make adverse determinations. However, in all Oscar states, only appeals can be denied by a licensed physician.</p> <p>The Plan requires the requesting provider to submit the following information when requesting an authorization:</p> <ul style="list-style-type: none"> <li>• Member information (name, Plan ID, date of birth).</li> </ul>	



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

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

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

Committee Information M/S	Committee Information MH/SUD
<b>Description: Pharmacy &amp; Therapeutics Committee (P&amp;T Committee)</b>	
<b>Purpose:</b> Oscar's Pharmacy and Therapeutics (P&T) Committee promotes the safe and appropriate use of cost-effective pharmaceuticals for members. The committee operates in compliance with NCQA standards and state/federal regulations for Oscar's individual, small group, and self-insured drug formularies in all states. The committee regularly reviews new drugs, drug classes, new drug indications, and new safety information. Policies & Procedures for pharmaceutical management and all formularies are reviewed at least annually.	
<b>Structure:</b> Oscar's P&T Committee commences at least quarterly and reports to the Utilization Management Committee. At least fifty percent of Oscar's thirteen voting members must be present to establish a quorum. Committee members represent a sufficient number of clinical specialties to adequately meet the needs of members. At least two-thirds of members are practicing physicians (MD/DO), practicing pharmacists (PharmDs), and other practicing health care professionals (RNs) who are licensed to prescribe drugs. At least one member shall be a pharmacist. Committee Chairs are appointed annually by Oscar's Vice President of Pharmaceuticals. Membership changes are reported to CMS during the contract year. Members complete a Conflict of Interest and Non-Disclosure Agreement, annually.	
Voting Members	Qualifications
Chief Medical Officer	Licensure: Medical Doctor Specialty: Internal Medicine
External Member	Licensure: Medical Doctor Specialty: Rheumatology
External Member	Licensure: PharmD



External Member	Licensure: Pharm D Specialty: Infectious disease
External Member	Licensure: Medical Doctor Specialty: Family Practice
External Member	Licensure: Medical Doctor Specialty: Psychiatry
External Member	Licensure: PharmD Specialty: Oncology
Managing Medical Director	Licensure: Medical Doctor Specialty: Pediatric
Medical Director	Licensure: Medical Doctor Specialty: Surgery
Medical Director	Licensure: Medical Doctor Specialty: Hematology-Oncology
Medical Director	Licensure: Medical Doctor Specialty: Neurology
Medical Director	Licensure: Medical Doctor Specialty: Family Practice
Medical Director	Licensure: Medical Doctor Specialty: Family Practice

### **Responsibilities:**

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

### Internal oversight of the P&T Committee:

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

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

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

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

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

Benefit Classification	Process Description: Medical/Surgical	Process Description: MH/SUD
Pharmacy	<p><b>Timeline and deadlines for review and approval:</b></p> <p><i>Urgent Prior Authorizations:</i>  Urgent PA decisions should be rendered within 72 hours of receipt of a complete urgent request. If an urgent request is incomplete, information should be requested within 24 hours of request receipt. Provider has a pending period of 2 calendar days. If additional information is received, a decision should be rendered within 2 calendar days of receipt of additional information. If no information is received, a decision should be rendered within 2 calendar days of the pending period expiring.</p>	

If an urgent request is for an expedited formulary exception request, decision should be rendered within 24 hours of receipt of the request. This TAT applies to both complete and incomplete NF exception requests. There are no extensions or pend times for NF exception requests. This is a federal & state requirement.

*Non-Urgent Prior Authorizations:*

If a non-urgent PA is complete, a decision should be rendered within 15 calendar days of receipt of the request. If the PA request is incomplete, Oscar should request information within 15 calendar days. Provider has a pending period of 45 calendar days to provide the additional information. If additional information is received, a decision should be rendered within 15 calendar days of receipt of additional information. If no information is received, a decision should be rendered within 15 calendar days of the pending period expiring.

For a standard formulary exception request, a decision should be rendered within 72 hours of receipt of the request. This TAT applies to both complete and incomplete NF exception requests. There are no extensions or pend times for NF exception requests. This is a federal & state requirement.

*Appeals:*

Urgent appeals should have a decision rendered within 72 hours of receipt of necessary information to conduct the appeal OR 72 hours from receipt of request, whichever is shorter. Provider should have reasonable access to a clinical peer within 1 business day of receiving notice of urgent appeal. Non-urgent appeals should have a decision rendered within 30 calendar days of receipt of request.

**Forms and/or other information required to be submitted by the provider:**

The Plan will collect only information necessary to make a utilization review determination. During prior and concurrent reviews, only the necessary and relevant section of medical records will be requested, as needed to verify medical necessity.

All records are maintained electronically in the Plan's PHI-compliant systems. Any PHI is protected as per the Plan's HIPAA and PHI protection policies. In no event will information obtained by the Plan be used by persons other than health care professionals, medical record technologists, or personnel who have been appropriately trained.

**UM manuals and any other documentation of UM processes that are relied upon to make a determination:**

The Plan conducts a full investigation of each request, taking into consideration all documents, clinical records, and other information submitted. In all cases, pharmacist and physician reviewers adhere to the clinical criteria and guidelines outlined in the Plan's UM Plan.

**Qualifications of UM reviewers:**

Licensed clinicians (e.g., pharmacists and medical directors) review authorization

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

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

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

substance use disorder are comparable to, and are applied no more stringently than the coverage factors, processes, development or implementation strategies, evidentiary standards used in applying the limitations to drugs used to treat medical or surgical disorders as evidenced by the above as-written NQTL analysis.

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

Findings:

	PA	
state	p_value	coef
GA	0.20	0.20

Findings: The P value is greater than 0.05 for whether a drug is more likely to have PA in GA. This indicates that there is no statistically significant difference in the PA restriction between similar MH/SUD drugs and M/S drugs

**Table 3 - Proportion of drugs subject to PA**

Condition	Total # subject to PA	% subject to PA
MH	348	1%
SUD	0	0%
M/S	5673	5%

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

	<p><b><i>Prior Authorization Analysis:</i></b></p> <p>The Plan evaluates the proportion of drugs subject to prior authorization for mental health drugs (MH), substance use disorder drugs (SUD) , and medical/surgical (M/S) drugs. When the factors for prior authorization are considered consistently across all drug types, the outcome shows that prior authorization is applied to a varying proportion of drugs across MH, SUD, and M/S categories. Prior authorization is applied to:</p> <ul style="list-style-type: none"> <li>• 5% of the drugs in the Medical/Surgical category.</li> <li>• 1% of the drugs in the Mental Health category.</li> <li>• 0% of the drugs in the Substance Use Disorder category.</li> </ul>
--	---

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

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

	apply prior authorization to mental health/substance use disorder drugs is comparable to, and applied no more stringently than, the process and methodology used to apply prior authorization to medical/surgical drugs.
--	--

<b>Non-Quantitative Treatment Limitation (NQTL) Analysis Index</b>	
<b>Non-Quantitative Treatment Limitation</b>	Prior Authorization
<b>Plan Type(s) Applicable</b>	Oscar Health Plan of Georgia
<b>Responsible Business Teams</b>	Clinical
<b>Names of Person(s) Responsible for Analysis Formation</b>	<p><b>Oscar:</b>  Insiya Taj, MPH, Associate, UM Optimization, (Over 5 years experience in healthcare and clinical research)  David Schaffzin, MD, Associate Medical Director, Utilization Management</p> <p><b>Optum Behavioral Health Solutions:</b>  Positions: Chief Medical Officer, National Senior Behavioral Medical Directors (MD), VP Benefits Integrity, VP, Outpatient and Specialty Programs, Director MH Parity and Benefits, Legal Counsel, and Senior Director, National Policy and Standards.  Credentials: Board Certified MDs, Licensed Psychologist, Licensed Nurse, Licensed Social Worker, and National Certified Counselor.</p>
<b>Last Update</b>	12/17/23
<b>Reviewers</b>	<p>Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)  Laura Barry MHA, RN, BSN, CCM, CPC, Manager, Clinical Policy</p>





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

### Prior Authorization

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

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

Medical/Surgical Terms	Mental Health/Substance Use Disorder Terms
Definition: The Plan defines prior authorization as the process by which the utilization review agent determines the medical necessity of otherwise covered health care services prior to the rendering of such health care services including, but not limited to, preadmission review, pretreatment review, utilization, and case management.	Prior authorization: A form of prospective utilization review of health care services proposed to be provided to a member. A pre-service review determines approval of services, in whole or in part, in advance of the member obtaining services.
<p><b>Coverage Terms (EOC language):</b></p> <p>Prior Authorization means the process by which Oscar determines the Medical Necessity of otherwise covered healthcare services prior to the rendering of such healthcare services including, but not limited to, preadmission review, pretreatment review, utilization management. For the purposes of this document, the term “Prior Authorization” is considered to be synonymous with “Preauthorization” or “Precertification.”</p> <p><b>Prior authorization for Inpatient and Outpatient services</b></p> <p>Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. The list of services subject to preauthorization can be accessed online at <a href="https://hioscar.com/prior-authorization">hioscar.com/prior-authorization</a>. If You do not obtain prior authorization before an elective admission to a Hospital or certain other facilities, it may result in a penalty. Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of this Plan limitations and exclusions, payment of premium and eligibility at the time care and services are provided. Please note that emergency admissions may be reviewed post admission. To obtain Prior Authorization or verify requirements for inpatient or outpatient services, including which services require Prior Authorization, You or Your Provider can call Oscar at 1-855-672-2755 or online at <a href="https://hioscar.com/prior-authorization">hioscar.com/prior-authorization</a>. In order to minimize the potential for care delays,</p>	

We recommend that Prior Authorization requests be received within the following timeframes when feasible:

- At least five (5) days prior to an elective admission as an inpatient in a Hospital, extended care or rehabilitation facility, or hospice facility
- At least thirty (30) days prior to the initial evaluation for organ transplant Services
- At least thirty (30) days prior to receiving clinical trial services

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
In-Network Inpatient Services	<p>All inpatient services are subject to this NQTL.</p> <ul style="list-style-type: none"> <li>• Acute/Elective Hospital</li> <li>• Hospice Long-Term Acute Care</li> <li>• Rehabilitation</li> <li>• Acute/Subacute</li> <li>• Skilled Nursing Facility</li> <li>• Procedures/Treatments/Surgeries, when place of service is inpatient</li> </ul>	<p>The following inpatient services are subject to this NQTL.</p> <ul style="list-style-type: none"> <li>• MH Non-Emergent Acute Inpatient</li> <li>• MH Subacute Residential Treatment</li> <li>• SUD Acute Inpatient Detoxification</li> <li>• SUD Acute Inpatient Rehabilitation</li> <li>• SUD Subacute Residential Treatment</li> </ul>
In-Network Outpatient Services	<ul style="list-style-type: none"> <li>• Physician-Administered Drugs</li> <li>• Certain DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) such as oxygen, CPAP, and diabetic supplies</li> <li>• Home Health Care Services</li> <li>• Advanced Imaging</li> <li>• Home-Based Speech Therapy</li> <li>• Physical Therapy</li> <li>• Occupational Therapy</li> <li>• Diagnostic Tests &amp; Evaluations, Laboratory Procedures</li> <li>• Non-Emergency Transportation</li> <li>• Unlisted Procedures</li> </ul>	<ul style="list-style-type: none"> <li>• Partial Hospitalization (PHP)/Day Treatment</li> <li>• Intensive Outpatient (IOP)</li> <li>• Applied Behavior Analysis (ABA)</li> <li>• Transcranial Magnetic Stimulation (TMS)</li> <li>• Electroconvulsive Therapy (ECT)</li> <li>• Psychological Testing</li> <li>• Physical Therapy<sup>1</sup></li> <li>• Occupational Therapy<sup>2</sup></li> <li>• Home-Based Speech Therapy<sup>3</sup></li> </ul>

<sup>1</sup> Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)

<sup>2</sup> Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)

<sup>3</sup> Physical health services subject to MH/SUD benefit if contains MH/SUD diagnosis (see M/S analysis)

	<ul style="list-style-type: none"> <li>Procedures/Treatments/Surgeries, when place of service is outpatient</li> </ul>	
--	--	--

**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:**

<b>Benefit Classification</b>	<b>Factors Considered: Medical/Surgical</b>	<b>Factors Considered: Mental Health/SUD</b>
In-Network Inpatient Services	<ol style="list-style-type: none"> <li>Safety risk</li> <li>Clinical appropriateness</li> <li>Cost</li> </ol>	<ol style="list-style-type: none"> <li>Clinical Appropriateness: The application of Prior Authorization promotes optimal clinical outcomes</li> <li>Value: The cost of the service exceeds the associated costs of conducting a prior authorization review</li> </ol>
In-Network Outpatient Services	<ol style="list-style-type: none"> <li>Cost variability</li> <li>Denial rate</li> <li>Cost percentile</li> <li>Safety risk</li> <li>New/emerging service/technology</li> <li>Clinical appropriateness</li> </ol>	<ol style="list-style-type: none"> <li>Clinical Appropriateness: Whether the application of prior authorization promotes optimal clinical outcomes</li> <li>Value: The cost of the service exceeds the associated costs of conducting a prior authorization review</li> <li>Variation Identified: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits</li> </ol>

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

Benefit Classification	Evidentiary Standards and Sources: Medical/Surgical	Evidentiary Standards and Sources: MH/SUD
In-Network Inpatient Services	<p>1. <b>Clinical appropriateness</b> is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level of care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>● As per World Professional Association for Transgender Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines.</li> <li>● As per the American Psychological Association (APA), Applied Behavior</li> </ul>	<p>1. <b>Clinical Appropriateness</b> is defined as those inpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.</p> <p>This factor is utilized to determine which services may be subject to prior authorization. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the prior authorization list if there are objective, evidence-based clinical criteria to be used in the prior authorization reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed technology are used to approve and develop Medical Necessity Criteria on which reviews are based.</p> <p>The evidentiary standards and sources:</p> <ul style="list-style-type: none"> <li>● Clinical criteria from nationally recognized third-party sources (e.g., ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)</li> </ul>

	<p>Analysis is appropriate for children with autism spectrum disorder.</p> <ul style="list-style-type: none"> <li>As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of cancer and individualized needs as documented in the medical record.</li> </ul> <p>Sources: Clinical criteria, Clinical evidence</p> <p>Evidentiary Standards:</p> <p>Clinical criteria</p> <ul style="list-style-type: none"> <li>Plan Clinical Guidelines</li> <li>MCG</li> <li>ASAM (SUD only)</li> <li>Hayes</li> <li>UpToDate</li> <li>National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)</li> </ul> <p>Clinical evidence</p> <ul style="list-style-type: none"> <li>The US National Library of Medicine;</li> <li>Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> <li>Published scientific evidence;</li> <li>In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).</li> </ul>	<ul style="list-style-type: none"> <li>Clinical Technology Assessment Committee (CTAC) review</li> <li>Objective, evidence-based policies and publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies</li> </ul> <p>Note: These evidentiary standards and sources are not defined in a quantitative manner.</p> <p>Clinical Evidence Used:</p> <ul style="list-style-type: none"> <li>Systematic reviews and meta analyses</li> <li>Randomized controlled trials</li> <li>Large non-randomized controlled trials</li> <li>Large prospective trials</li> <li>Comparative and cohort studies</li> <li>Cross sectional studies</li> <li>Retrospective studies</li> <li>Surveillance studies</li> <li>Case Reviews/Case series</li> <li>Anecdotal/editorial statements</li> <li>Professional opinions</li> </ul> <p>In the absence of strong and compelling scientific evidence, clinical policies may be based upon:</p> <ul style="list-style-type: none"> <li>National consensus statements</li> <li>Publications by recognized authorities such as government sources and/or professional societies</li> </ul> <p>2. <b>Value</b> is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review by at least 1:1. Consideration of this factor includes a review of national inpatient utilization or claims data</p>
--	--	--

	<p>Examples:</p> <ul style="list-style-type: none"> <li>• Physical Therapy/Occupational Therapy</li> <li>• Gender affirming surgeries</li> <li>• Confirming member has undergone hormone therapy and counseling</li> <li>• Mastectomy - appropriate in most cases, but need to review for medical necessity</li> <li>• Physician-administered drugs</li> <li>• Level of care setting</li> </ul> <p>Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</p> <p><b>2. High Cost</b></p> <p>Evidentiary Standard: The mean cost of an inpatient episode of care is &gt;\$12,000</p> <p>Source: claims data</p> <p><b>3. Safety risk</b> is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The prior authorization process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered. If there is a less restrictive level of care available to meet the member's health needs, prior authorization may be applied to ensure the member receives the least restrictive level of care that is clinically appropriate.</p>	<p>to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering prior authorization to determine value.</p> <p>The Evidentiary standard that defines and/or triggers the Value factor:</p> <ul style="list-style-type: none"> <li>• Value is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the service to prior authorization by at least 1:1</li> </ul> <p>The sources used to define the Value factor:</p> <ul style="list-style-type: none"> <li>• National internal claims data</li> <li>• National UM program operating costs</li> <li>• National UM authorization data</li> </ul>
--	---	--

	<p>Sources: National societies and health agencies, Clinical criteria<sup>4</sup>, Clinical evidence<sup>5</sup></p> <ul style="list-style-type: none"> <li>● Centers for Medicare &amp; Medicaid Services</li> <li>● World Health Organization</li> <li>● Institute For Safe Medication Practices</li> <li>● U.S. Food and Drug Administration</li> <li>● Drug labeling / safety information</li> </ul> <p>Evidentiary Standards:</p> <ul style="list-style-type: none"> <li>● Treatments that increase the likelihood of adverse health effects</li> <li>● Services that increase the likelihood of perioperative morbidity and mortality</li> <li>● Procedures, such as high-risk operations, that carry a mortality rate of 5% or more.</li> <li>● Procedures with significant or major impact on hemodynamics, fluid shifts, possible major blood loss.</li> <li>● Drugs (including those dosed at higher than standard doses) that may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse.</li> </ul> <p><i>Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach</i></p>	
--	--	--

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

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

	<p><i>to reducing patient harm at national level. Paris: OECD; 2017</i>  (<a href="http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf">http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf</a>).</p>	
In-Network Outpatient Services	<p>1. <b>Clinical appropriateness</b> is defined as services with a narrow appropriateness of indication as per evidence-based guidelines clearly defined by specialty societies and/or governing bodies. Clinical appropriateness is applicable when evidence-based criteria is required to confirm the service is (a) medically necessary, (b) delivered in the appropriate setting or level of care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member's illness, injury, or disease, taking into account factors such as treatment type, frequency, extent, site, and duration. Services must be provided by licensed practitioners (e.g., DNP, DO, MD, PA) in accordance with evidence-based practice.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>As per World Professional Association for Transgender Health (WPATH) guidelines, prior authorization review of sex reassignment (gender affirmation) surgery confirms a persistent diagnosis with gender dysphoria WPATH guidelines.</li> <li>As per the American</li> </ul>	<p>1. <b>Clinical Appropriateness</b> is defined as those outpatient services that as determined by internal medical experts to be in accordance with objective, nationally recognized clinical criteria and evidence-based policies.</p> <p>This factor is utilized to determine which services may be subject to prior authorization. Clinical appropriateness means there are objective, evidence-based clinical criteria to support medical necessity reviews. A service will only be included on the prior authorization list if there are objective, evidence-based clinical criteria to be used in the prior authorization reviews. In reviewing factors utilized in medical necessity determinations, this is where committee considerations of the service's clinical efficacy, safety, and appropriateness of the proposed technology are used to approve and develop Medical Necessity Criteria on which reviews are based.</p> <p>The evidentiary standards and sources:</p> <ul style="list-style-type: none"> <li>Clinical criteria from nationally recognized third-party sources (e.g., ASAM, LOCUS,</li> </ul>



	<p>Psychological Association (APA), Applied Behavior Analysis is appropriate for children with autism spectrum disorder.</p> <ul style="list-style-type: none"> <li>As per the National Comprehensive Cancer Network (NCCN), radiation and chemotherapy requires confirmation of certain types of cancer and individualized needs as documented in the medical record.</li> </ul> <p>Sources: Clinical criteria, Clinical evidence</p> <p>Evidentiary Standards:</p> <p>Clinical criteria</p> <ul style="list-style-type: none"> <li>Plan Clinical Guidelines</li> <li>MCG</li> <li>ASAM (SUD only)</li> <li>Hayes</li> <li>UpToDate</li> <li>National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)</li> </ul> <p>Clinical evidence</p> <ul style="list-style-type: none"> <li>The US National Library of Medicine;</li> <li>Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> <li>Published scientific evidence;</li> <li>In consultation with medical experts and providers who have expertise in the particular area of</li> </ul>	<p>CALOCUS-CASII and ECSII guidelines for MH/SUD services)</p> <ul style="list-style-type: none"> <li>Clinical Technology Assessment Committee (CTAC) review</li> <li>Objective, evidence-based policies, and publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies</li> </ul> <p>Note: These evidentiary standards and sources are not defined in a quantitative manner.</p> <p>Clinical Evidence Used:</p> <ul style="list-style-type: none"> <li>Systematic reviews and meta analyses</li> <li>Randomized controlled trials</li> <li>Large non-randomized controlled trials</li> <li>Large prospective trials</li> <li>Comparative and cohort studies</li> <li>Cross sectional studies</li> <li>Retrospective studies</li> <li>Surveillance studies</li> <li>Case Reviews/Case series</li> <li>Anecdotal/editorial statements</li> <li>Professional opinions</li> </ul> <p>In the absence of strong and compelling scientific evidence, clinical policies may be based upon:</p> <ul style="list-style-type: none"> <li>National consensus statements</li> <li>Publications by recognized authorities such as government sources and/or professional societies</li> </ul> <p>2. <b>Value</b> is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the outpatient service to prior authorization review by at least 1:1. Consideration of this factor</p>
--	--	---

	<p>the services (e.g., board-certified physician specialists).</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Physical Therapy/Occupational Therapy</li> <li>• Gender affirming surgeries</li> <li>• Confirming member has undergone hormone therapy and counseling</li> <li>• Mastectomy - appropriate in most cases, but need to review for medical necessity</li> <li>• Physician-administered drugs</li> <li>• Level of care setting</li> </ul> <p>Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</p> <p>2. <b>Denial rate</b> is defined as the percentage of prior authorization requests that are denied by the Plan.</p> <p>Source: Prior authorization data Evidentiary Standard: &gt;10%</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Benefit: Medical/Surgical Service: Outpatient Services: Treatments &amp; Procedures: Skin Treatments &amp; Procedures   UV / Laser therapy Denial rate applies to this service category. Denial rate is 70% for this service category.</li> <li>• Benefit: Mental Health/Substance Use Disorder Service: Partial Hospitalization</li> </ul>	<p>includes a review of national outpatient authorization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering prior authorization to determine value.</p> <p>The Evidentiary standard that defines and/or triggers the Value factor:</p> <ul style="list-style-type: none"> <li>• Value is defined as the cost of the outpatient service exceeding the administrative costs of subjecting the service to prior authorization by at least 1:1</li> </ul> <p>The sources used to define the Value factor:</p> <ul style="list-style-type: none"> <li>• National internal claims data</li> <li>• National UM program operating costs</li> <li>• National UM authorization data</li> </ul> <p>3. <b>Variation</b> is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services that are provided to a minimum of 50 unique members (the materiality threshold established by MH/SUD for purposes of the variation analysis). Consideration of this factor includes a review of national internal claims data for service-specific costs and calculating an overall mean of the service-specific average cost per patient. For any given MH/SUD service, if the average allowed cost per patient's episode of care is twice the average cost per patient's episode of care across all other</p>
--	--	--

	<p>Denial rate applies to this service category. Denial rate is 60% for this service category.</p> <p>3. <b>Cost variability</b> is defined as the cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members. Outpatient services are subject to variability in cost per episode of service relative to other services within the classification of benefits. For each service, the Plan calculates the Average Annual Allowed Amount per Unique Patient with Outpatient Claim Events for that Primary Service.</p> <p>Source: Claims data</p> <p>Evidentiary Standard: Cost per episode of service that triggers 2x the mean of other outpatient services.</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>Benefit: Medical/Surgical Service: Outpatient Services: Treatments &amp; Procedures: Musculoskeletal Surgery   Joint arthroscopy / arthroplasty / arthrodesis Cost variability applies to this service category. Cost variability is 5x the mean of other outpatient services.</li> <li>Benefit: Mental Health/Substance Use Disorder Service: Outpatient Psychiatric Testing Cost variability applies to this</li> </ul>	<p>MH/SUD outpatient services, prior authorization is applied.</p> <p>Source: National internal claims data</p> <p>Evidentiary Standard: Variation is defined as cost per episode of service (service units multiplied by unit cost) that trigger 2x the mean of other outpatient services that are provided to a minimum of 50 unique members (the materiality threshold established for purposes of the variation analysis).</p>
--	---	--

	<p>service category. Cost variability is 2.9x the mean of other outpatient services.</p> <p>4. <b>Cost percentile</b> is defined as the average cost per claim event for a particular outpatient service relative to other services within the classification of benefits.</p> <p>Source: Claims data</p> <p>Evidentiary Standard: <math>\geq</math> 85th Percentile</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Benefit: Medical/Surgical Service: Outpatient Services: Treatments &amp; Procedures: Digestive Treatments &amp; Procedures   Bariatric surgery Cost percentile applies to this service category. Cost is in the 100th percentile for this service category.</li> <li>• Benefit: Mental Health/Substance Use Disorder Service: Outpatient psychiatric testing Cost percentile applies to this service category. Cost is in the 100th percentile for this service category</li> </ul> <p>5. <b>Safety risk</b> is defined as healthcare services that have the potential to harm patients and increase the risk of adverse events. The prior authorization</p>	
--	---	--

	<p>process helps alleviate safety risks and protects patient health by ensuring that procedures, treatments, surgeries, and prescribed medications are medically necessary and appropriately administered.</p> <p>Sources: National societies and health agencies, Clinical criteria<sup>6</sup>, Clinical evidence<sup>7</sup></p> <ul style="list-style-type: none"> <li>● Centers for Medicare &amp; Medicaid Services</li> <li>● World Health Organization</li> <li>● Institute For Safe Medication Practices</li> <li>● U.S. Food and Drug Administration</li> <li>● Drug labeling / safety information</li> </ul> <p><b>Evidentiary Standards:</b></p> <ul style="list-style-type: none"> <li>● Treatments that increase the likelihood of adverse health effects</li> <li>● Services that increase the likelihood of perioperative morbidity and mortality</li> <li>● Procedures, such as high-risk operations, that carry a mortality rate of 5% or more.</li> <li>● Procedures with significant or major impact on hemodynamics, fluid shifts, possible major blood loss.</li> <li>● Drugs (including those dosed at higher than standard doses) that</li> </ul>	
--	---	--

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

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

	<p>may have adverse health effects, possibly dangerous interactions, medication errors, and/or risks for abuse or misuse.</p> <p><i>Slawomirski L, Auraaen A, Klazinga N. The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level. Paris: OECD; 2017 (<a href="http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf">http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf</a>).</i></p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Surgical procedures at risk for infection and complications (e.g., gastrectomy, hip replacement)</li> <li>• Advanced radiology procedures with exposure to radiation (e.g., CT, MRI, nuclear medicine)</li> <li>• Physician-administered drugs due to the risk for adverse effects and contraindications (e.g., chemotherapeutic agents)</li> </ul> <p>6. <b>New/ Emerging Service/ Technology</b> is defined as any health care service, testing, procedure, treatment, device or prescription drug for which safety and efficacy has not been established and proven is considered experimental, investigational, or unproven. Services that are not accepted as the standard medical treatment of the condition being treated are considered “new and emerging services and technologies.” This includes any health care service, testing, procedure, treatment, device, or</p>	
--	---	--

	<p>prescription drug that:</p> <ul style="list-style-type: none"> <li>○ Is not accepted as standard medical treatment of the condition; or</li> <li>○ Has not been approved by the U.S. Food and Drug Administration (FDA) to be lawfully used; or</li> <li>○ Has not been identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or</li> <li>○ Requires review and approval by any institutional review board (IRB) for the proposed use or are subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations; or</li> <li>○ Requires any Federal or other governmental agency approval not listed above that has not been and will not be granted at the time services will be provided.</li> </ul> <p>Sources: Clinical criteria, Clinical evidence</p> <p>Evidentiary Standards:</p> <p>Clinical criteria</p> <ul style="list-style-type: none"> <li>● Plan Clinical Guidelines</li> <li>● MCG</li> </ul>	
--	--	--

	<ul style="list-style-type: none"> <li>● ASAM (SUD only)</li> <li>● Hayes</li> <li>● UpToDate</li> <li>● National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)</li> </ul> <p>Clinical evidence</p> <ul style="list-style-type: none"> <li>● The US National Library of Medicine;</li> <li>● Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN);</li> <li>● Guidance or regulatory status published by Government Regulatory Agencies (e.g., CDC, CMS, FDA, NIH);</li> <li>● Published scientific evidence;</li> <li>● In consultation with medical experts and providers who have expertise in the particular area of the services (e.g., board-certified physician specialists).</li> </ul> <p>Examples:</p> <ul style="list-style-type: none"> <li>● Genetic, biomarker and molecular tests</li> <li>● Medical devices and implants</li> <li>● Novel therapies (e.g., gene therapy, CAR T-Cell therapy)</li> </ul>	
--	---	--

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

**Inpatient M/S**

	Clinical Appropriateness	Safety	High Cost
--	--------------------------	--------	-----------



Acute/Elective Hospital Rehabilitation	<b>X</b>	<b>X</b>	<b>X</b>
Hospice Long-Term Acute Care	<b>X</b>	<b>X</b>	<b>X</b>
Acute/Subacute	<b>X</b>	<b>X</b>	<b>X</b>
Skilled Nursing Facility	<b>X</b>	<b>X</b>	<b>X</b>
Procedures/Treatments/Surgeries, when place of service is inpatient	<b>X</b>	<b>X</b>	<b>X</b>

#### Outpatient M/S

Service	Cost variability	Denial rate	Cost percentile	Safety risk	New/ Emerging Service/ Technology	Clinical Appropriateness
Physician-Administered Drugs		<b>X</b>		<b>X</b>	<b>X</b>	<b>X</b>
DMEPOS		<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
Home Health Care Services		<b>X</b>				<b>X</b>
Advanced Imaging		<b>X</b>		<b>X</b>		
Diagnostic Tests & Evaluations, Laboratory Procedures		<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
Treatments/ Procedures	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>

Non-Emergency Transportation		<b>X</b>	<b>X</b>			
Unlisted Procedures	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>	

#### **Inpatient MH/SUD**

	Clinical Appropriateness	Value
Inpatient, MH	<b>X</b>	<b>X</b>
Inpatient, SUD	<b>X</b>	<b>X</b>
Residential, MH	<b>X</b>	<b>X</b>
Residential, MH	<b>X</b>	<b>X</b>

#### **Outpatient MH/SUD**

	Clinical Appropriateness	Value	Variation
Partial Hospitalization/Day Treatment	<b>X</b>	<b>X</b>	<b>X</b>
Intensive Outpatient	<b>X</b>	<b>X</b>	<b>X</b>
Applied Behavior Analysis (ABA)	<b>X</b>	<b>X</b>	<b>X</b>
Transcranial Magnetic Stimulation (TMS)	<b>X</b>	<b>X</b>	<b>X</b>
Electroconvulsive Therapy (ECT)	<b>X</b>		<b>X</b>
Psychological Testing	<b>X</b>	<b>X</b>	

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

**standards, and other factors used to apply the NQTLs to medical or surgical benefits:**

Prior Authorization Process M/S	Prior Authorization Process MH/SUD
<p><b>Purpose of PA</b> The prior-authorization process is part of the Utilization Review (UR) activities performed by the Plan Utilization Review is the assessment performed to determine if a medical service meets the Plan’s medical necessity criteria for coverage.</p> <p><b>Services Subject to PA &amp; Submitting PA Request</b> The Plan maintains a list of services that require prior authorization. This list is available on request by phone, by provider portal, or via the published provider manual. Authorizations can be submitted via phone, fax, or online through Oscar's provider portal.</p> <p><b>Reviewers</b> When a prior authorization request is submitted, it is reviewed by licensed clinicians to determine if the request meets medical necessity. Licensed clinicians (e.g. physicians and nurses) review authorization requests. Clinical reviewers must have an active unrestricted professional license in a state or territory of the United States, and within scope of practice relevant to the clinical area they are reviewing. Clinicians utilize the Plan’s policies and established, evidence based clinical criteria to determine if the request meets coverage determinations and/or medical necessity. Licensed clinicians (e.g. physicians and nurses) review authorization requests; only board certified physicians can make adverse determinations.</p> <p><b>Information Required When Requesting PA</b> The Plan requires the requesting provider to submit the following information when requesting an authorization:</p>	<p><b>Purpose of PA</b> Prior Authorization is a component of the OBHS utilization management (UM) program that helps ensure members receive appropriate care, based on their specific clinical status and health care needs before care is delivered for MH/SUD services.</p> <p>Prior authorization includes review of a member’s clinical information and application of evidence-based clinical criteria on a case-by-case basis to determine benefit coverage for requested services in accordance with the member’s health benefit plan prior to delivery of the requested services. The primary goal is to provide consistent application of clinical criteria to member clinical information to inform member choice.</p> <p><b>Services Subject to PA &amp; Submitting PA Request</b> Committees approve MH/SUD services to be subject to prior authorization. Services subject to prior authorization are accessible through the provider portal <a href="http://www.providerexpress.com">www.providerexpress.com</a> or by contacting customer service. Providers may submit prior authorization requests by telephone, fax, or online portal in accordance with plan requirements. Members may submit prior authorization requests via telephone, fax, or mail in accordance with plan requirements.</p> <p><b>Reviewers</b> Clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are made by clinical staff (i.e., physicians, nurses, licensed master’s level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors or Psychologists.</p>

<ul style="list-style-type: none"> <li>• Member information (name, Plan ID, date of birth).</li> <li>• Facility (if applicable).</li> <li>• referring and treating provider name, National Provider Identifier (NPI), and Taxpayer Identification Number (TIN).</li> <li>• Treatment information including diagnostic and/or procedure codes, requested amount and length of treatment(s).</li> </ul> <p><b>Notification of Determination:</b> Both the providers and members are notified of the determination consistent with state, federal and accreditation requirements and applicable appeal rights are provided.</p>	<p><b>Information Required When Requesting PA</b> During the clinical review process, OBHS personnel gather only the critical information needed (in compliance with state-specific restrictions for the type of information that can be requested).</p> <p>Requests for authorization must contain the following details regarding the admission:</p> <ul style="list-style-type: none"> <li>• Member name and Member ID number</li> <li>• Facility/Provider name and TIN or NPI</li> <li>• Description for admitting diagnosis</li> <li>• Service start date</li> <li>• Clinical information sufficient to make a coverage determination</li> </ul> <p><b>Notification of Determination:</b> The member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.</p> <p><b>**Note:</b> Optum Behavioral Health Solutions (OBHS) generally structures UM processes to comply with Federal ERISA requirements, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.</p>
--	--

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

Committee Information M/S	Committee Information MH/SUD
<p>The OMC Board of Directors has the ultimate authority and responsibility for the quality of care and services delivered to its members. The Board of Directors provides strategic planning and direction, budget approval, and staff allocation for the UM Department. The Board of Directors assigns day-to-day responsibility for implementation of the UM Program to the UM Subcommittee, which is a</p>	<p>For OBHS, committees approve MH/SUD services to be subject to prior authorization. Services subject to prior authorization are reviewed at least annually, or more frequently as needed. This process is overseen by the Clinical Quality and Operations Committee (CQOC). The Clinical Quality and Operations Committee (CQOC) receives oversight from the Quality Improvement Committee (QIC). Appointed by</p>

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

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

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

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

the Chief Medical Officer, a senior-level licensed psychiatrist (MD) Medical Director Chairs the CQOC along with a Vice Chair (PhD, MBA) who is a senior leader of clinical operations responsible for UM activities. Voting membership includes representation from licensed and board-certified psychiatrists (MDs), licensed Psychologists (PhDs) and a licensed nurse (RN). Committee voting membership includes participants from the following areas: Clinical Technology Assessment Committee (MDs), Clinical Criteria (LCSW, MSN, RN, PMHNP-BC), Clinical Operations of Direct Sites (MBA), Utilization Management (PhD), Senior Leader Quality Improvement (PhD), Appeals, Care Engagement Medical Operations (MD) and Medical Operations for UM (MD). Additional internal department representatives attend as non-voting membership, including Legal Counsel, Compliance, Accreditation, the Operational Policy and Standards Committee, Network Strategy and Benefits Integrity. The Clinical Quality and Operations Committee meets monthly and ad hoc, as necessary.

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

- Oversees the development and implementation of a National Utilization Management (UM) Program (NUMP) with the Utilization Management Program Description (UMPD) serving as the source document for the NUMP
- Proposes and evaluates UM-related Clinical QIAs
- Evaluates the effectiveness and efficiency of our UM program across all business operation sites
- Ensures the standardization of our UM program across all business operation sites
- Reviews Operational Policy and Standards Committee policies related to UM management as necessary
- Reviews, recommends, and votes on Clinical Criteria
- Review and approval of prior authorization requirements

- Reviews and approves modifications to the healthcare procedures and services subject to Prior Authorization.

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

Benefit Classification	Process Description: Medical/Surgical	Process Description: MH/SUD
In-Network Inpatient Services/Outpatient Services	<p><b>Timelines and deadlines for review and approvals:</b></p> <p>Urgent: If request is completed, decision and approvals are made within 72 hours of receipt of request</p> <p><b>Forms and/or other information required to be submitted by the provider:</b></p> <p>The Plan will collect only information necessary to make a utilization review determination and will not routinely require providers to code requests or submit medical records for all patients. During prior and concurrent reviews, only the necessary and relevant section of medical records will be requested, as needed to verify medical necessity.</p> <p>The Plan requires the requesting provider to submit the following information when requesting an authorization:</p> <ul style="list-style-type: none"> <li>• Member information (name, Plan ID, date of birth).</li> <li>• Facility (if applicable).</li> <li>• referring and treating provider name, National Provider Identifier (NPI), and Taxpayer Identification Number (TIN).</li> <li>• Treatment information including diagnostic and/or procedure codes, requested amount</li> </ul>	<p><b>Timelines and deadlines for review and approvals:</b></p> <p>Urgent: Within 72 hours from receipt of the request.</p> <p><b>Forms and/or other information required to be submitted by the provider:</b></p> <p>INN providers must obtain prior authorization for any service on the prior authorization list prior to rendering the service. INN providers submit service requests for prior authorization through the secure provider portal, by telephone, or by fax (where required). Members may submit prior authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to open a case. OBHS confirms receipt of the prior authorization request and confirms member eligibility and benefit plan coverage. OBHS screens cases to ensure availability of accurate and thorough case information. OBHS consults clinical criteria when making clinical benefit coverage determinations. OBHS may approve cases that do not require clinical evaluation or interpretation.</p> <p>If OBHS cannot approve the prior authorization request because it requires clinical evaluation or interpretation, the case is referred to a clinical reviewer. OBHS may gather more clinical information that may include but is not limited to consultations,</p>

	<p>and length of treatment(s).</p> <p><b>UM manuals and any other documentation of UM processes that are relied upon to make a determination:</b> The Plan conducts a full investigation of each request, taking into consideration all documents, clinical records, and other information submitted. In all cases, nurse and physician reviewers adhere to the clinical criteria and guidelines outlined in the Plan's UM Plan. The Plan uses externally developed, evidence-based medical necessity criteria and well as internally developed medical necessity criteria when making medical necessity coverage determinations related to M/S services.</p> <p><b>Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification):</b> When a prior authorization request is submitted, it is reviewed by licensed clinicians to determine if the request meets medical necessity. Clinicians utilize the Plan's policies and established, evidence based clinical criteria to determine if the request meets coverage determinations and/or medical necessity. Licensed clinicians (e.g. physicians and nurses) review authorization requests; only board certified physicians can make adverse determinations.</p>	<p>diagnosis, history of the presenting problem(s), and history of related treatment and services. The clinical reviewer uses applicable member clinical information, benefit plan documents, and medical necessity criteria in the case review.</p> <p><b>UM manuals and any other documentation of UM processes that are relied upon to make a determination:</b> Clinical reviewers base medical necessity determinations on objective evidence-based behavioral clinical policies and use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM®), Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.</p> <p>OBHS prior authorization processes are accredited by the National Committee for Quality Assurance (NCQA), which confirms that MH/SUD operations and policies identify appropriate turn-around times for decisions, require decision-making by appropriate personnel, and govern communication of adverse benefit determinations. In addition, prior authorization is governed at both the state and federal level, which may include consumer protections such as external review for adverse benefit determinations after internal appeal options are exhausted.</p> <p><b>Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification):</b> The clinical reviewer refers cases to a peer clinical reviewer if the requested clinical information is not received or the case cannot be approved. Peer-to-peer conversations are offered as</p>
--	---	---



		<p>required. If a peer clinical reviewer issues an adverse determination, then the adverse determination is communicated consistent with state, federal and accreditation requirements, including appeal rights, as applicable. All adverse determinations are made by Medical Directors or Psychologists.</p> <p><b>**Note:</b> Optum Behavioral Health Solutions (OBHS) generally structures UM processes to comply with Federal ERISA requirements, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.</p>
--	--	--

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

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



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

<b>Inter-rater reliability scores clinical reviewers (M/S) 2022:</b>	<b>Inter-rater reliability scores clinical reviewers (MH/SUD) 2022:</b>
<ul style="list-style-type: none"> <li>• Average IRR score: 92.0%</li> </ul>	<ul style="list-style-type: none"> <li>• Average IRR score: 96%</li> </ul>

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

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

Findings:

	<p><i>Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization for M/S services:</i></p>	<p><i>Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization for MH/SUD services:</i></p>
	<p><b><u>Medical/Surgical: Prior Authorization</u></b></p> <p>Prior Authorization denial rates (includes partial):</p> <ul style="list-style-type: none"> <li>• Total # of PA requests: <b>271,473</b></li> <li>• Total # of PA requests denied: <b>51,402</b></li> <li>• % of PA requests denied: <b>19.0 %</b></li> </ul> <p>OON stats:</p> <ul style="list-style-type: none"> <li>• Total # OON requests: <b>8,770</b></li> <li>• Percentage (from total # of requests): <b>3.23%</b></li> <li>• Total # denied: <b>6,746</b></li> <li>• Percentage of denied (from total OON requests): <b>77%</b></li> </ul> <p>Overturned appeal rates:</p> <ul style="list-style-type: none"> <li>• Total Appeals: <b>1,303</b></li> <li>• Total # overturned: <b>519</b></li> <li>• Overturn rate (%): <b>40%</b></li> </ul>	<p><b><u>MH/SUD: Prior Authorization</u></b></p> <p>Prior Authorization denial rates (includes partial):</p> <ul style="list-style-type: none"> <li>• Total # of PA requests: <b>14,325</b></li> <li>• Total # of PA requests denied: <b>637</b></li> <li>• % of PA requests denied: <b>4.4%</b></li> </ul> <p>OON stats:</p> <ul style="list-style-type: none"> <li>• Total # OON requests: <b>430</b></li> <li>• Percentage (from total # of requests): <b>3.0%</b></li> <li>• Total # denied: <b>206</b></li> <li>• Percentage of denied (from total OON requests): <b>47.9%</b></li> </ul> <p>Overturned appeal rates (includes partially overturned):</p> <ul style="list-style-type: none"> <li>• Total Appeals: <b>40</b></li> <li>• Total # overturned: <b>17</b></li> <li>• Overturn rate (%): <b>42.5%</b></li> </ul>
	<p>*Data is based on 2022 authorization data across Oscar commercial plans (excluding MA)</p>	

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

<p>In-Network Inpatient Services/Outpatient Services</p>	<p>The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:</p> <p>The Plan conducted a comparative analysis to determine which Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) services are subject to prior authorization “as written.”</p> <p>The factors that demonstrate whether inpatient benefits require Prior Authorization are aligned for MH/SUD benefits and M/S benefits. For both MH/SUD and M/S services, clinical appropriateness is a factor. Additionally, safety is a factor considered for M/S services which is also considered under medical necessity criteria when assessing the clinical appropriateness factor for MH/SUD services. Value (factor for MH/SUD benefits) is aligned with the cost (factor for M/S benefits) because both of these factors take into account the cost of services. For inpatient factors, claims data is used as a source to evaluate factors such as value and cost and objective, evidence-based clinical guidelines medical experts, and national guidelines are used as an evidentiary standard and source for factors such as clinical appropriateness and safety.</p> <p>The factors that demonstrate whether an outpatient benefit requires Prior Authorization are aligned for MH/SUD services and M/S services. The factors clinical appropriateness (MH/SUD and M/S) and safety (M/S) are aligned as they both take into consideration the appropriateness of a service and rely on objective, evidence-based clinical guidelines, medical experts, and national guidelines as an evidentiary standard and source. Safety is considered as an element under medical necessity criteria when assessing the clinical appropriateness factor for MH/SUD benefits and thus is aligned with the safety factor for M/S benefits.</p> <p>For the MH/SUD outpatient factor "value of applying a prior authorization," this factor closely aligns with M/S factors such as cost and denial rate. This is because the calculation of value takes into account the costs of rendered services compared to the administrative burden of reviewing a case which considers denial rates (e.g. considerably low denial rates might signal there is an unnecessary administrative burden of review). For these factors, authorization data and claims data is used as a source to derive the evidentiary standards to support these factors.</p> <p>Additionally, for both MH/SUD benefits and M/S benefits, variability in cost is considered as a factor that determines whether a service requires prior authorization. Variability for both MH/SUD and M/S benefits is evaluated by using a threshold of 2x the mean of other services and uses claims data as a source.</p> <p>One factor, new/emerging services, is considered for medical/surgical services but not for mental health services. The Plan has concluded that this does not result in more stringency towards mental health/substance use disorder benefits because this factor could result in additional services becoming subject to prior authorization for medical/surgical benefits.</p>
--	---

Operationally, the Plan performs in-operation data assessments for prior authorization procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across med/surg and MH/SUD services. The Plan concludes that in-operation, its methodology for prior authorization for mental health/substance use disorder services is comparable to and applied no more stringently than the methodology for prior authorization applied to medical/surgical services. A comparison of denial rates (including partial denials) reveals that prior authorization denial rates for M/S services are higher compared to denial rates of MH/SUD services indicating higher approval rates for MH/SUD benefits (19% v. 4.4%). This reveals that more services are denied when they are M/S services compared to MH/SUD services. Out-of-network (OON) denial rates (including partial denials) similarly reveal higher rates of denial for M/S services (77% v. 47.9%). This reveals that more OON services are denied when they are M/S services compared to MH/SUD services. Finally, overturned appeals are comparable between M/S services and MH/SUD services with a higher overturn rate for MH/SUD services (40% v. 42.5%) indicating that more appealed services are approved for MH/SUD benefits. The outcome measures show comparability (or in this case are more favorable to behavioral health benefits) in processes for prior authorization because the metrics reveal more favorable outcomes for MH/SUD benefits with higher rates of approval for services overall.

The Plan is responsible for coordinating responses to non-quantitative treatment limitations (NQTLs) with its Behavioral Health Vendor (Optum Behavioral Health Solutions) on an annual basis or as needed when there is a change to a current methodology or process directly related to the NQTL. The Plan conducts non-quantitative treatment limitations to review that factors, sources, evidentiary standards, and processes are applied no more strictly to Mental Health/Substance Use Disorder services when compared to Medical/Surgical services. If a discrepancy is identified, the Plan coordinates with Optum Behavioral Health Solutions to investigate if there is a risk of non-compliance to perform necessary remediation.

The prior authorization non-quantitative treatment limitation is approved on an annual basis by the Clinical Advisory Committee, which reports to the Utilization Management Subcommittee. The Associate of UM Optimization is responsible for conveying annual updates to the committee for review and formal sign-off. Non-quantitative treatment limitation changes and modifications, including factors or other modifications to the non-quantitative treatment limitation methodology, are determined during the most subsequent quarterly Clinical Advisory Subcommittee session or can be voted on by CAS committee members off-cycle

Conclusion: The findings of the comparative analysis reveal that the process and methodology to apply prior authorization to mental health/substance use disorder services is comparable to, and applied no more stringently than, the process and methodology used to apply prior authorization to medical/surgical services.



Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Provider Reimbursement
Plan Type(s) Applicable	Oscar Health Plan of Georgia
Responsible Business Teams	Contracting
Names of Person(s) Responsible for Analysis Formation	<p><b>Oscar:</b> Oscar's Manager of Contracting Strategy &amp; Analytics in collaboration with Optum Behavioral Health Solutions</p> <p><b>Optum Behavioral Health Solutions:</b> Positions/Titles: Director, Policy and Process Provider Network Administration, VP Benefits Integrity, Director MH Parity and Benefits, SVP Value and Benefit Management, VP Network Pricing, Credentialing Specialist, Associate Director Out-of-Network Pricing and Policy Credentials: Licensed Psychologist, Licensed Nurse, Registered Health Information Technician, Certified Professional Coder, Certified Professional Medical Auditor, Certified Professional Compliance Officer, Certified Evaluation and Management Coder</p>
Last Update	12/5/2023 Laura Finney
Reviewers	Alexandra Rubino, Associate Director, MHP (Over five years experience in Mental Health Parity reporting and operational compliance)



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

### Provider Reimbursement: Professional Services

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

#### General Description/Explanation of the NQTL:

**Strategy:** Optum Behavioral Health Solutions (OBHS) and Oscar Insurance Company use the methodologies described below to establish reimbursement for professional service providers.

**Process:** OBHS and Oscar Insurance Company use the process described below to negotiate and establish base reimbursement rate(s) for INN professional services.

Key steps in the INN professional services reimbursement negotiation process for MH/SUD services include:

- The provider submits a completed application to OBHS to be included in the MH/SUD provider network.
- Based on the above, OBHS offers a reimbursement rate to the provider for the services/programs the provider intends to offer.

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

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

Benefit Classification	Factors Considered: Medical/Surgical	Factors Considered: Mental Health/SUD
Professional Services Subject to In-Network Provider Reimbursement Methodology	<ol style="list-style-type: none"> <li>1. <b>Provider type</b> (e.g., physician vs. non-physician) and/or specialty including provider licensure, board certification, education, and training</li> <li>2. <b>Services and/or procedures</b> provided along with relevant modifiers</li> <li>3. Site of service/CMS Place of Service Code Set</li> <li>4. <b>CMS Fee Schedule</b> with locality</li> <li>5. <b>Market dynamics</b> including: <ul style="list-style-type: none"> <li>o Adequacy standards</li> <li>o Provider leverage</li> <li>o Network need</li> <li>o Provider member volume</li> <li>o Internal agreements rate</li> </ul> </li> <li>6. <b>Market benchmark rates</b></li> </ol> <p>The factors are not weighted.</p>	<ol style="list-style-type: none"> <li>1. <b>Provider type</b> (e.g., physician vs. non-physician) and/or specialty including provider licensure, board certification, education, and training</li> <li>2. <b>Services and/or procedures</b> provided</li> <li>3. <b>CMS Resource-Based Relative Value Scale (RBRVS)</b><sup>1</sup> using Relative Value Units (RVUs) to define the value of the service or procedure relative to all services and procedures on the scale. The value of the service is based upon the following factors: <ul style="list-style-type: none"> <li>o Provider Work (work)</li> <li>o Provider Expense (PE)</li> <li>o Provider Malpractice Insurance Expense (MP)</li> <li>o Geographic Practice Cost Indices (GCPI)</li> <li>o Conversion Factor (CF)</li> </ul> </li> <li>4. <b>Market dynamics</b> including: <ul style="list-style-type: none"> <li>o Provider leverage</li> <li>o Network need</li> <li>o Provider member volume</li> <li>o Market/Specialty prevailing rates</li> </ul> </li> </ol> <p>The factors are not weighted.</p>
Professional Services Subject to Out-of-	This plan has no OON benefits	This plan has no OON benefits

<sup>1</sup> CMS utilizes RBRVS to determine the professional fee schedule.

Network Provider Reimbursement Methodology		
Emergency Services	<p>See above for in-network reimbursement methodologies.</p> <p>Reimbursement methodologies for out-of-network claims comply with all federal and state law (e.g., No Surprises Act)</p>	<p>See above for in-network reimbursement methodologies.</p> <p>Reimbursement methodologies for out-of-network emergency care comply with all federal and state law (e.g., No Surprises Act)</p>

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

Benefit Classification	Evidentiary Standards: Medical/Surgical	Evidentiary Standards: MH/SUD
Professional Services Subject to In-Network Provider Reimbursement Methodology (includes Emergency)	<ol style="list-style-type: none"> <li>The provider type and/or specialty is assessed based upon the provider's credentials, licensure, board certification, education, and training.</li> <li>Most current versions of industry standard code sets, e.g., CPT, HCPCS, etc.</li> <li>CMS locality-specific Fee Schedules</li> <li>CMS site of service code set<sup>2</sup></li> <li> <ul style="list-style-type: none"> <li><b>Adequacy standards:</b> Regulatory adequacy standards (CMS) that</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>Provider type (e.g., physician vs. non-physician) and/or specialty including provider licensure, board certification, education, and training <p>The evidentiary standards:</p> <ul style="list-style-type: none"> <li>Provider type (e.g., physician vs. non-physician) and/or specialty including provider licensure, board certification, education, and training</li> </ul> </li> <li>Services and/or procedures provided <p>The evidentiary standards:</p> <ul style="list-style-type: none"> <li>Most current versions of industry standard code sets, e.g., Current Procedural</li> </ul> </li> </ol>

<sup>2</sup> [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set)



	<p>define the need of certain specialties</p> <ul style="list-style-type: none"> <li>• <b>Provider leverage:</b> Providers owned or employed by large health systems within a given geographic market have more leverage than those who are not, e.g., solo practitioner.</li> <li>• <b>Network need:</b> Supply and demand for a provider type is evaluated by looking at the volume of network providers of the same or similar provider type within the relevant geographic region relative to the Plan's membership and its network access and/or availability standards.</li> <li>• <b>Provider member volume:</b> Measured by looking at the volume of members treated by the provider, and/or volume of services billed by the provider, in a given year relative to the same or similar provider types in the same geographic market during the same timeframe.</li> <li>• <b>Internal agreements rate:</b> Internally derived average market pricing based upon available data including claims data, state published rates, CMS PPS. This provides a relative comparison for specialty rates in a particular locality.</li> </ul>	<p>Technology (CPT®), Healthcare Common Procedure Coding System (HCPCS), etc.</p> <p>3. CMS Resource-Based Relative Value Scale (RBRVS) using Relative Value Units (RVUs) to define the value of the service or procedure relative to all services and procedures on the scale. The <b>value of the service</b> is based upon the following factors</p> <ul style="list-style-type: none"> <li>• Provider Work (work)</li> <li>• Provider Expense (PE)</li> <li>• Provider Malpractice Insurance Expense (MP)</li> <li>• Geographic Practice Cost Indices (GCPI)</li> <li>• Conversion Factor (CF)</li> </ul> <p>Evidentiary standards:</p> <ul style="list-style-type: none"> <li>• The CMS RVU for a given service or procedure is derived using the following mathematical formula:  <math display="block">(\text{work RVU} \times \text{work GPCI}) + (\text{PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI}) \times \text{CF} = \text{CMS benchmark rate}</math> </li> </ul> <p>Work = Provider work reflects the provider's work when performing a procedure or service including provider's technical skills, physical effort, mental effort and judgment, stress related to patient risk, and the amount of time required to perform the service or procedure.  PE = Provider Expense reflects the costs for medical supplies, office supplies, clinical and administrative staff, and pro rata costs of building space, utilities, medical equipment, and office equipment.</p>
--	---	--

	<p>6. Market benchmark rates are purchased from third party data sources (e.g., Truven, state databases) in order to inform industry norms</p>	<p>MP = Malpractice Insurance expense reflects the cost of professional liability insurance based on an estimate of the relative risk associated with procedure or service.  CF = Conversion Factor  GPCI = Geographic Practice Cost Indices</p> <p>4. <b>Market dynamics</b> that may influence the offered rate include:</p> <ul style="list-style-type: none"> <li>● Provider leverage</li> <li>● Network need</li> <li>● Provider member volume</li> </ul> <p>Evidentiary standards:</p> <ul style="list-style-type: none"> <li>● Provider leverage: Providers owned or employed by large health systems within a given geographic market have more leverage than those who are not, e.g., solo practitioner.</li> <li>● Network need: Supply and demand for a provider type is evaluated by looking at the volume of network providers of the same or similar provider type within the relevant geographic region relative to the Plan's membership and its network access and/or availability standards.</li> <li>● Provider member volume: Measured by looking at the volume of members treated by the provider, and/or volume of services billed by the provider, in a given year relative to the same or similar provider types in the same geographic market during the same timeframe.</li> <li>● Market/Specialty Prevailing</li> </ul>
--	--	---

		Rates: internally derived average market pricing based upon available data including internal claims data and state published rates
--	--	---

Professional Services Subject to Out-of-Network Provider Reimbursement Methodology	The plan has no OON benefits.	The plan has no OON benefits.
Emergency Services	See above for in-network and reimbursement methodologies.  Reimbursement methodologies comply with all federal and state law (including the No Surprises Act)	See above for in-network reimbursement methodologies.  Out-of-network reimbursement methodologies for emergency care comply with all federal and state law (including the No Surprises Act)

Benefit Classification	Sources: Medical/Surgical	Sources: MH/SUD
Professional Services Subject to In-Network Provider Reimbursement Methodology (includes Emergency)	<ol style="list-style-type: none"> <li>1. Provider application/Credentialing application</li> <li>2. Most current version of industry standard code sets, e.g., CPT, HCPCS, etc.</li> <li>3. CMS market price<sup>3</sup></li> <li>4. CMS Site of Service Code Set</li> <li>5. <ul style="list-style-type: none"> <li>• Provider research</li> <li>• Provider Directory; state GeoAccess reports</li> <li>• Provider claims data</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>1. Credentialing application</li> <li>2. Most current version of industry standard code sets, e.g., Current Procedural Technology (CPT®), Healthcare Common Procedure Coding System (HCPCS), etc.</li> <li>3. <ul style="list-style-type: none"> <li>• Applicable CMS RVU</li> <li>• FAIR Health Medicare GapFill PLUS database</li> <li>• When there is no CMS RVU available for a given service or procedure, other rate-setting benchmark sources are used such as the FAIR Health Medicare GapFill Plus database</li> </ul> </li> </ol>

<sup>3</sup> <https://www.cms.gov/>

	<ul style="list-style-type: none"> <li>claims data, state published rates, CMS PPS data</li> </ul> <p>6. Market benchmark rates are purchased from Truven State databases</p>	<p>4.</p> <ul style="list-style-type: none"> <li>Provider research</li> <li>Provider Directory, state Quest (f/k/a GeoAccess) reports and member reported access data</li> <li>Provider claims data</li> <li>State rate and internal claims data</li> </ul>
Professional Services Subject to Out-of-Network Provider Reimbursement Methodology	The plan has no OON benefits.	The plan has no OON benefits.
Emergency	<p>See above for in-network reimbursement methodologies.</p> <p>Reimbursement methodologies comply with all federal and state law (including the No Surprises Act)</p>	<p>See above for in-network reimbursement methodologies.</p> <p>Reimbursement methodologies for emergency care comply with all federal and state law (including the No Surprises Act)</p>

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

Benefit Classification	Process Description
Professional Services Subject to In-Network Provider Reimbursement Methodology	<p>The Plan conducted a comparative analysis of the factors, evidentiary standards, and source information used to determine provider reimbursement rates for medical/surgical and mental health/substance use disorder professional services “as written.”</p> <p>Provider reimbursement for in-network services for both medical/surgical and mental health/substance use disorder considers the following factors: provider type, services provided, CMS resources, and market dynamics.</p>

The same evidentiary standards are taken into account which include: provider licensure, certification, education, and training, services provided, CMS resources, market dynamics which include provider leverage, network need, and provider member volume, and third-party data sources that inform industry norms with respect to reimbursement rates.

Additionally, the sources which define the factors for in-network reimbursement overlap and include: provider applications/credentialing application, the most up-to-date industry standard code sets, CMS resources, provider research, provider claims data, geo-access reports, and benchmark rates from third party resources. There is a minor difference in the analysis: for med/surg reimbursement methodology, market benchmark rates are a factor considered for reimbursement rates, while for mental health/SUD, market benchmark rates are used as a source to support the factors that determine provider reimbursement. Since market benchmark rates are taken into consideration for the reimbursement rate methodology for both MH/SUD and M/S, the underlying processes are comparable. For medical/surgical reimbursement methodology, the factor “market dynamics” is also supported by adequacy standards and internal agreements rate. Adequacy standards are aligned with the consideration of network need for MH/SUD services. Additionally, “internal agreements rate” is based on standardized rates from resources such as CMS which is also leveraged for MH/SUD reimbursement rates.

While the Plan does not have out-of-network (OON) benefits, the Plan adheres to state and federal requirements such as the No Surprises Act regarding out-of-network reimbursement across medical/surgical and mental health/substance use disorder services.

Further, the Plan conducted a comparison analysis using the allowed amounts for common CPT codes paid to medical/surgical providers and mental health/substance use disorder providers relative to CMS rates to assess whether the methodology used to reimburse mental health/substance use disorder providers is comparable to and applied no more stringently than the methodology used to reimburse medical/surgical providers.



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

Benefit Classification	Process Description
Professional Services Subject to In-Network Provider Reimbursement Methodology	<p>The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:</p> <ol style="list-style-type: none"><li>1. Provider reimbursement for medical/surgical providers and mental health/substance use disorder providers considers the following factors: provider type, services provided, CMS resources, and market dynamics.</li><li>2. Sources and evidentiary standards are aligned.</li><li>3. Operationally, the Plan conducted a comparison analysis using the allowed amounts for common CPT codes paid to medical/surgical providers and mental health/substance use disorder providers relative to CMS rates to assess whether the methodology used to reimburse mental health/substance use disorder providers is comparable to and applied no more stringently than the methodology used to reimburse medical/surgical providers.</li></ol> <p><b>Findings:</b> The findings of the analysis confirms that the factors, sources, and evidentiary standards used to determine provider reimbursement rates for medical/surgical services, are aligned with the factors, sources, and evidentiary standards used to determine provider reimbursement rates for mental health/substance use disorder services as-written. The Plan conducted a comparison analysis using the allowed amounts for common CPT codes paid to medical/surgical providers and mental health/substance use disorder providers in 2022 relative to CMS rates to assess whether the methodology used to reimburse mental health/substance use disorder providers is comparable to and applied no more stringently than the methodology used to reimburse medical/surgical providers.</p> <p>In the Plan's analysis, when comparing a common CPT code (99213) used by General Internists for medical/surgical services with Psychiatrists for mental health/substance use disorder services, the results indicate that the Plan's reimbursement of mental health/substance use disorder providers is no more stringent compared to physical health providers. For 99213, the average</p>

	<p>percent of reimbursement per claim compared to CMS is 137% for General Internists, while the average percent of reimbursement per claim compared to CMS is 112% for Psychiatrists.</p> <p>While outcomes are not determinative of parity non-compliance, the outcomes act as a warning sign to ensure that the underlying methodology for provider reimbursement is aligned for M/S and MH/SUD. It was determined by the non-quantitative treatment limitation analysis that the process and methodology used to determine and negotiate mental health/substance use disorder professional reimbursement rates in-operation is comparable to and applied no more stringently than the process and methodology used to negotiate medical/surgical professional reimbursement rates.</p> <p>Therefore, the provider reimbursement methodology for mental health/substance use disorder services is comparable to and applied no more stringently than the provider reimbursement methodology for medical/surgical services.</p>
--	--



Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Provider Reimbursement (Facility)
Plan Type(s) Applicable	Oscar Insurance Company
Responsible Business Teams	Contracting
Names of Person(s) Responsible for Analysis Formation	<p><b>Oscar:</b> Laura Finney, Senior Manager, Network Performance in collaboration with Optum Behavioral Health Services</p> <p><b>Optum Behavioral Health Solutions:</b> Positions/Titles: Director, Policy and Process Provider Network Administration, VP Benefits Integrity, Director MH Parity and Benefits, SVP Value and Benefit Management, VP Network Pricing Credentials: Licensed Psychologist, Licensed Nurse</p>
Last Update	12/5/2023 Laura Finney
Reviewers	Alexandra Rubino, Associate Director, MHP (Over 4 years experience in Mental Health Parity reporting and operational compliance)





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

### In-Network Provider Reimbursement: Facility-Based Services

**Strategy:** Optum Behavioral Health (OBH) and Oscar Health Insurance (OHI) uses the methodologies described below to establish reimbursement for facility-based services.

**Process:** Using the factors described below, OHI establishes a reimbursement proposal for in-network facility services. If the facility rejects the reimbursement proposal, then OHI may negotiate with the facility using the factors described in the steps below. For MH/SUD, OBHS uses the following process to propose reimbursement rate(s) for INN facility-based services. Key steps in the INN facility reimbursement negotiation process for MH/SUD services include:

1. The facility submits a completed credentialing application to OBHS to be included in the MH/SUD network
2. Based on the above, OBHS offers a reimbursement rate to the facility for the services/programs the facility intends to deliver
3. If the facility rejects the reimbursement proposal, OBHS may negotiate with the facility using the described factors below.

1. **The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification:**

Benefit Classification	Medical/Surgical Services to which the NQTL applies	Mental Health/SUD Services to which the NQTL applies
In-Network Facility-Based Services Subject to Reimbursement Methodology	In-network facility services, e.g., acute medical, rehabilitation center, etc.	<ul style="list-style-type: none"><li>• In-network acute inpatient</li><li>• In-network subacute inpatient</li><li>• In-network facility-based outpatient services</li></ul>
Out-of-Network Facility Based	Plan does not have OON benefits	Plan does not have OON benefits



Services Subject to Reimbursement Methodology		
Emergency Services	Services rendered in an emergency facility	Services rendered in an emergency facility

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

<b>Benefit Classification</b>	<b>Factors Considered: Medical/Surgical</b>	<b>Factors Considered: Mental Health/SUD</b>
In-Network Facility-Based Services Subject to Reimbursement Methodology	<ol style="list-style-type: none"><li>1. Facility type (e.g., acute care facility; subacute care facility; ancillary facility, etc.)</li><li>2. Type of facility-based service(s) and diagnosis/condition for which the service or procedure is intended to treat</li><li>3. Market dynamics that influence mutually negotiated rates including:<ul style="list-style-type: none"><li>o <b>Adequacy standards</b></li><li>o <b>Facility leverage</b></li><li>o <b>Network need</b></li><li>o <b>Facility's member volume</b></li><li>o <b>Internal agreements rate</b></li></ul></li><li>4. Market benchmark rates</li></ol> <p>These factors are not weighted.</p>	<ol style="list-style-type: none"><li>1. <b>Facility assessment</b> based on the facility's licensure, certification, and/or accreditation (e.g., acute care facility; subacute care facility; ancillary facility, etc.)</li><li>2. <b>Service(s) and diagnoses/conditions the facility purports to offer or treat</b></li><li>3. <b>Market dynamics</b> that may influence the offered rate:<ul style="list-style-type: none"><li>o Facility leverage within a given geographic market</li><li>o Network need</li><li>o Facility member volume</li><li>o Facility proposed rate relative to market pricing</li><li>o Availability of industry standard value-based reimbursement models</li></ul></li></ol> <p>These factors are not weighted.</p>

Out-of-Network Facility Based Services Subject to Reimbursement Methodology	This plan has no OON benefits	This plan has no OON benefits
Emergency Services	See above for in-network reimbursement methodologies.  Reimbursement methodologies comply with all federal and state law (including the No Surprises Act)	See above for in-network reimbursement methodologies.  Reimbursement methodologies comply with all federal and state law (including the No Surprises Act)

**3. The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical or surgical benefits:**

Benefit Classification	Evidentiary Standards: Medical/Surgical	Evidentiary Standards: MH/SUD
In-Network Facility-Based Services Subject to Reimbursement Methodology	<ol style="list-style-type: none"> <li>The facility type is assessed based upon the facility's licensure, certification and/or accreditation</li> <li>Most current version of industry standard code sets, e.g., revenue, MS-DRG (derived by ICD/DSM), CPT, HCPCS, etc.</li> <li> <ul style="list-style-type: none"> <li>Adequacy standards: Regulatory adequacy standards (CMS) that define the need of certain specialties</li> <li>Facility leverage: Facilities associated with large health systems within a given geographic market generally have more leverage</li> <li>Network need: Supply and demand for a facility service is evaluated by looking at the volume of</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>Facility type is determined based upon the facility's licensure, certification and/or accreditation</li> <li>Most current version of industry standard code sets, e.g., revenue, <i>Diagnostic and Statistical Manual of Mental Disorders</i> (DSM), Current Procedural Technology (CPT®), Healthcare Common Procedure Coding System (HCPCS), etc.</li> <li> <ul style="list-style-type: none"> <li>Facility leverage: Facilities associated with large health systems within a given geographic market generally have more leverage</li> <li>Network need: Supply and demand for a facility service is evaluated by looking at the volume of facilities with the same or similar programs and/or services</li> </ul> </li> </ol>

	<p>facilities with the same or similar programs and/or services within the relevant geographic region relative to the Plan's membership and its network access and/or availability standards</p> <ul style="list-style-type: none"> <li>• Facility member volume: Measured by looking at the volume of members treated by the facility, and/or volume of services billed by the facility, in a given year relative to the same or similar program types in the same geographic market during the same timeframe</li> <li>• Internal agreements rate: Internally derived average market pricing based upon available data including claims data, state published rates, CMS PPS. This provides a relative comparison for specialty rates in a particular locality.</li> </ul> <p>4. Market benchmark rates are purchased from third party data sources in order to inform industry norms</p>	<p>within the relevant geographic region relative to the Plan's membership and its network access and/or availability standards</p> <ul style="list-style-type: none"> <li>• Facility member volume: Measured by looking at the volume of members treated by the facility, and/or volume of services billed by the facility, in a given year relative to the same or similar program types in the same geographic market during the same timeframe</li> <li>• Facility proposed rate relative to market pricing: Internally derived average market pricing based upon available data including internal claims data, state published rates, CMS Prospective Payment System (PPS)</li> <li>• Availability of industry standard and proprietary value-based reimbursement models: value-based programs that reward health care providers with incentive payments for the quality of care they deliver</li> </ul>
--	---	--

Out-of-Network Facility Based Services Subject to Reimbursement Methodology	The Plan has no OON benefits	The Plan has no OON benefits
Emergency Services	See above for in-network reimbursement methodologies.	See above for in-network reimbursement methodologies.

	Reimbursement methodologies comply with all federal and state law (including the No Surprises Act)	Reimbursement methodologies comply with all federal and state law (including the No Surprises Act)
--	--	--

Benefit Classification	Sources: Medical/Surgical	Sources: MH/SUD
In-Network Facility-Based Services Subject to Reimbursement Methodology	<ol style="list-style-type: none"> <li>1. Facility application</li> <li>2. Most current version of industry standard code sets, e.g., revenue, MS-DRG, CPT, HCPCS, etc.</li> <li>3. <ul style="list-style-type: none"> <li>• Facility Research</li> <li>• Facility Directory; state GeoAccess reports</li> <li>• Internal claims data</li> <li>• Applicable CMS PPS, MS-DRG, state rate and internal claims data</li> </ul> </li> <li>4. Market benchmark rates are purchased from Truven</li> </ol>	<ol style="list-style-type: none"> <li>1. Facility credentialing application</li> <li>2. Most current version of industry standard code sets, e.g., revenue, <i>Diagnostic and Statistical Manual of Mental Disorders</i> (DSM), Current Procedural Technology (CPT®), Healthcare Common Procedure Coding System (HCPCS), etc.</li> <li>3. <ul style="list-style-type: none"> <li>• Internal Research</li> <li>• Facility directory, state Quest (f/k/a GeoAccess), member reported access data</li> <li>• Internal claims data</li> <li>• Applicable CMS PPS, state rate, and internal claims data</li> <li>• CMS value-based programs</li> <li>• Internally developed value-based programs</li> </ul> </li> </ol>

Out-of-Network Facility Based Services Subject to Reimbursement Methodology	The Plan has no OON benefits	The Plan has no OON benefits
Emergency Services	<p>See above for in-network reimbursement methodologies.</p> <p>Reimbursement methodologies comply with all federal and state law (including the No Surprises Act)</p>	<p>See above for in-network reimbursement methodologies.</p> <p>Reimbursement methodologies comply with all federal and state law (including the No Surprises Act)</p>

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

Benefit Classification	Process Description
In-Network Facility-Based Services Subject to Reimbursement Methodology	<p>The Plan conducted a comparison analysis of the factors, evidentiary standards, and source information used to determine facility reimbursement for in-network medical/surgical facilities and in-network mental health/substance use disorder services “as written.”</p> <p>Provider reimbursement for in-network facilities for both medical/surgical and mental health/substance use disorder considers the following same factors: facility type, services provided, and market dynamics.</p> <p>The same evidentiary standards are considered which include facility licensure, services provided, and market dynamics which include facility leverage, network need, facility member volume, and average market pricing. Additionally, the sources which define the factors overlap and include facility applications, the most up-to-date industry standard code sets, CMS resources, facility research, facility claims data, and geo-access reports. One difference in the analysis is that the medical/surgical side additionally takes into account market benchmark rates purchased through Truven to determine facility reimbursement. This is aligned with MH/SUD utilizing the availability of industry standards and value-based reimbursement models.</p> <p>Further, the Plan performs a data analysis to compare facility reimbursement for inpatient services for mental health/substance use disorder facilities and medical/surgical facilities in-operation.</p> <p>Across inpatient, outpatient, and professional facilities, the total percentage of allowed amounts to total charges is comparable to (with a M/S to BH ratio &lt; 110%) , or higher, for behavioral health when compared to physical health.</p>



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

Benefit Classification	Process Description
In-Network Facility-Based Services Subject to Reimbursement Methodology	<p>Oscar Health Insurance conducted a comparison analysis of the methodology and process used to determine and negotiate MH/SUD in-network facility reimbursement to assess whether the methodology and process is comparable to, and applied no more stringently than, the methodology and process used to determine and negotiate reimbursement for M/S facility-based services “in operation.”</p> <p><b>Findings/Conclusion:</b> The findings of the analysis confirms that the factors, sources, and evidentiary standards used to determine facility rates for medical/surgical services, are aligned with the factors, sources, and evidentiary standards used to determine facility rates for mental health/substance use disorder services as-written. Therefore, the facility reimbursement methodology for mental health/substance use disorder services is comparable to and applied no more stringently than the facility reimbursement methodology for medical/surgical services.</p>



Non-Quantitative Treatment Limitation (NQTL) Analysis Index	
Non-Quantitative Treatment Limitation	Step Therapy
Plan Type(s) Applicable	<b>Oscar Health Plan of Georgia</b>
Responsible Business Teams	Pharmacy
Names of Person(s) Responsible for Analysis Formation	Jeenal Patel, PharmD, Senior Clinical Formulary Pharmacist (Nine years Pharmacy experience, two of which were dedicated to Pharmacy at a Health Plan) Kemper May, PharmD, Manager, Formulary Operations (Seven years experience in Pharmacy at a Health Plan)
Last Update	12/11/2023
Reviewers	Alexandra Rubino, Associate Director, MHP (Over 5 years experience in Mental Health Parity reporting and operational compliance)





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

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

### General Description/Explanation of the NQTL:

Step Therapy (ST) is a pharmacy UM strategy typically employed in therapeutic classes with broad generic availability. ST is generally used to promote the use of the most cost-effective products in the therapeutic class, provided efficacy and safety are equivalent, and therefore, the decision to implement is largely based on the cost of brand products and the potential for reduced cost with greater utilization of generics and/or lower cost brands.

Utilization management criteria are developed based upon published clinical evidence supporting the different uses of a drug and coverage conditions are not affected or altered by the medication's intended area of utilization. Step therapy protocols require that alternative drugs be tried first, when clinically warranted, and for a certain duration before the prescribed drug can be covered by a plan. A prior authorization or exceptions process is available when the protocol is not satisfied, to collect information so that coverage consistent with the conditions included by the step therapy protocol can be evaluated and coverage determined under the benefit, based on medical necessity, can be made. Messaging is provided to the dispensing pharmacy advising that the plan's step therapy protocols require alternative drugs first before the prescribed drug will be covered.

### Plan/Coverage Terms:

#### Coverage Terms (Evidence of Coverage):

We sometimes require You to try an alternate drug before taking the one You were Prescribed

Some medications, despite being prescribed by Your Healthcare Provider, are covered by Oscar only after You have first tried a clinically appropriate alternative. Your pharmacist or Health Care Provider may refer to this as a 'Step Therapy Requirement'. Oscar uses our history of Your previous prescriptions (via submitted pharmaceutical claims) to automatically confirm if You have already tried the necessary alternative.

You or Your Doctor can request an exception

If You or Your Health Care Provider believe the alternative medication is not safe or appropriate to try, Your Healthcare Provider can submit a request for an exception by contacting Member Services at 855-672-2755. A request for an exception should also be submitted if You have previously tried the necessary alternative but while at another Health Plan.



If Your Health Care Provider does not obtain an exception or if we cannot confirm You have already tried the necessary alternative, the pharmacy will be alerted when attempting to submit a claim to Oscar and You will not receive coverage for Your medication.

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

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

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

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

Factor	Sources	Evidentiary Standards/Thresholds
Multiple dosage forms available for the same or similar chemical entities or availability of unique dosage forms	Medispan dosage form field indicator	Medications come in multiple dosage forms and the different dosage forms do not provide any additional clinical efficacy of the medication (e.g tablet vs. oral disintegrating tablet, vs. oral

		<p>solution). Different dosage forms can provide easier administration but in most cases do not provide additional efficacy of the medication. Example: Tizanidine (2mg, 4mg, 6mg) tablets are much more cost effective with equivalent efficacy compared to Tizandidine capsules (2mg, 4mg, 6mg). Example: Brand only Quillivant XR (Methylphenidate Hydrochloride Extended Release Oral Suspension) vs generic methylphenidate extended release capsules/tablets have equivalent efficacy.</p> <p>Multiple dosage forms are assessed by evaluating clinical efficacy. <b>Clinical efficacy</b> is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. <b>Clinical effectiveness</b> is based on the evidence of clinical trials that the interventions are considered to be effective for the general population.</p> <p><i>Evidentiary Standards:</i> The Plan measures efficacy by the below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition.</p> <p>Class I: "Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective. Class IIa: "Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy."</p> <p>Clinical Pharmacology Rating:</p> <ul style="list-style-type: none"> <li>● Strength of Recommendation of "strong".</li> <li>● Level of evidence rating of "High, Moderate"</li> </ul>
--	--	---

		Or rating systems considering efficacy of regimen/agent is moderately effective such as NCCN definition of 2b evidence “Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate” or higher levels of efficacy.
Clinical Appropriateness	<p>Clinical criteria</p> <ul style="list-style-type: none"> <li>• Plan Clinical Guidelines</li> <li>• CVS Caremark Clinical Guidelines</li> <li>• MCG</li> </ul> <p>Clinical evidence</p> <ol style="list-style-type: none"> <li>1) The US National Library of Medicine;</li> <li>2) Guidelines and publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., ACOG, IDSA, NCCN)</li> <li>3) UpToDate</li> <li>4) National Society Guidelines (e.g., ACOG, APA, NCCN, WPATH)</li> </ol>	<p>Clinical Appropriateness is applicable when evidence-based criteria is required to confirm the drug is (a) medically necessary, (b) delivered in the appropriate setting or level of care, and (c) substantiated by nationally recognized guidelines to be safe and effective for the member’s illness, injury, or disease, taking into account factors such as diagnosis, specialist care, and duration.</p> <p>Examples:</p> <ol style="list-style-type: none"> <li>1) For the treatment of osteoarthritis with hyaluronic acid injections, it is appropriate to require documentation of trial and failure of 8 weeks of nonoperative therapy such as anti-inflammatory medications, intra-articular steroid injections, analgesics, or physical therapy according to the current clinical practice guidelines</li> <li>2) The ADA guidelines recommend the use of metformin prior to escalating to another therapeutic class (SGLT-2s, DPP-IVs, GLP-1s).</li> </ol>
Regulatory Requirements - Certain prescription drugs are mandated to be covered as essential health benefits; drug formularies are often	Government regulations/state legislation websites, memos, bulletins	<ol style="list-style-type: none"> <li>1) ACA: The Affordable Care Act mandates that health plans cover recommended preventive services without charging a deductible, copayment, or co-insurance (at the lowest tier: Tier 0)</li> </ol>

regulated at the state level regarding utilization management edits such as prior authorization		<p>2) Perphenazine-Amitriptyline tablet required to be covered to meet state filing benchmarks</p> <p><i>**Note: State and/or Federal regulations and guidelines take precedence over other factors, sources, and evidentiary standards.</i></p>
Manufacturer Trade Agreements	CVS CFC Team - Proprietary Trade Agreements	<p>Manufacturers may offer competitive rebates in order for the Health Plan to employ the lowest net cost strategy for both the plan and members. As a result, manufacturers in certain instances may dictate if a prior authorization is allowed in order to offer competitive pricing.</p> <p>Example A: GLP-1s, DPP-IVs, and SGLT-2 inhibitors are <u>not</u> allowed to have prior authorization edits.</p> <p>Example B: The Hepatitis C category must treat all drugs at parity with regards to UM edits such as prior authorization.</p>
Availability of therapeutic alternatives	<p>Consensus documents and nationally sanctioned guidelines: Milliman Care Guidelines (MCG), Hayes, Inc., Up-To-Date</p> <p>Recognized drug compendia: US Pharmacopeia, Clinical Pharmacology, Lexicomp, Micromedex</p> <p>Publications of the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), and other organizations or government agencies</p> <p>Evidence-based reviews of peer-reviewed medical literature and relevant clinical information: American Journal of Medicine, SAMHSA, American Journal of Psychiatry, Journal of Clinical Oncology, NCCN etc.</p>	<p>The P&amp;T Committee will review the category/class to determine if an AB-rated drug with similar therapeutic efficacy and safety exists or if there is a unique indication or population that may benefit from the addition of the comparator product based on standards of practice, clinical guideline recommendation, and evidence-based reviews.</p> <p>Availability of therapeutic alternatives is assessed by evaluating clinical efficacy. <b>Clinical efficacy</b> is based on the evidence of clinical trials that the interventions produce the expected results under ideal controlled circumstances. <b>Clinical effectiveness</b> is based on the evidence of clinical trials that the interventions are considered to be effective for the general population.</p>

	<p>Standards of care recommended by clinical literature, medical or pharmacy societies, standard clinical drug references: Nexis, Orange Book, PubMed, UpToDate, JAMA, NCCN, American Heart Association, American Academy of Neurology</p> <p>Appropriate clinical drug information from other sources as applicable: FDA.gov, Clinicaltrial.gov, ASHP (American Society of Health-System Pharmacists)</p>	<p><i>Evidentiary Standards:</i> The Plan measures efficacy by the below as services considered Class I, or Class IIa or higher in efficacy such as Micromedex definition.</p> <p>Class I: "Evidence and/or expert opinion suggests that a given drug treatment for a specific indication is effective. Class IIa: "Evidence and/or expert opinion is conflicting as to whether a given drug treatment for a specific indication is effective, but the weight of evidence and/or expert opinion favors efficacy."</p> <p>Clinical Pharmacology Rating:</p> <ul style="list-style-type: none"> <li>● Strength of Recommendation of "strong".</li> <li>● Level of evidence rating of "High, Moderate"</li> </ul> <p>Or rating systems considering efficacy of regimen/agent is moderately effective such as NCCN definition of 2b evidence "Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate" or higher levels of efficacy.</p>
--	--	--

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

Benefit Classification	Comparative Analysis: Medical/Surgical and Mental Health/Substance Use Disorder
Pharmacy	<i>Process:</i>

*General:*

The step therapy process is part of the Utilization Management (UM) activities and is an assessment performed to determine if the member has tried and failed, or has an intolerance or contraindication to the preferred formulary agent(s).

The Plan maintains a list of services that require step therapy. This list is available on request by phone, by provider portal, or via the published formularies online. A prior authorization request for step therapy medications will be required if the member does not have a preferred medication(s) in their pharmacy claims history. If a member does have a paid claim for preferred medication(s) within a certain time frame, the step therapy medication will automatically pay for the member at the pharmacy. Prior authorizations can be submitted via phone, fax, or online through Oscar's provider portal. When a step therapy request is submitted, it is reviewed by licensed clinicians to determine if the request meets plan criteria. Clinicians utilize the Plan's policies and established, evidence based clinical criteria to determine if the request meets coverage determinations and/or medical necessity. Licensed clinicians (e.g., physicians and pharmacists) review step therapy requests; in most states, pharmacists can make adverse determinations. However, in all Oscar states, only appeals can be denied by a licensed physician.

If an urgent request is for an expedited formulary exception request, decision should be rendered within 24 hours of receipt of the request. This TAT applies to both complete and incomplete NF exception requests. There are no extensions or pend times for NF exception requests. This is a federal & state requirement.

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

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

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

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

*Purpose:*



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

**Structure:**

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

Voting Members	Qualifications
Chief Medical Officer	Licensure: Medical Doctor Specialty: Internal Medicine
External Member	Licensure: Medical Doctor Specialty: Rheumatology
External Member	Licensure: PharmD
External	Licensure:



	Member	Pharm D Specialty: Infectious disease
	External Member	Licensure: Medical Doctor Specialty: Family Practice
	External Member	Licensure: Medical Doctor Specialty: Psychiatry
	External Member	Licensure: PharmD Specialty: Oncology
	Managing Medical Director	Licensure: Medical Doctor Specialty: Pediatric
	Medical Director	Licensure: Medical Doctor Specialty: Surgery
	Medical Director	Licensure: Medical Doctor Specialty: Hematolog y- Oncology
	Medical Director	Licensure: Medical Doctor

	Specialty: Neurology
Medical Director	Licensure: Medical Doctor Specialty: Family Practice
Medical Director	Licensure: Medical Doctor Specialty: Family Practice

*Responsibilities:*

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

*Internal oversight of the P&T Committee:*

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

oversees the UM Program with input from the Quality Improvement Committee, and support from members of the UM staff (clinical and non-clinical).

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

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

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

### ***MHPAEA Summary***

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

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

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

### **In-Operation:**

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

	ST	
state	p_value	coef
GA	0.03	-1.12

Findings: The p-value is less than 0.05. The standard interpretation of this is that MH/SUD drugs are less likely to have an application of step therapy compared to M/S drugs.

---

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

**Table 4 - Proportion of drugs subject to ST**

Condition	Total # subject to ST	% subject to ST
MH	105	0.4%
SUD	0	0.0%
M/S	274	0.3%

***Step Therapy Analysis:***

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

- 0.3% of the drugs in the Medical/Surgical category.
- 0.4% of the drugs in the Mental Health category.
- 0% of the drugs in the Substance Use Disorder category.

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

Benefit Classification	Findings and Conclusions
Pharmacy	<p>The underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the Plan to conclude compliance with MHPAEA for the following reasons:</p> <p>The Plan conducted a comparative analysis to determine which Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) services are subject to step therapy “as written.”</p>

The factors, evidentiary standards, sources, and processes for applying step therapy to medical/surgical drugs are the same as the factors, evidentiary standards, sources, and processes for applying step therapy to mental health/substance use disorder drugs.

Conclusions: Operationally, the Plan performs in-operation data assessments for step therapy procedures to ensure that factors, sources, and evidentiary standards are applied in a consistent manner across med/surg and MH/SUD services. Operationally, there is no statistical evidence that MH/SUD drugs are more or less likely to have utilization management requirements such as step therapy. Further, when assessing the proportion of drugs subject to step therapy requirements, the proportion of drugs that require step therapy for M/S, MH, and SUD drugs is comparable across all three drug types. This reveals that step therapy requirements are not applied more stringently to MH and SUD drugs when compared to M/S drugs in-operation.

The findings of the comparative analysis reveal that the process and methodology to apply step therapy to mental health/substance use disorder drugs is comparable to, and applied no more stringently than, the process and methodology used to apply step therapy to medical/surgical drugs.

14 Char HIOS	58081GA0010005	58081GA0010024	58081GA0010021	58081GA0010050
Plan Name	Bronze Elite + PCP Saver Plus	Bronze Classic 4700	Bronze Classic PCP Saver Plus	Bronze Classic Standard
Plan Metal	BRNZ	BRNZ	BRNZ	BRNZ
Overall Result	PASS	PASS	PASS	PASS
Inpatient Test	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	100%	0%	0%	0%
% of Claims Subject to Coinsurance	0%	99%	99%	100%
% of Claims Subject to Deductible	0%	99%	99%	100%
Copay Applies to Substantially All	TRUE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	FALSE	TRUE	TRUE	TRUE
Copay or Coinsurance Substantially All	Copay	Coinsurance	Coinsurance	Coinsurance
Predominant Level	\$3,000	50%	50%	50%
Least Rich MH/SUD Copay	\$3,000.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	0.00%	50.00%	50.00%	50.00%
Deductible Applies to Any MH/SUD?	FALSE	TRUE	TRUE	TRUE
Outpatient Office Test	FALSE	TRUE	FALSE	TRUE
% of Claims Subject to Copay	85%	85%	8%	85%
% of Claims Subject to Coinsurance	0%	0%	35%	0%
% of Claims Subject to Deductible	0%	0%	35%	0%
Copay Applies to Substantially All	TRUE	TRUE	FALSE	TRUE
Coinsurance Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Deductible Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Copay or Coinsurance Substantially All	Copay	Copay	NA	Copay
Predominant Level	\$75	\$125	NA	\$50
Least Rich MH/SUD Copay	\$125.00	\$70.00	\$0.00	\$50.00
Least Rich MH/SUD Coinsurance	0.00%	0.00%	50.00%	0.00%
Deductible Applies to Any MH/SUD?	FALSE	FALSE	TRUE	FALSE
Outpatient Other Test	FALSE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	64%	10%	10%	1%
% of Claims Subject to Coinsurance	24%	79%	79%	88%
% of Claims Subject to Deductible	0%	79%	79%	88%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	FALSE	TRUE	TRUE	TRUE
Copay or Coinsurance Substantially All	NA	Coinsurance	Coinsurance	Coinsurance
Predominant Level	NA	50%	50%	50%
Least Rich MH/SUD Copay	\$350.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	0%	50%	50%	50%
Deductible Applies to Any MH/SUD?	FALSE	TRUE	TRUE	TRUE
Outpatient Combined Test	TRUE	FALSE	TRUE	FALSE
% of Claims Subject to Copay	69.00%	27.00%	9.00%	20.00%
% of Claims Subject to Coinsurance	19.00%	61.00%	69.00%	68.00%
% of Claims Subject to Deductible	0.00%	61.00%	69.00%	68.00%
Copay Applies to Substantially All	TRUE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	TRUE	TRUE
Deductible Applies to Substantially All	FALSE	FALSE	TRUE	TRUE
Copay or Coinsurance Substantially All	Copay	NA	Coinsurance	Coinsurance
Predominant Level	\$350	NA	50%	50%
Least Rich MH/SUD Copay	\$350.00	\$70.00	\$0.00	\$50.00
Least Rich MH/SUD Coinsurance	0.00%	50.00%	50.00%	50.00%
Deductible Applies to Any MH/SUD?	FALSE	TRUE	TRUE	TRUE
Emergency	TRUE	TRUE	TRUE	TRUE

14 Char HIOS	58081GA0010005	58081GA0010024	58081GA0010021	58081GA0010050
Plan Name	Bronze Elite + PCP Saver Plus	Bronze Classic 4700	Bronze Classic PCP Saver Plus	Bronze Classic Standard
Plan Metal	BRNZ	BRNZ	BRNZ	BRNZ
Overall Result	PASS	PASS	PASS	PASS
% of Claims Subject to Copay	100%	0%	0%	0%
% of Claims Subject to Coinsurance	0%	100%	100%	100%
% of Claims Subject to Deductible	0%	100%	100%	100%
Copay Applies to Substantially All	TRUE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	FALSE	TRUE	TRUE	TRUE
Copay or Coinsurance Substantially All	Copay	Coinsurance	Coinsurance	Coinsurance
Predominant Level	\$2,000	50%	50%	50%
Least Rich MH/SUD Copay	\$2,000.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	0.00%	50.00%	50.00%	50.00%
Deductible Applies to Any MH/SUD?	FALSE	TRUE	TRUE	TRUE



14 Char HIOS	58081GA0010051	58081GA0010035	58081GA0010053	58081GA0010030	58081GA0010030
Plan Name	Bronze Simple Standard	Gold Elite Saver Plus	Gold Classic Standard	Silver Elite Saver Plus	Silver Elite Saver Plus CSR 150
Plan Metal	BRNZ	GOLD	GOLD	SILV	CSR
Overall Result	PASS	PASS	PASS	PASS	PASS
Inpatient Test	TRUE	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	0%	100%	0%	1%	0%
% of Claims Subject to Coinsurance	0%	0%	100%	99%	99%
% of Claims Subject to Deductible	100%	0%	100%	0%	0%
Copay Applies to Substantially All	FALSE	TRUE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	FALSE	TRUE	FALSE	FALSE
Copay or Coinsurance Substantially All	NA	Copay	Coinsurance	Coinsurance	Coinsurance
Predominant Level	NA	\$1,000	25%	50%	20%
Least Rich MH/SUD Copay	\$0.00	\$1,000.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	0.00%	0.00%	25.00%	50.00%	20.00%
Deductible Applies to Any MH/SUD?	TRUE	FALSE	TRUE	FALSE	FALSE
Outpatient Office Test	TRUE	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	0%	86%	86%	86%	45%
% of Claims Subject to Coinsurance	0%	0%	0%	0%	0%
% of Claims Subject to Deductible	85%	0%	0%	0%	0%
Copay Applies to Substantially All	FALSE	TRUE	TRUE	TRUE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	FALSE	FALSE	FALSE
Deductible Applies to Substantially All	TRUE	FALSE	FALSE	FALSE	FALSE
Copay or Coinsurance Substantially All	NA	Copay	Copay	Copay	NA
Predominant Level	NA	\$25	\$30	\$60	NA
Least Rich MH/SUD Copay	\$0.00	\$25.00	\$30.00	\$60.00	\$0.00
Least Rich MH/SUD Coinsurance	0.00%	0.00%	0.00%	0.00%	0.00%
Deductible Applies to Any MH/SUD?	TRUE	FALSE	FALSE	FALSE	FALSE
Outpatient Other Test	TRUE	FALSE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	0%	65%	0%	14%	15%
% of Claims Subject to Coinsurance	0%	30%	95%	79%	79%
% of Claims Subject to Deductible	89%	0%	95%	0%	0%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	FALSE	TRUE	FALSE	FALSE
Copay or Coinsurance Substantially All	NA	NA	Coinsurance	Coinsurance	Coinsurance
Predominant Level	NA	NA	25%	50%	20%
Least Rich MH/SUD Copay	\$0.00	\$200.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	0%	0%	25%	50%	20%
Deductible Applies to Any MH/SUD?	TRUE	FALSE	TRUE	FALSE	FALSE
Outpatient Combined Test	TRUE	TRUE	FALSE	FALSE	FALSE
% of Claims Subject to Copay	0.00%	69.00%	15.00%	31.00%	22.00%
% of Claims Subject to Coinsurance	0.00%	25.00%	78.00%	60.00%	60.00%
% of Claims Subject to Deductible	88.00%	0.00%	78.00%	0.00%	0.00%
Copay Applies to Substantially All	FALSE	TRUE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	TRUE	FALSE	FALSE
Deductible Applies to Substantially All	TRUE	FALSE	TRUE	FALSE	FALSE
Copay or Coinsurance Substantially All	NA	Copay	Coinsurance	NA	NA
Predominant Level	NA	\$200	25%	NA	NA
Least Rich MH/SUD Copay	\$0.00	\$200.00	\$30.00	\$60.00	\$0.00
Least Rich MH/SUD Coinsurance	0.00%	0.00%	25.00%	50.00%	20.00%
Deductible Applies to Any MH/SUD?	TRUE	FALSE	TRUE	FALSE	FALSE
Emergency	TRUE	TRUE	TRUE	TRUE	TRUE

14 Char HIOS	58081GA0010051	58081GA0010035	58081GA0010053	58081GA0010030	58081GA0010030
Plan Name	Bronze Simple Standard	Gold Elite Saver Plus	Gold Classic Standard	Silver Elite Saver Plus	Silver Elite Saver Plus CSR 150
Plan Metal	BRNZ	GOLD	GOLD	SILV	CSR
Overall Result	PASS	PASS	PASS	PASS	PASS
% of Claims Subject to Copay	0%	100%	0%	0%	0%
% of Claims Subject to Coinsurance	0%	0%	100%	100%	100%
% of Claims Subject to Deductible	100%	0%	100%	0%	0%
Copay Applies to Substantially All	FALSE	TRUE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	FALSE	TRUE	FALSE	FALSE
Copay or Coinsurance Substantially All	NA	Copay	Coinsurance	Coinsurance	Coinsurance
Predominant Level	NA	\$500	25%	50%	20%
Least Rich MH/SUD Copay	\$0.00	\$500.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	0.00%	0.00%	25.00%	50.00%	20.00%
Deductible Applies to Any MH/SUD?	TRUE	FALSE	TRUE	FALSE	FALSE

14 Char HIOS	58081GA0010030	58081GA0010030	58081GA0010052	58081GA0010052
Plan Name	Silver Elite Saver Plus CSR 200	Silver Elite Saver Plus CSR 250	Silver Classic Standard	Silver Classic Standard CSR 150
Plan Metal	CSR	CSR	SILV	CSR
Overall Result	PASS	PASS	PASS	PASS
Inpatient Test	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	0%	0%	0%	0%
% of Claims Subject to Coinsurance	99%	99%	100%	100%
% of Claims Subject to Deductible	0%	0%	100%	0%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	FALSE	FALSE	TRUE	FALSE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	30%	50%	40%	25%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	30.00%	50.00%	40.00%	25.00%
Deductible Applies to Any MH/SUD?	FALSE	FALSE	TRUE	FALSE
Outpatient Office Test	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	86%	86%	86%	37%
% of Claims Subject to Coinsurance	0%	0%	0%	0%
% of Claims Subject to Deductible	0%	0%	0%	0%
Copay Applies to Substantially All	TRUE	TRUE	TRUE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Deductible Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Copay or Coinsurance Substantially All	Copay	Copay	Copay	NA
Predominant Level	\$15	\$60	\$40	NA
Least Rich MH/SUD Copay	\$15.00	\$60.00	\$40.00	\$0.00
Least Rich MH/SUD Coinsurance	0.00%	0.00%	0.00%	0.00%
Deductible Applies to Any MH/SUD?	FALSE	FALSE	FALSE	FALSE
Outpatient Other Test	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	15%	15%	1%	1%
% of Claims Subject to Coinsurance	79%	79%	92%	93%
% of Claims Subject to Deductible	0%	0%	92%	0%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	FALSE	FALSE	TRUE	FALSE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	30%	50%	40%	25%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	30%	50%	40%	25%
Deductible Applies to Any MH/SUD?	FALSE	FALSE	TRUE	FALSE
Outpatient Combined Test	FALSE	FALSE	FALSE	TRUE
% of Claims Subject to Copay	32.00%	32.00%	21.00%	9.00%
% of Claims Subject to Coinsurance	60.00%	60.00%	71.00%	71.00%
% of Claims Subject to Deductible	0.00%	0.00%	71.00%	0.00%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	TRUE	TRUE
Deductible Applies to Substantially All	FALSE	FALSE	TRUE	FALSE
Copay or Coinsurance Substantially All	NA	NA	Coinsurance	Coinsurance
Predominant Level	NA	NA	40%	25%
Least Rich MH/SUD Copay	\$15.00	\$60.00	\$40.00	\$0.00
Least Rich MH/SUD Coinsurance	30.00%	50.00%	40.00%	25.00%
Deductible Applies to Any MH/SUD?	FALSE	FALSE	TRUE	FALSE
Emergency	TRUE	TRUE	TRUE	TRUE

14 Char HIOS	58081GA0010030	58081GA0010030	58081GA0010052	58081GA0010052
Plan Name	Silver Elite Saver Plus CSR 200	Silver Elite Saver Plus CSR 250	Silver Classic Standard	Silver Classic Standard CSR 150
Plan Metal	CSR	CSR	SILV	CSR
Overall Result	PASS	PASS	PASS	PASS
% of Claims Subject to Copay	0%	0%	0%	0%
% of Claims Subject to Coinsurance	100%	100%	100%	100%
% of Claims Subject to Deductible	0%	0%	100%	0%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	FALSE	FALSE	TRUE	FALSE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	30%	50%	40%	25%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	30.00%	50.00%	40.00%	25.00%
Deductible Applies to Any MH/SUD?	FALSE	FALSE	TRUE	FALSE

14 Char HIOS	58081GA0010052	58081GA0010052	58081GA0010015	58081GA0010015
Plan Name	Silver Classic Standard CSR 200	Silver Classic Standard CSR 250	Silver Simple	Silver Simple CSR 150
Plan Metal	CSR	CSR	SILV	CSR
Overall Result	PASS	PASS	PASS	PASS
Inpatient Test	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	0%	0%	1%	0%
% of Claims Subject to Coinsurance	100%	100%	99%	99%
% of Claims Subject to Deductible	100%	100%	99%	0%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	TRUE	TRUE	FALSE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	30%	40%	50%	20%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	30.00%	40.00%	50.00%	20.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	TRUE	FALSE
Outpatient Office Test	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	86%	86%	86%	45%
% of Claims Subject to Coinsurance	0%	0%	0%	0%
% of Claims Subject to Deductible	0%	0%	9%	0%
Copay Applies to Substantially All	TRUE	TRUE	TRUE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Deductible Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Copay or Coinsurance Substantially All	Copay	Copay	Copay	NA
Predominant Level	\$20	\$40	\$80	NA
Least Rich MH/SUD Copay	\$20.00	\$40.00	\$80.00	\$0.00
Least Rich MH/SUD Coinsurance	0.00%	0.00%	0.00%	0.00%
Deductible Applies to Any MH/SUD?	FALSE	FALSE	FALSE	FALSE
Outpatient Other Test	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	1%	1%	14%	15%
% of Claims Subject to Coinsurance	93%	93%	79%	79%
% of Claims Subject to Deductible	93%	93%	83%	0%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	TRUE	TRUE	FALSE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	30%	40%	50%	20%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	30%	40%	50%	20%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	TRUE	FALSE
Outpatient Combined Test	FALSE	FALSE	FALSE	FALSE
% of Claims Subject to Copay	21.00%	21.00%	31.00%	22.00%
% of Claims Subject to Coinsurance	71.00%	71.00%	60.00%	60.00%
% of Claims Subject to Deductible	71.00%	71.00%	66.00%	0.00%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	FALSE	FALSE
Deductible Applies to Substantially All	TRUE	TRUE	FALSE	FALSE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	NA	NA
Predominant Level	30%	40%	NA	NA
Least Rich MH/SUD Copay	\$20.00	\$40.00	\$80.00	\$0.00
Least Rich MH/SUD Coinsurance	30.00%	40.00%	50.00%	20.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	TRUE	FALSE
Emergency	TRUE	TRUE	TRUE	TRUE

14 Char HIOS	58081GA0010052	58081GA0010052	58081GA0010015	58081GA0010015
Plan Name	Silver Classic Standard CSR 200	Silver Classic Standard CSR 250	Silver Simple	Silver Simple CSR 150
Plan Metal	CSR	CSR	SILV	CSR
Overall Result	PASS	PASS	PASS	PASS
% of Claims Subject to Copay	0%	0%	0%	0%
% of Claims Subject to Coinsurance	100%	100%	100%	100%
% of Claims Subject to Deductible	100%	100%	100%	0%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	TRUE	TRUE	FALSE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	30%	40%	50%	20%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	30.00%	40.00%	50.00%	20.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	TRUE	FALSE

14 Char HIOS	58081GA0010015	58081GA0010015	58081GA0010045	58081GA0010045	58081GA0010045
Plan Name	Silver Simple CSR 200	Silver Simple CSR 250	Silver Simple Diabetes	Silver Simple Diabetes CSR 150	Silver Simple Diabetes CSR 200
Plan Metal	CSR	CSR	SILV	CSR	CSR
Overall Result	PASS	PASS	PASS	PASS	PASS
Inpatient Test	TRUE	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	0%	0%	0%	0%	0%
% of Claims Subject to Coinsurance	99%	99%	99%	100%	100%
% of Claims Subject to Deductible	100%	100%	99%	0%	100%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	TRUE	TRUE	FALSE	TRUE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	25%	40%	50%	30%	30%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	25.00%	40.00%	50.00%	30.00%	30.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	TRUE	FALSE	TRUE
Outpatient Office Test	TRUE	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	86%	86%	37%	37%	37%
% of Claims Subject to Coinsurance	0%	0%	9%	8%	8%
% of Claims Subject to Deductible	8%	8%	9%	0%	8%
Copay Applies to Substantially All	TRUE	TRUE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	FALSE	FALSE	FALSE
Deductible Applies to Substantially All	FALSE	FALSE	FALSE	FALSE	FALSE
Copay or Coinsurance Substantially All	Copay	Copay	NA	NA	NA
Predominant Level	\$40	\$80	NA	NA	NA
Least Rich MH/SUD Copay	\$40.00	\$80.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	0.00%	0.00%	0.00%	0.00%	0.00%
Deductible Applies to Any MH/SUD?	FALSE	FALSE	FALSE	FALSE	FALSE
Outpatient Other Test	TRUE	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	15%	15%	10%	10%	10%
% of Claims Subject to Coinsurance	79%	79%	83%	84%	84%
% of Claims Subject to Deductible	84%	84%	84%	0%	84%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	TRUE	TRUE	FALSE	TRUE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	25%	40%	50%	30%	30%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	25%	40%	50%	30%	30%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	TRUE	FALSE	TRUE
Outpatient Combined Test	FALSE	FALSE	FALSE	FALSE	FALSE
% of Claims Subject to Copay	32.00%	32.00%	16.00%	16.00%	16.00%
% of Claims Subject to Coinsurance	60.00%	60.00%	66.00%	66.00%	66.00%
% of Claims Subject to Deductible	66.00%	66.00%	66.00%	0.00%	66.00%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE	FALSE	FALSE	FALSE
Deductible Applies to Substantially All	FALSE	FALSE	FALSE	FALSE	FALSE
Copay or Coinsurance Substantially All	NA	NA	NA	NA	NA
Predominant Level	NA	NA	NA	NA	NA
Least Rich MH/SUD Copay	\$40.00	\$80.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	25.00%	40.00%	50.00%	30.00%	30.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	TRUE	FALSE	TRUE
Emergency	TRUE	TRUE	TRUE	TRUE	TRUE

14 Char HIOS	58081GA0010015	58081GA0010015	58081GA0010045	58081GA0010045	58081GA0010045
Plan Name	Silver Simple CSR 200	Silver Simple CSR 250	Silver Simple Diabetes	Silver Simple Diabetes CSR 150	Silver Simple Diabetes CSR 200
Plan Metal	CSR	CSR	SILV	CSR	CSR
Overall Result	PASS	PASS	PASS	PASS	PASS
% of Claims Subject to Copay	0%	0%	0%	0%	0%
% of Claims Subject to Coinsurance	100%	100%	100%	100%	100%
% of Claims Subject to Deductible	100%	100%	100%	0%	100%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	TRUE	TRUE	FALSE	TRUE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	25%	40%	50%	30%	30%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	25.00%	40.00%	50.00%	30.00%	30.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	TRUE	FALSE	TRUE



14 Char HIOS	58081GA0010045	58081GA0010025	58081GA0010025	58081GA0010025
Plan Name	Silver Simple Diabetes CSR 250	Silver Simple PCP Saver	Silver Simple PCP Saver CSR 150	Silver Simple PCP Saver CSR 200
Plan Metal	CSR	SILV	CSR	CSR
Overall Result	PASS	PASS	PASS	PASS
Inpatient Test	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	0%	0%	0%	0%
% of Claims Subject to Coinsurance	100%	100%	100%	100%
% of Claims Subject to Deductible	100%	100%	0%	100%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	TRUE	FALSE	TRUE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	50%	40%	20%	40%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	50.00%	40.00%	20.00%	40.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	FALSE	TRUE
Outpatient Office Test	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	37%	77%	77%	77%
% of Claims Subject to Coinsurance	8%	9%	8%	8%
% of Claims Subject to Deductible	8%	9%	0%	8%
Copay Applies to Substantially All	FALSE	TRUE	TRUE	TRUE
Coinsurance Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Deductible Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Copay or Coinsurance Substantially All	NA	Copay	Copay	Copay
Predominant Level	NA	\$20	\$5	\$10
Least Rich MH/SUD Copay	\$0.00	\$20.00	\$5.00	\$10.00
Least Rich MH/SUD Coinsurance	0.00%	0.00%	0.00%	0.00%
Deductible Applies to Any MH/SUD?	FALSE	FALSE	FALSE	FALSE
Outpatient Other Test	TRUE	TRUE	TRUE	TRUE
% of Claims Subject to Copay	10%	1%	1%	1%
% of Claims Subject to Coinsurance	84%	93%	93%	93%
% of Claims Subject to Deductible	84%	93%	0%	93%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	TRUE	FALSE	TRUE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	50%	40%	20%	40%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	50%	40%	20%	40%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	FALSE	TRUE
Outpatient Combined Test	FALSE	FALSE	FALSE	FALSE
% of Claims Subject to Copay	16.00%	19.00%	19.00%	19.00%
% of Claims Subject to Coinsurance	66.00%	73.00%	73.00%	73.00%
% of Claims Subject to Deductible	66.00%	73.00%	0.00%	73.00%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	FALSE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	FALSE	TRUE	FALSE	TRUE
Copay or Coinsurance Substantially All	NA	Coinsurance	Coinsurance	Coinsurance
Predominant Level	NA	40%	20%	40%
Least Rich MH/SUD Copay	\$0.00	\$20.00	\$5.00	\$10.00
Least Rich MH/SUD Coinsurance	50.00%	40.00%	20.00%	40.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	FALSE	TRUE
Emergency	TRUE	TRUE	TRUE	TRUE

14 Char HIOS	58081GA0010045	58081GA0010025	58081GA0010025	58081GA0010025
Plan Name	Silver Simple Diabetes CSR 250	Silver Simple PCP Saver	Silver Simple PCP Saver CSR 150	Silver Simple PCP Saver CSR 200
Plan Metal	CSR	SILV	CSR	CSR
Overall Result	PASS	PASS	PASS	PASS
% of Claims Subject to Copay	0%	0%	0%	0%
% of Claims Subject to Coinsurance	100%	100%	100%	100%
% of Claims Subject to Deductible	100%	100%	0%	100%
Copay Applies to Substantially All	FALSE	FALSE	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	TRUE	TRUE	TRUE
Deductible Applies to Substantially All	TRUE	TRUE	FALSE	TRUE
Copay or Coinsurance Substantially All	Coinsurance	Coinsurance	Coinsurance	Coinsurance
Predominant Level	50%	40%	20%	40%
Least Rich MH/SUD Copay	\$0.00	\$0.00	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	50.00%	40.00%	20.00%	40.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE	FALSE	TRUE

14 Char HIOS	58081GA0010025	58081GA0010011
Plan Name	Silver Simple PCP Saver CSR 250	Secure
Plan Metal	CSR	CAT
Overall Result	PASS	PASS
Inpatient Test	TRUE	TRUE
% of Claims Subject to Copay	0%	0%
% of Claims Subject to Coinsurance	100%	0%
% of Claims Subject to Deductible	100%	100%
Copay Applies to Substantially All	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	FALSE
Deductible Applies to Substantially All	TRUE	TRUE
Copay or Coinsurance Substantially All	Coinsurance	NA
Predominant Level	40%	NA
Least Rich MH/SUD Copay	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	40.00%	0.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE
Outpatient Office Test	TRUE	TRUE
% of Claims Subject to Copay	77%	0%
% of Claims Subject to Coinsurance	8%	0%
% of Claims Subject to Deductible	8%	86%
Copay Applies to Substantially All	TRUE	FALSE
Coinsurance Applies to Substantially All	FALSE	FALSE
Deductible Applies to Substantially All	FALSE	TRUE
Copay or Coinsurance Substantially All	Copay	NA
Predominant Level	\$20	NA
Least Rich MH/SUD Copay	\$20.00	\$0.00
Least Rich MH/SUD Coinsurance	0.00%	0.00%
Deductible Applies to Any MH/SUD?	FALSE	TRUE
Outpatient Other Test	TRUE	TRUE
% of Claims Subject to Copay	1%	0%
% of Claims Subject to Coinsurance	93%	0%
% of Claims Subject to Deductible	93%	89%
Copay Applies to Substantially All	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	FALSE
Deductible Applies to Substantially All	TRUE	TRUE
Copay or Coinsurance Substantially All	Coinsurance	NA
Predominant Level	40%	NA
Least Rich MH/SUD Copay	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	40%	0%
Deductible Applies to Any MH/SUD?	TRUE	TRUE
Outpatient Combined Test	FALSE	TRUE
% of Claims Subject to Copay	19.00%	0.00%
% of Claims Subject to Coinsurance	73.00%	0.00%
% of Claims Subject to Deductible	73.00%	88.00%
Copay Applies to Substantially All	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	FALSE
Deductible Applies to Substantially All	TRUE	TRUE
Copay or Coinsurance Substantially All	Coinsurance	NA
Predominant Level	40%	NA
Least Rich MH/SUD Copay	\$20.00	\$0.00
Least Rich MH/SUD Coinsurance	40.00%	0.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE
Emergency	TRUE	TRUE

14 Char HIOS	58081GA0010025	58081GA0010011
Plan Name	Silver Simple PCP Saver CSR 250	Secure
Plan Metal	CSR	CAT
Overall Result	PASS	PASS
% of Claims Subject to Copay	0%	0%
% of Claims Subject to Coinsurance	100%	0%
% of Claims Subject to Deductible	100%	100%
Copay Applies to Substantially All	FALSE	FALSE
Coinsurance Applies to Substantially All	TRUE	FALSE
Deductible Applies to Substantially All	TRUE	TRUE
Copay or Coinsurance Substantially All	Coinsurance	NA
Predominant Level	40%	NA
Least Rich MH/SUD Copay	\$0.00	\$0.00
Least Rich MH/SUD Coinsurance	40.00%	0.00%
Deductible Applies to Any MH/SUD?	TRUE	TRUE