Mental Health Parity Review

The analysis below explains how [redacted] Clinical Management and Network Development policies and procedures comply with the non-quantitative treatment limitation requirements of the Mental Health Parity and Addiction Equity Act ("MHPAEA"). The explanation includes links to publicly available information concerning clinical policy and procedure including medical management, i.e.) medical necessity criteria and utilization management criteria as well as network development standards and procedures. This analysis is reviewed and updated periodically, but not less than annually. Self-funded plan sponsors are encouraged to request an updated version of this analysis as they conduct their periodic MHPAEA reviews.

While self-funded customers are responsible for determining plan compliance with MHPAEA, [redacted] has evaluated the benefits provided for its insured plans and concluded that such benefits are MHPAEA compliant. NQTL compliance review assesses our standard practices for management of our fully insured business. While we are unable to provide legal advice to our self- insured plan sponsors, it may be assumed that unless a plan sponsor has requested an exception to our standard practices deemed parity compliant, the clinical and administrative management would be the same as that which is done for our fully insured plans.

Non-quantitative Treatment Limitations (NQTLs)

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

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Service Definitions

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

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

In Network Outpatient (OP): Services or items provided by a contracted professional at a contracted professional's office, a contracted clinic, the member's home, or a contracted facility without admission as an overnight patient. This includes video and telephonic services, medications administered in an IN OP setting, and Durable Medical Equipment (DME). IN OP includes all IN items and services that do not fit in the IP, Prescription Drug or Emergency Care classifications. For purposes of the parity analysis, the IN OP classification is subdivided into office visits and all other OP services and items.

Out of Network Outpatient (OP): Services or items provided by a non-contracted professional at a non-contracted professional's office, a non-contracted clinic or a non-contracted facility without admission as an overnight patient. Includes video and telephonic services; medications administered in an OON OP setting; and Durable Medical Equipment (DME). OON OP includes all OON items and services that do not fit in the IP, Prescription Drug or Emergency Care classifications. For purposes of the parity analysis, the OON OP classification is subdivided into office visits and all other OP services and items.

Emergency Care: Any services or items provided for the treatment of an Emergency Condition in an emergency room or urgent services provided in an urgent care setting.

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

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

Classifications											
NQTLs	IN IP Med/Surg	IN IP M/SUD	OON IP Med/Surg	OON IP MH/SUD	IN OP Med/Surg	IN OP MH/SUD	OON OP Med/Surg	OON OP MH/SUD	Prescription Drugs	Emergency Care Med/Surg	Emergency Care MH/SUD
I. Utilization Management											
Precertification	X	X	X	X	X	X	X	X	(see separate pharmacy analysis)		
Concurrent Review	X	X	X	X	X	X	X	X			
Retrospective Review	X	X	X	X	X	X	X	X			
II. Medical Necessity Standards	X	X	X	X	X	X	X	X		X	X
III. Sequenced Treatment											
TMS	X	X	X	X							
IV. Treatment Plan											
ABA					X	X	X	X			
V. Benefit Exclusions											
Experimental and Investigational	X	X	X	X	X	X	X	X			
VI. Network											
Network adequacy	X	X			X	X					
Provider reimbursement and UCR	X	X	X	X	X	X	X	X		X	X
Provider Admission Standards	X	X			X	X					

The list below is subject to change from time to time please refer to 2020 Participating Provider Precertification List for Medical/Surgical services and Behavioral Health Precertification List for MH/SUD services.

Benefits Requiring Precertification		
Benefit Classification	**MH/SUD**	**Medical/Surgical**
Inpatient (In-Network and Out-of-Network)	• Planned IP Hospital • (Emergency admissions require notification within one business day post admission or as soon as possible.) • Residential Treatment for treatment of mental health and substance abuse	• Planned IP Hospital • (Emergency admissions require notification within one business day post admission or as soon as possible.) • Hip Procedures • Inpatient Surgeries • Knee Procedures Maternity Admission if inpatient stay exceeds 3 days for a vaginal delivery or 5 days for a cesarean delivery within 1 BD. • Obesity Surgery • Organ Transplant • Private Duty Nursing Care • Rehabilitation Facility • Skilled Nursing Facility • Gender Reassignment Surgery
Outpatient-All Other (In-Network) **External note**: It was recently discovered that a different precertification process may exist for medical outpatient-all other services requiring precertification compared to BH outpatient all-other services. This requires further internal investigation for ongoing parity	• Intensive Outpatient Programs (IOP) (not required as of 1/1/2019) • Partial Hospitalization (PH) • Psychological & Neurological Testing (not required as of 1/1/19)	- Autologous chondrocyte implantation - Cochlear device and/or implantation - Dental implants - Dialysis visits when request is initiated by a participating provider,

Benefits Requiring Precertification		
Benefit Classification	**MH/SUD**	**Medical/Surgical**
compliance. Updates to the Outpatient-All Other NQTL analysis will be provided shortly.	• Applied Behavior Analysis • TMS (Transcranial Magnetic Stimulation)	and dialysis is to be performed at a nonparticipating facility - Dorsal column (lumbar) neurostimulators; trial or implantation - Gastrointestinal (GI) tract imaging through capsule endoscopy - Infertility services and pre-implementation genetic testing - Lower Limb Prosthetics - Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint - Osseo integrated implant - Osteochondral allograft/knee - Private Duty Nursing - Proton beam radiotherapy - Reconstructive or other procedures that may be considered cosmetic, such as: - Blepharoplasty/canthoplasty - Breast reconstruction/breast enlargement - Excision of excessive skin due to weight loss - Lipectomy or excess fat removal - Surgery for varicose veins, except stab phlebectomy - Uvulopalatopharyngoplasty including laser-assisted procedures

Note: No NQTL is applied to any procedure, service, device, and therapy in the Outpatient-Office Visit (IN and OON). All IP benefits are subject to precertification.

I. Utilization Management

Factors, Sources, Methods and Stringency
Precertification, Concurrent Review and Retrospective Review NQTLs

The following framework organizes the factors, sources, methods and analysis and stringency application applied to the procedures, services, devices, and therapies to which Precertification, Concurrent Review, and Retrospective Review NQTLs apply in the Outpatient-All Other benefit classification in-network and out-of-network (INN, OON) A detailed analytical framework is not provided for the Inpatient benefit classification since the Precertification, Concurrent Review, and Retrospective Review NQTLs apply to all procedures, services, devices, and therapies in this classification for both medical/surgical and MH/SUD. **No** NQTL is applied to any procedure, service, device, and therapy in the Outpatient-Office Visit (IN and OON) and Emergency Services benefit classifications.

All precertification factors, both MH/SUD and medical/surgical, are singularly developed in unison through the coordination efforts of the Parity Taskforce who leverages both MH/SUD and medical/surgical subject matter experts in factor development and ongoing review. At [redacted], a single, national Precertification Committee of clinicians and other subject matter experts representing both MH/SUD and medical/surgical expertise then applies these determinants. This Precertification Committee oversees [redacted] National Precertification List (NPL), which physicians, hospitals and other health care professionals use for all plans to determine when medical/surgical or MH/SUD precertification is needed or required for each benefit classification for in-network services.

Analysis for the Addition of a Service to the NPL:

***PRECERTIFICATION FACTOR LIST APPLICABLE TO BOTH MEDICAL/SURGICAL AND MH/SUD BENEFITS:**

1. All medical/surgical and MH/SUD procedures, services, devices, and therapies subject to the precertification NQTL must meet one or more of the following review methodologies specific to each of the identified factors:
   a. Cost-- Cost of treatment is satisfied when the per service or per diem Medicare rate for applicable urban markets is at least $150 (on average across all urban markets)
   b. High cost growth -- High cost growth is satisfied when internal claims data demonstrates that the cost (per member per month) for the procedure, service, device, or therapy increased >10% in the most recent two-year period

c. Variability in cost and practice is satisfied when internal claims data demonstrates that there is greater than three-fold variability in cost per unit, overall length of treatment, or overall number of services per treatment for the procedure, service, device, or therapy in the most recent 12-month period AND

All medical/surgical and MH/SUD procedures, services, devices, and therapies subject to the precertification NQTL must meet both of the following review methodologies specific to each of the identified factors

2. There must be at least one EBC tool available to assist clinicians with precertification decisions. EBC may be sourced from national medical professional organizations, evidence-based evaluations by consensus panels and technology evaluation bodies, or criteria from professional associations AND
3. Administrative inability to apply Claims Rules (Claims Rules are automated claims system controls that decide if coverage criteria is met). A procedure, drug or technology cannot feasibly be managed by Claim Rules alone due to either subjectivity or complexity of criteria

Analysis for the Retention of a Service to the NPL:

- After the first year and annually thereafter, the ROI is calculated, and a decision is made to retain or remove from the NPL
  - ROI 3:1 or greater - retain
  - ROI 2 to 2.9:1 – NPL committee discussion of extenuating factors (see below)
  - ROI </= 1.9:1 and NOT integral to NPL Group/Category (example, breast reduction code may independently have a low ROI, but it is part of a procedure group for which precertification is required) - committee discussion of extenuating factors (criteria above, plus patient safety)
- Extenuating factors:
  - Patient safety
  - High cost growth (year-over-year trend >10%)
  - Variability in cost per episode greater than 3-fold, or variability of length of treatment per episode of care greater than 3-fold

[redacted] Benefit Classification Definition and Service Listing for Outpatient (OP), All Other That Require Precertification

Federal Parity Required Classification, 2019	MH/SUD service list	Medical/surgical service list (any surgery listed below is included in the OP All Other Category, to the extent such procedure is conducted in an outpatient surgery setting)
Outpatient, All Other ***Refers to outpatient services provided by a healthcare professional in a manner that the predominant trait of the outpatient service is something other than direct, personal interaction with the professional. Examples include outpatient services that are primarily dependent on a technological test or device, that are characterized by some type of physical intervention (e.g., a surgery or other procedure), or where services are provided as part of an integrated program. Outpatient services in the "other" sub-classification may be delivered in a variety of settings, including a healthcare facility, the community and or the home.***	-Transcranial Magnetic Stimulation (TMS) - Partial Hospitalization - Applied Behavior Analysis (ABA)	- Autologous chondrocyte implantation - Cochlear device and/or implantation - Dental implants - Dialysis visits when request is initiated by a participating provider, and dialysis is to be performed at a nonparticipating facility - Dorsal column (lumbar) neurostimulators; trial or implantation - Gastrointestinal (GI) tract imaging through capsule endoscopy - Infertility services and pre-implementation genetic testing - Laminectomy\Laminotomy Procedures (Cervical, Thoracic and Artificial Disc Surgery: Cervical Lumbar Lower Limb Prosthetics - Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint - Osseo integrated implant - Osteochondral allograft/knee - Private Duty Nursing - Proton beam radiotherapy - Reconstructive or other procedures that may be considered cosmetic, such as: - Blepharoplasty/canthoplasty - Breast reconstruction/breast enlargement - Excision of excessive skin due to weight loss - Lipectomy or excess fat removal - Surgery for varicose veins, except stab phlebectomy - Spinal Fusion - Uvulopalatopharyngoplasty, including laser-assisted procedures

INN Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	**MH/SUD**				
See NPL (above)	**Applied Behavioral Analysis (ABA)** **Transcranial Magnetic Stimulation** **Partial Hospitalization (PHP)**	Factors used in the development of the initiation of the precertification NQTL for outpatient / all other benefit classification are listed below. Note: **All factors are the same for medical/surgical and MH/SUD** • Cost • High cost growth • Variability in costs, length of treatment, or overall number of services for treatment • Evidence-based criteria • A procedure, drug, or technology cannot feasibly be managed by claim rules alone due to either subjectivity or complexity of criteria	The processes, strategies, and evidentiary standards used to define the factors include the following: The methods and analysis used in the development of the precertification NQTL include: • Review of Medicare rates • Internal claims database analysis • Review of generally accepted national evidence-based guidelines from national medical professional organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations such as: • Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Medicare Benefit Policy Manual • MCG guidelines National Comprehensive Cancer Network NCCN)	See below categorized by factor	[redacted] monitors the application of the precertification NQTL through several initiatives: • Mental Health Parity Task Force: Multi-disciplinary team that meets bi- weekly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care. • Denial rates: Rate of denials due to precertification reviews. Will be formally reviewed by the Parity Task Force at least annually. • Denial audits: Clinical denials due to precertification reviews are conducted randomly throughout the year by [redacted] Clinical Services Team. The Parity Task Force will review the results of these audits at least annually. • Average length of stay reviews: Average length of stay is reviewed throughout the year by [redacted] Clinical Services Team. The conjoint clinical teams review these results monthly and the Parity Task Force will review the results of these at least annually. • Complaints and appeals: [redacted] National Quality Oversight Committee, NQOC tracks and reviews trend rates of complaints and appeals at least annually. The Parity Task Force has determined that it will review the results of these reviews at least annually.

INN Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/SUD				
			guidelines (Category 1 and 2A recommendations) American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition • Applied Behavior Analysis Medical Necessity Guide • InterQual guidelines (as required by contractual provisions) • Level of Care Assessment Tool Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NCQA These processes, strategies, and evidentiary standards are represented in [redacted] Clinical Polices and in our published [redacted] Clinical Policy Bulletins (CPBs) [redacted]		• Annual surveys (CAHPS, Qualified Health Plan Enrollee Experience Survey, [redacted] BH Practitioner Experience Survey, [redacted] BH Provider (Facility) Experience Survey, [redacted] BH Member Experience Survey, Physician Practice Survey and surveys associated with [redacted] BH specialized clinical programs (i.e.) Member Care Coordination Results of state regulator reviews • Clinical Policy and Procedure Meeting Minutes i.e.) NPL Minutes and Charter • Across both Behavioral Health management and medical management, only clinical staff can make medical necessity/clinical determinations. For clinical coverage requests that the UM/clinical staff is unable to certify, these requests can be referred to a Board-Certified Specialty Reviewer. Cases are reviewed by a physician Medical Director, pharmacist, dentist, Oral and Maxillofacial surgeon, or consultant psychiatrist/psychologist for decision making Regular [redacted] Clinical Policy Council review and evaluation of the safety, effectiveness and appropriateness of medical technologies (i.e., drugs, devices, medical, behavioral and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided) that are covered under [redacted] medical plans (including behavioral health plans), or that may be eligible for coverage under [redacted] medical plans. The Clinical Policy Council reviews evidence regarding specific medical technologies and provides advice about the medical necessity and experimental status of that technology according to a defined structure and meeting cadence (as detailed in the Council Charter)

INN **Services/procedures to which the NQTL applies**		**Factors:** **Factors used in the development of the limitation**	**Sources** **Processes, strategies, evidentiary standards**	**Comparability Analysis** ***Results of the comparison of MH/SUD and Medical/Surgical***	**Stringency:** ***Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits***
Medical/ Surgical	**MH/SUD**				
			• Internal claims system review. Review of claims systems capabilities with Head of Operations to validate system functionality.		

INN Services/procedures to which the NQTL applies		**Factors:** **Factors used in the development of the limitation**	**Sources** **Processes, strategies, evidentiary standards**	**Comparability Analysis** ***Results of the comparison of MH/SUD and Medical/Surgical***	**Stringency:** ***Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits***
		Factor specific detail			
		All medical/surgical and MH/SUD procedures, services, devices, and therapies subject to the precertification NQTL meet one or more of the following review methodologies specific to each of the identified factors:			
		Cost of treatment Cost of treatment is satisfied when the per service or per diem Medicare rate for applicable urban markets is at least $150 (on average across all urban markets)	Medicare rates	A review of Medicare rates demonstrates that the procedure, service, device, and therapy meets the cost threshold of $150	
		High cost growth High cost growth is satisfied when internal claims data demonstrates that the cost (per member per month) for the procedure, service, device, or therapy increased >10% in the most recent two-year period	Internal claims data	Internal claims database analysis demonstrates that the high cost growth factor was implicated.	

INN Services/procedures to which the NQTL applies		**Factors:** **Factors used in the development of the limitation**	**Sources** **Processes, strategies, evidentiary standards**	**Comparability Analysis** ***Results of the comparison of MH/SUD and Medical/Surgical***	**Stringency:** ***Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits***
		Variability in cost and practice Variability in cost and practice is satisfied when internal claims data demonstrates that there is greater than three-fold variability in cost per unit, overall length of treatment, or overall number of services per treatment for the procedure, service, device, or therapy in the most recent 12-month period	Internal claims data	Internal claims database analysis demonstrates that the three-fold variability factor was implicated.	

INN Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical Surgical*	Stringency: Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits
		All medical/surgical and MH/SUD procedures, services, devices, and therapies subject to the precertification NQTL meet both of the following review methodologies specific to each of the identified factors:			
		Evidence based criteria (EBC) There must be at least one EBC tool available to assist clinicians with precertification decisions. EBC may be sourced from national medical professional organizations, evidence-based evaluations by consensus panels and technology evaluation bodies, or criteria from professional associations	Evidence-based guidelines and/or criteria exist for all medical/surgical and MH/SUD procedures, services, devices, and therapies subject to the precertification NQTL. Availability of EBC exists for all the services on the NPL (via [redacted] Clinical Policy Bulletins (CPBs) [redacted] • Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Medicare Benefit Policy Manual • MCG guidelines • National Comprehensive Cancer Network NCCN) guidelines (Category 1 and 2A recommendations) • InterQual guidelines (as required by contractual provisions) • American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition • Level of Care Assessment Tool (LOCAT)	Confirmation of evidence-based guidelines and criteria for all Medical Surgical and MH/SUD procedures, services, devices and therapies subject to the precertification NQTL and review of those guidelines demonstrates that a consistent methodology for the pre-certification NQTL was developed and applied, in policy and practice, comparably and no more stringently with respect to MH/SUD benefits than those applied to medical surgical benefits	

INN Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
		Administrative inability to apply Claims Rules (Claims Rules are automated claims system controls that decide if coverage criteria is met) A procedure, drug or technology cannot feasibly be managed by Claim Rules alone due to either subjectivity or complexity of criteria	Internal claims system review. Review of claims systems capabilities with Head of Operations to validate system functionality.	Assessment concludes that claims administration procedures cannot be implemented to administer the medical/surgical and MH/SUD procedures, services, devices, and therapies subject to the precertification NQTL due to subjectivity or complexity. (See benefit specific analysis)	

Below are the factors satisfied in support of inclusion of ABA, PHP and TMS to the NPL. The table also provides a counter example of the results for the only Medical/Surgical service considered for inclusion on the NPL in 2018.

	Factors Applied				
Service/Procedure	**Cost of treatment (at least $150.00)**	**High cost growth (increase of >10% past 2 years)**	**Variability in cost or practice (three-fold variability past year)**	**Evidence based criteria**	**Administrative inability to apply claims rules**
1. Applied Behavior Analysis (ABA) (MH/SUD)		X	X	X	X
2. Partial Hospitalization (PHP) (MH/SUD)			X	X	X
3. Transcranial Magnetic Stimulation (TMS) (MH/SUD)	X		X	X	X
4. Endoscopic Nasal Balloon Dilation (Medical/Surgical)	X			X	X

OON Services/procedures to which the NQTL applies		**Factors:** **Factors used in the development of the limitation**	**Sources** **Processes, strategies, evidentiary standards**	**Comparability Analysis** ***Results of the comparison of MH/SUD and Medical/Surgical***	**Stringency:** ***Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits***
Medical/ Surgical	**MH/SUD**				
Home health care Hospice (outpatient) Skilled nursing care Bariatric surgery (outpatient and inpatient) Infertility (done in Women's Health)	Applied Behavioral Analysis (ABA) Transcranial Magnetic Stimulation Partial Hospitalization (PHP)	Factors used in the development of the initiation of the precertification NQTL for outpatient / all other benefit classification are listed below. Note: **All factors are the same for medical/surgical and MH/SUD** • Frequency of services being administered on an OON basis • Duration of the typical course of treatment	The processes, strategies, and evidentiary standards used to define the factors include the following: The methods and analysis used in the development of the precertification NQTL include: • Internal claims database analysis .	In deciding what Out-of-Network, Outpatient Other Items and Services will be subject to precertification in our standard out of network precertification list [redacted] considers both the frequency of such services being administered on an OON basis as well as the duration of the typical course of treatment. The majority of services on both the medical or BH OON precertification list (home health, hospice skilled nursing, infertility, ABA, PHP, and TMS) are services that are delivered over a series of visits. Additionally, the services subject to precertification in	[redacted] monitors the application of the precertification NQTL through several initiatives: • Mental Health Parity Task Force: Multi-disciplinary team that meets bi- weekly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care. • Denial rates: Rate of denials due to precertification reviews. Will be formally reviewed by the Parity Task Force at least annually. • Denial audits: Clinical denials due to precertification reviews are conducted randomly throughout the year by [redacted] Clinical Services Team. The Parity Task Force will review the results of these audits at least annually. • Average length of stay reviews: Average length of stay is reviewed throughout the year by [redacted] Clinical Services Team. The conjoint clinical teams review these results monthly and the Parity Task Force will review the results of these at least annually. • Complaints and appeals: [redacted] National Quality Oversight Committee, NQOC tracks and reviews trend rates of complaints and appeals at least annually. The Parity Task Force has determined that it will review the results of these reviews at least annually.

OON Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/SUD				
				the Out-of-Network, Outpatient Other Items and Services category have substantial levels of utilization.	• Annual surveys (CAHPS, Qualified Health Plan Enrollee Experience Survey, [redacted] BH Practitioner Experience Survey, [redacted] BH Provider (Facility) Experience Survey, [redacted] BH Member Experience Survey, Physician Practice Survey and surveys associated with [redacted] BH specialized clinical programs (i.e.) Member Care Coordination Results of state regulator reviews • Clinical Policy and Procedure Meeting Minutes i.e.) NPL Minutes and Charter

Concurrent Review

Concurrent review is a utilization review service performed by licensed healthcare professionals to evaluate the patient's care while in the hospital or while undergoing outpatient treatment. The intent is to determine medical necessity and appropriateness of treatment, assess appropriateness of level of care and treatment setting, determine benefits and eligibility identify the patient's discharge and continuing care plan, and identify and refer potential quality of care and patient safety concerns for additional review.

Concurrent Review (Inpatient INN and OON; and Outpatient-All Other INN and OON): Concurrent Review, as further described below, is conducted for services listed on the National Precertification List for medical services or on the Behavioral Health Precertification list for MH/SUD. Concurrent Review involves a review for continued medical necessity for dates of service beyond the initial precertification authorization and occurs with subsequent coverage requests so that no gaps in the authorization exist. This means that staff reviews all dates of service that do not have a coverage determination with a subsequent request for an extension of services. The Concurrent Review process includes a review for medical necessity and for the appropriate level of care that meets the member's clinical needs. We use standardized clinical guidelines, monitor the member's progress, review for potential quality of care concerns, and ensure there is an adequate discharge plan in place. If medical necessity is not evident, the case is sent for review to a medical director who may call the attending physician for additional information before rendering a coverage determination. For medical/surgical care, additional units (e.g. days, sessions) of care are authorized based on the individual needs of the member (i.e. clinical judgement based on complexity and severity) guided by care guidelines (which in many cases prescribe care pathways, treatments and lengths of stay), by facility contract, and clinical criteria. For MH/SUD, clinical judgment guided by clinical criteria dictates the amount of additional units of care that are authorized.

MH/SUD's use of clinical judgment guided by clinical criteria as the sole process/strategy for determinations of additional units of care authorized exceeds the expectations of "comparability" under NQTL testing. Clinical judgement, when applied with the appropriate stringency controls discussed below, is a strategy that is more favorable to members. The medical/surgical utilization management team similarly uses clinical judgement as a process/strategy; however, clinical judgement is further constrained by facility contract, and care guidelines (which in many cases prescribe care pathways, treatments and lengths of stay). For both BH and medical/surgical, "severity" and "complexity", as used within our UM policies, are determined primarily based on the clinical judgement of expert reviewers and informed by the member's medical history, clinician progress notes, and discharge plans.

[redacted] relies on the following processes and strategies to ensure clinical judgement remains a process/strategy that exceeds the minimum requirements of Parity for MH/SUD concurrent review frequency determinations: comparison of denial rates and average length of stay, denial audits, NCQA accreditation, Medical Director Internal Quality Review, and peer-to-peer clinical review.

Being sensitive to the individualized nature of the use of clinical judgement in our concurrent review process, we have implemented robust processes and strategies to further support comparability and stringency analysis in operation. [redacted] maintains comparative analysis of denials rates and average length of stays that demonstrate that on scale, MH/SUD benefits historically have significantly fewer denials per 1,000 admissions and longer average lengths of stays than medical surgical comparable benefits.

Regarding BH Utilization Management (UM) Denial audits, among other things, the intent is to identify both strengths and opportunities for improvement in the delivery of UM services, and to measure compliance with National Committee of Quality Assurance (NCQA) File Review standards (which evaluate both BH and medical surgical UM practice and are designated as "must pass" for recertification). A random sample of UM denials, which includes all lines of business and product types, is conducted each week by two BH QM Analysts and one BH QM Consultant with oversight by a BH QM Manager. The goal for each audit is an aggregate audit score of at least 95%. An NCQA File Review tool is used to complete the audits. Quantitative and qualitative feedback is provided by the audit process each week via email to the BH Senior Medical Directors as well as the BH Directors, Managers, and Supervisors of Clinical Health Services.

The Medical Director Internal Quality Review is a process for re-adjudication of a claim in situations where a Senior Medical Director (SMD) or Medical Director (MD) auditor disagrees with a medical necessity determination made by a Medical Director (MD) and/or Physician Advisor (PA) and/or Clinician Advisor (CA). See attachment for details.

[redacted] Peer-to-peer review process seeks to decrease the risk of inconsistencies in the operationalization of concurrent review policies by allowing a treating practitioner, a clinician on behalf of the treating practitioner or a facility designated physician to discuss a clinical denial of coverage determination with a peer reviewer or behavioral health consultant psychiatrist/psychologist to mitigate the risk of operational disparities based on differences in the quantity/quality of written documentation the treating practitioner may provide.

Services/procedures to which the NQTL applies		**Factors:** **Factors used in the development of the limitation**	**Sources** **Processes, strategies, evidentiary standards**	**Comparability Analysis** ***Results of the comparison of MH/SUD and Medical/Surgical***	**Stringency:** ***Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits***
Medical/ Surgical	MH/SUD				
INPATIENT					
All inpatient medical/surgical services/ procedures on the National Precertification List (NPL)	All inpatient MH/SUD services/ procedures on the Behavioral Health Precertification List	All inpatient services, whether BH or medical/surgical, are subject to Concurrent Review; as such comparability analysis is not required	N/A	N/A	Refer to Stringency Analysis for Precertification NQTL
OUTPATIENT-ALL OTHER					
All medical/surgical outpatient all other services/ procedures on the National Precertification List (NPL)	All MH/SUD outpatient all other services/ procedures on the Behavioral Health Precertification List	The NQTL factors used in developing Concurrent Review comparability analysis are identical for both M/S and BH/SUD and are the same as those subject to the Precertification NQTL.	Refer to sources for Precertification NQTL	Refer to Comparability Analysis for Precertification NQTL	Refer to Stringency Analysis for Precertification NQTL

Retrospective Review

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

Services/procedures to which the NQTL applies		**Factors:** **Factors used in the development of the limitation**	**Sources** **Processes, strategies, evidentiary standards**	**Comparability Analysis** ***Results of the comparison of MH/SUD and Medical/Surgical***	**Stringency:** ***Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits***
Medical/ Surgical	MH/SUD				
INPATIENT					
All inpatient medical/surgical services/ procedures on the National Precertification List (NPL)	All inpatient MH/SUD services/ procedures on the Behavioral Health Precertification List	All inpatient services, whether BH or medical/surgical, are subject to Retrospective Review; as such comparability analysis is not required	N/A	NA	Refer to Stringency Analysis for Precertification NQTL
OUTPATIENT-ALL OTHER					
All medical/surgical outpatient all other services/ procedures on the National Precertification List (NPL)	All MH/SUD outpatient all other services/ procedures on the Behavioral Health Precertification List	The NQTL factors used in developing Retrospective Review comparability analysis are identical for both M/S and BH/SUD and are the same as those subject to the Precertification NQTL.	Refer to sources for Precertification NQTL	Refer to Comparability Analysis for Precertification NQTL	Refer to Stringency Analysis for Precertification NQTL

Item	Medical/Surgical	MH/SUD
Stringency Analysis		
Degree of Discretion	We apply the appropriate clinical criteria/guidelines and clinical judgment to the coverage determination. We allow discretion for making authorization decisions based on the professional scope of practice and clinical experience. See stringency controls above in support of the case that discretion does not arbitrarily disadvantage BH/SUD benefits.	
UM documentation requirements for MH/SUD and M/S	Documentation requirements: NCS 503 – Medical Review: **"F. Required Documentation:** The applicable UM system documentation includes member demographics and information supporting clinical and benefit coverage determinations. Staff includes the following documentation elements in the applicable UM system to support the coverage determination process: • The requested procedure/service/level of care. • The method of receipt (e.g., telephone, fax, e-mail, voice mail, on-site review), and the date of receipt10; • The specific clinical criteria/guidelines (including number, edition and name) used in decision making (e.g., MCG 22nd edition, M-70 Cellulitis; CPB # 0050: Varicose Veins; LOCAT, V5, RTC); • A determination as to whether clinical criteria/guidelines are met; and, • The disposition of all material submitted as part of the coverage determination process (e.g., shredding of duplicate provider medical records when applicable after a coverage determination, backend imaging for unique documents). Documentation for all coverage determinations (approvals and denials) requires all of the elements noted above as well as the following: • Date and time of the review (if different from the date and time of the system entry); • Name, title (if applicable) and the department/location (e.g., facility discharge planning department, PCP office) providing the information; • Relevant benefit limitations and the number of days, visits, services authorized through the current date, if applicable; • Pertinent clinical information to support coverage for the service or to substantiate the coverage denial determination; • Clinical criteria, guidelines, and/or other decision support tool(s) used in decision making including: • The specific criteria, guideline, standard met/not met; • Clear and specific documentation of the rationale used to make the coverage decision. • Coverage determination (e.g., approved, referred, or denied); • Notation of a same or similar specialty matched review (as appropriate) if conducted during the coverage determination process.	

II. Medical Necessity

Medical Necessity NQTL Analysis

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

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

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

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

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies as developed by the Claims Administrator are revised from time to time. [redacted] publishes information concerning utilization review and our medical necessity criteria here:

Within that site, there is a section dedicated specially to the criteria used for behavioral health conditions, which can be found here: We also publish clinical policy bulletins concerning services we may or may not cover, including behavioral health services that may be excluded on grounds that they are experimental and investigational, which detail the evidentiary bases for our coverage or exclusion determinations:

Services/ procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the limitation is applied more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/ SUD				
All inpatient, outpatient, and emergency care services		MHPAEA provides that a plan may develop medical policies that limit care for mental health/substance use disorder benefits based on medical necessity as long as it does so for medical/surgical benefits and the "evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition". 45 CFR 146.136(c)(4)(iii) (Example 4) (emphasis added). Medical necessity applies to all medical/surgical and mental health/substance use disorder benefits in each MHPAEA category and is based on objective clinical criteria as further detailed herein.	The processes, strategies, and evidentiary standards include: • Evidence in the peer-reviewed published medical literature, • Evidence-based consensus statements, expert opinions of healthcare providers • Evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies. • Technology assessments and structured evidence reviews • Review of generally accepted national evidence-based guidelines from national medical professional organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations such as: - Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage	The [redacted] Clinical Policy Council evaluates the safety, effectiveness and appropriateness of medical technologies (e.g., drugs, devices, medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided) that are covered under [redacted] medical plans, or that may be eligible for coverage under [redacted] medical plans. In making this determination, the Clinical Policy Council will review and evaluate evidence in the peer-reviewed published medical literature, information from the U.S. Food and Drug Administration and other Federal public health agencies, evidence-based guidelines from national medical professional organizations, and evidence-based evaluations by consensus panels and technology evaluation bodies. The Clinical Policy council is comprised of pharmacists and medical directors from the Medical Policy Administration	[redacted] monitors the application of the medical necessity NQTL as follows: [redacted] strategy regarding satisfaction of parity's NQTL requirements includes the utilization of an identical standard/definition of medical necessity. Medical and BH utilize appropriately applicable and generally accepted standards of practice to guide clinician with coverage determinations. For mental health treatments, [redacted] utilizes the Level of Care Assessment Tool (or LOCAT) as a guideline to determine the medically necessary level and types of care for [redacted] members. For substance use disorder treatments, [redacted] utilizes criteria developed by the American Society of Addiction Medicine (or ASAM) as a guideline to determine medical necessity. Every individual MH/SUD medical necessity determination is afforded independent clinical consideration based on the member's presentation. This point is made clear to [redacted] clinicians making medical necessity determinations in both the medical necessity tools utilized and in staff training. More information about both the LOCAT and ASAM criteria can be found on [redacted] website at [redacted]. For medical treatments [redacted] utilizes Milliman Care Guidelines (MCG) as a guideline to determine the medical necessity.

		Determinations (LCDs), and Medicare Benefit Policy Manual - MCG guidelines - American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition - Applied Behavior Analysis Medical Necessity Guide - InterQual guidelines (as required by contractual provisions) - Level of Care Assessment Tool (LOCAT) Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NQCA These processes, strategies, and evidentiary standards : are represented in [redacted] Clinical Polices and in our published [redacted] Clinical Policy Bulletins (CPBs) [redacted] In determining whether a medical technology is medically necessary and established, the Clinical Policy	(MPA) department, National Accounts department, Behavioral Health department, Clinical Pharmacy department and regional Patient Management units. The Clinical Policy council usually convenes twice monthly.	LOCAT The Level of Care Assessment Tool (LOCAT) was developed to provide guidelines for evaluating the medical necessity of levels and types of care for mental health disorders. The LOCAT criteria were developed internally by clinical experts, with input from academics and from the provider community in various parts of the country. In so doing, we evaluated LOCAT against criteria such as the Level of Care Utilization System (LOCUS), which was developed by the American Association of Community Psychiatrists, Milliman Care Guidelines, Interqual, Medicare, Magellan, CALOCUS, and guidelines from the American Psychiatric Association. The Level of Care Assessment Tool (LOCAT) was developed to provide guidelines for evaluating the medical necessity of levels and types of care for mental health disorders. The LOCAT criteria were developed internally by clinical experts, with input from academics and from the provider community in various parts of the country. In so doing, we evaluated LOCAT against criteria such as the Level of Care Utilization System (LOCUS), which was developed by the American Association of Community Psychiatrists, Milliman Care Guidelines, Interqual, Medicare, Magellan, CALOCUS, and guidelines from the American Psychiatric Association. Annually, [redacted] clinical experts evaluate LOCAT for continued alignment to generally accepted standards of care. Every 5 years, we also perform a particularly comprehensive review, which includes input from external subject-matter experts. Such a review is currently ongoing.

		Council will consider whether the following five criteria are met: • Whether the medical technology has final approval from the appropriate governmental regulatory bodies • Whether the scientific evidence permits conclusions about the effect of the medical technology on health outcomes • Whether the medical technology improves net health outcomes • Whether the medical technology is at least as beneficial as any established alternatives • Whether the medical technology is more costly (taking into account all health expenses incurred in connection with the medical technology) than any equally effective established alternatives		ASAM For members seeking treatment for substance use disorders, [redacted] utilizes the American Society of Addiction Medicine Criteria. The ASAM Criteria provides guidelines for evaluating the medical necessity of levels and types of care for substance use disorders. Courts and regulators consider ASAM a generally accepted, national standard for SUD treatment decisions. Some states, notably New York, New Jersey and Texas, require state-specific SUD level of care criteria. In those states, we use the criteria required by law. ASAM revises its criteria from time to time in keeping with its established best practices. Such practices can be found at [redacted]. Currently, [redacted] is using the most recent version of the ASAM guidelines. MCG For medical/surgical health treatments, [redacted] utilizes Milliman Care Guidelines, which nationally is a generally accepted standard of care tool, to guideline to clinicians in the making medically necessary level of care determinations for our [redacted] members. • Both new and revised CPB drafts undergo a comprehensive review process. This includes review by our Clinical Policy Council and external practicing clinicians, and approval by our chief medical officer or their designee. • Drafts of new and revised CPBs are distributed for review to members of the Clinical Policy Council prior to each meeting. Each new and revised draft CPB is placed on the Clinical Policy Council agenda and is discussed during

				the meeting. The Clinical Policy Council votes whether or not to recommend approval of each draft CPB. In addition, the Clinical Policy Council may recommend other revisions to a draft CPB. • The CPB draft may be revised based on the Clinical Policy Council's recommendations. CPB drafts are reviewed by our Legal department and the head of the MPA department, and further revisions to draft CPBs may be made based on their recommendations. Draft CPBs are sent to the chief medical officer or their designee for review and final approval. Draft CPBs that are approved by the chief medical officer or their designee will be published on our websites within 60 days of the Clinical Policy council's recommendations. • CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of medical technologies addressed in each CPB. If the Clinical Policy unit determines that new evidence or other information has emerged to warrant consideration of a change in our clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in position, the CPB may be updated with additional supporting background information and references. Each revised and updated CPB is submitted to the Clinical Policy Council for review and approval.

				• In developing our CPBs, for each medical technology selected for evaluation, the Clinical Policy unit conducts a comprehensive search of the peer-reviewed published medical literature indexed in the National Library of Medicine PubMed Database, assesses the regulatory status of the technology, reviews relevant evidence-based clinical practice guidelines and related documents indexed in the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse Database, and reviews relevant technology assessments indexed in the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Database. Also, the opinions of relevant experts may be obtained where necessary. • Each CPB includes a policy statement and references to the medical literature and other sources used in developing the clinical policy. In addition, the CPB may include a background section that describes the medical technology and provides the rationale for our policy. • In addition, each CPB has a coding section that provides applicable International Classification of Diseases (ICD), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.

III. Sequenced Treatment

Sequenced treatment generally refers to application of evidenced based guidelines that recommend use of the most effective forms of treatment first, moving to less effective ones if the highest rated treatments are not working for a specific patient. Certain BH and medical/surgical services (detailed below) are subject to sequenced treatment protocols as part of the medical necessity review

Sequenced Treatment NQTL Analysis					
Services/procedures to which the NQTL applies		**Factors: Factors used in the development of the limitation**	**Sources Processes, strategies, evidentiary standards**	**Comparability Analysis Results of the comparison of MH/SUD and Medical/Surgical**	**Stringency: Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits**
Medical/ Surgical	**MH/SUD**	Note: **all factors are the same for medical/surgical and MH/SUD** • Treatment efficacy based on evidence-based criteria (EBC) Evidenced based medicine is an approach to medical practice intended to optimize decision making by emphasizing the use of evidence from well-designed and well conducted research*. • There must be at least one EBC tool available to assist clinicians with	Evidence based guidelines and or criteria exist for all medical/surgical and MH/SUD uses of sequenced treatment. • Availability of EBC exist for all of these services via [redacted] Clinical Policy Bulletins (CPBs) CPB numbers for the one BH/SUD sequenced treatment noted and for all of the Medical Surgical sequenced treatments listed are noted and are available publicly.	Confirmation of evidence-based guidelines and criteria found in the specified CPBs for all Medical Surgical and MH/SUD procedures, services, devices and therapies including sequenced treatment and review of those guidelines demonstrates that a consistent methodology for sequenced therapy was MH/SUD benefits than those applied to medical surgical benefits	The Clinical Policy Bulletin (CPB) evidence-based guidelines used in the sequenced treatment requirements for medical surgical back pain invasive procedures, spinal surgery, total hip replacement and laminoplasty, obesity surgery, Vagus Nerve Stimulation, Spinal Cord Stimulation, Deep Brain Stimulation, Urinary incontinence procedures as well as those used for MH/SUD TMS undergo a comprehensive review process. This includes review by our Clinical Policy Council and external practicing clinicians, and approval by our chief medical officer or their

See List below	Transcranial Magnetic Stimulation	determinations related to sequenced treatment use. EBC may be sourced from (as noted above) national medical professional organizations, evidence-based evaluations by consensus panels and technology evaluation bodies or criteria from professional associations.	• Review of generally accepted national evidence-based guidelines from national medical professional organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations including: the NIMH sequenced treatment alternatives to relieve Depression (STAR*D Study), and an American Psychiatric Association (APA) practice guideline on major depression (2010, reaffirmed 2015).		designee. This process involves annual review of generally accepted national evidence-based guidelines. • Drafts of new and revised CPBs are distributed for review to members of the Clinical Policy Council prior to each meeting. Each new and revised draft CPB is placed on the Clinical Policy Council agenda and is discussed during the meeting. The Clinical Policy Council votes whether or not to recommend approval of each draft CPB. In addition, the Clinical Policy Council may recommend other revisions to a draft CPB. • The CPB draft may be revised based on the Clinical Policy Council's recommendations. CPB drafts are reviewed by our Legal department and the head of the MPA department, and further revisions to draft CPBs may be made based on their recommendations. Draft CPBs are sent to the chief medical officer or their designee for review and final approval. Draft CPBs that are approved by the chief medical officer or their designee will be published on our websites within 60 days of the Clinical Policy Council's recommendations.

					• CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of medical technologies addressed in each CPB. If the Clinical Policy unit determines that new evidence or other information has emerged to warrant consideration of a change in our clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in position, the CPB may be updated with additional supporting background information and references. Each revised and updated CPB is submitted to the Clinical Policy Council for review and approval. • In developing our CPBs, for each medical technology selected for evaluation, the Clinical Policy unit conducts a comprehensive search of the

					peer-reviewed published medical literature indexed in the National Library of Medicine PubMed Database, assesses the regulatory status of the technology, reviews relevant evidence-based clinical practice guidelines and related documents indexed in the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse Database, and reviews relevant technology assessments indexed in the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Database. Also, the opinions of relevant experts may be obtained where necessary.

MH/SUD		**Medical/Surgical Examples**	
Service	Clinical Policy Bulletin #	Service	Clinical Policy Bulletin #
TMS	0469	Back Pain Invasive Procedures	
		Spinal Surgery	
		Total Hip Replacement	
		Laminoplasty	
		Obesity Surgery	
		Vagus Nerve Stimulation	
		Spinal Cord Stimulation	
		Deep Brain Stimulation	
		Urinary incontinence	
		Sleep latency testing	
		Gender reassignment	
		Obstructive Sleep Apnea	
		Feeding programs	

IV. Treatment Plan Requirement

Treatment Plan Requirement NQTL Analysis

A treatment plan is an individualized plan of care; where specific target behaviors are clearly defined; frequency, rate, symptom intensity or duration, or other objective measures of baseline levels are recorded, and quantifiable criteria for progress are established. Certain BH and medical/surgical services (detailed below) require the inclusion of a treatment as part of the medical necessity review.

Services/procedures to which the NQTL applies		**Factors:** Factors used in the development of the limitation	**Sources** Processes, strategies, evidentiary standards	***Comparability Analysis*** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency:** *Evidence to establish that the imitation is applied no more ently, as written and in operation, MH/SUD benefits than to M/S benefits*
Medical/ Surgical	**MH/SUD**				
-Cardiac Rehabilitation -Physical Therapy -Occupational Therapy -Speech Therapy	-Applied Behavior Analysis	Note: **all factors are the same for medical/surgical and MH/SUD** • Treatment efficacy based on evidence-based criteria (EBC) Evidenced based medicine is an approach to medical practice intended to optimize decision making by emphasizing the use of evidence from well-designed and well conducted research*.	Evidence based guidelines and or criteria exist for all medical/surgical and MH/SUD uses of treatment plans to establish medical necessity. • Availability of EBC exist for all of these services via [redacted] Clinical Policy Bulletins (CPBs) CPB numbers for the one BH/SUD treatment plan required service noted and for all of the Medical Surgical treatment plan required	Confirmation of evidence-based guidelines and criteria found in the specified CPBs for all Medical Surgical and MH/SUD procedures, services, devices and therapies including treatment plan requirement and review of those guidelines demonstrates that a consistent methodology for services that require an individualized treatment plan was no more stringent for MH/SUD benefits than those applied to medical surgical benefits	The Clinical Policy Bulletin (CPB) evidence-based guidelines used in the treatment plan requirements for medical surgical Cardiac Rehabilitation: Outpatient, Physical Therapy, Occupational Therapy, Speech Therapy as well as those used for MH/SUD ABA undergo a comprehensive review process. This includes review by our Clinical Policy Council and external practicing clinicians, and approval by our chief medical officer or their designee. This process involves annual review of generally accepted national evidence-based guidelines. • Drafts of new and revised CPBs are distributed for review to members of the

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the limitation is applied no more [illegible]ently, as written and in operation, MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/SUD				
		There must be at least one EBC tool available to assist clinicians with determinations related to sequenced treatment use. EBC may be sourced from (as noted above) national medical professional organizations, evidence-based evaluations by consensus panels and technology evaluation bodies or criteria from professional associations.	services are noted and are available publicly at : • Review of generally accepted national evidence-based guidelines from national medical professional organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations including:		Clinical Policy Council prior to each meeting. Each new and revised draft CPB is placed on the Clinical Policy Council agenda and is discussed during the meeting. The Clinical Policy Council votes whether or not to recommend approval of each draft CPB. In addition, the Clinical Policy Council may recommend other revisions to a draft CPB. • The CPB draft may be revised based on the Clinical Policy Council's recommendations. CPB drafts are reviewed by our Legal department and the head of the MPA department, and further revisions to draft CPBs may be made based on their recommendations. Draft CPBs are sent to the chief medical officer or their designee for review and final approval. Draft CPBs that are approved by the chief medical officer or their designee will be published

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the limitation is applied no more [illegible]ently, as written and in operation, MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/SUD				on our websites within 60 days of the Clinical Policy Council's recommendations. • CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of medical technologies addressed in each CPB. If the Clinical Policy unit determines that new evidence or other information has emerged to warrant consideration of a change in our clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in position, the CPB may be updated with additional supporting background information and

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the limitation is applied no more [e]ntly, as written and in operation, MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/SUD				references. Each revised and updated CPB is submitted to the Clinical Policy Council for review and approval. • In developing our CPBs, for each medical technology selected for evaluation, the Clinical Policy unit conducts a comprehensive search of the peer-reviewed published medical literature indexed in the National Library of Medicine PubMed Database, assesses the regulatory status of the technology, reviews relevant evidence-based clinical practice guidelines and related documents indexed in the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse Database, and reviews relevant technology assessments indexed in the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Database. Also, the opinions of relevant experts

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the limitation is applied no more [illegible]ently, as written and in operation, MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/SUD				
					may be obtained where necessary.

MH/SUD		Medical/Surgical Examples	
Service	Clinical Policy Bulletin #	Service	Clinical Policy Bulletin #
ABA		Cardiac Rehabilitation: Outpatient	
		Physical Therapy	
		Occupational Therapy	
		Speech Therapy	

V. Benefit Exclusion

Experimental or Investigational Services or Unproven Services NQTL Analysis

Medical, surgical, diagnostic, psychiatric, substance abuse or health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the US Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use
- Subject to review and approval by any institutional review board for the proposed use
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the tion is applied no more stringently, ritten and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/ SUD				
All inpatient, outpatient, and emergency care services		Factors used in the development of the experimental/investigational NQTL are listed below. Note: **All factors are the same for medical/surgical and MH/SUD** Plans are not required to cover services that are not medically proven. Note: Certain plan sponsors consider this NQTL a subset of "Benefit Exclusions".	The processes, strategies, and evidentiary standards used to define the factors include the following: • There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or • Approval required by the FDA has not been granted for marketing; or • A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or • It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of	The [redacted] Clinical Policy Council evaluates whether a service or treatment should no longer be considered E&I. In making this determination, the Clinical Policy Council will review and evaluate evidence in the peer-reviewed published medical literature, information from the U.S. Food and Drug Administration and other Federal public health agencies, evidence-based guidelines from national medical professional organizations, and evidence-based evaluations by consensus panels and technology evaluation bodies. The Clinical Policy council is comprised of pharmacists and medical directors from the Medical Policy Administration (MPA)	[redacted] monitors the application of the medical necessity NQTL as follows: [redacted] utilizes MCG, American Society of Addiction Medicine (ASAM) and [redacted] Clinical Policy Bulletins (CPBs) to determine medical/surgical and MH/SUD benefit coverage. [redacted].com Utilization management. • Both new and revised CPB drafts undergo a comprehensive review process. This includes review by our Clinical Policy Council and external practicing clinicians, and approval by our chief medical officer or their designee. • Drafts of new and revised CPBs are distributed for review to members of the Clinical Policy Council prior to each meeting. Each new and revised draft CPB is placed on the Clinical Policy Council agenda and is discussed during the meeting. The Clinical Policy Council votes whether or not to recommend

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the tion is applied no more stringently, ritten and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/ SUD				

			the FDA and Department of Health and Human Services; or
			
			The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility, informed consent form used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.
			
			• Review of generally accepted national evidence-based guidelines from national medical professional organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations such as:
			  • Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Medicare Benefit Policy Manual
			  ▪ MCG guidelines
			• American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-
				department, National Accounts department, Behavioral Health department, Clinical Pharmacy department and regional Patient Management units. The Clinical Policy council usually convenes twice monthly.	approval of each draft CPB. In addition, the Clinical Policy Council may recommend other revisions to a draft CPB.
					• The CPB draft may be revised based on the Clinical Policy Council's recommendations. CPB drafts are reviewed by our Legal department and the head of the MPA department, and further revisions to draft CPBs may be made based on their recommendations. Draft CPBs are sent to the chief medical officer or their designee for review and final approval. Draft CPBs that are approved by the chief medical officer or their designee will be published on our websites within 60 days of the Clinical Policy council's recommendations.
					• CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the ıtion is applied no more stringently, ritten and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/ SUD				

			Occurring Conditions, Third Edition
			• Applied Behavior Analysis Medical Necessity Guide
			  • InterQual guidelines (as required by contractual provisions)
			  • Level of Care Assessment Tool
			
			Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NCQA
			
			These processes, strategies, and evidentiary standards: are represented in [redacted] Clinical Polices and in our published [redacted] Clinical Policy Bulletins (CPBs) [redacted]
			
			In determining whether a medical technology is medically necessary and established, the Clinical Policy Council will consider whether the following five criteria are met:
			
			• Whether the medical technology has final approval from the
					there is a change in the experimental and investigational status or medical necessity of medical technologies addressed in each CPB. If the Clinical Policy unit determines that new evidence or other information has emerged to warrant consideration of a change in our clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in position, the CPB may be updated with additional supporting background information and references. Each revised and updated CPB is submitted to the Clinical Policy Council for review and approval.
					• In developing our CPBs, for each medical technology selected for evaluation, the Clinical Policy unit conducts a comprehensive search of the peer-reviewed published medical literature indexed in the National Library of Medicine PubMed Database, assesses the regulatory status of the technology, reviews

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the tion is applied no more stringently, ritten and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/ SUD				
			appropriate governmental regulatory bodies • Whether the scientific evidence permits conclusions about the effect of the medical technology on health outcomes • Whether the medical technology improves net health outcomes • Whether the medical technology is at least as beneficial as any established alternatives • Whether the medical technology is more costly (taking into account all health expenses incurred in connection with the medical technology) than any equally effective established alternatives		relevant evidence-based clinical practice guidelines and related documents indexed in the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse Database, and reviews relevant technology assessments indexed in the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Database. Also, the opinions of relevant experts may be obtained where necessary. • Each CPB includes a policy statement and references to the medical literature and other sources used in developing the clinical policy. In addition, the CPB may include a background section that describes the medical technology and provides the rationale for our policy. • In addition, each CPB has a coding section that provides applicable International Classification of Diseases (ICD), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the tion is applied no more stringently, ritten and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/ SUD				
					Discretion: Exclusion of experimental/investigational benefits will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if [redacted] determines that: • The disease can be expected to cause death within one year, in the absence of effective treatment; and • The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, [redacted] will take into account the results of a review by a panel of independent medical professionals. They will be selected by [redacted]. This panel will include professionals who treat the type of disease involved. • Also, this exclusion will not apply with respect to drugs that: have been granted treatment investigational new drug (IND) or Group C treatment IND status; or are being studied at the Phase III

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the tion is applied no more stringently, ritten and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/ SUD				level in a national clinical trial sponsored by the National Cancer Institute; if [redacted] determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease. • With regard to [redacted] Medical Technology Evaluation and Clinical Policy Development Process, [redacted] Clinical Policy Bulletins (CPBs) previously referenced define our policy regarding the experimental and investigational status and medical necessity of medical technologies (e.g., medical and surgical procedures, devices, pharmaceuticals, biological products, behavioral health interventions, and the organizational and supportive systems within which such care is provided) that may be eligible for coverage under our medical plans. The CPBs are used in conjunction with the terms of the member's benefit plan and other [redacted]-recognized criteria to determine health care coverage for our members.

Services/procedures to which the NQTL applies		Factors: Factors used in the development of the limitation	Sources Processes, strategies, evidentiary standards	Comparability Analysis *Results of the comparison of MH/SUD and Medical/Surgical*	Stringency: *Evidence to establish that the ıtion is applied no more stringently, ritten and in operation, to MH/SUD benefits than to M/S benefits*
Medical/ Surgical	MH/ SUD				

Network NQTLS

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

Participating Provider Reimbursement NQTL

NQTL applies to MH/SUD	**NQTL applies to M/S**	**Factors** *Factors used in the development of the limitation*	**Sources** *Processes, Strategies, and evidentiary standards*	**Comparability** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency** *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Applies to all MH/SUD benefits delivered in-network	Applies to all M/S benefits delivered in-network	Note: **All factors are the same for medical/surgical and MH/SUD** • Reimbursement rate indices (e.g. Medicare reimbursement rates) • Market dynamics (e.g. supply and demand) • Provider type (e.g. MD, NP) • Service type (e.g. counseling, initial assessment) • Performance based programs	• Standard fee schedules: – Benchmarked from Medicare reimbursement rates – Developed for each market based on market analysis • Final negotiated rate – either standard rates or a negotiated fee schedule	MH/SUD rates can be higher but are not lower than medical rates for the same codes. The process to determine provider network reimbursement between Medical/Surgical and MH/SUD is as follows: Medical informs Behavioral Health that they are adjusting the standard rates for a given market. Medical supplies the new medical rates for the codes shared with the behavioral health fee schedule. BH will provide rates to medical for MH/SUD services the BH Network. Behavioral Health will compare the rates to the medical rates. If the medical rate is the higher	[redacted] monitors the application of this NQTL through several initiatives: • Mental Health Parity Task Force: Multi-disciplinary team that meets bi- weekly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care.

NQTL applies to MH/SUD	**NQTL applies to M/S**	**Factors** *Factors used in the development of the limitation*	**Sources** *Processes, Strategies, and evidentiary standards*	**Comparability** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency** *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
				rate, Behavioral Health will adopt the medical rate. Behavioral Health will cascade the rate down to the lower level providers using the following CMS guidelines: *MD's & Clinical Psychologists receive 100% of the rate. Master Level providers receive 75% of the new rate. Certified Nurse Specialist (CNS) receives 85% of the new rate. ** If the existing MH/SUD rate is higher than the 75% of the new rate, the already existing rate stays in place *** If the existing MH/SUD rate is higher than 85% of the new rate, the already existing rate stays in place The rates are effective at the same time as the new medical rates.	• Rates are updated, and new schedules are completed and reviewed by a different person to make sure they are accurate. The rates are reviewed on both Medical and BH by members of the enterprise senior network team as well as by members of the senior regional market team.

NQTL applies to MH/SUD	**NQTL applies to M/S**	**Factors** *Factors used in the development of the limitation*	**Sources** *Processes, Strategies, and evidentiary standards*	**Comparability** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency** *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
				MH/SUD rates can be updated in addition to the rate updates triggered by the Medical rate updates.	

Non-Participating Provider Reimbursement NQTL

NQTL applies to MH/SUD	**NQTL applies to M/S**	**Factors** *Factors used in the development of the limitation*	**Sources** *Processes, Strategies, and evidentiary standards*	**Comparability** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency** *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Applies to all MH/SUD benefits delivered out-of-network	Applies to all M/S benefits delivered out-of-network	Note: **All factors are the same for medical/surgical and MH/SUD** • Reasonable and Customary rates benchmarked from reimbursement rate indices	• Rate hierarchy (i.e. a preset algorithm that generates the rate that will be paid based on certain factors) • Market analysis when rate hierarchy is not applicable • Final negotiated rate	[redacted] compensates nonparticipating providers based on member's plan and benefit level subject to the lesser of either the billed charges or the allowable amount determined by a standard rate hierarchy that is the same for both MH/SUD and M/S.	[redacted] monitors the application of this NQTL through: • Mental Health Parity Task Force: Multi-disciplinary team that meets bi- weekly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care.

Participating Facility Reimbursement NQTL

NQTL applies to MH/SUD	**NQTL applies to M/S**	**Factors** *Factors used in the development of the limitation*	**Sources** *Processes, Strategies, and evidentiary standards*	**Comparability** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency** *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Applies to all MH/SUD benefits delivered in-network	Applies to all M/S benefits delivered in-network	Note: **All factors are the same for medical/surgical and MH/SUD** • market dynamics (e.g. supply and demand, volume with [redacted]) • Quality of care (e.g. use of evidence-based care) • Performance based programs • Scope and complexity of services provided • [redacted] membership presence within region	• Benchmarked from Medicare Inpatient Psychiatric Facility Prospective Payment System • Market analysis • Negotiated reimbursement models (e.g. per diem versus DRG) • Final rate negotiated from standard target ranges	Prior to negotiating such rates with a particular facility provider, [redacted] has developed a set of standard target rates based on the average rates paid for similar services in a particular market. These target rates are updated annually based on average rate increases. Rates are then negotiated on the basis of these target ranges, rather than a set fee schedule. In general, the majority of rates negotiated with freestanding facilities fall within a targeted rate range differential to the average as a whole.	[redacted] monitors the application of this NQTL through: • Mental Health Parity Task Force: Multi-disciplinary team that meets bi- weekly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care.

Non-Participating Facility Reimbursement NQTL

NQTL applies to MH/SUD	**NQTL applies to M/S**	**Factors** *Factors used in the development of the limitation*	**Sources** *Processes, Strategies, and evidentiary standards*	**Comparability** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency** *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Applies to all MH/SUD benefits delivered out of network	Applies to all M/S benefits delivered out of network	Note: **All factors are the same for medical/surgical and MH/SUD** • Reasonable and Customary rates benchmarked from reimbursement rate indices	• Rate hierarchy (i.e. a preset algorithm that generates the rate that will be paid based on certain factors) • Market analysis when rate hierarchy is not applicable • Final rate negotiated as part of the rate hierarchy process	[redacted] compensates nonparticipating providers based on member's plan and benefit level subject to the lesser of either the billed charges or the allowable amount determined by a standard rate hierarchy that is the same for both MH/SUD and M/S.	[redacted] monitors the application of this NQTL through several initiatives: • Mental Health Parity Task Force: Multi-disciplinary team that meets bi-weekly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care

Network Adequacy NQTL

NQTL applies to MH/SUD	**NQTL applies to M/S**	**Factors** *Factors used in the development of the limitation*	**Sources** *Processes, Strategies, and evidentiary standards*	**Comparability** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency** *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Applies to all MH/SUD benefits delivered in-network	Applies to all M/S benefits delivered in-network	Note: **All factors are the same for medical/surgical and MH/SUD** • Applicable state law, federal law, and accreditation network adequacy requirements	• NCQA standards • Network adequacy indicators include, but are not limited to: Number of providers by type for Urban, Suburban and Rural mileage; Provider to member ratios; Practitioner counts by specialty, mapping of provider to zip code, mapping of members to zip code, foreign language needs to membership, racial and ethnic composition of the membership. These standards are identical to those maintained by medical/surgical practitioners. • **Geocoding** – Utilizes an analytical tool that generates reports designed to provide a detailed picture of both facility and practitioner access coverage in a given geographical area. This information assists Network Development in targeting areas for new or continued	The same standards are used to define and monitor minimum requirements for network composition, ensure compliance with applicable state and federal regulatory standards, and to ensure compliance with applicable accreditations standards for both M/S and MH/SUD.	[redacted] monitors the application of this NQTL through several initiatives: • Mental Health Parity Task Force: Multi-disciplinary team that meets bi- weekly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care. • A qualitative and quantitative analysis by product/product line is performed using network adequacy data which includes member complaints/grievances and appeals, accessibility, availability, out of network requests, and member experience data (CAHPS or member experience survey). • Network adequacy complaints/grievances and appeals

NQTL applies to MH/SUD	**NQTL applies to M/S**	**Factors** *Factors used in the development of the limitation*	**Sources** *Processes, Strategies, and evidentiary standards*	**Comparability** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency** *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
			development by state, county, city or zip code.		at or in excess of .01 per thousand member months will trigger an additional review. The rate per thousand member months shall be calculated as follows: [# of complaints or appeals)/(monthly total for 12 months of membership/1000)] • Out-Of-Network requests for and utilization services will be reported at the product line-level per thousand members. The rate per thousand members shall be calculated as follows: [# of Out-of-Network requests)/1,000 enrollees] (membership/1000). The results of the above analysis will be reviewed in conjunction with the findings of the network availability and accessibility analyses to identify and prioritize opportunities for improvement. One improvement for non-behavioral health and one for behavioral health will be implemented.

Provider Admission Standards NQTL: Outpatient group and individual providers

NQTL applies to MH/SUD	**NQTL applies to M/S**	**Factors** *Factors used in the development of the limitation*	**Sources** *Processes, Strategies, and evidentiary standards*	**Comparability** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency** *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Applies to all MH/SUD benefits delivered in-network	Applies to all M/S benefits delivered in-network	Note: **All factors are the same for medical/surgical and MH/SUD** • Variation in quality of care and cost delivered • Applicable state law, federal law, and accreditation practice requirements	• Verification from [redacted], National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans and CMS approved primary sources, [redacted] utilizes the [redacted] •	The provider admission standards and process are the same between M/S and MH/SUD providers. The variances will only be dependent upon licensing board requirements	[redacted] monitors the application this NQTL through several initiatives: • Mental Health Parity Task Force: Multi-disciplinary team that meets bi- weekly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care.

Provider Admission Standards NQTL: Facility and Facility-Based Practitioners

NQTL applies to MH/SUD	**NQTL applies to M/S**	**Factors** *Factors used in the development of the limitation*	**Sources** *Processes, Strategies, and evidentiary standards*	**Comparability** *Results of the comparison of MH/SUD and Medical/Surgical*	**Stringency** *Evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to M/S benefits*
Applies to all MH/SUD benefits delivered in-network	Applies to all M/S benefits delivered in-network	Note: **All factors are the same for medical/surgical and MH/SUD** • Variation in quality of care delivered and cost • Applicable state law, federal law, and accreditation practice requirements	• Facility qualifications are reviewed to ensure facility meets [redacted] established requirements for organizational credentialing, including state licensing board, operating/certificate of occupancy, accreditation entity.	The provider admission standards and credentialing process are the same between M/S and MH/SUD providers. The variances will only be dependent upon licensing and/or accreditation requirements per facility type.	[redacted] monitors the application of this NQTL through: • Mental Health Parity Task Force: Multi-disciplinary team that meets bi- weekly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care.