Connecticut Nonquantitative Treatment Limitation "NQTL" Report

To

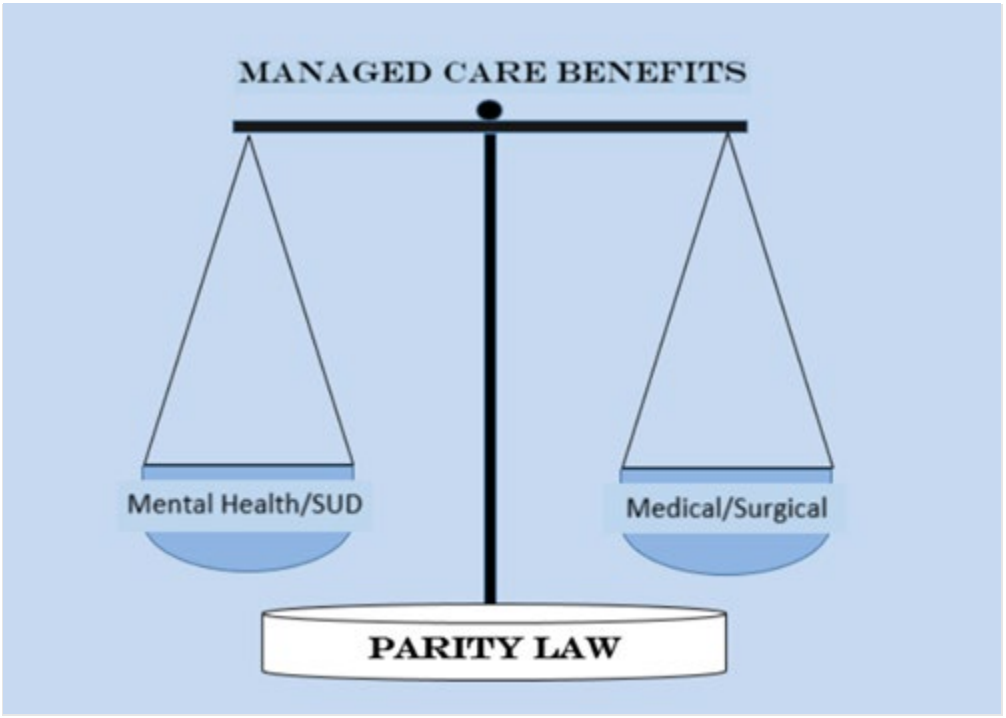
Insurance and Real Estate Committee

Submitted by

Connecticut Insurance Department

Andrew N. Mais, Commissioner

April 14, 2022



Pursuant to CGS, Sec. 38a-477ee, the Connecticut Insurance Department is providing the 2022 report concerning nonquantitative treatment limitations submitted by pertinent insurers to the Commissioner ("Report") pursuant to Subsection (b) of 38a-477ee for calendar year 2021.

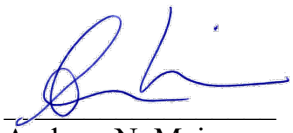
This report was compiled with data collected from six (6) entities.

The data targets three (3) primary areas of disclosure:

(1) Processes used to develop and select medical necessity criteria for mental health and substance use disorder benefits and medical and surgical benefits.
(2) A description of all medically necessary and administrative nonquantitative treatment limitations (NQTL) applied to mental health and substance use disorder benefits and medical and surgical benefits.
(3) Documentation of every evidentiary standard supporting each medical necessity criteria used within each NQTL, full disclosure of all factors used within each NQTL, and comparative analysis of the NQTL "as-written" and the NQTL "in-operation" as designed and as applied to processes for mental health and substance use disorder, demonstrating that they are comparable and being no less stringently designed and applied to the similar medical and surgical benefits.

To ensure that all carriers have provided a complete analysis, the scope of this report has been broadened this year to include three (3) critical areas for Mental Health Parity comparative review:
(1) A prospective analysis on the "as-written" benefit limiting standards,
(2) A concurrent or operational analysis on the in-practice benefit limiting processes, and
(3) A retrospective analysis on the operational outcomes of the benefit limiting impacts.

Respectfully,



Andrew N. Mais
Insurance Commissioner

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Connecticut Nonquantitative Treatment Limitation Annual Report 2022

I. Introduction

Pursuant to C.G.S. Section 38a-477ee, the Connecticut Insurance Department ("the Department") hereby submits its 2022 NQTL annual report to the Insurance and Real Estate Committee. Included are the various submissions received by the Commissioner pursuant to Subsection (b) of CGS, Section 38a-477ee reflecting calendar year 2021 data.

II. Background

In 2019, the Connecticut legislature passed Public Act 19-159 (the "Act"), which, among other things, mandates that each health carrier is required to submit, not later than March 1, 2021, and annually thereafter, a report to the Commissioner in a form and manner prescribed by the Commissioner, containing the following information for the calendar year immediately preceding:

(1) A description of the processes that such health carrier used to develop and select criteria to assess the medical necessity of (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits;

(2) A description of all nonquantitative treatment limitations that such health carrier applied to (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits; and

(3) The results of an analysis concerning the processes, strategies, evidentiary standards, and other factors that such health carrier used in developing and applying the criteria and each nonquantitative treatment limitation, provided the commissioner is not permitted to disclose such results in a manner that is likely to compromise the financial, competitive or proprietary nature of such results.

The results of such analysis shall, at a minimum:

(A) Disclose each factor that such health carrier considered, regardless of whether such health carrier rejected such factor, in designing each nonquantitative treatment limitation and determining whether to apply such nonquantitative treatment limitation,

(B) Disclose all evidentiary standards, which standards may be qualitative or quantitative in nature, applied under a factor, and, if no evidentiary standard is applied under such a factor, a clear description of such factor,

(C) Provide the comparative analyses, including the results of such analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the processes and strategies used to apply such nonquantitative treatment limitation, as written,

to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, and the processes and strategies used to apply such nonquantitative treatment limitation, as written, to medical and surgical benefits,

(D) Provide the comparative analyses, including the results of such analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, to medical and surgical benefits; and

(E) Disclose information that, in the opinion of the Insurance Commissioner, is sufficient to demonstrate that such health carrier, consistent with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder, applied each nonquantitative treatment limitation comparably, and not more stringently, to mental health and substance use disorder benefits, and medical and surgical benefits, and complied with 38a-488c and 38a-514c, 38a-488a and 38a-514, 38a-510 and 38a-544, and (IV) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Subsection (c) of CGS, Sec. 38a-477ee precludes the Commissioner from divulging the name or identity of any health carrier or entity that has contracted with such health carrier, and mandates that such name or identity shall be given confidential treatment and not be made public by the Commissioner.

The Consolidated Appropriations Act (CAA) of 2021 was enacted on December 27, 2020 (effective 2/2021). Section 203 of Title II of Division BB of the CAA amended Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), by expressly requiring group health plans and health insurance issuers imposing NQTLs on benefits to perform, demonstrate and document a comparative analysis of the design and application of any limitation on a benefits scope or duration.

This is an important update to MHPAEA because it significantly improved benefit comparability guidance for both the industry and the regulators. All stakeholders now have clear guidance on what is required and expected to demonstrate and perform a sufficient comparative analysis on benefit limiting practices and outcomes.

III. Description of Analysis

The federal MHPAEA defines nonquantitative treatment limitations as most commonly non-numeric standards that are designed and operationally applied in the

management and delivery of healthcare. It is understood and recognized that these NQTL standards ultimately result in limiting the scope of Mental Health, Substance Use Disorder and Medical/Surgical benefits. The law establishes that NQTLs are an important tool in the management of healthcare, but it also specifically requires that these NQTLs be designed and applied comparably between Mental Health, Substance Use Disorder and Medical/Surgical benefits and that the health insurers document and demonstrate this comparative analysis. The expectation is that NQTL components, such as prior-authorization or concurrent care review practices, would be applied to Mental Health and Substance Abuse Disorder benefits comparably and no more stringently than they would be applied to Medical/Surgical benefits. Finally, the federal law points out that these benefits can maintain comparable in-practice limiting standards that produce incongruent final operational outcomes because of justifiable clinical differences or experiences, but that these instances require an advanced comparative analysis demonstration.

This 2022 report has been significantly improved over last years, thanks to the Consolidated Appropriations Act of 2021. It has been updated to require health insurers to conduct (3) points in-time comparative benefit reviews: (1) A prospective analysis on all as-written benefit limiting standards, (2) A concurrent or operational analysis on all in-practice benefit limiting processes, and (3) A retrospective analysis on the operational outcomes of the benefit limiting impacts.

IV. Limitations of Analysis

The analysis is based on the 2021 health plan year and relies on information disclosed by the health carriers in their reports to the Department according to the Department revised Bulletin MC-24A.

V. Key Findings

While the data is limited to what was requested and what was disclosed, there are some observations to be made. Certain carriers provided sufficient information and supporting documentation regarding a reasoned discussion of findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as written and in operation.

Overall, health carriers made significant improvements in their comparative analysis. However, in certain instances there was often a failure to describe in sufficient detail how the NQTL was designed or how it is applied in practice to MH/SUD benefits and medical/surgical benefits; to maintain a comparative analysis process that traced and demonstrated congruency throughout the entire NQTL life cycle, from as-written, to in-operation and to its final benefit outcome. All insurers could significantly improve their depth and quality of their comparative review process by tying together all (3) of the comparative compliance checkpoints. This would provide a more thorough and

comprehensive comparative analysis. Again, the full scope of a comparative benefit review involves three critical checkpoints for analysis: (1) A prospective analysis on all as-written benefit limiting standards, (2) A concurrent or operational analysis on all in-practice benefit limiting processes, and (3) A retrospective analysis on the operational outcomes of the benefit limiting impacts.

VI. Detailed Findings

This discussion corresponds to the reports and charts attached as Health Carrier Individual Reports-Exhibit A Submissions.

The reader is encouraged to review those exhibits for full details.

Exhibit A

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (12) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of medical necessity criteria between medical/surgical and MH/SUD (while different medical necessity tools may be used; for example, LOCUS and Milliman, they're both nationally recognized tools for developing medical necessity criteria for the treatment of MH/SUD and Medical/Surgical benefits). Medically necessary means healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental Illness, substance use disorder, condition, disease or its symptoms that are all of the following as determined by the 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. XXXXX publishes information concerning utilization review and our medical necessity criteria here: https://www.XXXXX.com/health-care-professionals/utilization-management.html Within that site, there is a section dedicated specially to the criteria used for behavioral health conditions, which can be found here: https://www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html We also publish clinical policy bulletins concerning services we may or may not cover, including behavioral health services that may be excluded on grounds that they are experimental and investigational, which detail the evidentiary bases for our coverage or exclusion determinations: https://www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html Covered Services: All MH/SUD and Medical/Surgical services Factors: Medical necessity applies to all medical/surgical and mental health/substance use disorder benefits in each MHPAEA category and is based on generally accepted standards of care. Processes, Strategies, Evidentiary Standards: Note-“Processes”, “strategies”, “evidentiary standards”, and “other factors” are terms of equivalence; none of which have to be individually articulated in order to be sufficient NQTL analysis. A plain reading interpretation of the MHPAEA Final Rule makes it clear that “any” (emphasis added) processes, strategies, evidentiary standards, or other factors” used in applying the MH/SUD NQTL can be compared to any process, strategy, evidentiary standard, or other factors used in applying the medical/surgical NQTL for the purposes of comparability and stringency analysis. See 29 CFR 2590.712(c)(4). Therefore, throughout all of these answers you will see content populated under the combine header of "process, strategy, or evidentiary standard"—some of which may be supported qualitatively or some of which may be supported quantitatively (e.g. “cost” as a factor to add a service to the NPL). 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) 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 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 Utilization System (LOCUS) for adults 18 years old and above and the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS/CASII)	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of medical necessity criteria between medical/surgical and MH/SUD (while different medical necessity tools may be used; for example, LOCUS and Milliman, they're both nationally recognized tools for developing medical necessity criteria for the treatment of MH/SUD and Medical/Surgical benefits).

Development, Modification or Addition of Medical Necessity Criteria. Medical	Intensity Instrument (CALOCUS/CASII) Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NQCA These processes, strategies, and evidentiary standards : are represented in XXXXX Clinical Polices and in our published XXXXX Clinical Policy Bulletins (CPBs) https://www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html 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 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 No other evidentiary standards were considered and rejected. Comparability Analysis: XXXXX's strategy regarding satisfaction of parity's NQTL requirements includes the utilization of an identical standard/definition of medical necessity. Medical and MH/SUD utilize appropriately applicable and generally accepted standards of practice to guide clinician with coverage determinations. For substance use disorder treatments, XXXXX 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 XXXXX clinicians making medical necessity determinations in both the medical necessity tools utilized and in staff training. More information about LOCAT, LOCUS, CALOCUS/CASSII and ASAM criteria can be found on XXXXX's website at https://www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html. For medical treatments XXXXX utilizes Milliman Care Guidelines (MCG) as a guideline to determine the medical necessity. As Written: The definition of "medical necessity" for both MH/SUD and medical/surgical share the same definition in our standard Certificates of coverage. Additionally, the Clinical Policy Bulletins (CPB) and evidence-based guidelines used in the medical necessity review process have been found to be aligned to generally accepted practice standards. This validation is completed by our Clinical Policy Council and approval by our chief medical officer or their designee. This process involves annual review of generally accepted national evidence-based guidelines. In Operation: XXXXX monitors the application of the medical necessity 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: comparative rate of MH/SUD vs. medical/surgical denials due to precertification/concurrent reviews. Book of Business data will be formally reviewed by the Parity Task Force at least annually. •Internal Quality Reviews and Inter-Rater Reliability assessments: Clinical denials due to precertification reviews are conducted randomly throughout the year by XXXXX's Clinical Services Team. The Parity Task Force will review the results of these audits at least annually. •Average length of stay (ALOS) reviews: comparative ALOS of MH/SUD vs. medical/surgical cases. Book of Business data will be formally reviewed by the Parity Task Force at least annually. •Complaints and appeals: XXXXX's National Quality Oversight Committee, NQOC tracks and reviews trend rates of complaints and appeals at least annually. The Parity Task Force will review the results of these reviews at least annually. •Annual surveys: Comparative analysis of (Consumer Assessment of Healthcare Providers and Systems (CAHPs) survey, Qualified Health Plan Enrollee Experience Survey, XXXXX MH/SUD Practitioner Experience Survey, XXXXX MH/SUD Provider (Facility) Experience Survey, XXXXX MH/SUD Member Experience Survey, Physician Practice Survey and surveys •Review of NPL Committee Minutes Further detail on the criteria: LOCUS/CALOCUS XXXXX utilizes LOCUS and CALOCUS, which nationally is recognized (by several courts, regulators, and various external stakeholders) as a generally accepted standard of care tool, to guide clinicians in the making medically necessary level of care determinations for our XXXXX members. The Level of Care Utilization System (LOCUS) assessment was developed to help determine the resource intensity needs of individuals who receive adult mental health services. The LOCUS was developed by the American Association of Community Psychiatrists (AACP) in 1996. The LOCUS provides a system for assessment of needs based on 6 evaluation parameters: •Risk of harm •Functional status •Medical, addictive & psychiatric co-morbidity •Recovery Environment •Treatment and recovery history

Appropriateness and Level of Care Treatment Practices.	•Engagement and recovery status The LOCUS assessment is reviewed and updated annually. There are multiple venues for regular input from all users as well as processes for continuous review and update of the tools themselves based on this input. Venues include: •National Council for Community Behavioral Healthcare/AACP LOCUS Advisory Committee •Deerfield Solutions •AACP/AACAP Committee for CALOCUS/CASII AACP Board of Directors Products and Service Plank CALOCUS/CASII The Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS/CASII) assessment provides a framework for defining the appropriate character and intensity of both services and resources to meet the needs of children and adolescents . CALOCUS/CASII was developed by the American Association of Community Psychiatrists in collaboration with the American Association of Child and Adolescent Psychiatry and closely mirrors the structure of the LOCUS. The CALOCUS/CASI provides a system for assessment of needs based on 6 evaluation parameters: •Risk of harm •Functional status •Co-Occurrence of Conditions: medical, substance use, developmental and psychiatric •Environmental stress •Environmental support •Resilience and/or Response to Services oChild and Adolescent Engagement in Service oParent/Primary Caregiver Engagement in Services Similar to the LOCUS assessment, the CALOCUS/CASII assessment is reviewed and updated annually. There are multiple venues for regular input from all users as well as processes for continuous review and update of the tools themselves based on this input. Venues include: •National Council for Community Behavioral Healthcare/AACP LOCUS Advisory Committee •Deerfield Solutions •AACP/AACAP Committee for CALOCUS/CASII •AACP Board of Directors Products and Services Plank ASAM For members seeking treatment for substance use disorders, XXXXX utilizes the American Society of Addiction Medicine Criteria. The ASAM Criteria provides guidelines for evaluating the medical necessity of levels and types of care for substance use disorders. Many Courts and regulators consider ASAM a generally accepted, national standard for SUD treatment decisions. 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 https://www.asam.org/resources/the-asam-criteria/about. Currently, XXXXX is using the most recent version of the ASAM guidelines. MCG For medical/surgical health treatments, XXXXX 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 XXXXX members. Clinical Policy Bulletins (CPBs) The XXXXX 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 XXXXX medical plans, or that may be eligible for coverage under XXXXX medical plans. In making this determination, the Clinical Policy Council will review and evaluate evidence in the peer-reviewed published medical literature, information from the U.S. Food and Drug Administration and other Federal public health agencies, evidence-based guidelines from national medical professional organizations, and evidence-based evaluations by consensus panels and technology evaluation bodies. The Clinical Policy council is comprised of pharmacists and medical directors from the Medical Policy Administration (MPA) department, National Accounts department, Behavioral Health department, Clinical Pharmacy department and regional Patient Management units. The Clinical Policy council usually convenes twice monthly. •Both new and revised CPB drafts undergo a comprehensive review process. This includes review by 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 Medical Policy Administration department, and further revisions to draft CPBs may be made based on their recommendations. Draft CPBs are sent to the chief medical officer or their designee for review and final approval. Draft CPBs that are approved by the chief medical officer or their designee will be published on our websites within 60 days of the Clinical Policy council's recommendations. •CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of medical technologies addressed in each CPB. If the Clinical Policy unit determines that new evidence or other information has emerged to warrant consideration of a change in our clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in position, the CPB may be updated with additional supporting background information and references. Each revised and updated CPB is submitted to the Clinical Policy Council for review and approval. •In developing our CPBs, for each medical technology selected for evaluation, the Clinical Policy unit conducts a comprehensive search of the peer-reviewed published medical literature indexed in the National Library of Medicine PubMed Database, assesses the regulatory status of the technology, reviews relevant evidence-based clinical practice guidelines and related documents indexed in the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse Database, and reviews relevant technology assessments indexed in the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Database. Also, the opinions of relevant experts may be obtained where necessary. •Each CPB includes a policy statement and references to the medical literature and other sources used in developing the clinical policy. In addition, the CPB may include a background section that describes the medical technology and provides the rationale for our policy. •In addition, each CPB has a coding section that provides applicable International Classification of Diseases (ICD), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. XXXXX has confirmed that the evidence-based guidelines and criteria for all Medical/Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for determining medical necessity, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to Medical/Surgical benefits Summary: XXXXX has confirmed that the evidence-based guidelines and criteria for all Medical/Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for determining medical necessity, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to Medical/Surgical benefits. Plan Language: COC: Medically necessary, medical necessity The medical necessity requirements are in the Glossary section, where we define "medically necessary, medical necessity." That is where we also explain what our medical directors or a physician they assign consider when determining if a service is medically necessary. Important note: We cover medically necessary, sex-specific covered services regardless of identified gender. Medical necessity and precertification requirements Your plan pays for its share of the expense for covered services only if the general requirements are met. They are: •The service is medically necessary •For in-network benefits, you get the service from a network provider •You or your provider precertifies the service when required Medically necessary, medical necessity Health care services that are state or federally mandated or we at we determine a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that we determine are: •In accordance with generally accepted standards of medical practice •Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease •Not primarily for the convenience of the patient, physician or other health care provider •Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease SOB: No reference	
In-Patient & In-Network NQTL Practices	The description in column A reflects a benefit classification, as such NQTLs that apply to this benefit classification are: Prior Authorization/Precertification, Concurrent Review, Retrospective Review, Medical Necessity Criteria, Sequenced Treatment, Benefit Exclusion including for experimental and investigational purposes, Network Provider Reimbursement, Network Facility Reimbursement, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
In-Patient & Out-of-Network NQTL Practices	The description in column A reflects a benefit classification, as such NQTLs that apply to this benefit classification are: Prior Authorization/Precertification, Concurrent Review, Retrospective Review, Medical Necessity Criteria, Sequenced Treatment, Benefit Exclusion including for experimental and investigational purposes, Non-Participating Provider Reimbursement/UCR Determination, Non-Participating Facility Reimbursement/UCR Determination, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the

	There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	development of the limitations between medical/surgical and MH/SUD.
Out-Patient & In-Network NQTL Practices	The description in column A reflects a benefit classification which XXXXX subclassifies as Outpatient-Office Visit and Outpatient-All Other. NQTLs that apply to the Outpatient-Office Visit benefit classification are: Medical Necessity Criteria, Benefit Exclusion including for experimental and investigational purposes, Network Provider Reimbursement, Network Facility Reimbursement, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards. NQTLs that apply to the Outpatient-All Other Benefit classification are: Prior Authorization/Precertification, Concurrent Review, Retrospective Review, Medical Necessity Criteria, Sequenced Treatment, Treatment Plan Requirement, Benefit Exclusion including for experimental and investigational purposes, Network Provider Reimbursement, Network Facility Reimbursement, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
Out-Patient & Out-of-Network NQTL Practices	The description in column A reflects a benefit classification which XXXXX subclassifies as Outpatient-Office Visit and Outpatient-All Other. NQTLs that apply to the Outpatient-Office Visit benefit classification are: Medical Necessity Criteria, Benefit Exclusion including for experimental and investigational purposes, Non-Participating Provider Reimbursement/UCR Determination, Non-Participating Facility Reimbursement/UCR Determination, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards. NQTLs that apply to the Outpatient-All Other Benefit classification are: Prior Authorization/Precertification, Concurrent Review, Retrospective Review, Medical Necessity Criteria, Sequenced Treatment, Treatment Plan Requirement, Benefit Exclusion including for experimental and investigational purposes, Non-Participating Provider Reimbursement/UCR Determination, Non-Participating Facility Reimbursement/UCR Determination, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
Emergency Services/Benefits NQTL Practices	The description in column A reflects a benefit classification, as such NQTLs that apply to this benefit classification are: Prior Authorization/Precertification, Retrospective Review, Medical Necessity Criteria, Network Provider Reimbursement, Network Facility Reimbursement, Non-Participating Provider Reimbursement/UCR Determination, Non-Participating Facility Reimbursement/UCR Determination, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	The XXXXX Commercial Advanced Control and Standard Opt-Out Formularies, and Small Group Exchange Formularies with the applied pharmacy prior authorization, step therapy and quantity limit UM programs, which are components of the prescription drug benefit NQTLs, are designed and applied consistently across all drugs and drug classes and do not discriminate against individuals based on age, expected length of life, disability, degree of medical dependency, quality of life, gender identity, medical or mental health diagnosis, or other health conditions. The NQTL coverage factors considered, evidentiary standards used to apply the factors, processes in the development, and implementation strategies, applied to drugs used to treat mental health and Substance Use Disorder (MH/SUD) conditions are comparable to, and are applied no more stringently than the NQTL coverage factors considers, evidentiary standards used to apply the factors, processes in the development and implementation strategies, used in applying the limitations to drugs used to treat medical or surgical (MED/SURG) conditions or disorders.	See the Mental Health & Substance Use Disorder Benefit response. The same factors are considered, evidentiary standards used to apply the factors, processes in the development, and implementation strategies, applied to drugs used in MH/SUD conditions as for drugs used in MED/SURG conditions.
	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of prior authorization/precertification NQTL practices between medical/surgical and MH/SUD. All UM factors, processes, strategies, and evidentiary standards, 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, and the National Precertification List (NPL) Committee—a group of clinicians and other subject matter experts representing both MH/SUD and medical/surgical expertise then applies these determinants. This Precertification Committee oversees XXXXX's 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 INN services. Covered Services: A detailed analytical framework is not provided for Inpatient because this NQTL applies to all non-palliative procedures, services, devices, and therapies for both medical/surgical and MH/SUD; as such administration of this NQTL is identical. For Medical/Surgical: All outpatient all other non-palliative procedures, services, devices, and therapies on the National Precertification List (NPL) https://www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html For MH/SUD: All outpatient all other non-palliative procedures, services, devices, and therapies on the Behavioral Health Precertification List (MH/SUDPL) http://www.XXXXX.com/healthcare-professionals/assets/documents/MH/SUD_precert_list.pdf Factors: 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 average paid Medicare rate was at least $150 for the service being considered (based on XXXXX's national paid Medicare claims experience) b.High cost growth -- whether, based on internal XXXXX claims data, the per member per month expense for the services increased more than 10% in the most recent two-year period compared to an initial year baseline (for example, if the 2015 PMPM=$1.00, the 2016 PMPM=$2.00, and the 2017 PMPM=$3.00, then that would be a 200% trend increase over the two-year period - calculate by subtracting the 2015 PEPM from the 2017 PMPM and then divide by the 2015 PMPM) 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 evidenced-based criteria (EBC) available to assist clinicians with precertification decisions. EBC may be sourced from national medical	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of prior authorization/precertification NQTL practices between medical/surgical and MH/SUD.

professional organizations, evidence-based evaluations by consensus panels and technology evaluation bodies, or criteria from professional associations AN
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

*Note--as part of the intake completed for new services being added to the NPL, generally a forecasted ROI is produced (and such requirement is noted in the intake instructions). Such forecasted ROI helps mitigate the risk of a service satisfying the initial inclusion factors in year one but failing the retention framework in subsequent years. It is important to note that for both the inclusion framework or retention framework for the NPL all factors are equally applicable to the consideration of a medical/surgical service or MH/SUD service such that the in-writing component of parity is satisfied.

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 primarily based on the following:
–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 (see below)
* While ROI may be the primary factor used to determine retention of a service on the NPL, the NPL Committee may consider additional factors that concern the NPL Committee which are unrelated to medical cost (e.g. incorrect utilization, or need to retain services on list to make coverage determinations consistent with XXXXX's Clinica Policy Bulletins)

•Extenuating factors:
Extenuating factors are qualitative or quantitative points of consideration that, based on the expertise of XXXXX's NPL Committee, warrant additional consideration (beyon the ROI) in connection with the retention or removal of a service from the NPL. Such extenuating factors may include High-cost growth (as calculated using the methodology described in the inclusion section above), variability in practice or cost (as calculated using the methodology described in the inclusion section above), Safety, incidence of occurrence, incorrect utilization, consistency with XXXXX's Clinical Policy Bulletins, and End-to-end staff and system support for efficient management.

Processes, Strategies, Evidentiary Standards: 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) guidelines (Category 1 and 2A recommendations)
•American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, most recent version
•Applied Behavior Analysis Medical Necessity Guide
•InterQual guidelines (as required by contractual provisions)
•The Level of Care Utilization System (LOCUS) & Children and Adolescent Level of Care Utilization System (CALOCUS)
•Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NCQA
•Internal claims system review. Review of claims systems capabilities with Head of Operations to validate system functionality.
No other evidentiary standards were considered and rejected.
Comparability Analysis:
• A review of Medicare rates demonstrates that all the procedure, service, device, and therapy added to the NPL in 2021 meets the cost threshold of $150
• 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
As Written: MH/SUD and medical/surgical Precertification/Concurrent/and Retrospective Review all share the same definition in our standard Certificate of coverage. Additionally, XXXXX maintains one set of UM policies that are equally applicable to MH/SUD and medical/surgical.
In Operation: XXXXX 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: comparative rate of MH/SUD vs. medical/surgical denials due to precertification/concurrent reviews. Book of Business data will be formally reviewed by the Parity Task Force at least annually

	Parity Task Force at least annually. •Internal Quality Reviews and Inter-Rater Reliability assessments: Clinical denials due to precertification reviews are conducted randomly throughout the year by XXXXX's Clinical Services Team. The Parity Task Force will review the results of these audits at least annually. •Average length of stay (ALOS) reviews: comparative ALOS of MH/SUD vs. medical/surgical cases. Book of Business data will be formally reviewed by the Parity Task Force at least annually. •Complaints and appeals: XXXXX's National Quality Oversight Committee, NQOC tracks and reviews trend rates of complaints and appeals at least annually. The Parity Task Force will review the results of these reviews at least annually. •Annual surveys: Comparative analysis of (Consumer Assessment of Healthcare Providers and Systems (CAHPs) survey, Qualified Health Plan Enrollee Experience Survey, XXXXX MH/SUD Practitioner Experience Survey, XXXXX MH/SUD Provider (Facility) Experience Survey, XXXXX MH/SUD Member Experience Survey, Physician Practice Survey and surveys •Review of NPL Committee Minutes Summary: XXXXX has confirmed that the criteria for all Medical Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for the determining which services will be subject to UM, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to medical surgical benefits.
Prior-Authorization NQTL Practices	Plan Language: COC: Precertification You need pre-approval from us for some covered services. Pre-approval is also called precertification. In-network Your network physician is responsible for obtaining any necessary precertification before you get the care. Network providers cannot bill you if they fail to ask us for precertification. But if your physician requests precertification and we deny it, and you still choose to get the care, you will have to pay for it yourself. Out-of-network When you go to an out-of-network provider, you are responsible to get any required precertification from us. If you don't precertify: •Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details. •You will be responsible for the unpaid bills. •Your additional out-of-pocket expenses will not count toward your deductible or maximum out-of-pocket limit if you have any. Timeframes for precertification are listed below. For emergency services, precertification is not required, but you should notify us as shown. To obtain precertification, contact us. You, your physician or the facility must call us within these timelines: Non-emergency admission – Call at least 14 days before the date you are scheduled to be admitted Emergency admission – Call within 48 hours or as soon as reasonably possible after you have been admitted Urgent admission – Call before you are scheduled to be admitted Outpatient non-emergency medical services - Call at least 14 days before the care is provided, or the treatment or procedure is scheduled An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or injury. We will tell you and your physician in writing of the precertification decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan. For an inpatient stay in a facility, we will tell you, your physician and the facility about your precertified length of stay. If your physician recommends that you stay longer, the extra days will need to be precertified. You, your physician, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your physician in writing of an approval or denial of the extra days. If you or your provider request precertification and we don't approve coverage, we will tell you why and explain how you or your provider may request review of our decision. See the Claim decisions, grievances and appeal procedures section. Types of services that require precertification Precertification is required for inpatient stays and certain outpatient services and supplies. Precertification is required for the following types of services and supplies: •Inpatient services and supplies oStays in a hospital oStays in a skilled nursing facility oStays in a rehabilitation facility oStays in a hospice facility oStays in a residential treatment facility for treatment of mental health disorders and substance related disorders oObesity (bariatric) surgery •Outpatient services and supplies oApplied behavior analysis oComplex imaging oComprehensive infertility services and ART services

	oCosmetic and reconstructive surgery oEmergency transportation by airplane oInjectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications) oKidney dialysis oOutpatient back surgery not performed in a physician's office Knee surgery oPrivate duty nursing services oSleep studies oKnee surgery oWrist surgery oTranscranial magnetic stimulation (TMS) oPartial hospitalization treatment – mental health disorder and substance related disorders treatment diagnoses Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html. Certain prescription drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following precertification information applies to these prescription drugs: For certain drugs, your provider needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are medically necessary Step therapy is a type of precertification where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. However, if you are in a pain management program, this requirement will not apply. Step therapy will not be required for any prescribed drug for longer than 60 days. At the end of the 60 day period, your physician or PCP may feel the use of the step therapy provision is ineffective, and prescribe a different medication. Contact us or go online to get the most up-to-date precertification requirements and list of step therapy drugs. Medical necessity and precertification requirements Your plan pays for its share of the expense for covered services only if the general requirements are met. They are: •The service is medically necessary •For in-network benefits, you get the service from a network provider •You or your provider precertifies the service when required Precertification, precertify Pre-approval that you or your provider receives from us before you receive certain covered services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage. Step therapy A form of precertification under which certain prescription drugs are excluded from coverage, unless a first-line therapy drug is used first by you. The list of step therapy drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to step therapy is available upon request or on our website at https://www.XXXXX.com/individuals-families/find-a-medication.html. SOB: Precertification covered services reduction This only applies to out-of-network covered services: Your certificate contains a complete description of the precertification process. You will find details in the Medical necessity and precertification section. If precertification for covered services isn't completed, when required, it can result in the following benefit reductions: •Covered services reduced by the lesser of 50% of the benefit that would have been payable or $500 •The service is not covered You may have to pay an additional portion of the allowable amount because you didn't get precertification. This portion is not a covered service and doesn't apply to your deductible or maximum out-of-pocket limit, if you have one	
	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of concurrent review benefit NQTL benefit practices between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or

Concurrent Review Benefit NQTL Practices	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 or member precertification list (for OON) and for MH/SUD services on the Behavioral Health Precertification list or member precertification list. (See link for current precertification list: https://www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html). 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 number 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. XXXXX 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, Internal Quality Reviews (IQR) and Inter-Rater Reliability (IRR) assessments, NCQA Health Plan Accreditation, and peer-to-peer clinical review.	differences in the application, as written and in operation, of concurrent review benefit NQTL benefit practices between medical/surgical and MH/SUD.
Retrospective Review Benefit NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of retrospective review benefit NQTL benefit practices between medical/surgical and MH/SUD. 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. Retrospective review is utilized for OON Inpatient services that were not pre-certified and OON Outpatient All-Other services that are on the member precertification list and were not precertified. Retrospective Review is only used In Network for emergency inpatient admissions for participating facilities that have a deviation for late notification on the Late Notification Deviation list or a facility that is on the Internal or External Disaster Deviation List. The Late Notification Deviation list is a list of participating facilities that as part of their vendor contract they are eligible for retro review for emergent admits when they fail to notify us on the front end. The Internal and External disaster list is when there are disasters in certain States, such as hurricanes, that the facilities are allowed to request retro review for the specific timeframes noted on the deviation list since the facilities are not required to notify us on the front end. Both such lists are a benefit to in-network providers as the failure to precerify services generally results in an administrative denial with no recourse for the facility to balance bill the member. Covered Services: In-network: All emergent inpatient medical/surgical services/ procedures not precertified for providers on the Late Notification Deviation list or Internal or External Disaster Deviation List; Out-of-network: Medical/Surgical-All medical/surgical outpatient all other services/ procedures on the Member Precertification List; Out-of-network: MH/SUD - All MH/SUD outpatient all other services/ procedures on the Behavioral Health the Member Precertification List Factors: In-network: Retrospective review for providers is not a limitation; rather a benefit to providers who otherwise would have had their claims administratively denied. Retrospective Review is only used In Network for emergency inpatient admissions for participating facilities that have a deviation for late notification on the Late Notification Deviation list or a facility that is on the Internal or External Disaster Deviation List. The Late Notification Deviation list is a list of participating facilities that as part of their vendor contract they are eligible for retro review for emergent admits when they fail to notify us on the front end. The Internal and External disaster list is when there are disasters in certain States, such as hurricanes, that the facilities are allowed to request retro review for the specific timeframes noted on the deviation list since the facilities are not required to notify us on the front end. Both such lists are a benefit to in-network providers as the failure to precertify services generally results in an administrative denial with no recourse for the facility to balance bill the member.; Out-of-network factors: Frequency of services being administered on an OON basis and Duration of the typical course of treatment (data available in support of each of these factors available upon request). The NQTL factors used in developing Retrospective Review comparability analysis are identical for both outpatient-all other Medical/Surgical and MH/SUD services. Processes, Strategies, Evidentiary Standards: Inpatient: N/A; Outpatient-All Other: Internal claims database analysis (data available upon request). Comparability Analysis: Inpatient: N/A; Outpatient-All Other: As it relates to medical/surgical out-of-network utilization and average visits per member data, the medical/surgical services on the out-of-network precertification list all have the highest out-of-network utilization and average visits per member per year numbers compared to other medical/surgical Outpatient All Other services that are not on the out-of-network precertification list (with slight exception of gastric bypass which has an average visits per member per year that is more in line with other medical/surgical Outpatient All Other benefits that are not on the out-of-network precertification list)	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of retrospective review benefit NQTL benefit practices between medical/surgical and MH/SUD.

	As it relates to MH/SUD out-of-network utilization and average visits per member per year, the MH/SUD services on the out-of-network precertification list all have the highest average visits per member per year and all have significant out-of-network utilization compared to other MH/SUD All Other benefits not on the out-of-network precertification list. As Written: MH/SUD and medical/surgical Precertification/Concurrent/and Retrospective Review all share the same definition in our standard Certificates of coverage. Additionally, XXXXX maintains one set of UM policies that are equally applicable to MH/SUD and medical/surgical. In Operation: Refer to In Operation for Precertification NQTL Summary: XXXXX has confirmed that the criteria for all Medical/Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for determining which services will be subject to UM, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to Medical/Surgical benefits. Plan Language: COC & SOB: No reference	
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no automated claims edits/policies applied to MH/SUD benefits. Therefore, a NQTL analysis is not required. There are no non-comparable inconsistencies or differences in the application, as written and in operation, of billing code practices between medical/surgical and MH/SUD. For Billing Coding and Process NQTL Practices, Covered Services: All Med/Surg and MH/SUD services delivered in-network Factors: 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 Processes, Strategies, Evidentiary Standards: •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 No other evidentiary standards were considered and rejected. Comparability Analysis: MH/SUD standard fee schedule rates can be higher but are not lower than medical rates for the same codes that can be used by BH and medical/surgical providers. The process to determine provider network reimbursement between Medical/Surgical and MH/SUD is as follows: 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 in the BH Network. Behavioral Health will compare the rates to the medical rates. If the medical rate is the higher rate, Behavioral Health will adopt the medical rate. Behavioral Health will cascade the rate down to the lower level providers using the following CMS guidelines and commensurate with level of training : *MD's (MH/SUD and medical/surgical) & Clinical Psychologists receive 100% of the rate. Nurse Practitioners, Physician Assistants and Certified Nurse Specialist (MH/SUD and medical/surgical) receives 85% of the new rate.** Master Level Clinical Social Workers providers receive 75% of the new rate.*** ** If the existing MH/SUD rate is higher than 85% of the new rate, the already existing rate stays in place *** If the existing MH/SUD rate is higher than the 75% of the new rate, the already existing rate stays in place The rates are effective at the same time as the new medical rates. MH/SUD rates can be updated in addition to the rate updates triggered by the Medical rate updates. As Written: XXXXX maintains uniform reimbursement practices that are equally applicable to MH/SUD and medical/surgical. In Operation: XXXXX 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. •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. Summary: XXXXX has confirmed that the our practices and policies in developing our XXXXX standard market fee schedules is comparable in that the fee schedules would not pay a MH/SUD provider less than a med/surg provider for submission of the same billing code. Plan Language: COC:	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of billing coding and process NQTL practices between medical/surgical and MH/SUD.

	Negotiated charge For health coverage, this is either: •The amount a network provider has agreed to accept •The amount we agree to pay directly to a network provider or third party vendor (including any administrative fee in the amount paid) for providing services, prescription drugs or supplies to plan members. This does not include prescription drug services from a network pharmacy. We may enter into arrangements with network providers or others related to: •The coordination of care for members •Improving clinical outcomes and efficiencies Some of these arrangements are called: •Value-based contracting •Risk sharing •Accountable care arrangements These arrangements will not change the negotiated charge under this plan. For prescription drug services from a network pharmacy: The amount we established for each prescription drug obtained from a network pharmacy under this plan. This negotiated charge may reflect amounts we agreed to pay directly to the network pharmacy or to a third party vendor for the prescription drug, and may include a rebate, an additional service or risk charge set by us. We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may not change the negotiated charge under this plan. SOB: No reference	
Case & Medical Management NQTL Practices	This entire section is not applicable. NQTLs are "treatment limitations" that are not numerical in nature but otherwise may limit the scope or duration of MH/SUD benefits. Case Management is a voluntary service to our members. There are no adverse consequences to the member if a member decides not to enroll or use information provided during case management.	This entire section is not applicable. NQTLs are "treatment limitations" that are not numerical in nature but otherwise may limit the scope or duration of MH/SUD benefits. Case Management is a voluntary service to our members. There are no adverse consequences to the member if a member decides not to enroll or use information provided during case management.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	XXXXXX has confirmed that the criteria for all Medical/Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for determining which services will be subject to NQTLs, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to Medical/Surgical benefits.	

Exhibit A

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (12) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices	As required by Conn. Gen. Stat. Sec. 38a-591c, XXXXXX uses ASAM criteria for review of MH/SUD services.	For Medical/Surgical services, XXXXXX utilizes internally created medical polices and clinical guidelines and MCG.
In-Patient & In-Network NQTL Practices	Based on discussions with the DOI, Column A is reflective of the specific categories otherwsise described within this as well as other NQTLs that may exist. XXXXXX did not identify any inconsistencies or differences other than those set forth in this document.	Same as for MH/SUD.
In-Patient & Out-of-Network NQTL Practices	Based on discussions with the DOI, Column A is reflective of the specific categories otherwsise described within this as well as other NQTLs that may exist. XXXXXX did not identify any inconsistencies or differences other than those set forth in this document. It should be noted that HMO plans do not cover Out-of-Network benefits unless an out-of-network referral is approved.	Same as for MH/SUD.
Out-Patient & In-Network NQTL Practices	Based on discussions with the DOI, Column A is reflective of the specific categories otherwsise described within this as well as other NQTLs that may exist. XXXXXX did not identify any inconsistencies or differences other than those set forth in this document.	Same as for MH/SUD.
Out-Patient & Out-of-Network NQTL Practices	Based on discussions with the DOI, Column A is reflective of the specific categories otherwsise described within this as well as other NQTLs that may exist. XXXXXX did not identify any inconsistencies or differences other than those set forth in this document. It should be noted that HMO plans do not cover Out-of-Network benefits unless an out-of-network referral is approved.	Same as for MH/SUD.
Emergency Services/Benefits NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. We do not do utilization review for any emergency service claims attributed to behavioral health conditions. However, if a member is admitted, they or their provider is requested to notify us as soon as possible so we can review the number of days that are medically necessary.	Same as for MH/SUD.

Rx Formulary Design, Management and Pharmacy Services NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. XXXXXX maintains a single committee that reviews drugs for the formulary regardless of whether the drug is used to cover medical/surgical and MH/SUD. The committee includes a psychiatrist. The same review process is used to determine whether to: 1) include a drug on the formulary; 2) identify a tier for the drug to be placed in; and 3) apply prior authorization, step therapy, and quantity limits.	Same as for MH/SUD.
Prior-Authorization NQTL Practices -	There are no non-comparable inconsistencies or differences in the application, as written and in operation. All inpatient admissions are required to be prior authorized. For outpatient services, we apply the same factors, sources and processes for determining the services that appear on our prior authorization list. There is no prior authorization penalty applied to a MH/SUD service that is not prior authorized.	Same as for MH/SUD. However, unlike MH/SUD, a provider may be penalized if a provider does not obtain a prior authorization.
Concurrent Review Benefit NQTL Practices	We identified two disparaties associated with concurrent review. However, those disparities are not a concern from a MHPAEA perspective. For inpatient, out-of-network and outpatient, in-and-out-of-network, there were significantly more concurrent reviews done for MH/SUD services than medical/surgical services (Please reference Exhibit 01.CCR CCR Chart). When the provider asks for approval after the care has started, XXXXXX considers such a request for concurrent review. For medical/surgical services, if an in-network medical/surgical provider fails to obtain a prior authorization for a service on the prior authorization list, the provider's payment may be reduced and the provider is not able to balance bill the member, which incentivizes these providers to submit prior authorization requests. This reduction does not apply to mental health and substance use disorder services/providers. Thus, XXXXXX is more generous to network MH/SUD providers than medical/surgical providers. Additionally, many higher level MH/SUD cases (RTC, PHP and IOP) may be initiated as a result of a crisis, which may not allow for prior authorization to occur. In the case of an inpatient or outpatient non-network provider, they most likely don't know they will be seeing the member until that first visit. Accordingly, it is appropriate for there to be more concurrent reviews done for MH/SUD than medical/surgical. Due to the disparity in the number of cases, as reflected in Exhibit 01.CCR Chart that skews the approval percentages for MH/SUD and medical surgical (e.g., individual inpatient, out of network - medical/surgical 21 cases approved, 3 denied as compared to MH/SUD 108 approved, 24 denied; group outpatient in-network - medical/surgical 1 case approved, 0 denied as compared to MH/SUD 320 approved, 7 denied). Thus, the disparity is not statistically significant.	See MH/SUD.
	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of retrospective review benefit NQTL benefit practices between medical/surgical and MH/SUD. XXXXXX conducts a retrospective review when a claim is submitted and it is determined that the service is on our prior authorization list and a prior authorization was not requested. Additionally, XXXXXX will conduct a retrospective review for services for which it maintains a medical policy or clinical UM guideline and	

Retrospective Review Benefit NQTL Practices	review for services for which it maintains a medical policy or clinical UM guideline and the service does not require a prior authorization. Because XXXXXX requires prior authorization of inpatient services, we expect to have very few retrospective reviews unless the provider fails to preauthorize care. In the case of outpatient services, we expect the numbers of retrospective reviews to be much higher for medical/surgical services. This is because the majority of XXXXXX's medical policies/clinical UM guidelines are for medical/surgical services. Also, a significant number of MH/SUD services are associated with outpatient office visits. XXXXXX does not maintain a medical policy/clinical UM guideline for those services so no utilization management review would be performed.	Same as for MH/SUD.
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. XXXXXX relies on the same resources for coding our claims systems for the appropriate processing of claims, e.g. CMS, CPT Coding Manual, etc.	Same as for MH/SUD.
Case & Medical Management NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. XXXXXX relies on the requirements of state and federal law and NCQA for its processes and procedures and routinely audits its staff to ensure those requirements are followed.	Same as for MH/SUD.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	XXXXXX did not identify any areas of concern with respect to its NQTL analysis. As noted above, we do have two areas of disparity. The first one is the source of the medical policies used to review cases for medical necessity. XXXXXX is required by law to use ASAM for medical necessity reviews, so that disparity is compliant with MHPAEA. The second disparity involved concurrent reviews in operation analysis. As explained above, although there may be significantly more concurrent reviews done for MH/SUD services, the rationale as to why that happens (no prior authorization penalty for MH/SUD providers, the nature of the cases are such that it is unlikely the providers know in advance to request prior authorization) is not adverse to the MH/SUD providers or members receiving such services. Although there is a disparity in the percentages of cases approved for MH/SUD services as compared to medical/surgical, the number of medical surgical services are so small the disparity is not statistically significant. Therefore, XXXXXX is compliant with respect to the above NQTLs.	

[redacted]

EXHIBIT 2
CONTINUED STAY/CONCURRENT REVIEW
CONNECTICUT FULLY INSURED

Inpatient, In-Network

Line of Business	Approved	Denied	Percentage Approved
Individual M/S	2173	187	92%
Individual MH/SUD	928	27	97%
Group M/S	3569	320	92%
Group MH/SUD	1166	31	97%

Inpatient, Out-of-Network

Line of Business	Approved	Denied	Percentage Approved
Individual M/S	21	3	87%
Individual MH/SUD	108	24	82%
Group M/S	52	8	87%
Group MH/SUD	219	16	93%

Outpatient, In-Network

Line of Business	Approved	Denied	Percentage Approved
Individual M/S	1	1	50%
Individual MH/SUD	249	2	99%
Group M/S	1	0	100%
Group MH/SUD	320	7	98%

[redacted]

Outpatient, Out-of-Network

Line of Business	Approved	Denied	Percentage Approved
Individual M/S	0	0	0%
Individual MH/SUD	28	1	97%
Group M/S	0	0	0%
Group MH/SUD	76	6	93%

Report run on June 7, 2021 (outpatient) and June 16, 2021 (inpatient) by Business Info Developer Cons Sr.

[redacted]

Exhibit A

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (12) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	The only distinction in the Development, Modification or Addition of Medical Necessity Criteria as between M/S and MH/SUD services is the use of "The ASAM Criteria®" when conducting medical necessity reviews of SUD services. Services Subject to Medical Necessity: All inpatient and outpatient M/S services, whether in-network or out-of-network must be medically necessary. Services determined by the Company not to be medically necessary would excluded under the terms of the plan. The Company employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. The Company Medical Directors apply the definition of "medical necessity" set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, the Company's standard definition of "medical necessity" is as follows: Medically Necessary/Medical Necessity Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization: • required to diagnose or treat an illness, Injury, disease or its symptoms; • in accordance with generally accepted standards of medical practice; • clinically ap+B12:H17propriate in terms of type, frequency, extent, site and duration; • not primarily for the convenience of the patient, Physician or other health care provider; • not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and • rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by The Company or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. Development of Clinical Criteria The Company utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCGTM Guidelines when conducting medical necessity reviews of M/S services, procedures, devices, equipment, imaging, diagnostic interventions. The only distinction between the Development, Modification or Addition of Medical Necessity Criteria as between M/S and MH/SUD services is that ASAM Criteria are used for SUD services. The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. While The Company's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies. Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.	The only distinction in the Development, Modification or Addition of Medical Necessity Criteria as between M/S and MH/SUD services is the use of "The ASAM Criteria®" when conducting medical necessity reviews of SUD services. Services Subject to Medical Necessity: All inpatient and outpatient MH/SUD services, whether in-network or out-of-network must be medically necessary. Services determined by the Company not to be medically necessary would excluded under the terms of the plan. The Company employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. The Company Medical Directors apply the definition of "medical necessity" set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, the Company's standard definition of "medical necessity" is as follows: Medically Necessary/Medical Necessity Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization: • required to diagnose or treat an illness, Injury, disease or its symptoms; • in accordance with generally accepted standards of medical practice; • clinically appropriate in terms of type, frequency, extent, site and duration; • not primarily for the convenience of the patient, Physician or other health care provider; • not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and • rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by The Company or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. Development of Clinical Criteria The Company utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCGTM Guidelines when conducting medical necessity reviews of MH services, procedures, devices, equipment, imaging, diagnostic interventions and the ASAM criteria for conducting medical necessity reviews of SUD services. The only distinction between the Development, Modification or Addition of Medical Necessity Criteria as between M/S and MH/SUD services is that ASAM Criteria are used for SUD services. The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. While The Company's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies. Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.

	Factors The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. MTAC's policy development processes entails assessing behavioral health M/S technologies based upon the following factors: • Clinical efficacy • Safety • Appropriateness of the proposed treatment Sources and Evidentiary Standards The Company's Coverage Policy Unit (CPU), in partnership with The Company's Medical Technology Assessment Committee, conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. The Medical Technology Assessment Committee's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in The Company's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009: • Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. • Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials. • Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies. • Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies. • Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. An "in operation" review of The Company's application of the medical necessity NQTL, specifically approvals and denials rates, for Prior Authorization, Retrospective Review, and Concurrent Review across benefit classifications for a sampling of The Company plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. An "in operation" review of The Company's application of the medical necessity NQTL, specifically approvals and denials rates, for Prior Authorization, Retrospective Review, and Concurrent Review across benefit classifications for a sampling of The Company plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits, with the In-Patient, In-Network classification MH/SUD reflecting a 1% denial rate and M/S had a 15% denial rate; In-Patient, Out-of-Network classification reflected a volume too small to be statistically significant. The Out-Patient, In-Network classification MH/SUD reflecting an 8% denial rate and M/S had a 20% denial rate; Out-Patient, Out-of-Network classification MH/SUD reflecting a 5% denial rate and M/S had a 30% denial rate While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, The Company concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. In performing the operational analysis of the application of UM, The Company reviewed denial rates for both M/S and MH/SUD within each classification of benefits and for benefits subject to prior authorization, concurrent review, and retrospective review.	Factors The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. MTAC's policy development processes entails assessing behavioral healthMH/SUD technologies based upon the following factors: • Clinical efficacy • Safety • Appropriateness of the proposed treatment Sources and Evidentiary Standards The Company's Coverage Policy Unit (CPU), in partnership with The Company's Medical Technology Assessment Committee, conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. The Medical Technology Assessment Committee's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in The Company's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009: • Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. • Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials. • Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies. • Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies. • Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. An "in operation" review of The Company's application of the medical necessity NQTL, specifically approvals and denials rates, for Prior Authorization, Retrospective Review, and Concurrent Review across benefit classifications for a sampling of The Company plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. An "in operation" review of The Company's application of the medical necessity NQTL, specifically approvals and denials rates, for Prior Authorization, Retrospective Review, and Concurrent Review across benefit classifications for a sampling of The Company plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits, with the In-Patient, In-Network classification MH/SUD reflecting a 1% denial rate and M/S had a 15% denial rate; In-Patient, Out-of-Network classification reflected a volume too small to be statistically significant. The Out-Patient, In-Network classification MH/SUD reflecting an 8% denial rate and M/S had a 20% denial rate; Out-Patient, Out-of-Network classification MH/SUD reflecting a 5% denial rate and M/S had a 30% denial rate While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, The Company concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. In performing the operational analysis of the application of UM, The Company reviewed denial rates for both M/S and MH/SUD within each classification of benefits and for benefits subject to prior authorization, concurrent review, and retrospective review.
In-Patient & In-Network NQTL Practices	The Company applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The Company applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
In-Patient & Out-of-Network NQTL Practices	The Company applies In-Patient & Out-of-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The Company applies In-Patient & Out-of-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
Out-Patient & In-Network NQTL Practices	The Company applies Out-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The Company applies Out-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
Out-Patient & Out-of-Network NQTL Practices	The Company applies Out-Patient & Out-of-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The Company applies Out-Patient & Out-of-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
Emergency Services/Benefits NQTL Practices	The Company's integrated medical and behavioral health plans have only one, single benefit for emergency room and urgent care. Accordingly, there are no differences between how coverage for M/S and MH/SUD emergency room and urgent care services.	The Company's integrated medical and behavioral health plans have only one, single benefit for emergency room and urgent care. Accordingly, there are no differences between how coverage for M/S and MH/SUD emergency room and urgent care services.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	The Company does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design for its Standard, Value, Advantage, Performance, and Legacy formularies.	The Company does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design for its Standard, Value, Advantage, Performance, and Legacy formularies.
Prior-Authorization NQTL Practices	The only distinction in utilization management practices as between M/S and MH/SUD services is the Company's use of Peer-To-Peer reviewers for MH/SUD services. Where the Company has identified any discrepancies in operational policies between MH/SUD and M/S benefits, the Company has assessed whether the discrepancies present a comparability or stringency problem within the context of the NQTL requirement. The Company has determined there are no discrepancies in operational policies as between MH/SUD and M/S benefits that present comparability or stringency issues. Instances where discrepancies between the process of administering MH/SUD and M/S benefits do not present an NQTL issue include, for example, situations where a discrepancy in process is more advantageous to the administration of MH/SUD benefits than M/S benefits. Specifically, for any coverage request for which the Company anticipates issuing a denial the Company incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a The Company clinician proactively solicit a peer-to-peer review with the rendering provider. This is a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to the Company. As noted, the proactive peer review protocol used for MH/SUD reviews is more beneficial to enrollees seeking coverage for MH/SUD services, so it does not present a comparability/stringency issue.	The only distinction in utilization management practices as between M/S and MH/SUD services is The Company's use of Peer-To-peer reviewers for MH/SUD services. Where The Company has identified any discrepancies in operational policies between MH/SUD and M/S benefits, The Company has assessed whether the discrepancies present a comparability or stringency problem within the context of the NQTL requirement. The Company has determined there are no discrepancies in operational policies as between MH/SUD and M/S benefits that present comparability or stringency issues. Instances where discrepancies between the process of administering MH/SUD and M/S benefits do not present an NQTL issue include, for example, situations where a discrepancy in process is more advantageous to the administration of MH/SUD benefits than M/S benefits. Specifically, for any coverage request for which The Company anticipates issuing a denial The Company incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a The Company clinician proactively solicit a peer-to-peer review with the rendering provider. This is a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to The Company. As noted, the proactive peer review protocol used for MH/SUD reviews is more beneficial to enrollees seeking coverage for MH/SUD services, so it does not present a comparability/stringency issue.

Peer clinical reviewers are available for a peer-to-peer discussion regarding a UM review determination when requested by a customer's attending physician or ordering provider. Peer-to-peer reviews are available for both M/S and MH/SUD services. Policies are in place to outline when peer-to-peer reviews are available, conversation criteria, procedures, compliance with state and federal laws and Medical Director Appeals information. A "physician reviewer" can be a "peer reviewer," and other types of clinicians, including nurses and psychologists, can be peer reviewers if the enrollee's treating provider that submits the utilization review request has the same license and specialty as the reviewer. These individuals are clinicians employed by The Company to conduct utilization reviews with the treating provider. The Company policies outline the qualifications necessary to render adverse benefit determinations based on medical necessity. The individual rendering an adverse benefit determination based on medical necessity must be a peer reviewer to the enrollee's treating provider. Process The process by which prior authorization is applied to M/S benefits is comparable and applied no more stringently to MH/SUD benefits. For a service subject to prior authorization, the enrollee's treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e., peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). The Company typically authorizes 1-4 medical/surgical or MH/SUD inpatient days upon pre-service review. Factors The strategy used to design and apply the prior authorization/precertification review NQTL to M/S benefits is ensuring appropriate utilization of services for benefit purposes and, as appropriate, care planning. When determining that M/S Inpatient, In-Network benefits are subject to pre-service medical necessity review (i.e., prior authorization/precertification), The Company conducted a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Treatment types subject to a higher potential for fraud, waste and/or abuse • Projected return on investment and/or savings if treatment type is subjected to pre-service review Sources • Internal claims data • UM program operating costs • UM authorization data • Expert Medical Review • Nationally recognized evidence-based guidelines Evidentiary Standards The Company has determined the value of subjecting all inpatient in-network M/S and MH/SUD services to prior authorization/precertification review must exceeds the administrative costs by at least 1:1. Clinical Appropriateness is defined as those services that as determined in the exercise of the professional judgement of The Company's internal medical experts, are in accordance with generally accepted standards of care and nationally recognized guidelines. Nationally recognized guidelines are included in The Company's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 as outlined in the development of clinical criteria of Medical Necessity. Because the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization). An "in operation" review of The Company's application of the Prior Authorization NQTL, specifically approvals and denial information, in the In-Patient, In-Network classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. An "in operation" review of The Company's application of the Prior Authorization NQTL, specifically approvals and denial information, in the In-Patient, In-Network classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits, with the In-Patient, In-Network classification MH/SUD reflecting a 1% denial rate and M/S had a 15% denial rate; In-Patient, Out-of-Network classification reflected a volume too small to be statistically significant. The Out-Patient, In-Network classification MH/SUD reflecting an 8% denial rate and M/S had a 20% denial rate; Out-Patient, Out-of-Network classification MH/SUD reflecting a 5% denial rate and M/S had a 30% denial rate. A review of concurrent review appeals data shows an analysis of the total out-of-network appeal overturn rate as-between inpatient MH/SUD and M/S services includes 89% for MH/SUD services and 71% for M/S. Appeals for Out of Network, Out Patient show 67% denial for MH/SUD and 25% denial for M/S. The volume of MH/SUD appeals was very small with 9 each for IP and OP. Consistent with the MH/SUD Peer-to-Peer process, the rate of appeals, where the original denial for lack of medical necessity was upheld, is higher for MH/SUD than for M/S claims. This appeal rate, coupled with the utilization management data which illustrates higher Medical Necessity denial rates for M/S claims than MH/SUD is representative of The Company's proactive approach to peer-to-peer reviews with the rendering provider as a more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is conducted reactively, i.e., if the rendering provider outreaches to The Company. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, The Company concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.	Peer clinical reviewers are available for a peer-to-peer discussion regarding a UM review determination when requested by a customer's attending physician or ordering provider. Peer-to-peer reviews are available for both M/S and MH/SUD services. Policies are in place to outline when peer-to-peer reviews are available, conversation criteria, procedures, compliance with state and federal laws and Medical Director Appeals information. A "physician reviewer" can be a "peer reviewer," and other types of clinicians, including nurses and psychologists, can be peer reviewers if the enrollee's treating provider that submits the utilization review request has the same license and specialty as the reviewer. These individuals are clinicians employed by The Company to conduct utilization reviews with the treating provider. The Company policies outline the qualifications necessary to render adverse benefit determinations based on medical necessity. The individual rendering an adverse benefit determination based on medical necessity must be a peer reviewer to the enrollee's treating provider. Process The process by which prior authorization is applied to M/S benefits is comparable and applied no more stringently to MH/SUD benefits. For a service subject to prior authorization, the enrollee's treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e., peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). The Company typically authorizes 1-4 medical/surgical or MH/SUD inpatient days upon pre-service review. Factors The strategy used to design and apply the prior authorization/precertification review NQTL to M/S benefits is ensuring appropriate utilization of services for benefit purposes and, as appropriate, care planning. When determining that M/S Inpatient, In-Network benefits are subject to pre-service medical necessity review (i.e., prior authorization/precertification), The Company conducted a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Treatment types subject to a higher potential for fraud, waste and/or abuse • Projected return on investment and/or savings if treatment type is subjected to pre-service review Sources • Internal claims data • UM program operating costs • UM authorization data • Expert Medical Review • Nationally recognized evidence-based guidelines Evidentiary Standards The Company has determined the value of subjecting all inpatient in-network M/S and MH/SUD services to prior authorization/precertification review must exceeds the administrative costs by at least 1:1. Clinical Appropriateness is defined as those services that as determined in the exercise of the professional judgement of The Company's internal medical experts, are in accordance with generally accepted standards of care and nationally recognized guidelines. Nationally recognized guidelines are included in The Company's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 as outlined in the development of clinical criteria of Medical Necessity. Because the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization). An "in operation" review of The Company's application of the Prior Authorization NQTL, specifically approvals and denial information, in the In-Patient, In-Network classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. An "in operation" review of The Company's application of the Prior Authorization NQTL, specifically approvals and denial information, in the In-Patient, In-Network classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits, with the In-Patient, In-Network classification MH/SUD reflecting a 1% denial rate and M/S had a 15% denial rate; In-Patient, Out-of-Network classification reflected a volume too small to be statistically significant. The Out-Patient, In-Network classification MH/SUD reflecting an 8% denial rate and M/S had a 20% denial rate; Out-Patient, Out-of-Network classification MH/SUD reflecting a 5% denial rate and M/S had a 30% denial rate. A review of concurrent review appeals data shows an analysis of the total out-of-network appeal overturn rate as-between inpatient MH/SUD and M/S services includes 89% for MH/SUD services and 71% for M/S. Appeals for Out of Network, Out Patient show 67% denial for MH/SUD and 25% denial for M/S. The volume of MH/SUD appeals was very small with 9 each for IP and OP. Consistent with the MH/SUD Peer-to-Peer process, the rate of appeals, where the original denial for lack of medical necessity was upheld, is higher for MH/SUD than for M/S claims. This appeal rate, coupled with the utilization management data which illustrates higher Medical Necessity denial rates for M/S claims than MH/SUD is representative of The Company's proactive approach to peer-to-peer reviews with the rendering provider as a more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is conducted reactively, i.e., if the rendering provider outreaches to The Company. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, The Company concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

Concurrent Review Benefit NQTL Practices	The only distinction in utilization management practices as between M/S and MH/SUD services is the Company's use of Peer-To-Peer reviewers for MH/SUD services. Where the Company has identified any discrepancies in operational policies between MH/SUD and M/S benefits, the Company has assessed whether the discrepancies present a comparability or stringency problem within the context of the NQTL requirement. The Company has determined there are no discrepancies in operational policies as between MH/SUD and M/S benefits that present comparability or stringency issues. Instances where discrepancies between the process of administering MH/SUD and M/S benefits do not present an NQTL issue include, for example, situations where a discrepancy in process is more advantageous to the administration of MH/SUD benefits than M/S benefits. Specifically, for any coverage request for which the Company anticipates issuing a denial the Company incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a Company clinician proactively solicit a peer-to-peer review with the rendering provider. This is a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to the Company. As noted, the proactive peer review protocol used for MH/SUD reviews is more beneficial to enrollees seeking coverage for MH/SUD services, so it does not present a comparability/stringency issue. Peer clinical reviewers are available for a peer-to-peer discussion regarding a UM review determination when requested by a customer's attending physician or ordering provider. Peer-to-peer reviews are available for both M/S and MH/SUD services. Policies are in place to outline when peer-to-peer reviews are available, conversation criteria, procedures, compliance with state and federal laws and Medical Director Appeals information. A "physician reviewer" can be a "peer reviewer," and other types of clinicians, including nurses and psychologists, can be peer reviewers if the enrollee's treating provider that submits the utilization review request has the same license and specialty as the reviewer. These individuals are clinicians employed by The Company to conduct utilization reviews with the treating provider. The Company policies outline the qualifications necessary to render adverse benefit determinations based on medical necessity. The individual rendering an adverse benefit determination based on medical necessity must be a peer reviewer to the enrollee's treating provider. Process Concurrent Care Review occurs when a facility/provider requests to extend an inpatient stay beyond the previously authorized length of stay or more frequently based upon review of the level of care and clinical criteria. In M/S benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). The Company typically authorizes 1-4 medical/surgical/S inpatient days upon concurrent care review. UM coverage determinations of M/S services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. The Company uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care, home care, and behavioral health care for coverage guidance in utilization review of services that are not addressed in a The Company medical, or co-branded coverage policy. Factors When determining which M/S inpatient benefits are subject to concurrent care medical necessity review, The Company conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Treatment types subject to a higher potential for fraud, waste and/or abuse • Projected return on investment and/or savings if treatment type is subjected to concurrent care review • Clinical Appropriateness of concurrent review resulting in optimal clinical outcomes. If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, and the concurrent review is clinically appropriate for the level of care according to the applicable clinical criteria of the services, the treatment type is subject to concurrent care medical necessity review. Sources • Industry accepted procedures codes developed by: o American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book o American Hospital Association (AHA) publication of revenue codes o American Formulary Association (AFA) publication of codes o Centers for Medicare and Medicaid Services (CMS) publication of codes • Internal claims data • UM program operating costs • UM authorization data • Expert Medical Review of Clinical Criteria • Nationally recognized evidence-based guidelines Evidentiary Standards If the benefit or value of conducting concurrent review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent medical necessity review (prior authorization). Clinical Appropriateness is defined as those services that as determined in the exercise of the professional judgement of The Company's internal medical experts, are in accordance with generally accepted standards of care and nationally recognized guidelines. Nationally recognized guidelines are included in The Company's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 as outlined in the development of clinical criteria of Medical Necessity.	The only distinction in utilization management practices as between M/S and MH/SUD services is The Company's use of Peer-To-Peer reviewers for MH/SUD services. Where The Company has identified any discrepancies in operational policies between MH/SUD and M/S benefits, The Company has assessed whether the discrepancies present a comparability or stringency problem within the context of the NQTL requirement. The Company has determined there are no discrepancies in operational policies as between MH/SUD and M/S benefits that present comparability or stringency issues. Instances where discrepancies between the process of administering MH/SUD and M/S benefits do not present an NQTL issue include, for example, situations where a discrepancy in process is more advantageous to the administration of MH/SUD benefits than M/S benefits. Specifically, for any coverage request for which The Company anticipates issuing a denial The Company incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a The Company clinician proactively solicit a peer-to-peer review with the rendering provider. This is a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to The Company. As noted, the proactive peer review protocol used for MH/SUD reviews is more beneficial to enrollees seeking coverage for MH/SUD services, so it does not present a comparability/stringency issue. Peer clinical reviewers are available for a peer-to-peer discussion regarding a UM review determination when requested by a customer's attending physician or ordering provider. Peer-to-peer reviews are available for both M/S and MH/SUD services. Policies are in place to outline when peer-to-peer reviews are available, conversation criteria, procedures, compliance with state and federal laws and Medical Director Appeals information. A "physician reviewer" can be a "peer reviewer," and other types of clinicians, including nurses and psychologists, can be peer reviewers if the enrollee's treating provider that submits the utilization review request has the same license and specialty as the reviewer. These individuals are clinicians employed by The Company to conduct utilization reviews with the treating provider. The Company policies outline the qualifications necessary to render adverse benefit determinations based on medical necessity. The individual rendering an adverse benefit determination based on medical necessity must be a peer reviewer to the enrollee's treating provider. Process Concurrent Care Review occurs when a facility/provider requests to extend an inpatient stay beyond the previously authorized length of stay or more frequently based upon review of the level of care and clinical criteria. In M/S benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). The Company typically authorizes 1-4 medical/surgical/S inpatient days upon concurrent care review. UM coverage determinations of M/S services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. The Company uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care, home care, and behavioral health care for coverage guidance in utilization review of services that are not addressed in a The Company medical, or co-branded coverage policy. Factors When determining which M/S inpatient benefits are subject to concurrent care medical necessity review, The Company conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Treatment types subject to a higher potential for fraud, waste and/or abuse • Projected return on investment and/or savings if treatment type is subjected to concurrent care review • Clinical Appropriateness of concurrent review resulting in optimal clinical outcomes. If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, and the concurrent review is clinically appropriate for the level of care according to the applicable clinical criteria of the services, the treatment type is subject to concurrent care medical necessity review. Sources • Industry accepted procedures codes developed by: o American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book o American Hospital Association (AHA) publication of revenue codes o American Formulary Association (AFA) publication of codes o Centers for Medicare and Medicaid Services (CMS) publication of codes • Internal claims data • UM program operating costs • UM authorization data • Expert Medical Review of Clinical Criteria • Nationally recognized evidence-based guidelines Evidentiary Standards If the benefit or value of conducting concurrent review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent medical necessity review (prior authorization). Clinical Appropriateness is defined as those services that as determined in the exercise of the professional judgement of The Company's internal medical experts, are in accordance with generally accepted standards of care and nationally recognized guidelines. Nationally recognized guidelines are included in The Company's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 as outlined in the development of clinical criteria of Medical Necessity.

	An "in operation" review of The Company's application of the Concurrent Review NQTL, specifically approvals and denial information, in the "Inpatient, In-Network" classification revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, The Company concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. A review of concurrent review appeals data shows an analysis of the total out-of-network appeal overturn rate as-between inpatient MH/SUD and M/S services includes 89% for MH/SUD services and 71% for M/S. Appeals for Out of Network, Out Patient show 67% denial for MH/SUD and 25% denial for M/S. The volume of MH/SUD appeals was very small with 9 each for IP and OP. Consistent with the MH/SUD Peer-to-Peer process, the rate of appeals, where the original denial for lack of medical necessity was upheld, is higher for MH/SUD than for M/S claims. This appeal rate, coupled with the utilization management data which illustrates higher Medical Necessity denial rates for M/S claims than MH/SUD is representative of The Company's proactive approach to peer-to-peer reviews with the rendering provider as a more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is conducted reactively, i.e., if the rendering provider outreaches to The Company. The Company's methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.	An "in operation" review of The Company's application of the Concurrent Review NQTL, specifically approvals and denial information, in the "Inpatient, In-Network" classification revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, The Company concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. A review of concurrent review appeals data shows an analysis of the total out-of-network appeal overturn rate as-between inpatient MH/SUD and M/S services includes 89% for MH/SUD services and 71% for M/S. Appeals for Out of Network, Out Patient show 67% denial for MH/SUD and 25% denial for M/S. The volume of MH/SUD appeals was very small with 9 each for IP and OP. Consistent with the MH/SUD Peer-to-Peer process, the rate of appeals, where the original denial for lack of medical necessity was upheld, is higher for MH/SUD than for M/S claims. This appeal rate, coupled with the utilization management data which illustrates higher Medical Necessity denial rates for M/S claims than MH/SUD is representative of The Company's proactive approach to peer-to-peer reviews with the rendering provider as a more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is conducted reactively, i.e., if the rendering provider outreaches to The Company. The Company's methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.
Retrospective Review Benefit NQTL Practices	The Company applies the Retrospective Review NQTL comparably and no more stringently to MH/SUD benefits than to M/S benefits.	The Company applies the Retrospective Review NQTL comparably and no more stringently to MH/SUD benefits than to M/S benefits.
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	The Company applies Clinical Procedure Coding, Billing Coding and Process NQTL practices comparably and no more stringently to MH/SUD benefits than to M/S benefits.	The Company applies Clinical Procedure Coding, Billing Coding and Process NQTL practices comparably and no more stringently to MH/SUD benefits than to M/S benefits.
Case & Medical Management NQTL Practices	Participation in case management services is not required, and an enrollee's participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. For medical management see peer to peer review information in Prior auth and Concurrent.	Participation in case management services is not required, and an enrollee's participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. For medical management see peer to peer review information in Prior auth and Concurrent.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	1. Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices. The Company has analyzed process, strategies, evidentiary standards and other factors used to apply Medical Necessity MH/SUD and M/S benefits and has determined compliance with parity requirements. The Company's medical necessity coverage policy development and application process is consistent between M/S and MH/SUD. The Company's Coverage Policy development and application is consistent. Coverage Policies are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, Coverage Policy Unit and the impetus of new, emerging and evolving technologies. Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. The application of the IRR process across MH/SUD and M/S benefits is itself evidence of the comparability of The Company's diligence in monitoring the utilization management process. Further, the aforementioned IRR results for MH/SUD and M/S benefits evidence comparability and equivalent stringency in the process of performing coverage reviews; specifically, The Company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits as well as substantial agreement across reviewers who participated in the assessment. The Company concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The Company applies comparable evidence-based guidelines to define established standards of effective care in both M/S and MH/SUD benefits. Consistency in policy development, process and application evidences compliance with the NQTL requirement that the medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services. Compliance is further demonstrated through the Company's uniform definition of Medical Necessity for M/S and MH/SUD benefits. In performing the operational analysis of the application of UM, The Company reviewed denial rates for both M/S and MH/SUD within each classification of benefits and for benefits subject to prior authorization, concurrent review, and retrospective review. 2. Prior-Authorization NQTL Practices The Company applies prior authorization NQTL consistently to M/S benefits and MH/SUD benefits across benefit classifications. For both in-network and out-of-network M/S and MH/SUD benefits, The Company requires prior authorization of non-emergent inpatient services and certain Outpatient services. In reaching this conclusion, The Company has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria. The process by which prior authorization is applied to M/S and MH/SUD inpatient, in-network benefits is comparable and applied no more stringently to MH/SUD inpatient benefits. Coverage determinations of both M/S services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, The Company's methodology for determining which MH/SUD services within a classification of benefits are subject to prior authorization is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to prior authorization. The Company's methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to prior authorization, as written in policy/procedure and in operation, as well as its pre-service medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation, reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits. An "in operation" review of The Company's application of the Prior Authorization NQTL, specifically approvals and denial information, in the In-Patient, In-Network and Out-of-Network classification, Outpatient, In-Network and Out-of-Network, All Other classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, The Company concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.	

	3. Concurrent Review Benefit NQTL Practices The Company has analyzed process, strategies, evidentiary standards and other factors used to apply Concurrent review to MH/SUD and M/S benefits and has determined compliance with parity requirements. First, comparability in process is evidenced in the plan's turnaround time requirements, as well. For urgent concurrent review requests received at least twenty-four hours before expiration of the then-current approval, The Company responds within twenty-four hours of receipt of the request for an extended approval for both MH/SUD and M/S benefits. Similarly, for non-urgent concurrent review requests, The Company issues claim determinations for both M/S and MH/SUD services across inpatient and outpatient classifications within fifteen days of receipt of a complete claim. Second, The factors, and accompanying evidentiary standard used to determine whether prior authorization will apply to an inpatient or outpatient service pursuant to the above-described process, namely the ROI metric and cost benefit analysis, is likewise uniform for MH/SUD and M/S benefits. The Company does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the prior authorization list. The Company's Coverage Policies are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, Coverage Policy Unit and the impetus of new, emerging and evolving technologies. Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. The application of the IRR process across MH/SUD and M/S benefits is itself evidence of the comparability of The Company's diligence in monitoring the utilization management process. Further, the aforementioned IRR results for MH/SUD and M/S benefits evidence comparability and equivalent stringency in the process of performing coverage reviews; specifically, the Company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits as well as substantial agreement across reviewers who participated in the assessment. Lastly, The Company has assessed comparability/equivalent stringency of application of concurrent review in operation by assessing denial rates for benefits subject to concurrent review, the purpose of which is to identify potential discrepancies in how stringently the NQTL is applied in-operation to MH/SUD and M/S benefits, respectively, that warrant further scrutiny. A review of this data revealed comparable denial rates and, on average, lower concurrent review denial rates for MH/SUD benefits across the inpatient and outpatient classifications. While the outcomes of application of an NQTL are not determinative of compliance with the NQTL in-operation requirement, similar outcomes in application of concurrent review are, in conjunction with the comparable written process employed to apply concurrent review, strongly indicative of comparability and equivalent stringency across medical and MH/SUD benefits and, ultimately, therefore compliance with the NQTL requirement. The Company's methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.

Exhibit A

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (12) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	External clinical criteria and sources used are appropriate for MH/SUD services (i.e., ®, ASAM, LOCUS, CASII, CALOCUS-CASII, ECSII). Both MH/SUD and M/S primarily use external criteria. M/S uses evidence-based, medical internal policy. MH/SUD uses other evidenced-based sources when external criteria are silent on a specific diagnosis/treatment and/or when a diagnosis/treatment is new or emerging and not addressed in existing external criteria (i.e., ®, ASAM, LOCUS, CASII, CALOCUS-CASII, ECSII).	External clinical criteria and sources used are appropriate for M/S (MCG). Both MH/SUD and M/S primarily use external criteria. M/S uses evidence-based, medical internal policy. MH/SUD uses other evidenced-based sources when external criteria are silent on a specific diagnosis/treatments and/or when a diagnosis/treatment is new or emerging and not addressed in existing external criteria (i.e., ®, ASAM, LOCUS, CASII, CALOCUS-CASII, ECSII).
In-Patient & In-Network NQTL Practices	Both MH/SUD and M/S require UM for inpatient admissions. The list of services varies based on the inherent nature of MH/SUD and M/S inpatient provider types. • Hospital admissions that are elective or not the result of an emergency • MH Non-Emergent and Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment	Both M/S and MH/SUD require UM for inpatient admissions. The list of services varies based on the inherent nature of M/S and MH/SUD inpatient provider types. • Hospital admissions that are elective or not the result of an emergency • Acute Inpatient • Rehabilitation facility admissions • Skilled nursing facility admissions • Sub-acute care admissions
In-Patient & Out-of-Network NQTL Practices	Both MH/SUD and M/S require UM for inpatient admissions. The list of services varies based on the inherent nature of MH/SUD and M/S inpatient provider types. • Hospital admissions that are elective or not the result of an emergency • MH Non-Emergent and Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment	Both M/S and MH/SUD require UM for inpatient admissions. The list of services varies based on the inherent nature of M/S and MH/SUD inpatient provider types. • Hospital admissions that are elective or not the result of an emergency • Acute Inpatient • Rehabilitation facility admissions • Skilled nursing facility admissions • Sub-acute care admissions
Out-Patient & In-Network NQTL Practices	MH/SUD and M/S require prior authorization for certain outpatient services. Requests for ongoing services after the end of the initial prior authorization require review. This review is labeled prior authorization for most M/S and concurrent review for Partial Hospitalization Program (PHP) and Intensive Outpatient Treatment Program (IOP), but is essentially the same process.	M/S and MH/SUD require prior authorization for certain outpatient services. Requests for ongoing services after the end of the initial prior authorization require review. This review is labeled prior authorization for most M/S and concurrent review for PHP and IOP, but is essentially the same process.

Out-Patient & Out-of-Network NQTL Practices	MH/SUD and M/S require prior authorization for certain outpatient services. Requests for ongoing services after the end of the initial prior authorization require review. This review is labeled prior authorization for most M/S and concurrent review for PHP and IOP, but is essentially the same process.	M/S and MH/SUD require prior authorization for certain outpatient services. Requests for ongoing services after the end of the initial prior authorization require review. This review is labeled prior authorization for most M/S and concurrent review for PHP and IOP, but is essentially the same process.
Emergency Services/Benefits NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S.	No distinction in any NQTL practice between MH/SUD and M/S.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S.	No distinction in any NQTL practice between MH/SUD and M/S.
Prior-Authorization NQTL Practices	MH/SUD and M/S require prior authorization for certain outpatient services. Requests for ongoing services after the end of the initial prior authorization require review. This review is labeled prior authorization for most M/S and concurrent review for PHP and IOP, but is essentially the same process.	M/S and MH/SUD require prior authorization for certain outpatient services. Requests for ongoing services after the end of the initial prior authorization require review. This review is labeled prior authorization for most M/S and concurrent review for PHP and IOP, but is essentially the same process.
Concurrent Review Benefit NQTL Practices	MH/SUD and M/S require prior authorization for certain outpatient services. Requests for ongoing services after the end of the initial prior authorization require review. This review is labeled prior authorization for most M/S and concurrent review for PHP and IOP, but is essentially the same process.	M/S and MH/SUD require prior authorization for certain outpatient services. Requests for ongoing services after the end of the initial prior authorization require review. This review is labeled prior authorization for most M/S and concurrent review for PHP and IOP, but is essentially the same process.
Retrospective Review Benefit NQTL Practices	For care that requires authorization and authorization was not received, MH/SUD allows preclaim retrospective review and post-claim retrospective review when clinical information is received. Claims submitted without clinical information would be denied and require appeal for clinical review.	For care that requires authorization and authorization was not received, M/S standard practice is denial and require appeal for clinical review, unless provider contract language allows preclaim retrospective clinical review.
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S.	No distinction in any NQTL practice between MH/SUD and M/S.
Case & Medical Management NQTL Practices	MH/SUD offers supportive case management, which is voluntary and not required to receive services. Accordingly, Case Management is not an NQTL.	M/S offers supportive case management, which is voluntary and not required to receive services. Accordingly, Case Management is not an NQTL.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	**The Plan performed a comparative analysis and concluded the factors, evidentiary standards, and source information used to apply MH/SUD NQTLs subjected to this parity review evidenced in the Exhibit A submission are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S. The single variation in the retrospective review process for a narrow scope of services between M/S and MH/SUD identified above will be aligned.**	

Exhibit A
Annual Mental Health and Substance Use Benefits Compliance Report
Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:
Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (12) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	Carrier did not identify any substantial disparities in its practices related to the development, modification or addition of medical necessity criteria, its medical appropriateness and level of care treatment practices suggesting a more restrictive practice was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Clinical criteria used to review medical necessity of MH/SUD services is different from the criteria used to review medical necessity of Med/Surg benefits. This not reflective of a more restrictive process, but instead, is due to the difference in clinical conditions that apply to MH/SUD and Med/Surg services. There is no substantial difference in Carrier's practices related to the development and use of medical necessity criteria, which is managed through Medical Management committees staffed with clinical experts and other business professionals responsible for developing, reviewing, assessing, and approving the clinical criteria used to make MH/SUD and Med/Surg medical necessity decisions (reviewed annually or more frequently, as appropriate). Carrier's plans use the same definition of medical necessity for MH/SUD and Med/Surg benefits and such definition is consistent with how it is defined under applicable Connecticut law. Carrier uses objective, evidenced-based clinical criteria developed externally and internally for both MH/SUD and Med/Surg medical necessity determinations. For MH/SUD benefits, nationally recognized ASAM, LOCUS, CASSII, CALOCUS-CASII and ECSII external criteria is used. When externally developed MH/SUD criteria is not available, internally developed evidence-based criteria is used for MH/SUD utilization reviews. For Med/Surg medical necessity reviews, Carriers uses internally developed evidence-based clinical criteria and nationally recognized, evidence-based external criteria published by InterQual. Internally evidence-based criteria is developed based upon analysis of published peer reviewed literature, input from internal clinicians and/or actively practicing clinicians and experts, and feedback from relevant business units. Staff making utilization management determinations participate in annual inter-rater-reliability (IRR) audits to ensure clinical policies, criteria and benefits are applied consistently and appropriately to ensure in-operation compliance. Although 2021 data is not yet available, the 2020 overall rate of inter-rater reliability for MH/SUD utilization review determinations was 98.4%, exceeding the target goal of 90%. These results indicate a high degree of consistency in MH/SUD utilization management decision making. For Med/Surg utilization mangagement, staff must acheive a passing score of 85% or greater, and the 2020 data showed that Med/Surg staff achieved a passing score of 85% or higher during their initial testing or as a result of individualized coaching and retesting.	Same as response in MH/SUD column.
In-Patient & In-Network NQTL Practices	Responses below apply to Inpatient In-Network NQTLs applicable to the subcategories in this report.	Responses below apply to Inpatient In-Network NQTLs applicable to the subcategories in this report.
In-Patient & Out-of-Network NQTL Practices	Responses below apply to Inpatient Out-of-Network NQTLs applicable to the subcategories in this report.	Responses below apply to Inpatient Out-of-Network NQTLs applicable to the subcategories in this report.
Out-Patient & In-Network NQTL Practices	Responses below apply to Outpatient In-Network NQTLs applicable to the subcategories in this report.	Responses below apply to Outpatient In-Network NQTLs applicable to the subcategories in this report.
Out-Patient & Out-of-Network NQTL Practices	Responses below apply to Outpatient Out-of-Network NQTLs applicable to the subcategories in this report.	Responses below apply to Outpatient Out-of-Network NQTLs applicable to the subcategories in this report.
Emergency Services/Benefits NQTL Practices	Emergency services do not require authorization either for MH/SUD or for Med/Surg services. Carrier applies the same notice requirement (2 business days) for notification of MH/SUD and Med/Surg inpatient admissions following emergency services. Carrier did not identify any substantial disparities in the comparative analyses of the 2021 emergency services data suggesting a more restrictive practice was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Carrier's 2021 MH/SUD and Med/Surg emergency services data showed the same low denial rate of 5.8%.	Same as response in MH/SUD column.
	Carrier's policies and procedures related to the formulary design and utilization management of pharmacy benefits consider similar factors, strategies and evidentiary	Same as response in MH/SUD column.

Rx Formulary Design, Management and Pharmacy Services NQTL Practices	standards, and are, as written and as applied, comparable and no more stringent for MH/SUD benefits than for medical/surgical benefits. Examples of factors considered include generally accepted standards of clinical practice, safety, efficacy, FDA approval and indications, contraindications, cost efficiency and utilization, dosing and dispensing standards, potential for overdose or abuse, prevalence for fraud, waste and abuse, and drug interactions. Examples of evidentiary standards and sources used to define such factors, include recognized medical literature, published clinical guidelines and standards, information published by pharmaceutical manufacturers, safety profile of medication, evidence-based empirical data and research studies, FDA approval and indications, national accreditation standards, market and competitive benchmark information, quality and clinical efficiency data, cost and trend data, state and federal requirements. The processes, strategies and evidentiary standards behind Carrier's pharmacy benefit utilization management requirements ensure that members have access to appropriate medically necessary, safe and effective and cost efficient MH/SUD and Med/Surg medications as described in the plan. With respect to formulary design, the majority of the MH/SUD prescriptions are offered on the lower cost tiers, which provides more access and minimizes the financial burden for members who need these prescriptions. For example, Carrier's 2021 formulary showed that more than half of the MH/SUD prescriptions are in Tier 1 or Tier 2. In addition, no disparities have been identified that suggest a more stringent utilization management process was applied to MH/SUD prescriptions as compared to Med/Surg prescriptions. The total drugs subject to utilization management (step therapy or prior authorization) on Carrier's formularies are comparable, with 13.59% of MH drugs on the 4 Tier formulary requiring step therapy or prior authorization and 12.86% of Med/Surg drugs requiring step therapy or prior authorization; and with 11.30% of MH drugs on the 5 Tier formulary requiring step therapy or prior authorization and 14.05% of Med/Surg drugs requiring step therapy or prior authorization of this formulary. Although the percentage of MH drugs with step therapy requirements is slightly higher (by 4.8%) when compared to Med/Surg drugs, this reflects Carrier's intent to use step therapy as an alternative, less restrictive utilization management protocol for MH drugs compared to the more restrictive, administratively burdensome prior authorization process. In fact, Carrier's rationale for selecting prescriptions that would be subject to step therapy in its 2021 formulary are consistent with the factors, sources, and processes outlined in the written policy, demonstrating application of such policy in operation. Specifically, the policy indicates that step therapy may be recommended when there is a logical succession of drug therapy for a particular Med/Surg or MH/SUD condition. Consistent with the policy, the rationale for applying step therapy to Carrier's 2021 MH/SUD and Med/Surg medications shows that there were multiple agents available for each of the Med/Surg and MH/SUD drugs selected for step therapy and that step therapy was applied where: (i) there were lower cost and equally effective alternatives (e.g. antidepressants (MH) and anticonvulsants (Med/Surg)), (ii) where there were clinical standards on what drugs should be used as the first line of therapy or is the mostly commonly used drug for particular conditions (e.g. psychotherapeutic and neurological agents/Misc. (MH) and antidiabetics (Med/Surg)), and (iii) where there was the need to monitor medical necessity (e.g. antidiabetic drugs).	
Prior-Authorization NQTL Practices	Carrier's policies and procedures related to its NQTLs, as written and as applied, are comparable and no more stringent for MH/SUD benefits than for med/surg benefits. In designing and applying utilization management protocols, Carrier considers similar factors, strategies and evidentiary standards. Examples of factors (which are not weighted) considered include utilization, cost, clinical efficacy, safety, quality (e.g. practice pattern variability), prevalence of fraud waste and abuse; and examples of evidentiary standards and sources used to define such factors, include recognized medical literature, published clinical guidelines and standards, evidence-based empirical data and research studies, national accreditation standards, market and competitive benchmark information, quality and clinical efficiency data, cost and trend data, claims and utilization data, state and federal requirements, and Medicare published data, policies and standards. Carrier uses prior authorization as a tool to ensure members receive medically appropriate care in the least restrictive setting that best meets the individual member's specific needs. Carrier did not identify any substantial disparities in the comparative analyses of the 2021 prior authorization requests suggesting a more restrictive prior authorization review process was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Carrier's 2021 clinical utilization review data (excluding pharmacy) showed there were 7,345 total prior authorization requests (in-network and out-of-network combined), such that 94% were for Med/Surg services and 6% were for MH/SUD services. Carrier's approval rate for such prior authorization requests showed that 96% of the MH/SUD requests were approved and 86% of the Med/Surg priori authorization request were approved. Similar results were found for in-network (INN) and out-of network (OON) prior authorization requests analyzed separately, showing: (i) 97% approval rate of INN MH/SUD reviews and 86% approval rate for INN Med/Surg reviews, and (ii) 84% approval rate of OON MH/SUD reviews and 75% approval rate of OON Med/Surg reviews.	Same as response in MH/SUD column.
Concurrent Review Benefit NQTL Practices	Carrier's policies and procedures related to its NQTLs, as written and as applied, are comparable and no more stringent for MH/SUD benefits than for med/surg benefits. In designing and applying utilization management protocols, Carrier considers similar factors, strategies and evidentiary standards. Examples of factors (which are not weighted) considered include utilization, cost, clinical efficacy, safety, quality (e.g. practice pattern variability), prevalence of fraud waste and abuse; and examples of evidentiary standards and sources used to define such factors, include recognized medical literature, published clinical guidelines and standards, evidence-based empirical data and research studies, national accreditation standards, market and competitive benchmark information, quality and clinical efficiency data, cost and trend data, claims and utilization data, state and federal requirements, and Medicare published data, policies and standards. Carrier uses concurrent review to ensure the member continues to receive, effective, medically necessary care while in active treatment and to ensure proper discharge and transition of care planning. Carrier did not identify any substantial disparities in the comparative analyses of the 2021 concurrent reviews suggesting a more restrictive concurrent review process was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Carrier's 2021 clinical utilization review data (excluding pharmacy), showed there were significantly fewer concurrent reviews for MH/SUD services as compared to Med/Surg services. Specifically, of the 1,032 total concurrent review, 72% were for Med/Surg services and only 28% were for MH/SUD services. Further, Carrier's data showed that 99% of concurrent reviews for MH/SUD services were approved and 82% of concurrent reviews were approved for Med/Surg services. Similar results were found for in-network (INN) and out-of network (OON) concurrent reviews analyzed separately, showing: (i) 100% approval rate of INN MH/SUD concurrent reviews and 82% approval rate for INN Med/Surg concurrent reviews, and (ii) 92% approval rate of OON MH/SUD concurrent reviews and 77% approval rate of OON Med/Surg concurrent reviews.	Same as response in MH/SUD column.
	Carrier's policies and procedures related to its NQTLs, as written and as applied, are comparable and no more stringent for MH/SUD benefits than for medical/surgical benefits.	Same as response in MH/SUD column.

Retrospective Review Benefit NQTL Practices	In designing and applying utilization management protocols, Carrier considers similar factors, strategies and evidentiary standards. Examples of factors (which are not weighted) considered include utilization, cost, clinical efficacy, safety, quality (e.g. practice pattern variability), prevalence of fraud waste and abuse; and examples of evidentiary standards and sources used to define such factors, include recognized medical literature, published clinical guidelines and standards, evidence-based empirical data and research studies, national accreditation standards, market and competitive benchmark information, quality and clinical efficiency data, cost and trend data, claims and utilization data, state and federal requirements, and Medicare published data, policies and standards. The retrospective review process provides members or providers with an opportunity for a post-service review of a request for coverage when the administrative authorization or notification requirements of the plan have not been met. Retrospective reviews are conducted to identify potential inappropriate utilization, clinical appropriateness of treatment, proper use of benefits, quality concerns, practice pattern variability, and/or provider education needs regarding procedural requirements. Carrier did not identify any substantial disparities in the comparative analyses of the 2021 retrospective reviews suggesting a more restrictive retrospective review process was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Carrier's 2021 clinical utilization review data (excluding pharmacy) showed there were significantly fewer retrospective reviews for MH/SUD as compared to Med/Surg services. Specifically, of the 2,752 total retrospective reviews, 99% were for Med/Surg services and only 1% were for MH/SUD services. Further, Carrier's data showed a 100% approval rate of retrospective reviews for MH/SUD services and a 38% approval rate for Med/Surg services. Similar results were found for in-network (INN) and out-of network (OON) retrospective review requests analyzed separately, showing: (i) 100% approval rate of INN MH/SUD reviews and 38% approval rate for INN Med/Surg reviews, and (ii) 100% approval rate of OON MH/SUD reviews and 20% approval rate of OON Med/Surg reviews.	
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	Carrier did not identify any substantial disparities in its practices related to the clinical procedure coding, billing coding and process NQTL practices. In designing and applying payment integrity protocols, Carrier considers similar factors, strategies and evidentiary standards for MH/SUD and Med/Surg benefits in designing payment integrity NQTLs, with such factors (which are not weighted) and sources defining the factors to include trends in and prevalence of fraud waste and abuse (e.g. claim outliers, unsual or inappropriate billing patterns, overutilization), industry standards, CMS published standards and policies, competitive information, clinical resources, internal claims analysis, medical record reviews, state and federal enforcement actions. Carrier's payment integrity process are intended to ensure appropriate billing for health care services, the appropriate administration of benefits under the health plan, including safeguarding plan assets, and to prevent, manage and detect billing and payment errors, and fraud, waste and abuse. Carrier's claims records of prepayment reviews initiated between January 1, 2021 and October 1, 2021 related to out of network professional services (rendered in any state) showed that, in all cases, MH/SUD and Med/Surg prepayment reviews were initiated based upon the factors and sources identified above, namely, the reviews were flagged by cross billing, upcoding, unusual or concerning billing patterns, claims outliers, and other known fraud schemes. Carrier's payment integrity processes for MH/SUD and Med/Surg benefits, as written and as applied, are comparable and no more stringent for MH/SUD benefits than for Med/Surg benefits.	Same as response in MH/SUD column.
Case & Medical Management NQTL Practices	Medical Management NQTLs: Please refer back to responses above under RX, Prior Authorization, Concurrent Review, and Retrospective Review NQTLs. When combining all utilization review protocols, Carrier's average approval rate of in-network utilization reviews for MH/SUD services was 99%, while the Med/Surg average approval rate was 68%. Carrier's average approval of out-of-network utilization reviews for MH/SUD services was 92%, while Med/Surg average approval was 57%. In addition, with respect to clinical (medical necessity) appeal requests, significantly fewer MH/SUD services were appealed as compared to Med/Surg services, demonstrating the initial utilization management determination for MH/SUD services was appropriate. Specifically, of the 80 total internal clinical appeals, 95% were Med/Surg appeals and only 5% were MH/SUD appeals. This is also consistent with what might be expected, since the overall approval rate for MH/SUD services at the initial utilization review request was higher than the approval rate for Med/Surg services. There was no substantial difference in the rate of denial (upholding plan's original denial) or overturned appeals for MH/SUD and Med/Surg clinical appeals. Carrier's rate of denial for clinical appeals was the same for MH/SUD and Med/Surg appeals and Carrier overturned slightly more clinical MH/SUD appeals than Med/Surg appeals. There were no clinical external clinical appeals filed for MH/SUD benefits, while there were 3 external clinical appeals filed for Med/Surg benefits. Case Management: Carrier's case management practices are not an NQTL under MHAPEA because these processes do not include benefit determinations and do not limit the scope or duration of benefits. Carrier makes case management services available to members for MH/SUD and Med/Surg services on a voluntary basis. Case management is separate and distinct from the Carrier's utilization management program and is made available to members regardless of the outcome of any benefit determination made separately through the utilization management process.	Same as response in MH/SUD column.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	Based on the foregoing, Carrier has demonstrated that its processes, strategies, evidentiary standards and other factors used to design and apply the NQTLs identified in this report, both as written and in operation, are comparable and no more stringently applied for MH/SUD benefits than for Med/Surg benefits. In designing and applying such NQTLs, Carrier considers similar factors, strategies and evidentiary standards and administers such NQTLs in a comparable manner. The following key points were considered in reaching Carrier's conclusion: 1. Following the definition under applicable Connecticut law, Carrier uses the same definition of medical necessity for MH/SUD and Med/Surg utilization reviews and uses objective, externally and internally developed evidence-based clinical criteria to make MH/SUD and Med/Surg utilization review decisions. Carrier's IRR testing demonstrated that clinical staff making utilization management decisions for MH/SUD benefits exceeded the testing goals, demonstrating in-operation application of the utilization management NQTLs was consistent with the written policies and health plan terms. 2. Carrier did not identify any substantial disparities in its NQTL practices suggesting a more restrictive practice was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. For example, when reviewing relevant records, Carrier found that its rationale for requiring certain MH/SUD and Med/Surg benefits to be subject to an NQTL was consistent with the rationale established under the written policies and procedures applicable to such NQTLs. This demonstrates consistent application of the NQTLs both as written and in-operation. In addition, approval rates for the various types of utilization review determinations were higher for MH/SUD benefits than for Med/Surg benefits for both in-network and out-of-network services and denial rates for emergency services was the same and very low. All of this demonstrates that the plan, as written and as applied, complies with MHPAEA.	

Exhibit A
Annual Mental Health and Substance Use Benefits Compliance Report
Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:
Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (12) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	1a) MH/SUD uses externally developed, evidenced based clinical criteria when making medical necessity determinations for technologies (e.g., services, interventions). MH/SUD external criteria includes ASAM, LOCUS, CASII, CALOCUS-CASII and ECSII. 1b) MH/SUD also uses internally developed evidence-based, medical necessity criteria (e.g., medical and clinical policies) when making medical necessity coverage determinations related to Mental Health/Substance Use Disorder (MH/SUD) technologies (e.g., services, interventions, devices, medically administered drugs, etc.) that fall outside the scope of the ASAM, LOCUS, CASII, CALOCUS-CASII and ECSII criteria and/or relate to advancements in technologies or types of care that are not addressed by the most recent versions of ASAM, LOCUS, CASII, CALOCUS-CASII and ECSII criteria. These are written specific to applicable MH/SUD services. 2) MH/SUD has committees and a structure that develops and approves medical policies/behavioral clinical policies and/or clinical criteria. For MH/SUD, the Clinical Technology Assessment Committee (CTAC) assesses and develops clinical policies which are reviewed and validated by the Clinical Quality and Operations Committee (CQOC). CTAC is comprised of board-certified psychiatrists, addictionologists, behavioral health professionals and clinical representatives from the Research & Evaluation organization. CQOC is comprised of, but is not limited to, Senior Behavioral Health Medical Directors, Senior Leaders of Clinical Operations and representatives from the following areas Clinical Quality Improvement Department, Utilization Management, Clinical Operations, Appeals, Legal, Compliance, Network Strategy, and Provider Experience. All medical/clinical policies are reviewed and/or updated at least once annually by both MH/SUD and M/S committees. 3) The MH/SUD clinical evidence hierarchies use the following formats with sources specific to behavioral services: - Well-designed evidence-based studies - Observational studies - Case studies - Consensus statements - Clinical and professional opinion papers	1a) M/S uses externally developed, evidenced based clinical criteria when making medical necessity determinations for technologies (e.g., services, interventions, devices, medically administered drugs, etc.). Current M/S external criteria includes InterQual. 1b) M/S uses internally developed evidence-based, medical necessity criteria (e.g., medical and clinical policies) when making medical necessity coverage determinations related to Medical/Surgical (M/S) technologies (e.g., services, interventions, devices, medically administered drugs, etc.) that fall outside the scope of the InterQual criteria and/or relate to advancements in technologies or types of care that are not addressed by the most recent versions of InterQual criteria. These are different as they are written specific to applicable the M/S service. 2) M/S has committees and a structure that develop and approve medical/clinical policies and/or clinical criteria. For M/S, the Medical Technology Assessment Committee (MTAC) is responsible for assessing and developinged medical/clinical policies. The MTAC informs the National Medical Care Management Committee (NMCMC) of any decisions for validation. MTAC is comprised of board-certified physicians representing diverse specialties and subspecialties. All medical/clinical policies are reviewed and/or updated at least once annually by both MH/SUD and M/S committees. 3) The M/S clinical evidence hierarchies use the following formats with sources specific to medical services: - Well-designed evidence-based studies - Observational studies - Case studies - Consensus statements - Clinical and professional opinion papers
In-Patient & In-Network NQTL Practices	MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. physician, RN, LPC, LISW, etc.) and all adverse determinations are made by Medical Directors. However, while different due to areas of expertise and specialty, they are comparable in areas such as criteria application training, supervision, and interrater reliability testing to make authorization decisions. MH/SUD employs staff in areas of expertise and specialty appropriate to make authorization determinations related to MH/SUD services.	M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. M/S employs staff in areas of expertise and specialty appropriate to make authorization determinations related to M/S services.
In-Patient & Out-of-Network NQTL Practices	MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. physician, RN, LPC, LISW, etc.) and all adverse determinations are made by Medical Directors. However, while different due to areas of expertise and specialty, they are comparable in areas such as criteria application training, supervision, and interrater reliability testing to make authorization decisions. MH/SUD employs staff in areas of expertise and specialty appropriate to make authorization determinations related to MH/SUD services.	M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. M/S employs staff in areas of expertise and specialty appropriate to make authorization determinations related to M/S services.
Out-Patient & In-Network NQTL Practices	MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. physician, RN, LPC, LISW, etc.) and all adverse determinations are made by Medical Directors. However, while different due to areas of expertise and specialty, they are comparable in areas such as criteria application training, supervision, and interrater reliability testing to make authorization decisions. MH/SUD employs staff in areas of expertise and specialty appropriate to make authorization determinations related to MH/SUD services.	M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. M/S employs staff in areas of expertise and specialty appropriate to make authorization determinations related to M/S services.

	For each of the (12) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps		
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits		
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***	
Out-Patient & Out-of-Network NQTL Practices	MH/SUD is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. physician, RN, LPC, LISW, etc.) and all adverse determinations are made by Medical Directors. However, while different due to areas of expertise and specialty, they are comparable in areas such as criteria application training, supervision, and interrater reliability testing to make authorization decisions. MH/SUD employs staff in areas of expertise and specialty appropriate to make authorization determinations related to MH/SUD services.	M/S is staffed by clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. M/S employs staff in areas of expertise and specialty appropriate to make authorization determinations related to M/S services.	
Emergency Services/Benefits NQTL Practices	Prior Authorization, Concurrent Review and Retrospective Review are not performed on Emergency Services. Emergency (ER) services for MH/SUD, which a layperson would consider an emergency (and as defined by the state), are covered without medical necessity. This would include MH/SUD services, (post-medical stabilization).	Prior Authorization, Concurrent Review and Retrospective Review are not performed on Emergency Services. Emergency (ER) services for M/S, which a layperson would consider an emergency, are covered without medical necessity.	
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical policies through one Pharmacy & Therapeutics (P&T) Committee. The P&T Committee assesses the prescription drug's place in therapy, and its relative safety and efficacy.	For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical policies through one Pharmacy & Therapeutics (P&T) Committee. The P&T Committee assesses the prescription drug's place in therapy, and its relative safety and efficacy.	
Prior-Authorization NQTL Practices	Inpatient Services: •MH Non-Emergent Acute Inpatient •MH Subacute Residential Treatment •SUD Acute Inpatient Detoxification •SUD Acute Inpatient Rehabilitation •SUD Subacute Residential Treatment Outpatient Services: •Partial Hospitalization/Day Treatment •Intensive Outpatient •Applied Behavioral Analysis (ABA) •Transcranial Magnetic Stimulation (TMS) •Electroconvulsive Therapy (ECT) •Psychological Testing •Community Based Detoxification	Inpatient Services: •Cerebral Seizure Monitoring – Inpatient Video EEG •Inpatient admissions – post-acute services Outpatient Services: •Ventricular Assist Devices •Arthroplasty •Arthroscopy •Bariatric •Bone Growth Stimulator •Breast Reconstruction (non-mastectomy) •Cancer supportive care •Cardiology •Cardiovascular •Cartilage Implants •Chemotherapy Services •Clinical Trials •Cochlear Implants and Other Auditory Implants •Congenital Heart Disease •Continuous Glucose Monitoring •Cosmetic and reconstructive procedures •Durable Medical Equipment (DME) over $1,000 •End-stage renal disease (ESRD) dialysis services •Foot Surgery •Functional Endoscopic Sinus Surgery (FESS) •Gender Dysphoria Treatment •Genetic and Molecular Testing to include BRCA gene testing	•Home Health Care – Non-nutritional •Hysterectomy (abdominal and laparoscopic surgeries) •Infertility •Injectable Medications •MR-guided focused ultrasound (MRgFUS) to threat uterine fibroid •Non-Emergency Air Transport •Orthognathic Surgery •Orthotics over $1,000 •Pain Management and Injection •Physical Therapy/Occupational Therapy (PT/OT) •Potentially unproven services (including experimental/investigational and/or linked services) •Prosthetics over $1,000 •Radiation Therapy •Radiology •Rhinoplasty •Sinuplasty •Site of Service – Office-based program •Site of Service – Outpatient hospital •Site of Service – Outpatient hospital expansion •Sleep Apnea Procedures & Surgeries •Sleep Studies •Spinal Cord Stimulators •Spinal Surgery •Stimulators – not related to spine •Transplant •Vein Procedures

	For each of the (12) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps		
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits		
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***	
Concurrent Review Benefit NQTL Practices	Inpatient Services: •All inpatient services for facilities reimbursed on a per diem basis Outpatient Services: •Partial Hospitalization/Day Treatment •Intensive Outpatient	Inpatient services: •All inpatient services for facilities reimbursed on a per diem basis. Outpatient services: •Cancer supportive care •Chemotherapy Services •Continuous Glucose Monitoring •Durable Medical Equipment (DME) over $1,000 •Home Health Care – Non-nutritional •Infertility •Injectable Medications •Intensity modulated radiation therapy (IMRT) •Pain Management and Injection •Physical Therapy/Occupational Therapy (PT/OT) •Proton Beam Therapy	
Retrospective Review Benefit NQTL Practices	Inpatient Services: •MH Non-Emergent Acute Inpatient •MH Subacute Residential Treatment •SUD Acute Inpatient Detoxification •SUD Acute Inpatient Rehabilitation •SUD Subacute Residential Treatment Outpatient Services: •Partial Hospitalization/Day Treatment •Intensive Outpatient •Applied Behavioral Analysis (ABA) •Transcranial Magnetic Stimulation (TMS) •Electroconvulsive Therapy (ECT) •Psychological Testing •Community Based Detoxification	Inpatient Services: •Cerebral Seizure Monitoring – Inpatient Video EEG •Inpatient admissions – post-acute services Outpatient Services: •Ventricular Assist Devices •Arthroplasty •Arthroscopy •Bariatric •Bone Growth Stimulator •Breast Reconstruction (non-mastectomy) •Cancer supportive care •Cardiology •Cardiovascular •Cartilage Implants •Chemotherapy Services •Clinical Trials •Cochlear Implants and Other Auditory Implants •Congenital Heart Disease •Continuous Glucose Monitoring •Cosmetic and reconstructive procedures •Durable Medical Equipment (DME) over $1,000 •End-stage renal disease (ESRD) dialysis services •Foot Surgery •Functional Endoscopic Sinus Surgery (FESS) •Gender Dysphoria Treatment •Genetic and Molecular Testing to include BRCA gene testing	•Home Health Care – Non-nutritional •Hysterectomy (abdominal and laparoscopic surgeries) •Infertility •Injectable Medications •MR-guided focused ultrasound (MRgFUS) to threat uterine fibroid •Non-Emergency Air Transport •Orthognathic Surgery •Orthotics over $1,000 •Pain Management and Injection •Physical Therapy/Occupational Therapy (PT/OT) •Potentially unproven services (including experimental/investigational and/or linked services) •Prosthetics over $1,000 •Radiation Therapy •Radiology •Rhinoplasty •Sinuplasty •Site of Service – Office-based program •Site of Service – Outpatient hospital •Site of Service – Outpatient hospital expansion •Sleep Apnea Procedures & Surgeries •Sleep Studies •Spinal Cord Stimulators •Spinal Surgery •Stimulators – not related to spine •Transplant •Vein Procedures
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	Procedure Coding Edits and Reimbursement Policies may differ among MH/SUD and M/S due to the nature of the claims, but the process of how the edits and policies are developed and applied are the same.	Procedure Coding Edits and Reimbursement Policies may differ among MH/SUD and M/S due to the nature of the claims, but the process of how the edits and policies are developed and applied are the same.	
Case & Medical Management NQTL Practices	Case management services are available, but not required. No limitations exist for case management services; therefore, case management is not considered to be a NQTL.	Case management services are available, but not required for certain chronic disease. No limitations exist for case management services; therefore, case management is not considered to be a NQTL.	

	For each of the (12) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
(STEP-5): A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.	The Plan conducted comparative analyses of the strategies, processes, factors, evidentiary standards, and source information for each of the 12 categories, to ensure MH/SUD is comparable to, and not more stringent than, M/S. The findings of the analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used by MH/SUD were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used by M/S. The Plan concluded the methodologies used by MH/SUD were comparable to, and applied no more stringently than, the methodologies used by M/S.	

Exhibit A

Annual Mental Health and Substance Use Benefits Compliance Report
Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (12) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	Except for pharmacy, XXXXXXXX delegates XXXXX to perform utilization review services including medical necesity determinations. XXXXX utilizes ASAM Criteria for determinations of medical necessity for Substance Use Disorder (SUD) requests. A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Medical Necessity Criteria, except for the ASAM criteria required for SUD as previously noted. The criteria are utilized to process other NQTLs, which have shown that MH/SUD services are reviewed in a manner equal to or no more stringently than M/S services.	Except for pharmacy, XXXXXXXX delegates XXXXX to perform utilization review services including medical necesity determinations. Other than the ASAM Criteria, which can only be utilized for SUD, XXXXX utilizes the same criteria sets, developed in an identical manner, for both medical/surgical (M/S) and mental health (MH) medical necessity reviews. A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Medical Necessity Criteria, except for the ASAM criteria required for SUD as previously noted. The criteria are utilized to process other NQTLs, which have shown that MH/SUD services are reviewed in a manner equal to or no more stringently than M/S services.
In-Patient & In-Network NQTL Practices	No differences	No differences
In-Patient & Out-of-Network NQTL Practices	No differences	No differences
Out-Patient & In-Network NQTL Practices	XXXXXX policies and processes for Out-Patient & In-Network NQTL practices are identical for M/S and MH/SUD. XXXXXXXX follows XXXXXX recommendations for which specific M/S benefits to place under NQTL practices (prior authorization, concurrent review and/or retrospective review) with the exception of the following. Due to XXXXXXXX having a young, healthier student membership, XXXXXXXX has determined that the following M/S benefits are not cost effective for NQTL practices and therefore do not require prior authorization, concurrent review and/or retrospective review: • Musculoskeletal and Pain Management • Sleep Management A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Outpatient In-Network NQTL practices. An in-operation analysis has shown that Outpatient In-Network MH/SUD services are reviewed in a manner equal to or no more stringently than Outpatient In-Network M/S services.	XXXXXX policies and processes for Out-Patient & In-Network NQTL practices are identical for M/S and MH/SUD. XXXXXXXX follows XXXXXX recommendations for which specific M/S benefits to place under NQTL practices (prior authorization, concurrent review and/or retrospective review) except for the following. XXXXXXXX has determined that outpatient MH/SUD benefits which do not fall under any M/S benefit are not cost effective for NQTL practices and therefore do not require prior authorization, concurrent review and/or retrospective review. For example, the following benefits would not require any NQTL practices: • Partial Hospitalization Program (PHP) • Intensive Outpatient Program (IOP) • Transcranial magnetic stimulation (TMS) Outpatient MH/SUD services that also fall under an M/S benefit would require NQTL practices. For example, outpatient surgery requires prior authorization and, if not authorized, retrospective review. Therefore, outpatient transgender surgeries such as mammoplasty or mastectomy, require the same NQTLs. A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Outpatient In-Network NQTL practices. An in-operation analysis has shown that Outpatient In-Network MH/SUD services are reviewed in a manner equal to or no more stringently than Outpatient In-Network M/S services.

Out-Patient & Out-of-Network NQTL Practices	XXXXXX policies and processes for Out-Patient & Out-Of-Network NQTL practices are identical for M/S and MH/SUD. XXXXXXXX follows XXXXXX recommendations for which specific M/S benefits to place under NQTL practices (prior authorization, concurrent review and/or retrospective review) with the exception of the following. Due to XXXXXXXX having a young, healthier student membership, XXXXXXXX has determined that the following M/S benefits are not cost effective for NQTL practices and therefore do not require prior authorization, concurrent review and/or retrospective review: • Musculoskeletal and Pain Management • Sleep Management A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Outpatient Out-Of-Network NQTL practices. An in-operation analysis has shown that Outpatient Out-Of-Network MH/SUD services are reviewed in a manner equal to or no more stringently than Outpatient Out-Of-Network M/S services.	XXXXXX policies and processes for Out-Patient & Out-Of-Network NQTL practices are identical for M/S and MH/SUD. XXXXXXXX follows XXXXXX recommendations for which specific M/S benefits to place under NQTL practices (prior authorization, concurrent review and/or retrospective review) except for the following. XXXXXXXX has determined that outpatient MH/SUD benefits which do not fall under any M/S benefit are not cost effective for NQTL practices and therefore do not require prior authorization, concurrent review and/or retrospective review. For example, the following benefits would not require any NQTL practices: • Partial Hospitalization Program (PHP) • Intensive Outpatient Program (IOP) • Transcranial magnetic stimulation (TMS) Outpatient MH/SUD services that also fall under an M/S benefit would require NQTL practices. For example, outpatient surgery requires prior authorization and, if not authorized, retrospective review. Therefore, outpatient transgender surgeries such as mammoplasty or mastectomy, require the same NQTLs. A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Outpatient Out-Of-Network NQTL practices. An in-operation analysis has shown that Outpatient Out-Of-Network MH/SUD services are reviewed in a manner equal to or no more stringently than Outpatient Out-Of-Network M/S services.
Emergency Services/Benefits NQTL Practices	No differences	No differences
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	Policies and processes for Rx Rormulary Design, Management and Pharmacy Services NQTL Practices are identical for M/S and MH/SUD, with the exception of the following. Some sources used in evaluating formulary design, PA, QL, and ST criteria include FDA Prescribing Information, professionally recognized treatment guidelines used to define clinically appropriate standards of care, nationally recognized Compendia - Truven Health Analytics Micromedex DrugDEX (DrugDEX), and peer-reviewed medical literature. A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Formulary Design, except for the ASAM criteria required for SUD as previously noted. An in-operation analysis has shown that MH/SUD prescribed medications are reviewed in a manner equal to or no more stringently than M/S prescribed medications.	Policies and processes for Rx Rormulary Design, Management and Pharmacy Services NQTL Practices are identical for M/S and MH/SUD, with the exception of the following. Some sources used in evaluating formulary design, PA, QL, and ST criteria include FDA Prescribing Information, professionally recognized treatment guidelines used to define clinically appropriate standards of care, such as ASAM criteria or APA treatment guidelines, nationally recognized Compendia - Truven Health Analytics Micromedex DrugDEX (DrugDEX), and peer-reviewed medical literature. A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Formulary Design, except for the ASAM criteria required for SUD as previously noted. An in-operation analysis has shown that MH/SUD prescribed medications are reviewed in a manner equal to or no more stringently than M/S prescribed medications.
	XXXXXX policies and processes for Prior Authorization practices are identical for M/S and MH/SUD. XXXXXXXX follows XXXXXX recommendations for which specific M/S benefits to place under Prior Authorization with the exception of the following. Due to XXXXXXXX having a young, healthier student membership, XXXXXXXX has determined that the following M/S benefits are not cost effective for NQTL practices and therefore do not require prior authorization: • Musculoskeletal and Pain Management	XXXXXX policies and processes for Prior Authorization practices are identical for M/S and MH/SUD. XXXXXXXX follows XXXXXX recommendations for which specific MH/SUS benefits to place under Prior Authorization except for the following. XXXXXXXX has determined that outpatient MH/SUD benefits which do not fall under any specific M/S benefit are not cost effective for Prior Authorization and therefore do not require prior authorization review. For example, the following benefits would not require any Prior Authorization:

Prior-Authorization NQTL Practices	~~Musculoskeletal and Pain Management~~ • Sleep Management A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Prior Authorization NQTL practices. An in-operation analysis has shown that Prior Authorization MH/SUD requests are reviewed in a manner equal to or no more stringently than Prior Authorization M/S requests.	~~Authorization.~~ • Partial Hospitalization Program (PHP) • Intensive Outpatient Program (IOP) • Transcranial magnetic stimulation (TMS) Outpatient MH/SUD services that also fall under an M/S benefit would require Prior Authorization. For example, outpatient surgery requires prior authorization. Therefore, outpatient transgender surgeries such as mammoplasty or mastectomy, require Prior Authorization. A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Prior Authorization NQTL practices. An in-operation analysis has shown that Prior Authorization MH/SUD requests are reviewed in a manner equal to or no more stringently than Prior Authorization M/S requests.
Concurrent Review Benefit NQTL Practices	All Inpatient services require Concurrent Review. The only differences between M/S and MH/SUD benefits that require Concurrent Review are the types of services contained within the category of "Inpatient." Both M/S and MH/SUD have benefits for "Acute Inpatient" and "Acute Rehabilitation", but "Inpatient Skilled Nursing" and "Inpatient Hospice are only available under the M/S benefit while "Residential" (considered an "Inpatient" service because it requires 24-hour health care facility professional supervision) is only available under the MH/SUD benefit. A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Concurrent Review NQTL practices. An in-operation analysis has shown that Concurrent Review MH/SUD requests are reviewed in a manner equal to or no more stringently than Concurrent Review M/S requests.	All Inpatient services require Concurrent Review. The only differences between M/S and MH/SUD benefits that require Concurrent Review are the types of services contained within the category of "Inpatient." Both M/S and MH/SUD have benefits for "Acute Inpatient" and "Acute Rehabilitation", but "Inpatient Skilled Nursing" and "Inpatient Hospice are only available under the M/S benefit while "Residential" (considered an "Inpatient" service because it requires 24-hour health care facility professional supervision) is only available under the MH/SUD benefit. A 5-step review demonstrated there is a single set of factors, evidentiary standards, sources, and written policies and procedures for both M/S and MH/SUD Concurrent Review NQTL practices. An in-operation analysis has shown that Concurrent Review MH/SUD requests are reviewed in a manner equal to or no more stringently than Concurrent Review M/S requests.
Retrospective Review Benefit NQTL Practices	No differences	No differences
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	No differences	No differences
Case & Medical Management NQTL Practices	No differences; XXXXXXXX does not utilize NQTLs on Case Management	No differences; XXXXXXXX does not utilize NQTLs on Case Management
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	**A review of XXXXXXXX and XXXXXX Policies and Procedures for all classifications and sub-classifications of NQTLs showed that the NQTLs are applied consistently to M/S benefits and MH/SUD benefits throughout all classifications and sub-classifications. The same policies and procedures are utilized in creating the NQTLs, choosing the benefits for each NQTL, and applying the review standards and processes. Any differences noted between the specific benefits for M/S and MH/SUD within any single classification or subclassification is due to the differences in the nature of M/S benefits versus MH/SUD benefits. For example, while both M/S and MH/SUD Inpatient benefits include Acute Inpatient and Inpatient Rehabilitation services, M/S covers Inpatient Skilled Nursing services while MH/SUD covers Residential Mental Health services. However, all Inpatient services, for both M/S and MH/SUD require Concurrent Review. Prior Authorization has similar differences, where only MH/SUD benefits that also fall under a broad M/S category, such as outpatient surgery or habilitative services, requires Prior Authorization. Utilizing these rules assures that XXXXXXXX is in compliance with the Mental Health Parity regulations.**	