Connecticut Nonquantitative Treatment Limitation (NQTL) Report

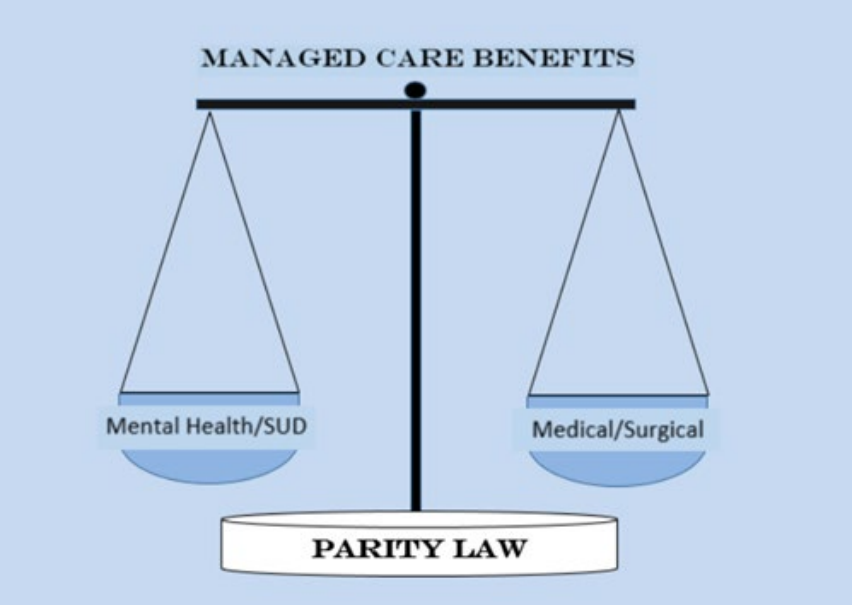
To

Insurance and Real Estate Committee

Presented by

Connecticut Insurance Department
Andrew N. Mais, Commissioner

April 12, 2024



Pursuant to CGS, Sec. 38a-477ee, the Connecticut Insurance Department is providing the 2024 report concerning nonquantitative treatment limitations submitted by pertinent insurers to the Commissioner ("Report").

The Report includes each NQTL report that the Insurance Commissioner received pursuant to Subsection (b) of 38a-477ee for calendar year 2023.

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.

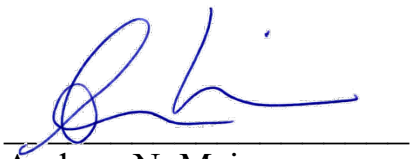
(2) A description of all medically necessary and administrative nonquantitative treatment limitations (NQTL's) applied to mental health and substance use disorder benefits and medical and surgical benefits.

(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. This has been enhanced to include (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.

This Report evaluates Benefit Limiting practices between mental health/substance use disorder benefits and medical/surgical benefits using Three (3) Parity Analysis Checkpoints, prospective analysis on the as-written benefit limiting outcomes, concurrent or operational analysis on the in-practice benefit limiting processes, and retrospective analysis on the operational outcomes of any benefit limiting impact whenever they produce substantially disparate outcome results.

We hope you find this report informative.

Respectfully,



Andrew N. Mais
Insurance Commissioner

Connecticut Nonquantitative Treatment Limitation Annual Report 2024
(Calendar Year 2023 Data)

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Connecticut Nonquantitative Treatment Limitation Annual Report-2023

I. Introduction

Pursuant to C.G.S. Section 38a-477ee, the Connecticut Insurance Department ("the Department") hereby submits its 2023 NQTL annual report to the General Assembly. Included are the various reports received by the Commissioner pursuant to Subsection (b) of CGS, Section 38a-477ee reflecting calendar year 2023 data.

II. Background

In 2019, the Connecticut legislature passed Public Act 19-159 (the "Act"), which, among other things, mandated that each health carrier was 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.

(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.

In accordance with the Act, 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 any and 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 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 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.

(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 to medical and surgical benefits. Carriers are also required to demonstrate that they have 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.

In addition to our statute applicable federal law, through the enactment of the Consolidation Appropriations Act imposed additional requirements. The Consolidated Appropriations Act 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, (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 NQTL's are an important tool in the management of healthcare, but it also specifically requires that these NQTL's 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's 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 report requires health insurers to conduct (3) points in-time comparative benefit limiting reviews whenever they differ between similar benefit classifications within mental health/substance use disorder benefits and medical/surgical benefits : (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 whenever actual outcome results are substantially disparate or non-comparative.

IV. Limitations of Analysis

The analysis is based on the 2023 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, in operation and with the outcome results.

Overall, health carriers have continued to provide a more extensive analysis of any MH/SUD and Med/Surg benefit differences. Based on the Department's initial assessment of the exhibits, it was observed that there were certain instances where insufficient information appears to have been provided. The Department plans to conduct targeted examinations specific to each carrier, based on the information that was submitted.

However, the Department did identify some NQTL disparate result or outcomes between the MH/SUD and Med/Surg benefits that resulted in possible parity non-compliance. After further review of the outcome data a determination was made that services provided were more limited for Med/Surg benefits. Also, the Department discovered that some parity compliance programs did maintain inconsistent analysis practices for certain classifications but that these

differences did not produce inequitable outcomes or rise to the level of requiring administrative action.

It should be noted that Insurers have maintained a high degree of cooperativeness and willingness with the department as we work to improve and advance the effectiveness of this program.

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 (1)

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, evidence-based external criteria published by independent third parties (i.e ASAM, InterQual, LOCUS, CASSII, CALOCUS-CASII and ECSII). 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. The most recent results on the overall rate of inter-rater reliability for MH/SUD utilization review determinations showed that 98.8% exceeded the target goal of 90%. These results indicate a high degree of consistency in MH/SUD utilization management decision making. For Med/Surg utilization management, staff must achieve a passing score of 85% or greater, and the most recent 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. In addition, to the above, the Carrier reviewed the total 2023 claim outcomes for services rendered to Connecticut members, including both administrative and clinical claim outcomes, for Med/Surg and MH/SUD services. The overall percentage of Med/Surg claims approved/paid was 54% and the overall percentage of MH/SUD claims approved/paid was 77%. These results further support that the Carrier's application of NQTLs is comparable and no more stringent for MH/SUD benefits than it is for Med/Surg benefits.	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	Carrier did not identify any substantial disparities in the comparative analyses of the 2023 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. 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's 2023 data showed there were no claims for MH/SUD emergency services provided to its members and that 88% of claims for Med/Surg emergency services were covered by Carrier.	Same as response in MH/SUD column.
Rx Formulary Design,	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	Same as response in MH/SUD column.

Management and Pharmacy Services NQTL Practices	for members who need these prescriptions. For example, Carrier's 2023 formulary showed that more than half of the MH/SUD prescriptions are in Tier 1 or Tier 2, while less than half of Med/Surg 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 32.31% of MH/SUD drugs on the Premium 4 Tier formulary requiring step therapy or prior authorization and 20.82% of Med/Surg drugs requiring step therapy or prior authorization; and with 30.95% of MH/SUD drugs on the Value 5 Tier formulary requiring step therapy or prior authorization and 22.03% of Med/Surg drugs requiring step therapy or prior authorization of this formulary. In 2023, Carrier applied age-related prior authorization protocols to select classes of medications to support quality utilization management programs based on FDA-approved labeling, clinical guidelines and standardized diagnostic tools utilized to provide treatment. For instance, in an effort to improve the safety of antidepressant utilization in the pediatric population, Carrier implemented a prior authorization program for antidepressant use in members 12 years of age and younger. This is because there are covered first line antidepressants that are FDA-approved for use in patients less than or equal to 12 years of age and/or recommended as a preferred treatment option for pediatrics and adolescents by clinical guidelines and expert opinion. For members over age 12, this age-related prior authorization requirement does not apply. Carrier also applies an age-related prior authorization requirement for certain medical prescriptions. For instance, Carrier requires prior authorization for topical retinoid medications used to treat acne and other conditions in patients 26 years or older. Since these quality utilization management programs apply to entire therapeutic classes of medications, the percentage of unique generic product identifiers (GPI-10s) may appear to be higher with behavioral health medications, as compared to Med/Surg unique GPI-10s. However, this is not indicative of a more restrictive process for behavioral health prescription benefits, but instead, reflects the differences in generally accepted clinical standards of care applicable to pediatric, adolescent and adult patients for certain medications based on FDA-approved labeling, clinical guidelines and standardized diagnostic tools utilized to provide treatment. Moreover, there are fewer unique GPI-10s managed by non-age-related utilization management protocols for MH/SUD prescriptions, as compared to Med/Surg prescriptions. Carrier continues to rely on FDA-approved labeling, expert opinion, clinical guidelines and standardized diagnostic tools to implement and maintain utilization management programs. In this case, Carrier demonstrated that those factors and standards (e.g., the clinical standards of care for pediatric and adolescent patients) were relied upon in applying utilization management protocols to MH/SUD and Med/Surg prescription benefits in 2023. Based on the foregoing, the results further support that the Carrier's application of NQTLs is comparable and no more stringent for MH/SUD pharmacy benefits than it is for Med/Surg pharmacy benefits.	
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 clinical appropriateness/clinical efficacy, variation in utilization patterns including underutilization or overutilization relative to clinical benchmarks, and the potential value for meaningful results from utilization management activity relative to the administrative cost. In addition, examples of evidentiary standards and sources used to define such factors, include recognized medical literature, evidence-based empirical data and research studies, quality and clinical efficiency data, state and federal requirements, publications by government sources and/or professional societies, utilization data, cost and trend data, and internal and external subject matter expert feedback. Carrier uses prior authorization to verify member eligibility, facilitate the appropriate utilization of services and facilitate coordination of care prior to services being provided. Prior authorization is used as a tool to ensure members receive medically appropriate care in accordance with the member's benefit plan. Carrier did not identify any substantial disparities in the comparative analyses of the 2023 prior authorization utilization management protocol 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 2023 clinical utilization review data (excluding pharmacy) showed there were 841 total prior authorization requests (in-network and out-of-network combined), 95% were for Med/Surg services and 5% were for MH/SUD services. Carrier's approval rate for such prior authorization requests showed that 83.6% of the Med/Surg requests were approved and 95% of the MH/SUD prior authorization requests were approved.	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 clinical appropriateness/clinical efficacy, variation in utilization patterns including underutilization or overutilization relative to clinical benchmarks, and the potential value for meaningful results from utilization management activity relative to the administrative cost. In addition, examples of evidentiary standards and sources used to define such factors, include recognized medical literature, evidence-based empirical data and research studies, quality and clinical efficiency data, state and federal requirements, publications by government sources and/or professional societies, utilization data, cost and trend data, and internal and external subject matter expert feedback. Carrier uses concurrent review to assess the continued medical necessity and appropriateness of utilization of services during care, and to facilitate coordination of care as appropriate, while service is ongoing. Concurrent review ensures the member continues to receive 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 2023 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 2023 clinical utilization review data (excluding pharmacy) showed there were 549 Concurrent review requests, 97.3% were for Med/Surg services and 2.7% were for MH/SUD services. Carrier's approval rate for these requests showed that 99.6% of the Med/Surg requests were approved and 100% of the MH/SUD concurrent review requests were approved.	Same as response in MH/SUD column.
Retrospective Review Benefit	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.

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 clinical appropriateness/clinical efficacy, variation in utilization patterns including underutilization or overutilization relative to clinical benchmarks, and the potential value for meaningful results from utilization management activity relative to the administrative cost. In addition, examples of evidentiary standards and sources used to define such factors, include recognized medical literature, evidence-based empirical data and research studies, quality and clinical efficiency data, state and federal requirements, publications by government sources and/or professional societies, utilization data, cost and trend data, and internal and external subject matter expert feedback. 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, quality concerns, and/or provider education needs regarding procedural requirements. Carrier did not identify any substantial disparities in the comparative analyses of the 2023 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 2023 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 total 213 retrospective reviews, 98.6% were for Med/Surg services and 1.4% were for MH/SUD services. Further, Carrier's data showed a 100% approval rate of retrospective reviews for MH/SUD services and a 13.8% approval rate for Med/Surg services.	
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. The Carrier's claims processing systems are configured based on industry standard claim processing methodologies. Carrier uses a variety of sources to configure claims systems for the appropriate processing of MH/SUD and Med/Surg claims, including the American Medical Association, the Centers for Medicare & Medicaid Services, the CPT Coding Manual and the Healthcare Common Procedures Coding system code set.	Same as response in MH/SUD column.
Case & Medical Management NQTL Practices	Medical Management NQTLs: Please refer back to responses above under RX/Formulary Design, Prior Authorization, Concurrent Review, and Retrospective Review NQTLs. Carrier did not identify any substantial disparities in the comparative analyses of the 2023 utilization management reviews suggesting a more restrictive utilization management process was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Carrier considers the same factors and sources in designing its NQTLs and follows comparable processes in administering its MH/SUD and Med/Surg benefits. Carrier also considers the same factors and sources in developing clinical criteria used to perform utilization management reviews. When combining all utilization review protocols, Carrier's average approval rate for MH/SUD services was higher than the average approval rate for Med/Surg services. In addition, of the 8 total internal clinical appeals received, 75% were Med/Surg appeals and 25% were MH/SUD appeals, with a consistent approval rate for MH/SUD and Med/Surg services (100% approval rate for MH/SUD appeals and 100% approval rate for Med/Surg appeals). There were no clinical external clinical appeals filed for MH/SUD benefits and there were 2 external clinical appeals filed for Med/Surg benefits with a 50% approval rate. This further demonstrates there were no substantial disparities in the utilization management procedures, including appeals, suggesting a more restrictive process, either as written or as applied, for MH/SUD benefits than for Med/Surg benefits. The low percentage of MH/SUD appeals also suggests accuracy and consistency in the initial utilization management process for such services, which is further corroborated by the Carrier's IRR scores. Case Management: The Carrier's Case Management practices are not an NQTL under MHPAEA because they do not result in benefit determinations and do not limit the scope or duration of benefits. Case Management services are available to members on a voluntary basis, and Case Management is separate and distinct from the Plan's Utilization Management program. The Plan's Case Management practices do not impose or influence a modification of a benefit determination or its scope or duration because Case Management is focused on educating members about best practices to manage their conditions, including with respect to transitions of care, coordination of care, medication adherence, necessary referrals, and follow-up appointments. For example, the Plan's Case Management teams will reach out to members who were recently discharged from the hospital to ensure that the members understand their discharge instructions and have any necessary medications. Case Management will also assist members with obtaining any required resources, such as medical equipment and supplies and appropriate home care. Case Management may also help members with getting referrals and appointments. The Carrier's Case Management program does not adversely impact the scope of care, treatment, or benefits delivered any differently than if patients had not participated in the case management practice.	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 follows consistent processes in the design of utilization management protocols and development of clinical criteria used in connection with such protocols. 2. Carrier's IRR testing demonstrated that clinical staff making utilization management decisions for MH/SUD benefits was high and exceeded the testing goals, demonstrating in-operation consistency and comparability with the written policies and plan terms related to NQTLs. 3. Carrier's overall rate of approved/paid claim outcomes for clinical and administrative claims were consistent among MH/SUD and Med/Surg services (higher for MH/SUD claims). 4. Carrier's overall approval rates for the various types of utilization review determinations were higher for MH/SUD benefits than for Med/Surg benefits. 5. Carrier's written processes demonstrate compliance with MHPAEA, as Carrier applies the same notification process for MH/SUD and Med/Surg emergency services. Carrier's 2023 data appliable to MH/SUD and Med/Surg emergency care also demonstrates in-operation compliance with MHPAEA. 6. Carrier's pharmacy benefit formulary tiering showed MH/SUD drugs generally on lower, less expensive tiers and consistency in the utilization management processes (prior authorization and step therapy) for pharmacy benefits, including consistency in factors and sources utilized by Carrier in applying utilization management protocols.	

EXHIBIT A (2a)

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 (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are <u>different</u> within the similarly Mapped Classifications and when compared <u>between the two benefits</u>. 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.	There are no practices that limit benefits that are different in regards to the development of medical necessity criteria. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.	There are no practices that limit benefits that are different in regards to the development of medical necessity criteria. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.
In-Patient & In-Network NQTL Practices	In-Patient & In-Network NQTL practices are applied consistently to M/S benefits and MH/SUD benefits.	In-Patient & In-Network NQTL practices are applied consistently to M/S benefits and MH/SUD benefits.
In-Patient & Out-of-Network NQTL Practices	In-Patient & Out-of-Network NQTL practices are applied consistently to M/S benefits and MH/SUD benefits.	In-Patient & Out-of-Network NQTL practices are applied consistently to M/S benefits and MH/SUD benefits.
Out-Patient & In-Network NQTL Practices	Out-Patient & In-Network NQTL practices are applied consistently to M/S benefits and MH/SUD benefits.	Out-Patient & In-Network NQTL practices are applied consistently to M/S benefits and MH/SUD benefits.
Out-Patient & Out-of-Network NQTL Practices	Out-Patient & Out-of-Network NQTL practices are applied consistently to M/S benefits and MH/SUD benefits.	Out-Patient & Out-of-Network NQTL practices are applied consistently to M/S benefits and MH/SUD benefits.
Emergency Services/Benefits NQTL Practices	There are no practices that limit benefits that are different in regards to the emergency services. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.	There are no practices that limit benefits that are different in regards to the emergency services. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.

Rx Formulary Design, Management and Pharmacy Services NQTL Practices	Rx formulary design, management, and pharmacy services are applied consistently to M/S benefits and MH/SUD benefits.	Rx formulary design, management, and pharmacy services are applied consistently to M/S benefits and MH/SUD benefits.
Prior-Authorization NQTL Practices	There are no practices that limit benefits that are different in regards to prior authorization decision-making. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.	There are no practices that limit benefits that are different in regards to prior authorization decision-making. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.
Concurrent Review Benefit NQTL Practices	There are no practices that limit benefits that are different in regards to concurrent review decision-making. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits	There are no practices that limit benefits that are different in regards to concurrent review decision-making. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.
Retrospective Review Benefit NQTL Practices	There are no practices that limit benefits that are different in regards to retrospective review decision-making. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.	There are no practices that limit benefits that are different in regards to retrospective review decision-making. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no practices that limit benefits that are different in regards to clinical procedure, billing coding and process. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.	There are no practices that limit benefits that are different in regards to clinical procedure, billing coding and process. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.
Case & Medical Management NQTL Practices	There are no practices that limit benefits that are different in regards to case and medical management NQTL practices. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.	There are no practices that limit benefits that are different in regards to case and medical management NQTL practices. The factors, sources, processes, evidentiary standards, and in-operation assessments are in alignment across classification of benefits.

Network Adequacy & Provider Reimbursement Rates	The companies consider the composition of its current M/S network providers and MH/SUD network providers by provider type and/or specialty, in addition to census (membership) data, to ensure that the company(ies) maintain an adequate M/S provider network and an adequate MH/SUD provider network to meet the clinical needs of its customers, contracted requirements and identified client expectations as applicable "Access" is the extent to which the company(ies) have providers of an appropriate type and number distributed geographically to meet the needs of members and "availability" is defined as the timeliness within which a member can obtain services by appointment (i.e, routine appointment within 10 business days for the initial visit, as prescribed by NCQA and 30 days for routine follow-up care, unless otherwise required by state law). The company(ies) conduct oversight and monitoring of the adequacy of its M/S provider network(s) and MH/SUD provider network to assess whether they are meeting its internal and regulatory driven network access standards. These reviews are done twice annually for MH/SUD benefits and not less than annually for M/S providers. When access to care standards are not met, each engage in active recruitment of the relevant provider type and/or specialty at issue. The company(ies) each maintain separate but aligned policies regarding measuring access and availability of providers and services. Such aligned policies include identical population and density parameters, including an identical calculation for provider to customer ratio and	The companies consider the composition of its current M/S network providers and MH/SUD network providers by provider type and/or specialty, in addition to census (membership) data, to ensure that the company(ies) maintain an adequate M/S provider network and an adequate MH/SUD provider network to meet the clinical needs of its customers, contracted requirements and identified client expectations as applicable "Access" is the extent to which the company(ies) has providers of an appropriate type and number distributed geographically to meet the needs of members and "availability" is defined as the timeliness within which a member can obtain services by appointment (i.e, routine appointment within 10 business days for the initial visit, as prescribed by NCQA and 30 days for routine follow-up care, unless otherwise required by state law). The company(ies) each conduct oversight and monitoring of the adequacy of its M/S provider network(s) and MH/SUD provider network to assess whether they are meeting its internal and regulatory driven network access standards. These reviews are done twice annually for MH/SUD benefits and not less than annually for M/S providers. When access to care standards are not met, each engage in active recruitment of the relevant provider type and/or specialty at issue. The company(ies) each maintain separate but aligned policies regarding measuring access and availability of providers and services. Such aligned policies include identical population and density parameters, including an identical calculation for provider to customer ratio and

	defined terms related to population density including urban, suburban and rural. The company(ies) conduct annual analysis of network adequacy requirements. The company(ies) acknowledge provider types are not identical, and cannot be made identical due to the inherent differences between M/S and MH/SUD provider services, credentialing and licensing requirements. The company(ies) use Quest Analytics software program to determine the distance between a participant and defined provider types and evaluate the availability of providers within the network. Availability standards are established by utilizing Federal and State standards and internal performance metrics for both the M/S and MH/SUD provider networks. The company(ies)'s M/S provider availability does not include facility to patient ratios while the company(ies)'s MH/SUD includes ratios for inpatient facilities, residential facilities and ambulatory programs and requires access to care standards for facilities within 25 miles of an urban setting, 30 miles of a suburban setting and 40 miles of a rural setting. While certain M/S providers are classified and tracked as high volume/high impact, MH/SUD does not create the same distinction because all MH/SUD providers are considered high impact. The company(ies) measures prescribers including MD, Nurse Practitioners, Physicians Assistants, Psychologists and Masters Level providers and each are considered high impact due to the critical importance of access. In plans without an out-of-network benefit, in the event an enrollee cannot secure a provider or appointment within a reasonable time/distance or with reasonable appointment availability the company(ies) will authorize out-of-network services at the in-network benefit level. Enrollees are able to receive assistance in locating a provider or appointment by contacting the phone number on the back of their ID card. As an additional way of ensuring meaningful access to services, the company(ies) also measures, consistent with NCQA standards, accessibility of care to MH/SUD providers annually using findings from enrollee surveys and complaints	defined terms related to population density including urban, suburban and rural. The companies conduct annual analysis of network adequacy requirements. The company(ies) acknowledge provider types are not identical, and cannot be made identical due to the inherent differences between M/S and MH/SUD provider services, credentialing and licensing requirements. The companies use Quest Analytics software program to determine the distance between a participant and defined provider types and evaluate the availability of providers within the network. Availability standards are established by utilizing Federal and State standards and internal performance metrics for both the M/S and MH/SUD provider networks. The company(ies)'s M/S provider availability does not include facility to patient ratios while the company(ies)'s MH/SUD includes ratios for inpatient facilities, residential facilities and ambulatory programs and requires access to care standards for facilities within 25 miles of an urban setting, 30 miles of a suburban setting and 40 miles of a rural setting. While certain M/S providers are classified and tracked as high volume/high impact, MH/SUD does not create the same distinction because all MH/SUD providers are considered high impact. The company(ies) measures prescribers including MD, Nurse Practitioners, Physicians Assistants, Psychologists and Masters Level providers and each are considered high impact due to the critical importance of access. In plans without an out-of-network benefit, in the event an enrollee cannot secure a provider or appointment within a reasonable time/distance or with reasonable appointment availability the company(ies) will authorize out-of-network services at the in-network benefit level. Enrollees are able to receive assistance in locating a provider or appointment by contacting the phone number on the back of their ID card. As an additional way of ensuring meaningful access to services, the company(ies) also measures, consistent with NCQA standards, accessibility of care to MH/SUD providers annually using findings from enrollee surveys and complaints and by measuring results against the accessibility standards

	and by measuring results against the accessibility standards and metrics. The company(ies) uses the continuous quality improvement (CQI) process to identify opportunities for improvement. The company(ies) has reviewed and rendered uniform, where appropriate, its M/S and MH/SUD network adequacy policies and procedures to ensure comparability across M/S and MH/SUD providers. These policies and procedures are reviewed at least annually to ensure the continued sufficiency of the standards in meeting enrollees' needs. The company(ies) uses a combined network adequacy policy and a similar reporting template is used for both M/S and MH/SUD benefits. Both MH/SUD and M/S negotiations are based upon provider and information availability at a single point in-time. Network adequacy standards (Network Need) is a contributing factor for both MH/SUD and M/S providers during a reimbursement negotiation. It is important to note that different providers and facilities have vastly different negotiating or so-called bargaining power. A provider's bargaining power depends on several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider. As expected, providers and facilities that for a variety of reasons have more bargaining power are able to negotiate higher reimbursement. The company(ies) measures accessibility of care to behavioral (prescriber and non-prescriber), PCP, and High- Impact/High-Volume SPC providers using findings from customer surveys and complaints, and by measuring results against the accessibility standards and metrics annually. The company(ies) uses the continuous quality improvement ("CQI") process to identify opportunities for improvement and when network adequacy gaps are identified and brought to the attention of the Behavioral Health Provider	and metrics. The company(ies) uses the continuous quality improvement (CQI) process to identify opportunities for improvement. The company(ies) has reviewed and rendered uniform, where appropriate, its M/S and MH/SUD network adequacy policies and procedures to ensure comparability across M/S and MH/SUD providers. These policies and procedures are reviewed at least annually to ensure the continued sufficiency of the standards in meeting enrollees' needs. The company(ies) uses a combined network adequacy policy and a similar reporting template is used for both M/S and MH/SUD benefits. Both MH/SUD and M/S negotiations are based upon provider and information availability at a single point in-time. Network adequacy standards (Network Need) is a contributing factor for both MH/SUD and M/S providers during a reimbursement negotiation. It is important to note that different providers and facilities have vastly different negotiating or so-called bargaining power. A provider's bargaining power depends on several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider. As expected, providers and facilities that for a variety of reasons have more bargaining power are able to negotiate higher reimbursement. The company(ies) measures accessibility of care to behavioral (prescriber and non-prescriber), PCP, and High- Impact/High-Volume SPC providers using findings from customer surveys and complaints, and by measuring results against the accessibility standards and metrics annually. The company(ies) uses the continuous quality improvement ("CQI") process to identify opportunities for improvement and when network adequacy gaps are identified and brought to the attention of the Behavioral Health Provider Operations Program Management Team (for either provider

	Operations Program Management Team (for either provider or facility). The companies monitor network adequacy on at least an annual basis and creates recruitment and corrective action plans to address any deficiencies. Recruitment activity may include targeted specialties, market specific initiatives, customer notifications and network adequacy corrective actions determined during annual review as well as Quality Management analysis of provider surveys and customer complaints related to access and availability. Recruitment plans to address network adequacy are developed and modified as needed throughout the year. The company(ies) is currently implementing processes to bolster action plans to recruit MH/SUD providers in areas of need, consistent with its focus on developing robust MH/SUD provider networks. In many instances, deficiencies are a result of insufficient availability of providers/facilities. Both MH/SUD and M/S networks are held to the same 90% standard. In most instances inability to meet the 90% threshold is related to insufficient provider availability. Lack of providers/facilities tends to impact behavioral more than medical. The company(ies) actively recruits providers in areas where there may be access deficiencies. In some cases, not enough providers exist in a given geographic area and thus the company(ies) cannot meet a network adequacy standard due to provider unavailability. In such situations, the company(ies) takes steps to ensure that an enrollee in a plan using this network would be able to receive medically necessary services from an out of network provider, and the services would be treated as in-network for purposes of cost-sharing or other requirements. If the company(ies) identifies a network adequacy deficiency, it attempts to remediate the deficiency. The identified potential provider may decline participation in the network or may not respond to recruitment efforts. If the company(ies) identifies a non-contracted provider needed for adequacy/accessibility, it may offer higher rates than what would otherwise be standard in order to close the gap.	or facility). The companies monitor network adequacy on at least an annual basis and creates recruitment and corrective action plans to address any deficiencies. Recruitment activity may include targeted specialties, market specific initiatives, customer notifications and network adequacy corrective actions determined during annual review as well as Quality Management analysis of provider surveys and customer complaints related to access and availability. Recruitment plans to address network adequacy are developed and modified as needed throughout the year. The company(ies) is currently implementing processes to bolster action plans to recruit MH/SUD providers in areas of need, consistent with its focus on developing robust MH/SUD provider networks. In many instances, deficiencies are a result of insufficient availability of providers/facilities. Both MH/SUD and M/S networks are held to the same 90% standard. In most instances inability to meet the 90% threshold is related to insufficient provider availability. Lack of providers/facilities tends to impact behavioral more than medical. The company(ies) actively recruits providers in areas where there may be access deficiencies. In some cases, not enough providers exist in a given geographic area and thus the company(ies) cannot meet a network adequacy standard due to provider unavailability. In such situations, the company(ies) takes steps to ensure that an enrollee in a plan using this network would be able to receive medically necessary services from an out of network provider, and the services would be treated as in-network for purposes of cost-sharing or other requirements. If the company(ies) identifies a network adequacy deficiency, it attempts to remediate the deficiency. The identified potential provider may decline participation in the network or may not respond to recruitment efforts. If the company(ies) identifies a non-contracted provider needed for adequacy/accessibility, it may offer higher rates than what would otherwise be standard in order to close the gap. NCQA does not prescribe goals for geo access. The

	NCQA does not prescribe goals for geo access. The company(ies) uses a 90% standard, which aligns with CMS network adequacy requirements, which require that 90% of customers have access to providers based on network adequacy access requirements for time and distance standards. Reimbursement Whether for initial negotiation or renegotiation, the company(ies) uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. The company(ies)'s preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, BH pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested. In determining any rate in both the M/S and MH/SUD facility agreements, the company(ies) assesses supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction	company(ies) uses a 90% standard, which aligns with CMS network adequacy requirements, which require that 90% of customers have access to providers based on network adequacy access requirements for time and distance standards. Reimbursement Whether for initial negotiation or renegotiation, the company(ies) uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. The company(ies)'s preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, BH pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested. In determining any rate in both the M/S and MH/SUD facility agreements, the company(ies) assesses supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; and customer complaint data. That is, the

	surveys; and customer complaint data. That is, the company(ies)'s reimbursement rate development and negotiation processes are ultimately designed to ensure achievement of its adequacy standards for MH/SUD and M/S providers, and any departure from the standard fee schedules is informed by market demand, which may include, for example, the need to maintain, or achieve, network adequacy for a provider type in a particular geographic area. Provider Reimbursement – Outpatient Reimbursement rates for in-network M/S and MH/SUD outpatient services are determined as follows: (1) CMS (Medicare) RVU (relative value units); (2) Ingenix data derived from practitioner charges, where available is used to fill gaps on procedure codes that do not have a Medicare rate; (3) Clinical Lab and Pathology codes, where applicable; (4) Site of Service (SOS) (e.g. office, facility); (5) Geographical Practice Cost Index (GPCI). For both M/S and MH/SUD services where there is no CMS rate or RVU nor vendor benchmark available, the final rate for a service covered by the contract is determined to be (1) billed charges for the service; (2) negotiated discount off of billed charges for the service during the contracting process. In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff participating in contract negotiation are trained on internal company policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard	company(ies)'s reimbursement rate development and negotiation processes are ultimately designed to ensure achievement of its adequacy standards for MH/SUD and M/S providers, and any departure from the standard fee schedules is informed by market demand, which may include, for example, the need to maintain, or achieve, network adequacy for a provider type in a particular geographic area. Provider Reimbursement – Outpatient Reimbursement rates for in-network M/S and MH/SUD outpatient services are determined as follows: (1) CMS (Medicare) RVU (relative value units); (2) Ingenix data derived from practitioner charges, where available is used to fill gaps on procedure codes that do not have a Medicare rate; (3) Clinical Lab and Pathology codes, where applicable; (4) Site of Service (SOS) (e.g. office, facility); (5) Geographical Practice Cost Index (GPCI). For both M/S and MH/SUD services where there is no CMS rate or RVU nor vendor benchmark available, the final rate for a service covered by the contract is determined to be (1) billed charges for the service; (2) negotiated discount off of billed charges for the service during the contracting process. In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff participating in contract negotiation are trained on internal company policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider-specific reimbursement requests

	methodologies, provider-specific reimbursement requests and escalate for justification and approval any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting process ensures by policy the consideration of such factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies. Facility Reimbursement – Inpatient In-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient's insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc. Per diem reimbursement for both M/S and MH/SUD facility-based services are based upon the following factors and accompanying evidentiary standards: (1) geographic market,	and escalate for justification and approval any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting process ensures by policy the consideration of such factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies. Facility Reimbursement – Inpatient In-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient's insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc. Per diem reimbursement for both M/S and MH/SUD facility-based services are based upon the following factors and accompanying evidentiary standards: (1) geographic market, which may be adjusted based upon Medicare Geographical

	which may be adjusted based upon Medicare Geographical Practice Cost Index ("GPCI"); (2) type of provider and/or specialty (e.g. physician practitioner v. non-physician practitioner v. facility); (3) supply of provider type and/or specialty; (4) network need and/or demand for provider type and/or specialty; (5) Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit ("RVU"); and (6) Training, experience and licensure of providers billing for professional services under the facility agreement. The company(ies)'s methodology and process for negotiating in-network provider reimbursements for M/S and MH/SUD services within a classification of benefits are comparable and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. The company(ies) also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, the company(ies)'s Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across medical/surgical and MH/SUD provider types.	Practice Cost Index ("GPCI"); (2) type of provider and/or specialty (e.g. physician practitioner v. non-physician practitioner v. facility); (3) supply of provider type and/or specialty; (4) network need and/or demand for provider type and/or specialty; (5) Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit ("RVU"); and (6) Training, experience and licensure of providers billing for professional services under the facility agreement. The company(ies)'s methodology and process for negotiating in-network provider reimbursements for M/S and MH/SUD services within a classification of benefits are comparable and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. The company(ies) also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, The company(ies)'s Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across medical/surgical and MH/SUD provider types.

Medical Necessity (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 underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA for the following reasons: 1. The factors, sources, and evidentiary standards used to develop medical necessity criteria are the same. 2. As written, the same process is employed when developing medical necessity criteria and the clinical advisory committee is responsible for developing and maintaining clinical guidelines and medical necessity criteria across M/S and MH/SUD benefits. 3. In-operation, the Plan performs in-operation data assessments to ensure that the underlying methodology for developing medical necessity criteria is applied no more stringently to MH/SUD services when compared to M/S services. Findings/Conclusion: The findings of the comparative analysis reveal that the methodology for medical necessity criteria development for MH/SUD benefits is comparable to, and applied no more stringently than, the methodology for medical necessity criteria for M/S benefits. When reviewing the inter-rater reliability testing scores for clinical-decision making in 2023, medical reviewers' and behavioral health reviewers' average IRR scores met the relative benchmarks of 95% and 95% respectively. Medical clinical reviewers scored an average IRR score of 95% for 2023, while behavioral health clinical reviewers scored an average IRR score of 95%. Inter-rater reliability testing is employed to ensure high quality, evidence-based decision making and consistent application of clinical criteria across its clinical UM staff. Since behavioral health clinical reviewers achieved an average score of 95% and medical clinical reviewers achieved an average score of 95%, there is evidence that reviewers apply consistent evidence-based decision making when rendering medical necessity determinations. Thus, the underlying processes, strategies, evidentiary standards and other factors as-written and in-operation used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA.
Prior Authorization (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 underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA for the following reasons: 1. The factors, sources, and evidentiary standards used to determine the methodology for assigning services to the prior authorization list is the same for MH/SUD benefits and M/S benefits. 2. As written, the same process is employed when rendering prior authorization decisions and for assigning services to the prior authorization list across MH/SUD benefits and M/S benefits.

	3. In-operation, the Plan performs in-operation data assessments to ensure that the underlying methodology for developing the prior authorization list is applied no more stringently to MH/SUD benefits when compared to M/S benefits. Across all categories of prior authorization, there are higher denial rates for prior authorizations for M/S services when compared to MH/SUD services using 2023 utilization review data. The outcome measures show that prior authorization methodologies are comparable (or in this case the outcome measures are more favorable to MH/SUD benefits) because the metrics reveal more favorable outcomes for MH/SUD benefits with higher rates of approval for services overall. This is a breakdown of the metric comparison used to compare the as-written prior authorization processes discussed above: For in-network inpatient, out-of-network inpatient, in-network outpatient other, out-of-network outpatient other, in-network outpatient office, and out-of-network outpatient office, the rate of denial when reviewing 2023 utilization review data across Plans reveals that the rate of denial is higher for M/S services when compared to MH/SUD services. Findings/Conclusion: The findings of the comparative analysis reveal that the process and methodology to apply prior authorization to MH/SUD benefits is comparable to, and applied no more stringently than, the process and methodology used to apply prior authorization to M/S benefits.
Concurrent Review (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 underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA for the following reasons: 1. The factors, sources, and evidentiary standards used to determine the methodology for assigning services to the concurrent review list is the same for MH/SUD benefits and M/S services. 2. As written, the same process is employed when rendering concurrent review decisions and for assigning services to the concurrent review list across MH/SUD benefits and M/S services. 3. In-operation, the Plan performs in-operation data assessments to ensure that the underlying methodology for developing the concurrent review list is applied no more stringently to MH/SUD services when compared to M/S services. Across all categories of concurrent review requests, there are higher denial rates for concurrent review for M/S benefits when compared to MH/SUD benefits. The outcome measures show that concurrent review methodologies are comparable (or in this case the outcome measures are more favorable to MH/SUD benefits) because the metrics reveal more favorable outcomes for MH/SUD benefits with higher rates of approval for services overall. For in-network inpatient, out-of-network inpatient, in-network outpatient other, out-of-network outpatient other, and in-network outpatient office and out-of-network outpatient office, the rate of denial when reviewing 2023 utilization review data across Plans reveals that the rate of denial is higher for M/S services when compared to MH/SUD services. Findings/Conclusion: The findings of the comparative analysis reveal that the process and methodology to apply concurrent review to MH/SUD benefits is comparable to, and applied no more stringently than, the process and methodology used to apply concurrent review to M/S benefits.

Retrospective Review (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 underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA for the following reasons: 1. The factors, sources, and evidentiary standards used to determine the methodology for assigning services to the retrospective review list is the same for MH/SUD benefits and M/S benefits. 2. As written, the same process is employed when rendering retrospective review decisions and for assigning services to the retrospective review list across MH/SUD benefits and M/S benefits. 3. In-operation, the Plan performs in-operation data assessments to ensure that the underlying methodology for developing the retrospective review list is applied no more stringently to mental health/substance use disorder services when compared to medical/surgical services. Across all categories of retrospective review requests, there are higher denial rates for retrospective review for M/S services when compared to MH/SUD services. The outcome measures show that retrospective review methodologies are comparable (or in this case the outcome measures are more favorable to MH/SUD benefits) because the metrics reveal more favorable outcomes for MH/SUD benefits with higher rates of approval for services overall. This is a breakdown of the metric comparison used to compare the as-written prior authorization processes discussed above: For in-network inpatient, out-of-network inpatient, in-network outpatient other, out-of-network outpatient other, in-network outpatient office, and out-of-network outpatient office, the rate of denial when reviewing 2023 utilization review data across Plans reveals that the rate of denial is higher for M/S services when compared to MH/SUD services. Findings/Conclusion: The findings of the comparative analysis reveal that the process and methodology to apply retrospective review to MH/SUD services is comparable to, and applied no more stringently than, the process and methodology used to apply retrospective review to M/S services.

Experimental/Investigational (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 underlying processes, strategies, evidentiary standards and other factors used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA for the following reasons: 1. The factors, sources, and evidentiary standards used to determine experimental/investigational services are the same. 2. As written, the same process is employed for experimental/investigational determinations and the clinical advisory committee is responsible for developing and maintaining clinical guidelines and medical necessity criteria across M/S benefits and MH/SUD benefits. 3. In-operation, the Plan performs in-operation data assessments to ensure that the underlying methodology for experimental/investigational determinations is applied no more stringently to MH/SUD benefits when compared to M/S benefits. Findings/Conclusion: The findings of the comparative analysis reveal that the methodology for experimental/investigational determinations for MH/SUD benefits is comparable to, and applied no more stringently than, the methodology for experimental/investigational determinations for M/S benefits. When reviewing the inter-rater reliability testing scores for clinical-decision making in 2023, medical clinical reviewers' and behavioral health clinical reviewers' average IRR scores met the relative benchmarks of 80% and 90% respectively. Medical clinical reviewers scored an average IRR score of 95% for 2023, while behavioral health clinical reviewers scored an average IRR score of 95% as well. Inter-rater reliability testing is employed to ensure high quality, evidence-based decision making and consistent application of clinical criteria across its clinical UM staff. Since behavioral health clinical reviewers achieved an average score of 95% and medical clinical reviewers achieved an average score of 95%, there is evidence that reviewers apply consistent evidence-based decision making when rendering medical necessity determinations. Thus, the underlying processes, strategies, evidentiary standards and other factors as-written and in-operation used to apply the NQTL to MH/SUD benefits and to M/S benefits have led the Plan to conclude compliance with MHPAEA.

EXHIBIT A (2b)

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 (13) 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.	Medical Necessity is defined 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	Medical Necessity is defined 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. • 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. 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, the company(ies) Medical Director or Review Organization may rely on the clinical coverage policies maintained by the company(ies) or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug	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. • 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. 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, the company(ies) Medical Director or Review Organization may rely on the clinical coverage policies maintained by the company(ies) 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(ies) utilizes its own internally developed coverage policies and the MCG™ Guidelines when conducting medical necessity reviews of M/S or Mental Health (MH) services, and the "The ASAM Criteria®" when conducting medical necessity reviews of Substance Use Disorder (SUD) services and technologies. As a point of clarification, the use of the various guidelines for clinical criteria/medical necessity (both external and internal) do not overlap and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, the company(ies) always applies MCG clinical criteria to MH services. Where MCG does not have clinical criteria for a specific MH service, the company(ies) has developed its own clinical criteria. Where a specific the company(ies) medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria® or	Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines." **Development of Clinical Criteria** The company(ies) utilizes its own internally developed coverage policies and the MCG™ Guidelines when conducting medical necessity reviews of M/S or Mental Health (MH) services, and the "The ASAM Criteria®" when conducting medical necessity reviews of Substance Use Disorder (SUD) services and technologies. As a point of clarification, the use of the various guidelines for clinical criteria/medical necessity (both external and internal) do not overlap and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, the company(ies) always applies MCG clinical criteria to MH services. Where MCG does not have clinical criteria for a specific MH service, the company(ies) has developed its own clinical criteria. Where a specific the company(ies) medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria® or

	MCG™ Guidelines as evidenced in the company(ies)'s Utilization Management Guidelines Policy. The company(ies)'s Coverage Policy Unit (CPU), in partnership with the company(ies)'s Medical Technology Assessment Committee ("MTAC"), 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 company(ies) maintains one policy applicable to the company(ies) (M/S) and the company(ies) (MH/SUD) that outlines the requirements for a consistent process in the development of evidence-based coverage policies for a wide variety of medical technologies. The process is further set forth herein. The MTAC develops clinical criteria to assist both M/S and MH/SUD medical directors in determining whether a technology is medically necessary, not medically necessary, or experimental, investigational, or unproven, based on an evaluation of peer reviewed, evidence based scientific literature, information from appropriate governing regulatory bodies (e.g. US Food and Drug Administration), and professional society recommendations." All internally developed coverage policies are posted publicly and shared upon request to providers and members. MCG Clinical	MCG™ Guidelines as evidenced in the company(ies)'s Utilization Management Guidelines Policy. The company(ies)'s Coverage Policy Unit (CPU), in partnership with the company(ies)'s Medical Technology Assessment Committee ("MTAC"), 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 company(ies) maintains one policy applicable to the company(ies) Healthcare (M/S) and the company(ies) (MH/SUD) that outlines the requirements for a consistent process in the development of evidence-based coverage policies for a wide variety of medical technologies. The process is further set forth herein. The MTAC develops clinical criteria to assist both M/S and MH/SUD medical directors in determining whether a technology is medically necessary, not medically necessary, or experimental, investigational, or unproven, based on an evaluation of peer reviewed, evidence based scientific literature, information from appropriate governing regulatory bodies (e.g. US Food and Drug Administration), and professional society recommendations." All internally developed coverage policies are posted publicly and

	Guidelines and/or ASAM Guidelines are also shared upon request. As all services under the benefit plan are subject to the plan definition of medical necessity, this definition applies to emergency and urgent services for M/S and MH/SUD services. Since the company(ies) does not include any Prior Authorization or utilization management of emergency or urgent care services for either M/S or behavioral health services, there are no additional criteria or guidelines that are used. **Factors** The company(ies) maintains medical necessity criteria (also referred to as clinical criteria) for all behavioral health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG, the American Society of Addiction Medicine ("ASAM") or are developed by the company(ies) from the comparison of national, scientific and evidenced based criteria sets. The company(ies)'s Medical Technology Assessment Committee ("MTAC") reviews clinical research and guidelines for new clinical procedures and technologies to determine whether	shared upon request to providers and members. MCG Clinical Guidelines and/or ASAM Guidelines are also shared upon request. As all services under the benefit plan are subject to the plan definition of medical necessity, this definition applies to emergency and urgent services for M/S and MH/SUD services. Since the company(ies) does not include any Prior Authorization or utilization management of emergency or urgent care services for either M/S or behavioral health services, there are no additional criteria or guidelines that are used. **Factors** The company(ies) maintains medical necessity criteria (also referred to as clinical criteria) for all behavioral health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG, the American Society of Addiction Medicine ("ASAM") or are developed by the company(ies) from the comparison of national, scientific and evidenced based criteria sets. The company(ies)'s Medical Technology Assessment Committee ("MTAC") reviews clinical research and guidelines for

	these services have demonstrated clinical efficacy or are still deemed experimental/investigational. The company(ies) reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process. The company(ies) requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all MH/SUD benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. 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. **Sources and Evidentiary Standards** The use of the various guidelines for clinical criteria/medical necessity (both external and internal) do not overlap and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific the company(ies) medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Coverage Policy Unit (CPU), in partnership with the company(ies)'s Medical Technology Assessment Committee ("MTAC"), 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,	new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. The company(ies) reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process. The company(ies) requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all MH/SUD benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. 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. **Sources and Evidentiary Standards** The use of the various guidelines for clinical criteria/medical necessity (both external and internal) do not overlap and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific the company(ies) medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Coverage Policy Unit (CPU), in partnership with the company(ies)'s Medical Technology Assessment Committee ("MTAC"), conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical

	technologies and pharmaceuticals. MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists. The company(ies)-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the "Behavioral Health" clinicians listed in the "Coverage Policy SME" tab – consulted when drafting or reviewing coverage policies). The MTAC'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(ies)'s "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in the company(ies)'s Medical Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48)): Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.	and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists. The company(ies)-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the "Behavioral Health" clinicians listed in the "Coverage Policy SME" tab – consulted when drafting or reviewing coverage policies). The MTAC'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(ies)'s "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in the company(ies)'s Medical Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48)): 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. The MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. All MH and SUD services, whether in-network or out-of-network, must be medically necessary as per review of MCG guidelines for M/H and ASAM for SUD. Services determined by the company(ies) not to be medically necessary would be excluded under the terms of the plan unless otherwise dictated by regulatory requirement or specific plan design.	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. The MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. All M/S and MH services, whether in-network or out-of-network, must be medically necessary as per review of MCG guidelines. Services determined by the company(ies) not to be medically necessary would be excluded under the terms of the plan unless otherwise dictated by regulatory requirement or specific plan design.
In-Patient & In-Network NQTL Practices	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The company(ies) 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(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.

Out-Patient & In-Network NQTL Practices	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
Out-Patient & Out-of-Network NQTL Practices	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
Emergency Services/Benefits NQTL Practices	The company(ies)'s integrated medical and behavioral health plans have a 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(ies)'s integrated medical and behavioral health plans have a 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(ies) 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(ies) 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(ies)'s use of a proactive Peer-To-Peer review for MH/SUD services. **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the company(ies) ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials. The company(ies)'s medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the company(ies)'s Clinical Coverage policies and plan documents approved for use in care management determinations. The company(ies)'s Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the company(ies)'s Clinical Coverage policies and plan documents for initial or prior authorization for level of	The only distinction in utilization management practices as between M/S and MH/SUD services is the company(ies)'s use of a proactive Peer-To-Peer review for MH/SUD services. **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the company(ies) ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials. The company(ies)'s medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the company(ies)'s Clinical Coverage policies and plan documents approved for use in care management determinations. The company(ies)'s Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the company(ies)'s Clinical Coverage policies and plan documents for initial or prior authorization for level of

	care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the company(ies) anticipates issuing a denial the company(ies) 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. After completing the peer-to-peer review with the rendering provider, the company(ies) Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the company(ies) Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the company(ies) clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the company(ies)'s pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The company(ies)'s pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in 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(ies).	care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the company(ies) anticipates issuing a denial the company(ies) incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a company(ies) clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the company(ies) Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the company(ies) Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the company(ies) clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the company(ies)'s pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The company(ies)'s pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in 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(ies).

Concurrent Review Benefit NQTL Practices	The only distinction in utilization management practices as between M/S and MH/SUD services is the company(ies)'s use of a proactive Peer-To-Peer review for MH/SUD services. **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the company(ies) ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials. The company(ies)'s medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the company(ies)'s Clinical Coverage policies and plan documents approved for use in care management determinations. The company(ies)'s Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the company(ies)'s Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower	The only distinction in utilization management practices as between M/S and MH/SUD services is The company(ies)'s use of a proactive Peer-To-Peer review for MH/SUD services. **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the company(ies) ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials. The company(ies)'s medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the company(ies)'s Clinical Coverage policies and plan documents approved for use in care management determinations. The company(ies)'s Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the company(ies)'s Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower

	level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the company(ies) anticipates issuing a denial the company(ies) incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a company(ies) clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the company(ies) Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the company(ies) Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the company(ies) clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the company(ies)'s pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The company(ies)'s pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in 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(ies).	level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the company(ies) anticipates issuing a denial the company(ies) incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a company(ies) clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the company(ies) Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the company(ies) Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the company(ies) clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the company(ies)'s pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The company(ies)'s pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in 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(ies).

Retrospective Review Benefit NQTL Practices	The company(ies) applies the Retrospective Review NQTL comparably and no more stringently to MH/SUD benefits than to M/S benefits.	The company(ies) 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(ies) 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(ies) 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.
Network Adequacy & Provider Reimbursement Rates	The company(ies) consider the composition of its current M/S network providers and MH/SUD network providers by provider type and/or specialty, in addition to census (membership) data, to ensure that the company(ies) maintain an adequate M/S provider network and an adequate MH/SUD provider network to meet the clinical needs of its customers, contracted requirements and identified client expectations as applicable "Access" is the extent to which the company(ies) has providers of an appropriate type and number distributed geographically to meet the needs of members and "availability" is defined as the timeliness within which a member can obtain services by appointment (i.e, routine appointment within 10 business days for the initial visit, as prescribed by NCQA and 30 days for routine follow-up care, unless otherwise required by state law). The company(ies) each conduct oversight and monitoring of the adequacy of its M/S provider network(s) and MH/SUD provider network to assess whether they are meeting its internal and regulatory driven network access standards. These reviews are done twice annually for MH/SUD benefits and not less than annually for M/S providers. When	The company(ies) consider the composition of its current M/S network providers and MH/SUD network providers by provider type and/or specialty, in addition to census (membership) data, to ensure that the company(ies) maintain an adequate M/S provider network and an adequate MH/SUD provider network to meet the clinical needs of its customers, contracted requirements and identified client expectations as applicable "Access" is the extent to which the company(ies) has providers of an appropriate type and number distributed geographically to meet the needs of members and "availability" is defined as the timeliness within which a member can obtain services by appointment (i.e, routine appointment within 10 business days for the initial visit, as prescribed by NCQA and 30 days for routine follow-up care, unless otherwise required by state law). The company(ies) each conduct oversight and monitoring of the adequacy of its M/S provider network(s) and MH/SUD provider network to assess whether they are meeting its internal and regulatory driven network access standards. These reviews are done twice annually for MH/SUD benefits and not less than annually for M/S providers. When

	access to care standards are not met, each engage in active recruitment of the relevant provider type and/or specialty at issue.The company(ies) each maintain separate but aligned policies regarding measuring access and availability of providers and services. Such aligned policies include identical population and density parameters, including an identical calculation for provider to customer ratio and defined terms related to population density including urban, suburban and rural. The company(ies) conduct annual analysis of network adequacy requirements. The company(ies) acknowledge provider types are not identical, and cannot be made identical due to the inherent differences between M/S and MH/SUD provider services, credentialing and licensing requirements. The company(ies) use Quest Analytics software program to determine the distance between a participant and defined provider types and evaluate the availability of providers within the network. Availability standards are established by utilizing Federal and State standards and internal performance metrics for both the M/S and MH/SUD provider networks. The company(ies)'s M/S provider availability does not include facility to patient ratios while the company(ies)'s MH/SUD includes ratios for inpatient facilities, residential facilities and ambulatory programs and requires access to care standards for facilities within 25 miles of an urban setting, 30 miles of a suburban setting and 40 miles of a rural setting. While certain M/S providers are classified and	access to care standards are not met, each engage in active recruitment of the relevant provider type and/or specialty at issue.The company(ies) each maintain separate but aligned policies regarding measuring access and availability of providers and services. Such aligned policies include identical population and density parameters, including an identical calculation for provider to customer ratio and defined terms related to population density including urban, suburban and rural. The company(ies) conduct annual analysis of network adequacy requirements. The company(ies) acknowledge provider types are not identical, and cannot be made identical due to the inherent differences between M/S and MH/SUD provider services, credentialing and licensing requirements. The company(ies) use Quest Analytics software program to determine the distance between a participant and defined provider types and evaluate the availability of providers within the network. Availability standards are established by utilizing Federal and State standards and internal performance metrics for both the M/S and MH/SUD provider networks. The company(ies)'s M/S provider availability does not include facility to patient ratios while the company(ies)'s MH/SUD includes ratios for inpatient facilities, residential facilities and ambulatory programs and requires access to care standards for facilities within 25 miles of an urban setting, 30 miles of a suburban setting and 40 miles of a rural setting. While certain M/S providers are classified and

	tracked as high volume/high impact, MH/SUD does not create the same distinction because all MH/SUD providers are considered high impact. The company(ies) measures prescribers including MD, Nurse Practitioners, Physicians Assistants, Psychologists and Masters Level providers and each are considered high impact due to the critical importance of access. In plans without an out-of-network benefit, in the event an enrollee cannot secure a provider or appointment within a reasonable time/distance or with reasonable appointment availability the company(ies) will authorize out-of-network services at the in-network benefit level. Enrollees are able to receive assistance in locating a provider or appointment by contacting the phone number on the back of their ID card. As an additional way of ensuring meaningful access to services, the company(ies) also measures, consistent with NCQA standards, accessibility of care to MH/SUD providers annually using findings from enrollee surveys and complaints and by measuring results against the accessibility standards and metrics. The company(ies) uses the continuous quality improvement (CQI) process to identify opportunities for improvement. The company(ies) has reviewed and rendered uniform, where appropriate, its M/S and MH/SUD network adequacy policies and procedures to ensure comparability across M/S and MH/SUD providers. These policies and procedures are reviewed at least annually to ensure the continued sufficiency of the standards in meeting enrollees' needs. The company(ies) uses a combined network adequacy policy and a similar reporting template is used for both M/S and MH/SUD benefits. Both MH/SUD and M/S negotiations are based upon provider and information availability	tracked as high volume/high impact, MH/SUD does not create the same distinction because all MH/SUD providers are considered high impact. The company(ies) measures prescribers including MD, Nurse Practitioners, Physicians Assistants, Psychologists and Masters Level providers and each are considered high impact due to the critical importance of access. In plans without an out-of-network benefit, in the event an enrollee cannot secure a provider or appointment within a reasonable time/distance or with reasonable appointment availability the company(ies) will authorize out-of-network services at the in-network benefit level. Enrollees are able to receive assistance in locating a provider or appointment by contacting the phone number on the back of their ID card. As an additional way of ensuring meaningful access to services, the company(ies) also measures, consistent with NCQA standards, accessibility of care to MH/SUD providers annually using findings from enrollee surveys and complaints and by measuring results against the accessibility standards and metrics. The company(ies) uses the continuous quality improvement (CQI) process to identify opportunities for improvement. The company(ies) has reviewed and rendered uniform, where appropriate, its M/S and MH/SUD network adequacy policies and procedures to ensure comparability across M/S and MH/SUD providers. These policies and procedures are reviewed at least annually to ensure the continued sufficiency of the standards in meeting enrollees' needs. The company(ies) uses a combined network adequacy policy and a similar reporting template is used for both M/S and MH/SUD benefits. Both MH/SUD and M/S negotiations are based upon provider and information availability

	at a single point in-time. Network adequacy standards (Network Need) is a contributing factor for both MH/SUD and M/S providers during a reimbursement negotiation. It is important to note that different providers and facilities have vastly different negotiating or so-called bargaining power. A provider's bargaining power depends on several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider.As expected, providers and facilities that for a variety of reasons have more bargaining power are able to negotiate higher reimbursement. The company(ies) measures accessibility of care to behavioral (prescriber and non-prescriber), PCP, and High-Impact/High-Volume SPC providers using findings from customer surveys and complaints, and by measuring results against the accessibility standards and metrics annually. The company(ies) uses the continuous quality improvement ("CQI") process to identify opportunities for improvement and when network adequacy gaps are identified and brought to the attention of the Behavioral Health Provider Operations Program Management Team (for either provider or facility). The company(ies) monitor network adequacy on at least an annual basis and creates recruitment and corrective action plans to address any deficiencies. Recruitment activity may include targeted specialties, market specific initiatives, customer notifications and network adequacy corrective actions determined during annual review as well as Quality Management analysis of provider surveys and customer complaints related to access and availability. Recruitment plans to address network adequacy are developed and modified as needed throughout the year. The company(ies) is currently implementing processes to bolster action plans to recruit MH/SUD providers in areas of need, consistent with its focus on developing robust MH/SUD provider networks. In many instances, deficiencies are a result of insufficient availability of providers/facilities. Both MH/SUD and M/S networks are held to the same 90% standard. In most instances inability to meet the	at a single point in-time. Network adequacy standards (Network Need) is a contributing factor for both MH/SUD and M/S providers during a reimbursement negotiation. It is important to note that different providers and facilities have vastly different negotiating or so-called bargaining power. A provider's bargaining power depends on several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider.As expected, providers and facilities that for a variety of reasons have more bargaining power are able to negotiate higher reimbursement. The company(ies) measures accessibility of care to behavioral (prescriber and non-prescriber), PCP, and High-Impact/High-Volume SPC providers using findings from customer surveys and complaints, and by measuring results against the accessibility standards and metrics annually. The company(ies) uses the continuous quality improvement ("CQI") process to identify opportunities for improvement and when network adequacy gaps are identified and brought to the attention of the Behavioral Health Provider Operations Program Management Team (for either provider or facility). The company(ies) monitor network adequacy on at least an annual basis and creates recruitment and corrective action plans to address any deficiencies. Recruitment activity may include targeted specialties, market specific initiatives, customer notifications and network adequacy corrective actions determined during annual review as well as Quality Management analysis of provider surveys and customer complaints related to access and availability. Recruitment plans to address network adequacy are developed and modified as needed throughout the year. The company(ies) is currently implementing processes to bolster action plans to recruit MH/SUD providers in areas of need, consistent with its focus on developing robust MH/SUD provider networks. In many instances, deficiencies are a result of insufficient availability of providers/facilities. Both MH/SUD and M/S networks are held to the same 90% standard. In most instances inability to meet the

	90% threshold is related to insufficient provider availability. Lack of providers/facilities tends to impact behavioral more than medical. The company(ies) actively recruits providers in areas where there may be access deficiencies. In some cases, not enough providers exist in a given geographic area and thus the company(ies) cannot meet a network adequacy standard due to provider unavailability. In such situations, the company(ies) takes steps to ensure that an enrollee in a plan using this network would be able to receive medically necessary services from an out of network provider, and the services would be treated as in-network for purposes of cost-sharing or other requirements.If the company(ies) identifies a network adequacy deficiency, it attempts to remediate the deficiency. The identified potential provider may decline participation in the network or may not respond to recruitment efforts. If the company(ies) identifies a non-contracted provider needed for adequacy/accessibility, it may offer higher rates than what would otherwise be standard in order to close the gap. NCQA does not prescribe goals for geo access. The company(ies) uses a 90% standard, which aligns with CMS network adequacy requirements, which require that 90% of customers have access to providers based on network adequacy access requirements for time and distance standards. ReimbursementWhether for initial negotiation or renegotiation, the company(ies) uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee	90% threshold is related to insufficient provider availability. Lack of providers/facilities tends to impact behavioral more than medical. The company(ies) actively recruits providers in areas where there may be access deficiencies. In some cases, not enough providers exist in a given geographic area and thus the company(ies) cannot meet a network adequacy standard due to provider unavailability. In such situations, the company(ies) takes steps to ensure that an enrollee in a plan using this network would be able to receive medically necessary services from an out of network provider, and the services would be treated as in-network for purposes of cost-sharing or other requirements. If the company(ies) identifies a network adequacy deficiency, it attempts to remediate the deficiency. The identified potential provider may decline participation in the network or may not respond to recruitment efforts. If the company(ies) identifies a non-contracted provider needed for adequacy/accessibility, it may offer higher rates than what would otherwise be standard in order to close the gap. NCQA does not prescribe goals for geo access. The company(ies) uses a 90% standard, which aligns with CMS network adequacy requirements, which require that 90% of customers have access to providers based on network adequacy access requirements for time and distance standards. ReimbursementWhether for initial negotiation or renegotiation, the company(ies) uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee

	schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. The company(ies)'s preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, BH pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested.In determining any rate in both the M/S and MH/SUD facility agreements, the company(ies) assesses supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; and customer complaint data. That is, the company(ies)'s reimbursement rate development and negotiation processes are ultimately designed to ensure achievement of its adequacy standards for MH/SUD and M/S providers, and any departure from the standard fee schedules is informed by market demand, which may include, for example, the need to maintain, or achieve, network adequacy for a provider type in a particular geographic area.Provider Reimbursement – OutpatientReimbursement rates for in-network M/S and MH/SUD	schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. The company(ies)'s preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, BH pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested.In determining any rate in both the M/S and MH/SUD facility agreements, the company(ies) assesses supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; and customer complaint data. That is, the company(ies)'s reimbursement rate development and negotiation processes are ultimately designed to ensure achievement of its adequacy standards for MH/SUD and M/S providers, and any departure from the standard fee schedules is informed by market demand, which may include, for example, the need to maintain, or achieve, network adequacy for a provider type in a particular geographic area.Provider Reimbursement – OutpatientReimbursement rates for in-network M/S and MH/SUD

	outpatient services are determined as follows: (1) CMS (Medicare) RVU (relative value units); (2) Ingenix data derived from practitioner charges, where available is used to fill gaps on procedure codes that do not have a Medicare rate; (3) Clinical Lab and Pathology codes, where applicable; (4) Site of Service (SOS) (e.g. office, facility); (5) Geographical Practice Cost Index (GPCI). For both M/S and MH/SUD services where there is no CMS rate or RVU nor vendor benchmark available, the final rate for a service covered by the contract is determined to be (1) billed charges for the service; (2) negotiated discount off of billed charges for the service during the contracting process. In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff	outpatient services are determined as follows: (1) CMS (Medicare) RVU (relative value units); (2) Ingenix data derived from practitioner charges, where available is used to fill gaps on procedure codes that do not have a Medicare rate; (3) Clinical Lab and Pathology codes, where applicable; (4) Site of Service (SOS) (e.g. office, facility); (5) Geographical Practice Cost Index (GPCI). For both M/S and MH/SUD services where there is no CMS rate or RVU nor vendor benchmark available, the final rate for a service covered by the contract is determined to be (1) billed charges for the service; (2) negotiated discount off of billed charges for the service during the contracting process. In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff

	participating in contract negotiation are trained on internal the company(ies) policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider-specific reimbursement requests and escalate for justification and approval any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting process ensures by policy the consideration of such factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies.Facility Reimbursement – InpatientIn-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just	participating in contract negotiation are trained on internal the company(ies) policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider-specific reimbursement requests and escalate for justification and approval any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting process ensures by policy the consideration of such factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies.Facility Reimbursement – InpatientIn-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just

	under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient's insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc. Per diem reimbursement for both M/S and MH/SUD facility-based services are based upon the following factors and accompanying evidentiary standards: (1) geographic market, which may be adjusted based upon Medicare Geographical Practice Cost Index ("GPCI"); (2) type of provider and/or specialty (e.g. physician practitioner v. non-physician practitioner v. facility); (3) supply of provider type and/or specialty; (4) network need and/or demand for provider type and/or specialty; (5) Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit ("RVU"); and (6) Training, experience and licensure of providers billing for professional services under the facility agreement.The company(ies)'s methodology and process for negotiating in-network provider reimbursements for M/S and MH/SUD services within a classification of benefits are comparable and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. The company(ies) also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, the company(ies)'s Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across medical/surgical and MH/SUD provider types.	under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient's insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc. Per diem reimbursement for both M/S and MH/SUD facility-based services are based upon the following factors and accompanying evidentiary standards: (1) geographic market, which may be adjusted based upon Medicare Geographical Practice Cost Index ("GPCI"); (2) type of provider and/or specialty (e.g. physician practitioner v. non-physician practitioner v. facility); (3) supply of provider type and/or specialty; (4) network need and/or demand for provider type and/or specialty; (5) Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit ("RVU"); and (6) Training, experience and licensure of providers billing for professional services under the facility agreement. The company(ies)'s methodology and process for negotiating in-network provider reimbursements for M/S and MH/SUD services within a classification of benefits are comparable and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. The company(ies) also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, the company(ies)'s Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across medical/surgical and MH/SUD provider types.

(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(ies) 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(ies)'s medical necessity coverage policy development and application process is consistent between M/S and MH/SUD. The company(ies)'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(ies)'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(ies)'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(ies) concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The company(ies) 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(ies)'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(ies) 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(ies) 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(ies) requires prior authorization of non-emergent inpatient services and certain Outpatient services. In reaching this conclusion, the company(ies) 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(ies)'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(ies)'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(ies)’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(ies) 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(ies) 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(ies) 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(ies) 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(ies) 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(ies)'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(ies)'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(ies)'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(ies) 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. **4. Network Admissions and Reimbursement** The company(ies) continues to invest in the breadth of the behavioral network, which has doubled since 2017 to approximately 229k mental and behavioral health care providers, includes the largest virtual network (75k) and is consistently ranked in the top behavioral health networks in local markets. This years-long process is consistent with the goal of providing access and availability through the company(ies) networks.

	The company(ies) assesses supply and demand of both M/S and MH/SUD provider types and/or specialties based upon the same indicators including NCQA and NAIC, and federal/state, network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; customer complaint data. The conclusion of such assessments may result in an increase or decrease in the provider's reimbursement rate. Over the past several years the company(ies) has conducted a comprehensive review of its MH/SUD network admission standards, including network access standards, contracting processes and reimbursement rates applicable to Network Providers. The company(ies)'s behavioral health network remains open, and the company(ies) accepts all credentialed behavioral health providers who request to join the network. Any variances in contracting processes as well as a range of reimbursement rates based on percentages of Medicare RVUs as compared to M/S reimbursement rates were identified and analyzed for adherence to the NQTL requirement. The company(ies) may agree to increased reimbursement rates as necessary to meet access needs, particularly in specialty provider board certification shortage areas such as psychiatry and child and adolescent care. In connection with its ongoing NQTL compliance efforts, the company(ies) has taken proactive, additional steps to continually ensure the comparability of standards for provider admissions into the MH/SUD provider network, including reimbursement rate methodology, to ensure the processes, strategies and evidentiary standards implemented are not more stringent for MH/SUD services than M/S services. The company(ies) has aligned contracting policies and processes and rolled out a facility reimbursement strategy shifting from reactively addressing disparate outcomes between M/S and MH/SUD reimbursement rates to proactively updating reimbursement rates for facilities for which rate increases have not been requested in the past two years. As evidence of the company(ies)'s success in establishing rates that help ensure the acquisition and retention of providers in its MH/SUD network, the facility rate renegotiation report for January 1, 2022 through December 31, 2022 documented 580 facility renegotiations, of which 573 negotiations were completed, and 3 were discontinued due to the provider's non-responsiveness, 2 were discontinued due to being duplicative requests, 1 facility reworked its proposal and 1 facility closed. The company(ies) has also reviewed more than 8,700 reimbursement rates for outpatient based fee schedules. The outpatient rate negotiation report for January 1, 2022 through December 31, 2022 includes a total of 8,742 rate increases with 7,901 completed and 841 were denied or incomplete due to the non-responsiveness of the provider. Network adequacy standards for MH/SUD providers are comparable to similar M/S specialists. In most instances the behavioral network adequacy standards require a customer to travel fewer miles to see a MS/SUD specialist as compared to an M/S specialist, effectively making MH/SUD providers more accessible to customers as compared to medical specialists. Currently, for both M/S and MH/SUD providers, at least 90% of enrollees are required to have the designated access to meet the company(ies)'s network adequacy standard. Adequacy standards are not set arbitrarily, but are based on State regulatory requirements. In addition to rolling out reimbursement upgrades for so-called stagnant contracts (that is, facility contracts that have not requested an increase in rates within the past 5 years and have remained at the same percentage of Medicare), facility based reimbursement is transitioning from a service level approach of negotiation to a total cost of care to address both competitiveness through the use of pricing benchmarks and market based analysis. This approach aligns with the methodology and process for updating inpatient reimbursement rates for hospitals providing M/S services. The company(ies) is currently creating a database including various benchmarking sources for the comparison of in-network rates against pricing benchmarks to assess affordability and to ensure the

	closure of any unsubstantiated gaps in reimbursement rates. Lastly, for new providers entering the network, the company(ies) has aligned the contracting process and has developed and implemented a standard reimbursement methodology for the negotiation of MH/SUD reimbursement rates with M/S contracting and reimbursement methodology. Such alignment includes the implementation of standard fee schedules and the implementation of established outpatient facility and practitioner fee schedules and exceptions to standard fee schedule requests in order to contract with and retain providers essential to the integrity of the MH/SUD provider network. Consistent with the NQTL requirement for comparability/stringency, the company(ies) has confirmed that standards for provider admission into the MH/SUD provider network, including credentialing, adequacy, and provider reimbursement rates for inpatient and outpatient services are comparable to, and applied no more stringently than, that of the M/S provider network as written and in operation. Put differently, the company(ies)'s network has the ability to meet the MH/SUD services needs of our enrollees by providing reasonable access to a sufficient number of in-network providers for both inpatient and outpatient services.

EXHIBIT A (3a)
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 (13) 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.	Step 1 The Plan covers MH/SUD services/technologies (e.g., services, interventions, devices, medically administered MH/SUD drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member's disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII) guidelines as well as internally developed objective, evidence-based, behavioral clinical policies. Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination. The Plan publishes its medical necessity criteria, which are available through the website and upon request. This document includes the following information: • Process for developing and approving medical necessity criteria for MH/SUD services and technologies • Description of the NQTL and application (Step 1) • Factors used to determine which services and technologies are subject to the NQTL (Step 2) • Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3) • NQTL "as written" and "in operation" comparability and stringency analysis (Step 4) • Findings and conclusions (Step 5)	Step 1 The Plan covers M/S services/technologies (e.g., services, interventions, devices, medically administered M/S drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member's disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as InterQual® and MCG® as well as internally developed objective, evidence-based, medical clinical policies. Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination. The Plan publishes its medical necessity criteria, which are available through website and upon request. This document includes the following information: • Process for developing and approving medical necessity criteria for M/S services and technologies • Description of the NQTL and application (Step 1) • Factors used to determine which services and technologies are subject to the NQTL (Step 2) • Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3) • NQTL "as written" and "in operation" comparability and stringency analysis (Step 4) • Findings and conclusions (Step 5) The Plan concludes that the methodologies used to develop and approve medical necessity criteria and medical clinical policies for M/S services and technologies are comparable and applied no more stringently for MH/SUD both "as written" and "in operation." Per the Clinical Services Medical Management Operational Policy: Approved Definitions, Medical Necessity is defined as: "Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following. • In accordance with Generally Accepted Standards of Medical Practice.

	The Plan concludes that the methodologies used to develop and approve medical necessity criteria and behavioral clinical policies for MH/SUD services and technologies are comparable and applied no more stringently for MH/SUD than M/S both "as written" and "in operation." Per the Clinical Services Medical Management Operational Policy: Approved Definitions, Medical Necessity is defined as: "Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following. • 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-related and addictive disorders, disease or its symptoms. • Not mainly for your convenience or that of your doctor or other health care provider. • 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. The September 2023, MH/SUD National Network Manual defines Medical Necessity as "Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or state laws (also referred to as Clinical Necessity)." The Plan delegates MH/SUD services to its Managed Behavioral Health Organization (MBHO) vendor. Both M/S and MH/SUD have UM program descriptions that are the foundation for the objectives and guidelines of the Plan's UM strategy. Medical necessity criteria or medical/behavioral clinical policies are not included in the UM program descriptions. The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, MH/SUD uses externally developed evidence-based medical necessity criteria (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. All MH/SUD internally developed medical and behavioral clinical policies are reviewed at least annually. The MH/SUD Clinical Criteria Development/Selection and Application Policy outline the processes to ensure medical necessity criteria are developed consistently. The Plan uses the following standard process to review externally developed medical necessity criteria: The Clinical Quality and Operations Committee (CQOC) assesses and approves the use of externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based,	• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms. • Not mainly for your convenience or that of your doctor or other health care provider. • 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. The Plan delegates UM of MH/SUD to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. M/S have UM program descriptions that are the foundation for the objectives and guidelines of the Plan's UM strategy. Medical necessity criteria or medical/behavioral clinical policies are not included in the UM program descriptions. The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, M/S use externally developed evidence-based medical necessity criteria (e.g., InterQual and MCG) when making clinical coverage determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical clinical policies are used when making medical necessity clinical coverage determinations. All M/S internally developed medical and behavioral clinical policies are reviewed at least annually. The M/S Clinical Review Criteria Operational Policy outlines the processes to ensure medical necessity criteria are developed consistently. The Plan uses the following standard process to review externally developed medical necessity criteria: The Medical Technology Assessment Committee (MTAC) assesses externally developed clinical criteria for M/S services and technologies. MTAC uses scientifically based, clinical evidence and the Hierarchy of Clinical Evidence in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members. MTAC is comprised of, but not limited to, medical directors with diverse medical and surgical specialties and sub-specialties, representatives from business segments, legal services, consumer affairs, medical policy development and operations teams, benefit interpretation team, and other guests, as needed. MTAC voting members include medical directors with the following specialties (note that some doctors have multiple specialties): • Plastic Surgery • Internal Medicine (x7) • Medical Oncology • Thoracic and Cardiothoracic Vascular Surgery (x2) • Preventative Medicine • Pediatrics • Diagnostic Radiology and Vascular/Interventional Radiology • Ophthalmology • Physical Medicine & Rehabilitation Pain Medicine • Family Practice • Emergency Medicine The National Medical Care Management Committee (NMCMC) annually reviews and validates medical necessity criteria endorsed by MTAC. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient

	clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its assessment and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. The CQOC is comprised of representatives from sub-committees, representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician. The Plan uses the following standard process to develop and approve internal medical necessity criteria: The Plan uses committees to assess technologies and conduct a thorough review of scientifically based clinical evidence and peer-reviewed literature in accordance with the M/S and MH/SUD Behavioral Health Hierarchies of Clinical Evidence to develop behavioral clinical policies that apply to the technologies. The CQOC develops and approves behavioral clinical policies for MH/SUD services when externally developed criteria are not available. CQOC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. The Clinical Technology Assessment Committee (CTAC) is a sub-committee of CQOC and is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies. CTAC's purpose is to make determinations regarding technologies that may or may not be experimental, investigational, or unproven (EIU). CTAC members include behavioral health medical directors, senior leaders of clinical operations, research and development, clinical review, legal, compliance, and policy. CTAC voting members include six psychiatrists and one licensed independent social worker (LISW), plus two co-chairs, both of whom are psychiatrists. CTAC obtains approval of its determinations from the CQOC. When assessing the safety efficacy, and appropriateness of services/technologies used to treat MH/SUD conditions, CQOC and CTAC first look for scientifically based clinical evidence and peer reviewed literature. In addition, the committees will look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials and cohort studies. In addition, CTAC (for EIU) and CQOC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions. In the absence of any strong and compelling scientific evidence, CQOC (and CTAC for potential EIU technologies) assesses services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.	care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization, Concurrent Review, and Retrospective Review processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. MTAC reports to the UMPC. The Plan uses the following standard process to develop and approve internal medical necessity criteria: The Plan uses committees to assess technologies and conduct a thorough review of scientifically based clinical evidence and peer-reviewed literature in accordance with the Hierarchies of Clinical Evidence to develop medical clinical policies that apply to the technologies. MTAC develops and approves medical clinical policies for M/S services and technologies when externally developed criteria are not available. MTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members. When assessing the safety, efficacy, and appropriateness of the services/technologies used to treat M/S conditions, MTAC first looks for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies. In the absence of any strong and compelling scientific evidence, MTAC assesses technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD). MTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.

	CQOC (and CTAC for potential EIU technologies) will not deem a service or technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.
	
	The CQOC reviews and validates behavioral clinical policies endorsed by CTAC. If CQOC determines that any behavioral clinical policies are not appropriately supported by clinical evidence, then CQOC refers the behavioral clinical policy back to CTAC.
	
	Internally developed medical and behavioral clinical policies are publicly available here online.
	
	The Plan uses the following standard process to apply medical necessity criteria:
	
	MH/SUD clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available, MH/SUD use externally developed evidence-based medical necessity criteria (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making medical necessity coverage benefit determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, behavioral clinical policies are used when making medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This means that there are either externally developed medical necessity criteria available or there are internally developed behavioral clinical policies available. MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria.
	
	Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies.
	
	Per the M/S Clinical Services Medical Management Operational Policy: Approved Definitions, Medical Necessity is defined as follows:
	"Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following.
	• 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-related and addictive disorders, disease or its symptoms.
	• Not mainly for your convenience or that of your doctor or other health care provider.
	• 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.
		The NMCMC annually reviews and validates medical clinical policies endorsed by MTAC. If NMCMC determines that any medical clinical policies are not appropriately supported by clinical evidence, then NMCMC refers the medical clinical policy back to MTAC. As of April 1, 2023, UMPC began reviewing and validating the medical clinical policies endorsed by MTAC. If UMPC determines that any medical clinical policies are not appropriately supported by clinical evidence, then UMPC refers the medical clinical policy back to MTAC.
		
		Internally developed medical and behavioral clinical policies are publicly available online:
		The Plan uses the following standard process to apply medical necessity criteria:
		
		M/S clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available, M/S use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG) when making medical necessity coverage benefit determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical clinical policies are used when making medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This means that there are either externally developed medical necessity criteria available or there are internally developed medical clinical policies available. M/S clinical reviewers do not have to make a choice between using internal or external medical necessity criteria.
		
		Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The M/S Peer Clinical Review Operational Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical clinical policies.
		
		Step 2
		The M/S Factors are the same as MH/SUD
		
		Step 3
		Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. These evidentiary standards and sources apply for the following:
		I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
		
		• Factor – M/S Committee Considerations, including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical clinical policies and medical necessity criteria
		  ○ Clinical Effectiveness – Is a characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective
		  ○ Safety of Service or Technology - Is a state in which hazards and conditions leading to physical or psychological harm are minimized to preserve the health and wellbeing of a person receiving health care
		  ○ Appropriateness of the Proposed Service or Technology – The service or technology is suitable for the member's clinical presentation and the expected health benefits from the medical service or technology are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin
		
		• The Plan's evidentiary standard and sources that define and/or trigger the M/S Committee Considerations factor:

	The MH/SUD National Policy Definitions List defers to the definition of Medical Necessity as set forth in member Plan documents: "This term is variable and defined in the member's applicable Plan or Coverage document."
	
	The September 2023, MH/SUD National Network Manual defines Medical Necessity as: "Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or state laws (also referred to as Clinical Necessity)."
	
	Step 2
	The Plan relies on the following factor to develop and approve medical necessity criteria:
	II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
	
	• MH/SUD Committee Considerations (Qualitative) including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical/behavioral clinical policies and medical necessity criteria
	
	Step 3
	Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. These evidentiary standards and sources apply for the following:
	II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
	
	• Factor – MH/SUD Committee Considerations, including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical/behavioral clinical policies and medical necessity criteria
	  ○ Clinical Effectiveness – Is a characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective
	  ○ Safety of Service or Technology - Is a state in which hazards and conditions leading to physical or psychological harm are minimized to preserve the health and wellbeing of a person receiving health care
	  ○ Appropriateness of the Proposed Service or Technology – The service or technology is suitable for the member's clinical presentation and the expected health benefits from the medical service or technology are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin
	
	• The Plan's evidentiary standard and sources that define and/or trigger the MH/SUD Committee Considerations factor:
	  ○ The Plan uses scientifically based clinical evidence and the Behavioral Health Hierarchies of Clinical Evidence to determine which MH/SUD services or technologies are safe and
		○ The Plan uses scientifically based clinical evidence and the Clinical Evidence to determine which M/S services or technologies are safe and effective and, therefore, eligible for benefit coverage. The Clinical Evidence detail the hierarchy of clinical evidence that is preferred when assessing which health services or technologies are safe and effective. To be deemed safe and effective, a health service or technology only has to have evidence in at least one category.
		  ○ M/S assesses evidence from the following when developing or approving medical clinical policies/medical necessity criteria:
		• Scientifically based clinical evidence
		• Peer-reviewed literature
		• Hierarchy of Clinical Evidence
		• In the absence of strong and compelling scientific evidence, medical policies may be based upon:
		  ○ National guidelines and consensus statements
		  ○ CMS NCDs
		  ○ Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence, e.g., American College of Physicians (ACP), The Society for Post-Acute and Long-Term Care Medicine (AMDA), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), etc.
		• InterQual or MCG (for review of external medical necessity criteria)
		
		Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available.
		
		Step 4
		As Written
		
		The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information MH/SUD uses to
		• develop internal, objective, evidence-based, behavioral clinical policies and
		• approve third-party, externally developed clinical criteria to the strategies, processes, factors, evidentiary standards, and source information M/S uses to:
		• develop internal, objective, evidence-based, medical clinical policies and
		• approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S "as written."
		
		National internal committees evaluate the applicable factors and standards described in Steps 2 and 3 when developing and approving Medical Necessity criteria.
		
		Review of Factor and Evidentiary Standards
		When developing and approving medical clinical policies/medical necessity criteria, M/S committees both consider clinical efficacy, safety, and appropriateness of the proposed services or technologies.
		
		The M/S Hierarchies of Clinical Evidence use the following categories of sources:
		• Well-designed evidence-based studies
		• Observational studies
		• Case studies

	effective and, therefore, eligible for benefit coverage. The Behavioral Health Hierarchies of Clinical Evidence detail the hierarchy of clinical evidence that is preferred when assessing which health services or technologies are safe and effective. To be deemed safe and effective, a health service or technology only has to have evidence in at least one category. o MH/SUD assesses evidence from the following when developing or approving behavioral clinical policies/medical necessity criteria: • Scientifically based clinical evidence • Peer-reviewed literature • Behavioral Health Hierarchy of Clinical Evidence • In the absence of strong and compelling scientific evidence, behavioral clinical policies/clinical criteria may be based upon: o National consensus statements o Publications by recognized authorities such as government sources and/or professional societies o ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII (for review of external medical necessity criteria) Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available. These evidentiary standards and sources MH/SUD services and technologies and are defined in a qualitative manner. The factor and evidentiary standards used as the basis for developing and approving MH/SUD medical necessity criteria are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for developing and approving M/S medical necessity criteria "as written" and "in operation." Step 4 As Written The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information MH/SUD uses to • develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria to the strategies, processes, factors, evidentiary standards, and source information M/S uses to: • develop internal, objective, evidence-based, medical clinical policies and • approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S "as written." National internal committees evaluate the applicable factors and standards when developing and approving Medical Necessity criteria. Review of Factor and Evidentiary Standards	• Consensus statements • Clinical and professional opinion papers Review of Operational Policies and Procedures The Plan reviewed the following M/S operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. M/S • Hierarchy of Clinical Evidence o The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which M/S health services or technologies are safe and effective and, therefore, eligible for benefit coverage. In developing the hierarchy, M/S uses scientifically based clinical evidence to identify safe and effective health services or technologies for members. • MTAC Charter o MTAC's mission is to review the scientifically based clinical evidence used in the development of M/S medical policies and clinical programs in an effort to ensure transparency and consistency and to identify safe and effective health services or technologies for members. MTAC's Charter outlines the structure, objectives, responsibilities, and scope of the activities carried out by the committee • NMCMC Charter o The NMCMC is responsible for overseeing the development, implementation, and evaluation of the M/S UM program • Utilization Management Program Committee Charter o The UMPC is responsible for oversight of the UM program and the development and maintenance of the scope and processes of prior authorization, concurrent review, and retrospective review, including defining the services that require prior authorization, concurrent review, and post-service review • Applying Benefit Plan and Review Criteria Standard Operating Procedure o This standard operating procedure outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making clinical coverage determinations • UMPD for the Companies o This document summarizes the philosophy, structure and standards that govern M/S medical management, utilization management and utilization review responsibilities and functions • Clinical Review Criteria Operational Policy o The purpose of this operational policy is to document that M/S will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently Where available, M/S use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG) when making clinical coverage determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. MTAC and CQOC (and CTAC for EIU) develop internal clinical policies only. MTAC and CQOC review and approve externally developed medical necessity criteria. In either case, a comparable process is followed. In some cases, the Plan is obligated by State regulations to use certain externally developed medical necessity criteria. The committees assess the clinical efficacy, safety, and appropriateness of the proposed services or technologies used for the treatment of

	When developing and approving medical and behavioral clinical policies/medical necessity criteria, MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed services or technologies.
	
	The MH/SUD Behavioral Health Hierarchies of Clinical Evidence are comparable. MH/SUD use the following categories of sources:
	• Well-designed evidence-based studies
	• Observational studies
	• Case studies
	• Consensus statements
	• Clinical and professional opinion papers
	
	Review of Operational Policies and Procedures
	The Plan reviewed the following MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.
	
	MH/SUD
	• Behavioral Health Hierarchy of Clinical Evidence
	  ○ The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which MH/SUD health services or technologies are safe and effective and, therefore, eligible for benefit coverage. In developing the hierarchy, MH/SUD uses scientifically based clinical evidence to identify safe and effective health services or technologies for members
	• CTAC Charter
	  ○ CTAC is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies
	• CQOC Charter
	  ○ The role and purpose of the CQOC is to review and approve externally developed medical necessity criteria, develop behavioral clinical policies when externally developed criteria is not available, and to review and validate CTAC's assessment of EIU technologies
	• Management of Behavioral Health Benefits
	  ○ The purpose of this policy is to describe the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and ensure that members receive appropriate, high quality behavioral health services or technologies in a timely manner
	• Clinical Criteria Development Selection and Application Policy
	  ○ This document addresses selection, development, and use of clinical criteria in making benefit determinations. MH/SUD uses written clinical criteria consistent with National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) requirements and applicable laws and regulations
	  ○ MH/SUD selects and uses clinical criteria that are consistent with generally accepted standards of care, including objective criteria that are based on sound clinical evidence. MH/SUD uses the criteria to make standardized coverage determinations and to inform discussions about evidence-based practices and discharge planning
		health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD potential EIU technologies, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S technologies including the Hierarchy of Clinical Evidence. Additionally, CQOC's assessment process for MH/SUD services, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S services including the Hierarchy of Clinical Evidence.
		
		All M/S medical clinical policies are reviewed at least annually.
		
		Review of processes to review externally developed medical necessity criteria
		
		A standard and comparable process is followed to review externally developed, third party medical necessity criteria. The MTAC assesses externally developed clinical criteria for M/S services or technologies. MTAC uses scientifically based, clinical evidence and the Hierarchy of Clinical Evidence in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members.
		
		M/S committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services or technologies to approve medical clinical policies.
		
		Further, both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.
		
		The Plan uses InterQual medical necessity criteria for M/S services or technologies because InterQual monitors more than 3,000 guidelines, guideline issuers and medical societies for newly published medical literature, and an independent clinical review panel drawn from more than 1,000 experts provides authoritative peer review. The M/S medical necessity criteria sets apply to specific clinical conditions and do not overlap.
		
		Review of processes to develop and approve internal medical necessity criteria
		
		MTAC develops and approves medical clinical policies for M/S services or technologies. MTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members.
		
		In the absence of any strong and compelling scientific evidence, MTAC assess services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs.
		
		MTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies.
		
		M/S committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services and technologies to develop or approve medical clinical policies.
		
		Review of Medical Necessity Processes

	Where available, MH/SUD use externally developed evidence-based medical necessity criteria (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, behavioral clinical policies are used when making medical necessity clinical coverage determinations. CQOC (and CTAC for EIU) develop internal clinical policies only. CQOC review and approve externally developed medical necessity criteria. In either case, a comparable process is followed. In some cases, the Plan is obligated by State regulations to use certain externally developed medical necessity criteria. The committees assess the clinical efficacy, safety, and appropriateness of the proposed services or technologies used for the treatment of health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD potential EIU technologies, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S technologies including the Hierarchy of Clinical Evidence. Additionally, CQOC's assessment process for MH/SUD services, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S services including the Hierarchy of Clinical Evidence. All MH/SUD behavioral clinical policies are reviewed at least annually. Review of processes to review externally developed medical necessity criteria The CQOC assesses externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services or technologies to approve medical/behavioral clinical policies. Further, both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors. ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII are widely recognized as best-in-class externally developed medical necessity criteria sources. The MH/SUD external medical necessity criteria is developed by nationally recognized organizations. The MH/SUD medical necessity criteria sets apply to specific clinical conditions and do not overlap. Review of processes to develop and approve internal medical necessity criteria CQOC (and CTAC for EIU technologies) develops and approves behavioral clinical policies for MH/SUD services and technologies. CQOC/CTAC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CQOC/CTAC conducts its processes in a timely manner to ensure	M/S clinical reviewers follow a hierarchy of authority when making medical necessity determinations. M/S clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations (see enclosed M/S Applying Benefit Plan and Review Criteria Standard Operating Procedure). Internally developed clinical policies or externally developed third party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. As there is no duplication between internally and externally developed medical necessity criteria, M/S clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. The Plan generally assesses the appropriate application of its medical necessity criteria in operation by comparing the results of its mandatory M/S Inter-Rater Reliability (IRR) assessment outcomes. In Operation The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to • develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria to the strategies, processes, factors, evidentiary standards, and source information M/S uses to: • develop internal, objective, evidence-based, medical clinical policies and • approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S "in operation." Review of Factor and Evidentiary Standards When reviewing and developing medical clinical policies and medical necessity criteria, M/S committees both consider clinical efficacy, safety, and appropriateness of the proposed services and technologies. The Hierarchies of Clinical Evidence are comparable. The factors and evidentiary standards were applied to M/S services and technologies comparably and not more stringently to MH/SUD services than to M/S services and technologies "in operation." Review of Operational Policies and Procedures The Plan reviewed M/S operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. The M/S Clinical Review Criteria Operational Policy outline the processes to ensure medical necessity criteria are developed consistently. Second level, or peer review, determinations include clinical judgment; the M/S Peer Clinical Review Operational Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical clinical policies. Further, review of the committee charters confirms that both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors. Review of process to develop and approve medical necessity criteria The strategy for developing and approving medical necessity criteria is comparable for both M/S and applied no more stringently to MH/SUD services and technologies. The Plan conducted a review of the M/S processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:

	transparency and consistency, and to identify safe and effective MH/SUD services and technologies for members. When assessing services and technologies used to treat M/S and MH/SUD conditions, both MTAC and CQOC/CTAC first look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. CQOC/CTAC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions. In the absence of any strong and compelling scientific evidence, CQOC/CTAC assess services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs. Neither CQOC nor CTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services and technologies to develop or approve medical/behavioral clinical policies. Review of Medical Necessity Processes MH/SUD clinical reviewers follow a hierarchy of authority when making medical necessity determinations. MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations (see enclosed MH/SUD Clinical Criteria Development Selection and Application Policy). Internally developed clinical policies or externally developed third party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. As there is no duplication between internally and externally developed medical necessity criteria, MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. The Plan generally assesses the appropriate application of its medical necessity criteria in operation by comparing the results of its mandatory MH/SUD Inter-Rater Reliability (IRR) assessment outcomes. In Operation The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to • develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria to the strategies, processes, factors, evidentiary standards, and source information M/S uses to: • develop internal, objective, evidence-based, medical clinical policies and • approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than,	• The committees follow standard processes outlined in their respective charters and apply their respective Hierarchies of Clinical Evidence when developing, assessing, and approving medical clinical policies and medical necessity criteria. o MTAC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new medical clinical policies when external criteria were not available o UMPC reviewed and validated the MTAC assessment and approval of medical necessity criteria. • If UMPC determine that any internally developed medical clinical policies are not appropriately supported by clinical evidence, then UMPC refer the medical necessity criteria back to MTAC. Review of Use of Medical Necessity Criteria M/S utilize medical clinical policies and medical necessity criteria when making medical necessity clinical coverage benefit determinations related to M/S services and technologies. All M/S clinical staff and peer reviewers who make clinical coverage benefit determinations utilizing medical clinical policies and medical necessity criteria are required to participate in an IRR assessment to ensure clinical policies and medical necessity criteria are applied in a consistent and appropriate manner “in operation.” Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager. Second level, or peer review, medical necessity benefit coverage determinations include clinical judgment. The M/S Peer Clinical Review Operational Policy outlines the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical clinical policies.

	the strategies, processes, factors, evidentiary standards, and source information used by M/S "in operation."
	
	Review of Factor and Evidentiary Standards
	When reviewing and developing medical/behavioral clinical policies and medical necessity criteria, MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed services and technologies. The Behavioral Health Hierarchies of Clinical Evidence are comparable. The factors and evidentiary standards were applied to MH/SUD services and technologies comparably and not more stringently to MH/SUD services than to M/S services and technologies "in operation."
	
	Review of Operational Policies and Procedures
	The Plan reviewed MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. The MH/SUD Clinical Criteria Development/Selection and Application Policy outline the processes to ensure medical necessity criteria are developed consistently. Second level, or peer review, determinations include clinical judgment; the MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal behavioral clinical policies. Further, review of the committee charters confirms that both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.
	
	Review of process to develop and approve medical necessity criteria
	The strategy for developing and approving medical necessity criteria is comparable and applied no more stringently to MH/SUD than M/S services and technologies. The Plan conducted a review of the MH/SUD processes to confirm comparability. The review focused on the following aspects of the process for MH/SUD:
	• The committees follow standard processes outlined in their respective charters and apply their respective Hierarchies of Clinical Evidence when developing, assessing, and approving medical/behavioral clinical policies and medical necessity criteria.
	  ○ CQOC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new behavioral clinical policies when external criteria were not available.
	  ○ CTAC developed behavioral clinical policies for EIU.
	• CQOC reviewed and approved EIU behavioral clinical policies developed by CTAC
	• If CQOC determines that any internally developed behavioral clinical policies are not appropriately supported by clinical evidence, then CQOC refer the medical necessity criteria back to CTAC.
	
	Review of Use of Medical Necessity Criteria
	MH/SUD utilize behavioral clinical policies and medical necessity criteria when making medical necessity clinical coverage benefit determinations related to MH/SUD services and technologies. All MH/SUD clinical staff and peer reviewers who make clinical coverage benefit	

	determinations utilizing behavioral clinical policies and medical necessity criteria are required to participate in an IRR assessment to ensure clinical policies and medical necessity criteria are applied in a consistent and appropriate manner "in operation." Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager. Second level, or peer review, medical necessity benefit coverage determinations include clinical judgment. The MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical clinical policies.	
In-Patient & In-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
In-Patient & Out-of-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications.

	The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
Out-Patient & In-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
Out-Patient & Out-of-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
Emergency Services/Benefits NQTL Practices	Prior Authorization, Concurrent Review and Retrospective Review are not performed on MH/SUD Emergency services. Emergency services for MH/SUD, as defined by the prudent layperson standard (and as defined by the state), are covered without medical necessity.	Prior Authorization and Concurrent Review are not performed on M/S Emergency services. Emergency services for M/S, as defined by the prudent layperson standard (and as defined by the state), are covered without medical necessity.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	Prescription Drug List (PDL) Design Step 1 There are no differences in how the NQTL procedure is generally applied	Prescription Drug List (PDL) Design Step 1 There are no differences in how the NQTL procedure is generally applied

	Step 2 There are no differences in the factors Step 3 There are no differences in the evidentiary standards and sources Step 4 The Pharmacy & Therapeutics (P&T) Committee assesses a MH/SUD prescription drug's place in therapy, and its relative safety and efficacy, in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. 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 a single P&T Committee. The Plan reviewed the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis The findings of the Prescription Drug Tier Analysis (see data below) indicated the percent of prescription drugs by tiers for MH/SUD prescription drugs were comparable to the percent of prescription drugs by tiers for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. The following are results of each analysis in 2022: • January 2021 – 59.0% of MH/SUD drugs are on Tiers 1 and 2 • May 2022 – 57.9% of MH/SUD drugs are on Tiers 1 and 2 • September 2022 – 56.9% of MH/SUD drugs are on Tiers 1 and 2 These evaluations were based on the Advantage PDL, which is the most commonly used PDL. Prescription Drug Prior Authorization / Step Therapy / Quantity Limits For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop MH/SUD drug policies through a single Pharmacy & Therapeutics (P&T) Committee. The findings of the prescription drug prior authorization or step therapy outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for M/S prescription drugs. Data is for (January, May, and September 2023). The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. The following are results of each analysis in 2023 • January 2023 – 33.7% (165) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits	Step 2 There are no differences in the factors Step 3 There are no differences in the evidentiary standards and sources Step 4 The Pharmacy & Therapeutics (P&T) Committee assesses a M/S prescription drug's place in therapy, and its relative safety and efficacy, in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. 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 a single P&T Committee. 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Prescription Drug Prior Authorization / Step Therapy / Quantity Limits For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop M/S drug policies through a single Pharmacy & Therapeutics (P&T) Committee. The findings of the prescription drug prior authorization or step therapy outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for M/S prescription drugs. Data is for (January, May, and September 2023). The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. The following are results of each analysis in 2023 • January 2023 – 38.5% (1,575) of M/S drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • May 2023 – 39.3% (1,618) of M/S drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • September 2023 – 40.1% (1,657) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits

	• May 2023 – 33.7% (165) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • September 2023 – 34.0% (166) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits All analysis and material documentation is available upon request.	
Prior-Authorization NQTL Practices	**IP and INN** Step 1 The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to its delegated MH/SUD MBHO vendor. The Plan requires INN providers and facilities to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., Schedule of Benefits). The INN provider's submission of a request (notification) triggers the inpatient Prior Authorization process. INN providers may submit Prior Authorization requests through the secure provider portal, by telephone, or by fax (where required). Providers communicate basic information to create a case. As outlined in the MH/SUD National Network Manual, inpatient behavioral health services require an initial Prior Authorization or notification in advance of the service. As described in the Management of Behavioral Health Benefits Policy, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review.	**IP and INN** Step 1 The Plan requires INN facilities and providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., Schedule of Benefits). The INN provider's submission of a request (notification) triggers the Prior Authorization process. INN providers can submit Prior Authorization requests through the secure provider portal, their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the M/S Provider Administrative Guide, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve cases that meet applicable clinical criteria. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews

	Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded. Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD facilities based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to notify the Plan of admissions and provide member information. The Plan covers the first 8 to 21 days of a stay depending on the specific level of care without review. The Plan evaluates INN MH/SUD facilities performance annually as described in the MH/SUD National Network Manual. Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical	applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination and appeal rights and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate. M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer

	reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable. List of MH/SUD Services Subject to NQTL – • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Step 2 The Plan confirmed that the MH/SUD and M/S factors are the same. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value. For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. Step 3	• Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled Performance Assessment and Incentives, at no time are initial clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable. List of MH/SUD Services Subject to NQTL • Arthroplasty • Bariatric Surgery • Breast Reconstruction (non-mastectomy) • Cardiology • Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • Clinical Trials • Congenital Heart Disease • Cosmetic and Reconstructive Procedures • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Gender Dysphoria Treatment • Hysterectomy • Inpatient admissions – post-acute services • Orthognathic Surgery • Sleep Apnea Procedures and Surgeries • Spinal Surgery • Transplant • Ventricular Assist Devices Step 2 The Plan confirmed that the MH/SUD and M/S factors are the same. For M/S, meeting Clinical Appropriateness is determinative in imposing the limitation. While the Value factor is considered for M/S, it is not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization.

	For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value.
	
	Step 4
	• Timeframe to Submit. The Administrative Guide (for M/S) and National Network Manual (for MH/SUD) were reviewed for notification timeframes. The timeframes for the provider or member to notify of an inpatient admission were reviewed and determined that MH/SUD was comparable and no more stringent.
	  ○ MH/SUD – As outlined in MH/SUD National Network Manual, MH/SUD requires notification within one business day after an inpatient admission to a facility unless a longer period is required by contract or state-specific requirements.
	• Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
	  ○ MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.
	
	Outcomes Data reviewed for comparability
	
	INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
	
	There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1 and Plan 2.
	
	Plan 1
	Administrative Denial Rate - 0% (0 out of 31 cases)
	Clinical Denial Rate - 0% (0 out of 31 cases)
	
	Plan 2
	Administrative Denial Rate - 0% (0 out of 13 cases)
	Clinical Denial Rate - 0% (0 out of 13 cases)
	
	Plan 3
	Administrative Denial Rate - 0% (0 out of 115 cases)
	Clinical Denial Rate - 0.87% (1 out of 115 cases)
	
	All analysis and material documentation is available upon request.
	
	IP and OON
		Step 3
		For M/S, meeting Clinical Appropriateness is determinative in imposing the limitation. While the Value factor is considered for M/S, it is not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization.
		
		Step 4
		• Timeframe to Submit. The Administrative Guide (for M/S) and National Network Manual (for MH/SUD) were reviewed for notification timeframes. The timeframes for the provider or member to notify of an inpatient admission were reviewed and determined that MH/SUD was comparable and no more stringent.
		  ○ M/S – As outlined in the M/S Administrative Guide, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated.
		• Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
		  ○ M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors.
		
		Outcomes Data reviewed for comparability
		
		INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
		
		There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3.
		
		Plan 1
		Administrative Denial Rate - 0% (0 out of 118 cases)
		Clinical Denial Rate - 27.73% (28 out of 118 cases)
		
		Plan 2
		Administrative Denial Rate - 0% (0 out of 17 cases)
		Clinical Denial Rate - 17.675 (3 out of 17 cases)
		
		Plan 3
		Administrative Denial Rate - 4.17% (8 out of 192 cases)
		Clinical Denial Rate - 19.79% (38 out of 182 cases)
		
		All analysis and material documentation is available upon request.
		
		IP and OON
		Step 1
		Members are responsible for obtaining Prior Authorization for services rendered by OON facilities and providers. The member's benefit plan document (i.e., Schedule of Benefits) identify the services for which the member is responsible for obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process.

	Step 1 The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to its delegated MH/SUD MBHO vendor. Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., Schedule of Benefits) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before inpatient MH/SUD services are received. OON provider's submission of a request (notification) triggers the Prior Authorization process. OON providers may submit Prior Authorization requests on behalf of the member by telephone, or by fax (where required). Providers communicate basic information to create a case. As described in the Management of Behavioral Health Benefits Policy, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely	Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone or by fax (where required). Members or providers communicate basic information to create a case. The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to the initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve cases that meet applicable clinical criteria. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate.

	communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded. Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.	M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

	Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable.
	
	List of MH/SUD Services Subject to NQTL:
	• Inpatient, MH
	• Inpatient, SUD
	• Residential, MH
	• Residential, SUD
	
	Step 2
	For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value.
	
	Step 3
	For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value.
	
	Step 4
	• Timeframe to Submit. The timeframes for the member or OON provider on behalf of the member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent.
	  ○ MH/SUD – Per the member's Plan documents, the Prior Authorization should be requested before OON services are received.
	  ▪ Unplanned or emergency services are not subject to Prior Authorization
	• Review of Staff Qualifications For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
	  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.
	
	Outcomes Data reviewed for comparability
	
	OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
		List of MH/SUD Services Subject to NQTL
		Plan 1:
		• Bariatric Surgery
		• Clinical Trials
		• Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy)
		• Hospice
		• Inpatient Admissions - Inpatient Stay and Post-Acute Services
		• Pregnancy - Maternity Services - Maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery
		• Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
		• Temporomandibular Joint Services
		• Transplant
		• Ventricular Assist Devices
		
		Plan 2:
		• Bariatric Surgery
		• Clinical Trials
		• Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy)
		• Hospice
		• Inpatient Admissions - Inpatient Stay and Post-Acute Services
		• Pregnancy - Maternity Services - Maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery
		• Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
		• Spine Surgery
		• Temporomandibular Joint Services
		• Transplant
		• Ventricular Assist Devices
		
		Plan 3:
		• Clinical Trials
		• Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy)
		• Hospice Care
		• Inpatient Admissions - Inpatient Stay and Post-Acute Services
		• Obesity Surgery
		• Pregnancy - Maternity Services - Maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery
		• Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
		• Temporomandibular Joint (TMJ) Services
		• Transplant
		• Ventricular Assist Devices
		
		Step 2
		For M/S, meeting Clinical Appropriateness is determinative in imposing the limitation. While the Value factor is considered for M/S, it is not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization.

	There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3.
	
	Plan 1
	Administrative Denial Rate - 0% (0 out of 31 cases)
	Clinical Denial Rate - 0% (0 out of 31 cases)
	
	Plan 2
	Administrative Denial Rate - 0% (0 out of 13 cases)
	Clinical Denial Rate - 0% (0 out of 13 cases)
	
	Plan 3
	Administrative Denial Rate - 0% (0 out of 115 cases)
	Clinical Denial Rate - 0.87% (1 out of 115 cases)
	
	All analysis and material documentation is available upon request.
	
	OP and INN
	Step 1
	The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to its delegated MH/SUD MBHO vendor.
	
	The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., Schedule of Benefits).
	
	INN providers may submit Prior Authorization requests through the secure provider portal, by telephone, or by fax (where required). Providers and members communicate basic information to create a case. As outlined in the MH/SUD National Network Manual, most routine outpatient behavioral health services do not require an initial pre-authorization or notification in advance of the service. The INN provider's submission of a request (notification) triggers the Prior Authorization process.
	
	As described in the Management of Behavioral Health Benefits Policy, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.
	
	First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's
		Step 3
		For M/S, meeting Clinical Appropriateness is determinative in imposing the limitation. While the Value factor is considered for M/S, it is not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization.
		
		Step 4
		• Timeframe to Submit. The timeframes for the member or OON provider on behalf of the member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent.
		  ○ M/S – Per the member's Plan documents, the timeframes vary depending upon the services requested from as soon as possible to six months prior to the OON service.
		• Review of Staff Qualifications For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
		  ○ M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by Medical Directors.
		
		Outcomes Data reviewed for comparability
		
		OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
		
		There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3.
		
		Plan 1
		Administrative Denial Rate - 0% (0 out of 31 cases)
		Clinical Denial Rate - 0% (0 out of 31 cases)
		
		Plan 2
		Administrative Denial Rate - 0% (0 out of 13 cases)
		Clinical Denial Rate - 0% (0 out of 13 cases)
		
		Plan 3
		Administrative Denial Rate - 0% (0 out of 115 cases)
		Clinical Denial Rate - 0.87% (1 out of 115 cases)
		
		All analysis and material documentation is available upon request.
		
		OP and INN
		Step 1
		The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., Schedule of Benefits). The INN provider's submission of a request (notification) triggers the Prior Authorization process.
		
		INN providers may submit Prior Authorization requests through the secure provider portal, their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a

	clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements, before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded. Intensive Outpatient Program (IOP) Practice Management. The Plan identifies INN MH/SUD IOP facilities and clinics that demonstrate effective performance based on readmission rates, lengths of stay, and post-discharge outcomes for inclusion in Practice Management. INN MH/SUD facilities or clinics that meet these performance criteria do not have to obtain Prior Authorization for IOP services. Instead, the facilities submit claims post-service, which the Plan pays. Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD providers based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to notify the Plan of admissions to Partial Hospitalization Program (PHP) and provide member information. The Plan covers the first 17 days of admission to PHP without review. Facilities notify the Plan if additional days are needed. The Plan evaluates INN MH/SUD facilities' performance annually as described in the MH/SUD National Network Manual. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM)	case. As outlined in the M/S Care Provider Administrative Guide, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review. First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria. Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based, medical clinical policies or use clinical criteria from third-party sources such as InterQual® or MCG® guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate.

	Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable. List of MH/SUD Services Subject to NQTL: • Partial Hospitalization (PHP)/Day Treatment • Intensive Outpatient (IOP) • Electroconvulsive Therapy (ECT) • Psychological Testing • Applied Behavior Analysis (ABA)	M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.

	• Transcranial Magnetic Stimulation (TMS)
	
	Step 2
	For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value. For MH/SUD meeting Clinical Appropriateness plus Value and/or Variation is determinative in adding new services to the prior authorization list.
	
	Step 3
	• The Plan's evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor are:
	  ○ Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines)
	  ○ Clinical Technology Assessment Committee (CTAC) review
	  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.)
	• The Plan's evidentiary standards that define and/or trigger the Patient Safety factor:
	  ○ Clinical criteria from nationally recognized third-party sources (e.g., ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines)
	  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.)
	• The Plan's sources used to define the Patient Safety factor:
	  ○ Clinical criteria from nationally recognized third-party sources (e.g., ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines)
	  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.)
	
	For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value.
	
	Step 4
	• Timeframe to Submit. INN providers must submit Prior Authorization requests for MH/SUD outpatient services any time prior to receiving services.
	• Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
	  ○ MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's
		List of MH/SUD Services Subject to NQTL
		• 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)
		• Gastroenterology Endoscopy (GI)
		• 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 treat uterine fibroid
		• Non-Emergency Air Transport
		• Orthognathic Surgery
		• Orthotics over $1,000
		• Out-of-network services
		• *Pain Management and Injection
		• *Physical Therapy/Occupational Therapy (PT/OT)
		• Potentially unproven services (including experimental/investigational and/or linked services)
		• Pregnancy (Voluntary notification for case and disease management enrollment)
		• Prostate Procedures
		• 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

	level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
	
	Outcomes Data reviewed for comparability
	INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
	
	The findings of a comparative analysis for each Plan product (see data below) indicated the Prior Authorization process for MH/SUD INN outpatient services was comparable to the Prior Authorization process for INN M/S outpatient services.
	
	Plan 1
	Administrative Denial Rate - 0.41% (1 out of 245 cases)
	Clinical Denial Rate - 3.67% (9 out of 245 cases)
	
	Plan 2
	Administrative Denial Rate - 0.63% (1 out of 159 cases)
	Clinical Denial Rate - 4.40% (7 out of 159 cases)
	
	Plan 3
	Administrative Denial Rate - 0.22% (1 out of 447 cases)
	Clinical Denial Rate - 3.36% (15 out of 447 cases)
	
	All analysis and material documentation is available upon request.
	
	OP and OON
	Step 1
	The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to its delegated MH/SUD MBHO vendor.
	
	Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., Schedule of Benefits) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before outpatient MH/SUD services are received.
	
	OON providers may submit Prior Authorization requests on behalf of the member by telephone, online (for certain services) or by fax (where required). Providers communicate basic information to create a case. OON provider's submission of a request (notification) triggers the Prior Authorization process.
	
	As described in the Management of Behavioral Health Benefits Policy, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff may approve coverage requests that do not require clinical
		• Sleep Studies
		• Specific medications (as indicated on the prescription drug list
		• (PDL))
		• Spinal Cord Stimulators
		• Spinal Surgery
		• Stimulators – not related to spine
		• *Therapeutic Radiopharmaceuticals
		• Transplant
		• Vein Procedures
		
		Step 2
		For M/S, meeting Clinical Appropriateness is determinative in imposing the limitation. While the Value factor is considered for M/S, it is not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization. For M/S, meeting Clinical Appropriateness is determinative in adding new services to the prior authorization list.
		
		Step 3
		• The Plan's evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor are:
		  ○ Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services)
		  ○ Medical Technology and Assessment Committee (MTAC) review
		  ○ Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.)
		• The Plan's evidentiary standards that define and/or trigger the Patient Safety factor:
		  ○ Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services)
		  ○ Objective, evidence-based medical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Medical Association, , etc.)
		• The Plan's sources used to define the Patient Safety factor:
		  ○ Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services)
		  ○ Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.)
		
		Step 4
		• Timeframe to Submit. The timeframes for the provider or member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was comparable and no more stringent. INN providers must submit Prior Authorization requests for M/S outpatient services at least two weeks before the planned service.
		• Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level/Peer Clinical Reviews. For M/S and MH/SUD outpatient Prior Authorization, non-clinical staff may approve cases that do not require clinical evaluation or interpretation. Non-clinical staff may administratively deny cases when member benefits are exhausted/excluded. M/S INN outpatient cases that are submitted through the provider portal may also be approved based on the member diagnosis and the clinical information submitted.
		• Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
		• M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
		
		Outcomes Data reviewed for comparability

	evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request additional clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are excluded. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to	INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The findings of a comparative analysis for each Plan product (see data below) indicated the Prior Authorization process for MH/SUD INN outpatient services was comparable to the Prior Authorization process for INN M/S outpatient services. Plan 1 Administrative Denial Rate - 0.20% (29 out of 14254 cases) Clinical Denial Rate - 15.59% (2222 out of 14254 cases) Plan 2 Administrative Denial Rate - 0.14% (2 out of 1411 cases) Clinical Denial Rate - 17.43% (246 out of 1411 cases) Plan 3 Administrative Denial Rate - 0.83% (166 out of 19911 cases) Clinical Denial Rate - 9.33% (1858 out of 19911 cases) All analysis and material documentation is available upon request. **OP and OON** Step 1 Members are responsible for obtaining Prior Authorization for services rendered by OON providers. The member's benefit plan document (i.e., Schedule of Benefits) identifies the services for which the member is responsible for obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process. Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone, online or by fax (where required). Members or providers communicate basic information to create a case. The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to clinical reviewers. First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

	pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable. List of MH/SUD Services Subject to NQTL: • Intensive Outpatient (IOP) • Partial Hospitalization (PHP)/Day Treatment • Psychological Testing • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) • Electroconvulsive Therapy (ECT) Step 2 For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services.	Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual® or MCG® guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate. M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.

	Step 3
	• The Plan's evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor are:
	  ○ Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines)
	  ○ Clinical Technology and Assessment Committee (CTAC) review
	
	For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value.
	
	Factor - Patient Safety is defined as "the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum" by the World Health Organization.
	
	• The Plan's evidentiary standards that define and/or trigger the Patient Safety factor:
	  ○ Clinical criteria from nationally recognized third-party sources (e.g., ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines)
	  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
	• The Plan's sources used to define the Patient Safety factor:
	  ○ Clinical criteria from nationally recognized third-party sources (e.g., ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines)
	  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
	
	Step 4
	• Timeframe to Submit. The timeframes for the member, or OON provider on behalf of the member, to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent.
	  ○ MH/SUD: Per the member's Plan documents, the Prior Authorization should be requested before OON services are received.
	• Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and with state, federal, and accreditation requirements (NCQA).
	  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by medical directors or psychologists.
	
	Outcomes Data reviewed for comparability
		As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:
		• Chief Medical Officer, Medical Management (Co-Chair)
		• Senior Vice President, Clinical Advancement (Co-Chair)
		• Chief Medical Officer
		• Senior Vice President, Clinical Appeals & Grievances
		• Chief Medical Officer, Clinical Policy
		• Chief Medical Officer, Employer & Individual
		• Chief Medical Officer, Medicare & Retirement
		• Chief Medical Officer, Community & State
		• Chief Medical Officer, Individual & Family Plans
		• Vice President, Clinical Transformation & Affordability
		• Senior Director, Mental Health Parity
		• Vice President, Utilization Management Strategy & Implementation
		
		One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.
		
		Per the M/S policy entitled, Performance Assessment and Incentives, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.
		
		M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.
		
		List of MH/SUD Services Subject to NQTL
		OP OON M/S Services Subject to Prior Authorization Plan 1:
		• Bariatric Surgery
		• Breast Pumps
		• Clinical Trials
		• Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy)
		• Diabetes Equipment - Before obtaining DME over $1000
		• Durable Medical Equipment (DME)
		• Formulas/Specialized Foods
		• Genetic Testing/BRCA Gene Testing
		• Hearing Aids over $1000
		• Home health care - non-nutritional
		• Infertility
		• Lab, X-Ray and Diagnostics - For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram
		• Lab, X-Ray and Major Diagnostics - For CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology
		• Non-emergency Air Transport
		• Orthodontia
		• Orthotics
		• Pain Management
		• Pharmaceutical Products – For IV infusions only

	OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON outpatient cases from 01/01/2023 - 12/31/2023 to support an analysis of clinical outcomes data for Plan 3. Plan 1 Administrative Denial Rate - 2.27% (5 out of 220 cases) Clinical Denial Rate - 7.27% (16 out of 220 cases) Plan 2 Administrative Denial Rate - 2.92% (4 out of 137 cases) Clinical Denial Rate - 6.57% (9 out of 137 cases) Plan 3 Administrative Denial Rate - 4.23% (3 out of 71 cases) Clinical Denial Rate - 5.63% (4 out of 71 cases) All analysis and material documentation is available upon request.	• Preimplantation Genetic Testing (PGT) and Related Services • Prosthetics • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Scopic Procedures • Surgery - Outpatient - For all outpatient surgeries: blepharoplasty, cardiac catheterization, cochlear implants, uvulopalatopharyngoplasty, pacemaker insertion, pain management procedures, vein procedures, spine surgery, total joint replacements, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery • Therapeutic Treatments - Outpatient - Services that require prior authorization: Dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MR-guided focused ultrasound • Transplant services (including evaluation) OP OON M/S Services Subject to Prior Authorization Plan 2: • Bariatric Surgery • Breast Pumps • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Diabetes Equipment - Before obtaining DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized Foods • Genetic Testing/BRCA Gene Testing • Hearing Aids over $1000 • Home health care - non-nutritional • Infertility • Lab, X-Ray and Diagnostics - For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram • Lab, X-Ray and Major Diagnostics - For CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology • Non-emergency Air Transport • Orthodontia • Orthotics • Pain Management • Pharmaceutical Products – For IV infusions only • Preimplantation Genetic Testing (PGT) and Related Services • Prosthetics • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Scopic Procedures • Spine Surgery • Surgery - Outpatient - For all outpatient surgeries: blepharoplasty, cardiac catheterization, cochlear implants, uvulopalatopharyngoplasty, pacemaker insertion, pain management procedures, vein procedures, spine surgery, total joint replacements, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery

		• Therapeutic Treatments - Outpatient - Services that require prior authorization: Dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MR-guided focused ultrasound • Transplant services (including evaluation) OP OON M/S Services Subject to Prior Authorization Plan 3: • Bariatric Surgery • Breast Pumps • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Diabetes Equipment- Before obtaining DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized Foods • Genetic Testing/BRCA Gene Testing • Hearing Aids over $1000 • Home health care - non-nutritional • Infertility • Lab, X-Ray and Diagnostics - For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram • Lab, X-Ray and Major Diagnostics - For CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology • Non-emergency Air Transport • Orthodontia • Orthotics • Pain Management and Injections • Pharmaceutical Products – IV Infusions only • Prosthetics • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Scopic Procedures - Outpatient Diagnostic and Therapeutic • Surgery - Outpatient - For all outpatient surgeries: Blepharoplasty, cardiac catheterization, cochlear implants, uvulopalatopharyngoplasty, pacemaker insertion, pain management procedures, vein procedures, spine surgery, total joint replacements, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery • Therapeutic Treatments - Outpatient - Services that require prior authorization: dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy, and MR-guided focused ultrasound • Transplant services (including evaluation) Step 2 For M/S, meeting Clinical Appropriateness is determinative in imposing the limitation. While the Value factor is considered for M/S, it is not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization. Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor are: ○ Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG)

		○ Medical Technology and Assessment Committee (MTAC) review For M/S, meeting Clinical Appropriateness is determinative in imposing the limitation. While the Value factor is considered for M/S, it is not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization. Factor - Patient Safety is defined as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum" by the World Health Organization. • The Plan’s evidentiary standards that define and/or trigger the Patient Safety factor: ○ Clinical criteria from nationally recognized third-party sources (e.g., InterQual) ○ Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) • The Plan’s sources used to define the Patient Safety factor: ○ Clinical criteria from nationally recognized third-party sources (e.g., InterQual) ○ Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4 • Timeframe to Submit. The timeframes for the member, or OON provider on behalf of the member, to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent. ○ M/S: Per the member’s Plan documents, the timeframes vary depending upon the services requested from as soon as possible to six months prior to the OON service • Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and with state, federal, and accreditation requirements (NCQA). ○ M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals. Outcomes Data reviewed for comparability OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON outpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 3. Plan 1 Administrative Denial Rate - 0.17% (3 out of 1729 cases) Clinical Denial Rate - 26.08% (451 out of 1729 cases) Plan 2 Administrative Denial Rate - 3.32% (7 out of 211 cases) Clinical Denial Rate - 31.75% (67 out of 211 cases) Plan 3 Administrative Denial Rate - 0.47% (56 out of 11903 cases)

		Clinical Denial Rate - 9.70% (1154 out of 11903 cases) All analysis and material documentation is available upon request.
Concurrent Review Benefit NQTL	**IP and INN** Step 1 The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to its delegated MH/SUD MBHO vendor. Initial Concurrent Review. All INN inpatient admissions are subject to the Concurrent Review process. The Plan requires INN providers and facilities to timely notify the Plan of MH/SUD inpatient admissions. INN facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements. Provider notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone. As described in the Management of Behavioral Health Benefits Policy, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements.	**IP and INN** Step 1 Initial Concurrent Review. The Plan requires INN facilities and providers to timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Provider notification triggers the inpatient Concurrent Review process. Providers can notify the Plan through the secure provider portal, their connected electronic medical record, by telephone, or by fax (where required). The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

	Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information. Ongoing Concurrent Review. INN providers may request coverage for additional days by contacting the Plan prior to the expiration of the last covered day of an approved MH/SUD inpatient admission. The Plan's INN MH/SUD general acute care facilities are reimbursed on a per diem basis. The Plan conducts ongoing Concurrent Review for INN MH/SUD admissions depending on the applicable clinical criteria and the member's clinical presentation. Upon receipt of a request for coverage of additional days, the Plan reviews the medical necessity of inpatient admissions. Clinical reviewers and peer clinical reviewers follow the initial Concurrent Review process. Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted. The Plan routinely monitors Concurrent Review program performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and	Ongoing Concurrent Review. INN M/S facilities may request coverage of additional days prior to the expiration of the last day of an approved inpatient admission. The Plan conducts ongoing Concurrent Reviews for additional days for approved inpatient M/S admissions as follows: • General acute care facilities reimbursed on a per diem basis: every two days • General acute care facilities reimbursed on a diagnosis related group (DRG) basis: when the inpatient admission meets the number of days stated in the provider participation agreement • Skilled Nursing Facility (SNF) admissions: initial Concurrent Review at day three and then weekly. Subsequent reviews may be sooner if clinically appropriate • Acute Inpatient Rehab (AIR) admissions: initial Concurrent Review at day five and then weekly. Subsequent reviews may be sooner if clinically appropriate • Long Term Acute Care Hospital (LTACH) admissions: initial Concurrent Review at day 14 and then weekly The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate. M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC

	representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable. List of services subject to NQTL: • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Step 2 There are no differences in the factors used Step 3 There are no differences in the standards and sources used Step 4 • Timeframe to Submit. The National Network Manual (for MH/SUD) was reviewed for notification timeframes. The timeframe for the provider or member to notify of an admission was reviewed and determined that MH/SUD was comparable and no more stringent. o INN MH/SUD facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements. • Determinations and Non-clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews. o For MH/SUD, non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required. • Adverse Benefit Determinations and Peer-to-Peer Conversations.	ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable. List of services subject to NQTL Plan 1 and Plan 2: • Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • Hospice • Inpatient admissions – post-acute services • Transplants • Ventricular Assist Devices Plan 3: • Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • End-stage renal disease (ESRD) dialysis services • Inpatient admissions – post-acute services • Transplant • Ventricular Assist Devices Step 2 There are no differences in the factors used Step 3 There are no differences in the standards and sources used

	○ INN inpatient MH/SUD services ▪ The Plan offers INN inpatient MH/SUD facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows INN inpatient MH/SUD facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued. ▪ For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information. If during the course of the peer-to-peer conversation the provider withdraws their original request and submits a new request, the case is approved. • Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). ○ MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. • Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies and use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines. The Plan offered INN MH/SUD facilities the opportunity to discuss a potential adverse benefit determination with a peer clinical reviewer prior to issuing the adverse benefit determination. Outcomes Data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 2. Plan 1 Administrative Denial Rate - 0.57% (1 out of 174 cases) Clinical Denial Rate - 1.72% (3 out of 174 cases) Plan 2 Administrative Denial Rate - 1.01% (1 out of 99 cases) Clinical Denial Rate - 1.01% (1 out of 99 cases) Plan 3 Administrative Denial Rate - 0.35% (1 out of 282 cases) Clinical Denial Rate - 0% (0 out of 282 cases)	Step 4 • Timeframe to Submit. The Administrative Guide (for M/S) was reviewed for notification timeframes. The timeframe for the provider or member to notify of an admission was reviewed and determined that MH/SUD was comparable and no more stringent. ○ INN M/S facilities must notify the Plan within 24-hours for week-day admissions, unless otherwise indicated. • Determinations and Non-clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews. ○ For M/S, non-clinical staff may approve requests for coverage of cases in scenarios where the Plan identified applicable clinical criteria always indicate that an inpatient level of care is medically necessary. Non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers determine whether the inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. If the case cannot be approved by the clinical reviewer, it is referred to a peer (physician) clinical reviewer. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required. • Adverse Benefit Determinations and Peer-to-Peer Conversations. ○ INN inpatient M/S services ▪ The Plan offers INN M/S facilities and providers the opportunity to discuss adverse benefit determinations after the adverse benefit determination is issued. Only M/S peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S inpatient services. ▪ For M/S, adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Modified coverage requests that are approved are recorded as partial denials. • Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). ○ M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors. • Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies and use clinical criteria from third party sources such as InterQual and MCG. The Plan offered INN M/S facilities the opportunity to discuss an adverse benefit determination with a peer clinical reviewer when it issued the adverse benefit determination. Outcomes Data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 2. Plan 1 Administrative Denial Rate - 0% (0 out of 305 cases) Clinical Denial Rate - 18.69% (57 out of 305 cases) Plan 2

	All analysis and material documentation is available upon request. **IP and OON** Step 1 The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to its delegated MH/SUD MBHO vendor. Initial Concurrent Review. All OON inpatient admissions are subject to the Concurrent Review process. The Plan requires that members ensure that OON providers and facilities timely notify the Plan of inpatient admissions. Notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone. As described in the Management of Behavioral Health Benefits Policy, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a	Administrative Denial Rate - 0% (0 out of 42 cases) Clinical Denial Rate - 16.67% (7 out of 42 cases) Plan 3 Administrative Denial Rate - 0.69% (6 out of 867 cases) Clinical Denial Rate - 14.07% (122 out of 867 cases) All analysis and material documentation is available upon request. **IP and OON** Step 1 Initial Concurrent Review. Members are required to ensure that OON facilities and providers timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Notification triggers the inpatient Concurrent Review process. OON facilities can notify the Plan by telephone or fax (where required). The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

	benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information. Ongoing Concurrent Review. OON providers may request coverage for additional days by contacting the Plan prior to expiration of the last covered day of an approved MH/SUD inpatient admission. The Plan's OON MH/SUD general acute care facilities are reimbursed on a per diem basis. The Plan conducts ongoing Concurrent Review for OON MH/SUD admissions depending on the applicable clinical criteria and the member's clinical presentation. Upon receipt of a request for coverage of additional days, the Plan reviews the medical necessity of inpatient admissions. Clinical reviewers and peer clinical reviewers follow the initial Concurrent Review process. Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted. The Plan routinely monitors Concurrent Review program performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The	Ongoing Concurrent Review. OON M/S facilities may request coverage of additional days prior to the expiration of the last day of an approved inpatient admission. The Plan conducts ongoing Concurrent Reviews for additional days for approved inpatient M/S admissions as follows: • General acute care facilities reimbursed on a per diem basis: every two days • General acute care facilities reimbursed on a diagnosis related group (DRG) basis: when the inpatient admission meets the number of days stated in the provider participation agreement • Skilled Nursing Facility (SNF) admissions: initial Concurrent Review at day three and then weekly. Subsequent reviews may be sooner if clinically appropriate • Acute Inpatient Rehab (AIR) admissions: initial Concurrent Review at day five and then weekly. Subsequent reviews may be sooner if clinically appropriate • Long Term Acute Care Hospital (LTACH) admissions: initial Concurrent Review at day 14 and then weekly The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual® or MCG® guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate. M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and OBH. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC

	Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.
	
	Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.
	
	MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable.
	
	list of services subject to NQTL
	• MH Non-Emergent Acute Inpatient
	• MH Subacute Residential Treatment
	• SUD Acute Inpatient Detoxification
	• SUD Acute Inpatient Rehabilitation
	• SUD Subacute Residential Treatment
	
	Step 2
	There are no differences in the factors used
	
	Step 3
	There are no differences in the standards and sources used
	
	Step 4
	• Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.
	  ○ For MH/SUD, non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
	
	• Adverse Benefit Determinations and Peer-to-Peer Conversations.
	  ○ The Plan offers OON inpatient MH/SUD facilities and providers the opportunity to discuss a potential adverse benefit determination before the Plan issues such determination. This process allows OON inpatient MH/SUD facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued.
	  ○ For MH/SUD, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information. If during the course of the peer-to-peer conversation the provider withdraws their original request and submits a new request, the case is approved.
		ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:
		• Chief Medical Officer, Medical Management (Co-Chair)
		• Senior Vice President, Clinical Advancement (Co-Chair)
		• Chief Medical Officer
		• Senior Vice President, Clinical Appeals & Grievances
		• Chief Medical Officer, Clinical Policy
		• Chief Medical Officer, Employer & Individual
		• Chief Medical Officer, Medicare & Retirement
		• Chief Medical Officer, Community & State
		• Chief Medical Officer, Individual & Family Plans
		• Vice President, Clinical Transformation & Affordability
		• Senior Director, Mental Health Parity
		• Vice President, Utilization Management Strategy & Implementation
		
		One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.
		
		Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.
		
		M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable.
		
		List of services subject to NQTL
		Applies to all inpatient services for facilities reimbursed on a per diem basis
		
		Step 2
		There are no differences in the factors used
		
		Step 3
		There are no differences in the standards and sources used
		
		Step 4
		• Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews.
		  ○ For M/S, non-clinical staff may approve requests for coverage of cases in scenarios where the Plan identified applicable clinical criteria always indicate that an inpatient level of care is medically necessary. Non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (nurses) determine whether the inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. If the case cannot be approved by the clinical reviewer, it is referred to a peer (physician) clinical reviewer. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.
		
		• Adverse Benefit Determinations and Peer-to-Peer Conversations.
		  ○ OON inpatient M/S services

	• Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
	  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.
	
	• Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies and use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.
	
	Outcomes Data reviewed for comparability
	
	OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
	
	There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2 and Plan 3.
	
	Plan 1
	Administrative Denial Rate - 0% (0 out of 34 cases)
	Clinical Denial Rate - 8.82% (3 out of 34 cases)
	
	Plan 2
	Administrative Denial Rate - 0% (0 out of 17 cases)
	Clinical Denial Rate - 0% (0 out of 17 cases)
	
	Plan 3
	Administrative Denial Rate - 10.91% (6 out of 55 cases)
	Clinical Denial Rate - 7.27% (4 out of 55 cases)
	
	All analysis and material documentation is available upon request.
	
	OP and INN
	Step 1
	The MH/SUD National Policy Definitions List defines a Concurrent (Review) Request as: "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care."
	
	The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is
		▪ The Plan offers OON M/S facilities and providers the opportunity to discuss adverse benefit determinations after the adverse benefit determination is issued. Only M/S peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S inpatient services.
		▪ For M/S, adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded. Modified coverage requests that are approved are recorded as partial denials.
		  ○ OON inpatient MH/SUD services
		
		• Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA).
		  ○ M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors.
		
		• Clinical Criteria. For M/, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies and use clinical criteria from third party sources such as InterQual and MCG.
		
		Outcomes Data reviewed for comparability
		
		OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
		
		There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2 and Plan 3.
		
		Plan 1
		Administrative Denial Rate - 0% (0 of 11 cases)
		Clinical Denial Rate - 18.18% (2 out of 11 cases)
		
		Plan 2
		Administrative Denial Rate - 0% (0 out of 2 cases)
		Clinical Denial Rate - 100% - 0% (2 out of 2 cases)
		
		Plan 3
		Administrative Denial Rate - 14.29% (1 out of 7 cases)
		Clinical Denial Rate - 42.86% (3 of 7 cases)
		
		All analysis and material documentation is available upon request.
		
		OP and INN
		Step 1
		Per the Clinical Services Medical Management Operational Policy: Approved Definitions, Concurrent Review is defined as: "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review.""
		
		The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's

	governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Concurrent Review MH/SUD outpatient services consists of the following: The Plan reclassifies MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services. Refer to the INN outpatient Prior Authorization NQTL. **OP and OON** Step 1 The MH/SUD National Policy Definitions List defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care." The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Concurrent Review of MH/SUD outpatient services consists of the following: The Plan reclassifies MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services. Refer to the OON outpatient Prior Authorization NQTL.	operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. Concurrent Review of M/S outpatient services consists of the following: The Plan requires INN M/S providers to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services. Refer to the INN outpatient Prior Authorization NQTL **OP and OON** Step 1 Per the Clinical Services Medical Management Operational Policy: Approved Definitions, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review."" The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan requires members, or OON M/S providers on the member's behalf, to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services. Refer to the OON outpatient Prior Authorization NQTL.
Retrospective Review Benefit NQTL Practices	**IP and INN** Step 1	**IP and INN** Step 1

	The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to its delegated MH/SUD MBHO vendor. MH/SUD claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve requests for payment or refer requests to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.	Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of inpatient admission post discharge from an INN facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (e.g., Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage) . The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

	Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate.
	
	The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.
	
	The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.
	
	The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician.
	
	Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.
	
	MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.
	
	List of services subject to NQTL
	• MH/SUD claims/requests that include the following services are subject to Retrospective Review:
	  ○ Inpatient (non-emergent) MH Acute Care
	  ○ Inpatient Detoxification
	  ○ Inpatient Rehabilitation
	  ○ Residential Detoxification
	  ○ Residential Rehabilitation
	  ○ Residential MH Treatment
	
	Step 2
	There are no differences in the factors used
		The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.
		
		The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.
		
		As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:
		• Chief Medical Officer, Medical Management (Co-Chair)
		• Senior Vice President, Clinical Advancement (Co-Chair)
		• Chief Medical Officer
		• Senior Vice President, Clinical Appeals & Grievances
		• Chief Medical Officer, Clinical Policy
		• Chief Medical Officer, Employer & Individual
		• Chief Medical Officer, Medicare & Retirement
		• Chief Medical Officer, Community & State
		• Chief Medical Officer, Individual & Family Plans
		• Vice President, Clinical Transformation & Affordability
		• Senior Director, Mental Health Parity
		• Vice President, Utilization Management Strategy & Implementation
		
		One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.
		
		Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.
		
		M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.
		
		List of servivces subject to NQTL
		• Services that have not previously been reviewed in Prior Authorization or Concurrent Review
		• M/S Claims that are denied, if requested by an INN facility
		• Services where the service or procedure codes do not match a diagnosis code
		• EIU services
		• Services that are subject to benefit limits/exclusions
		• Codes identified by the Plan as subject to Retrospective Review

	Step 3
	• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
	  ○ Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines)
	  ○ Clinical Technology Assessment Committee (CTAC) review
	  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
	
	Step 4
	• Timeframe to submit. The MH/SUD National Network Manual (for MH/SUD) was reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent.
	  ○ For MH/SUD, facilities have 180 days after the service is rendered to request a Retrospective Review
	
	• Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
	  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
	
	• Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.
	
	The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process.
	
	Outcomes data reviewed for comparability
	
	INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
	
	There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3.
	
	Plan 1
	Administrative Denial Rate - 0% (0 out of 11 cases)
	Clinical Denial Rate - 18.18% (2 out of 11 cases)
		Step 2
		There are no differences in the factors used
		
		Step 3
		• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
		  ○ Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG)
		  ○ Medical Technology and Assessment Committee (MTAC) review
		  ○ Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.)
		
		Step 4
		• Timeframe to submit. The Administrative Guide (for M/S) was reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent.
		  ○ For M/S, facilities must request the Retrospective Review within the requirements outlined in their provider contract
		
		• Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements.
		  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
		
		• Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG.
		
		The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Additionally, M/S claims/requests for inpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.
		
		Outcomes data reviewed for comparability
		
		INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
		
		There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3.
		
		Plan 1

	Plan 2 Administrative Denial Rate - 0% (0 out of 6 cases) Clinical Denial Rate - 16.67% (1 out of 6 cases) Plan 3 Administrative Denial Rate - 4.35% (1 out of 23 cases) Clinical Denial Rate - 4.35% (1 out of 23 cases) All analysis and material documentation is available upon request. **IP and OON** Step 1 The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to its delegated MH/SUD MBHO vendor. MH/SUD claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes, or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. The OON provider may bill non-reimbursable charges to the member.	Administrative Denial Rate - 76.6% (144 out of 188 cases) Clinical Denial Rate - 4.26% (8 out of 144 cases) Plan 2 Administrative Denial Rate - 83.33% (20 out of 24 cases) Clinical Denial Rate - 0% (0 out of 24 cases) Plan 3 Administrative Denial Rate - 57.85% (383 out of 662 cases) Clinical Denial Rate - 6.95% (46 out of 662 cases) All analysis and material documentation is available upon request. **IP and OON** Step 1 Retrospective Review of M/S Inpatient Admissions consist of the following: Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of an inpatient admission post discharge from an OON facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, cases are referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as

	Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.	clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® Guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation

	MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.
	
	List of services subject to NQTL
	• MH/SUD claims/requests that include the following services are subject to Retrospective Review:
	  ○ Inpatient (non-emergent) MH Acute Care
	  ○ Inpatient Detoxification
	  ○ Inpatient Rehabilitation
	  ○ Residential Detoxification
	  ○ Residential Rehabilitation
	  ○ Residential MH Treatment
	
	Step 2
	There are no differences in the factors used
	
	Step 3
	• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
	  ○ Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines)
	  ○ Clinical Technology Assessment Committee (CTAC) review
	  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
	
	Step 4
	• Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
	  ○ For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review
	
	• Notification of Decisions to Providers and Members. The Plan notifies MH/SUD OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.
	• Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
	  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
		One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.
		
		Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.
		
		M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.
		
		List of services subject to NQTL
		• Services that have not previously been reviewed in Prior Authorization or Concurrent Review
		• Services where the service or procedure codes do not match a diagnosis code
		• EIU services
		• Services that are subject to benefit limits/exclusions
		• Codes identified by the Plan as subject to Retrospective Review
		
		Step 2
		There are no differences in the factors used
		
		Step 3
		• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
		  ○ Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG)
		  ○ Medical Technology and Assessment Committee (MTAC) review
		  ○ Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.)
		
		Step 4
		• Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
		  ○ For M/S, members must notify the Plan within timely filing requirements
		
		• Notification of Decisions to Providers and Members. The Plan notifies M/S OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.
		• Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements.
		  ○ M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
		
		• Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG.
		
		Outcomes data used for comparability

	• Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines. Outcomes data reviewed for comparability OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3. Plan 1 Administrative Denial Rate - 0% (0 out of 7 cases) Clinical Denial Rate - 28.57% (2 out of 7 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 5 cases) Clinical Denial Rate - 20% (1 out of 5 cases) Plan 3 Administrative Denial Rate - 0% (0 out of 3 cases) Clinical Denial Rate - 0% (0 out of 3 cases) All analysis and material documentation is available upon request. **OP and INN** Step 1 The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to its delegated MH/SUD MBHO vendor. MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.	OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3. Plan 1 Administrative Denial Rate - 0% (0 out of 2 cases) Clinical Denial Rate - 0% (0 out of 2 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 0 cases) Clinical Denial Rate - 0% (0 out of 0 cases) Plan 3 Administrative Denial Rate - 53.33% (8 out of 15 cases) Clinical Denial Rate - 20% (3 out of 15 cases) All analysis and material documentation is available upon request. **OP and INN** Step 1 Retrospective Review of M/S Outpatient Services consists of the following: Retrospective Review for certain outpatient services begins after the Plan receives claims from INN providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN providers may also request Retrospective Review of outpatient claims that are denied. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physician or nurse) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an

	First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.	adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines. Monitoring/Quality Oversight: The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual

	The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.
	
	The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.
	
	Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.
	
	MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.
	
	List of services subject to NQTL
	• MH/SUD claims/requests that include the following services are subject to Retrospective Review:
	  ○ Partial Hospitalization Program (PHP)/Day Treatment
	  ○ Intensive Outpatient Program (IOP)
	  ○ Transcranial Magnetic Stimulation (TMS)
	  ○ Electroconvulsive Therapy (ECT)
	  ○ Psychological Testing
	  ○ Applied Behavioral Analysis (ABA)
	
	Step 2
	There are no differences in the factors used
	
	Step 3
	• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
	  ○ Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines)
	  ○ Clinical Technology Assessment Committee (CTAC) review
	  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
	
	Step 4
		• Chief Medical Officer, Medicare & Retirement
		• Chief Medical Officer, Community & State
		• Chief Medical Officer, Individual & Family Plans
		• Vice President, Clinical Transformation & Affordability
		• Senior Director, Mental Health Parity
		• Vice President, Utilization Management Strategy & Implementation
		
		One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.
		
		Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.
		
		M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.
		
		List of services subject to NQTL
		• Services that have not previously been reviewed in Prior Authorization or Concurrent Review
		• Claims that are denied, if requested by INN provider
		• Services where the service or procedure codes do not match a diagnosis code
		• EIU services
		• Services that are subject to benefit limits/exclusions
		• Codes identified by the Plan as subject to Retrospective Review
		
		Step 2
		There are no differences in the factors used
		
		Step 3
		• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
		  ○ Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines)
		  ○ Clinical Technology Assessment Committee (CTAC) review
		  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
		
		Step 4
		• Timeframe to submit. The Administrative Guide (for M/S) was reviewed for requirements relating to timeliness of notification to the Plan and it was determined MH/SUD was no more stringent.
		  ○ For M/S, providers must request the Retrospective Review within the requirements outlined in their provider contract
		
		• Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements.

	• Timeframe to submit. The MH/SUD National Network Manual (for MH/SUD) were reviewed for requirements relating to timeliness of notification to the Plan and it was determined MH/SUD was no more stringent.
	  ○ For MH/SUD, providers have 180 days after the service is rendered to request a Retrospective Review
	
	• Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
	  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
	
	• Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based, behavioral clinical policies or use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.
	
	Outcomes data reviewed for comparability
	INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
	
	There is an insufficient number of MH/SUD INN outpatient cases from 01/01/2023 - 12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3.
	
	Plan 1
	Administrative Denial Rate - 0% (0 out of 13 cases)
	Clinical Denial Rate - 7.69% (1 out of 13 cases)
	
	Plan 2
	Administrative Denial Rate - 0% (0 out of 12 cases)
	Clinical Denial Rate - 0% (0 out of 12 cases)
	
	Plan 3
	Administrative Denial Rate - 0% (0 out of 20 cases)
	Clinical Denial Rate - 0% (0 out of 20 cases)
	
	All analysis and material documentation is available upon request.
	
	OP and OON
	Step 1
	The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to its delegated MH/SUD MBHO vendor.
		○ M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
		
		• Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based, medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG.
		
		Outcomes data reviewed for comparability
		INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
		
		There is an insufficient number of MH/SUD INN outpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3.
		
		Plan 1
		Administrative Denial Rate - 26.43% (318 out of 1203 cases)
		Clinical Denial Rate - 20.28% (244 out of 1203 cases)
		
		Plan 2
		Administrative Denial Rate - 30.51% (36 out of 118 cases)
		Clinical Denial Rate - 16.10% (19 out of 118 cases)
		
		Plan 3
		Administrative Denial Rate - 36.31% (5372 out of 14793 cases)
		Clinical Denial Rate - 8.38% (1239 out of 14793 cases)
		
		All analysis and material documentation is available upon request.
		
		OP and OON
		Step 1
		Retrospective Review for certain outpatient services begins after the Plan receives claims from OON providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission.
		
		Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.
		
		First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based

	MH/SUD claims/requests for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. The OON provider may bill non-reimbursable charges to the member. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-	clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. The OON provider may bill non-reimbursable charges to the member. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to- end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC

	Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.
	
	Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate.
	
	The Plan conducts monthly quality audits of individual non-clinical staff clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.
	
	The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.
	
	The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.
	
	Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.
	
	MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.
	
	List of services subject to NQTL
	• MH/SUD claims that include the following services are subject to Retrospective Review:
	  ○ Partial Hospitalization Program (PHP)/Day Treatment
	  ○ Intensive Outpatient Program (IOP)
	  ○ Transcranial Magnetic Stimulation (TMS)
	  ○ Electroconvulsive Therapy (ECT)
	  ○ Psychological Testing
	• Applied Behavioral Analysis (ABA)
	
	Step 2
	There are no differences in the factors used
		ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:
		• Chief Medical Officer, Medical Management (Co-Chair)
		• Senior Vice President, Clinical Advancement (Co-Chair)
		• Chief Medical Officer
		• Senior Vice President, Clinical Appeals & Grievances
		• Chief Medical Officer, Clinical Policy
		• Chief Medical Officer, Employer & Individual
		• Chief Medical Officer, Medicare & Retirement
		• Chief Medical Officer, Community & State
		• Chief Medical Officer, Individual & Family Plans
		• Vice President, Clinical Transformation & Affordability
		• Senior Director, Mental Health Parity
		• Vice President, Utilization Management Strategy & Implementation
		
		One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.
		
		Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.
		
		M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.
		
		List of services subject to NQTL
		• Services that have not previously been reviewed in Prior Authorization or Concurrent Review
		• Services where the service or procedure codes do not match a diagnosis code
		• EIU services
		• Services that are subject to benefit limits
		• Codes identified by the Plan as subject to Retrospective Review
		• Applied Behavioral Analysis (ABA)
		
		Step 2
		There are no differences in the factors used
		
		Step 3
		• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
		  ○ Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines)
		  ○ Clinical Technology Assessment Committee (CTAC) review
		  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
		
		Step 4

	Step 3
	• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
	  ○ Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines)
	  ○ Clinical Technology Assessment Committee (CTAC) review
	  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
	
	Step 4
	• Timeframe to submit. The timeframe for the member to submit a Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
	  ○ For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review
	
	• Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state, and federal requirements.
	  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
	
	• Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.
	
	Outcomes data for comparability
	
	OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
	
	There is an insufficient number of MH/SUD OON outpatient cases from 01/01/2023 - 12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3.
	
	Plan 1
	Administrative Denial Rate - 16.67% (3 out of 18 cases)
	Clinical Denial Rate - 11.11% (2 out of 18 cases)
	
	Plan 2
	Administrative Denial Rate - 0% (0 out of 13 cases)
		• Timeframe to submit. The timeframe for the member to submit a Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
		  ○ For M/S, members must notify the Plan within timely filing requirements
		
		• Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state, and federal requirements.
		  ○ M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
		
		• Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG.
		
		Outcomes data reviewed for comparability
		OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
		
		There is an insufficient number of MH/SUD OON outpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3.
		
		Plan 1
		Administrative Denial Rate - 48.85% (106 out of 217 cases)
		Clinical Denial Rate - 16.13% (35 out of 217 cases)
		
		Plan 2
		Administrative Denial Rate - 75% (3 out of 4 cases)
		Clinical Denial Rate - 25% (1 out of 4 cases)
		
		Plan 3
		Administrative Denial Rate - 51.33% (271 out of 528 cases)
		Clinical Denial Rate - 11.36% (60 out of 528 cases)
		
		All analysis and material documentation is available upon request.

	Clinical Denial Rate - 15.38% (2 out of 13 cases) Plan 3 Administrative Denial Rate - 0% (0 out of 10 cases) Clinical Denial Rate - 0% (0 out of 10 cases) All analysis and material documentation is available upon request.	
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no differences in clinical procedure coding, billing coding and process NQTL practices that limit benefits within the similarly mapped classification when compared between medical/surgical and mental health/substance use disorder.	There are no differences in clinical procedure coding, billing coding and process NQTL practices that limit benefits within the similarly mapped classification when compared between medical/surgical and mental health/substance use disorder.
Case & Medical Management NQTL Practices	Medical Case Management is a collaborative process between a member, that member's treating providers, and the Plan to improve the member's functional health and well-being and support the member's recovery. Such programs seek to achieve this goal by proactively engaging members before their health declines and helping them avoid escalation to higher levels of care (for example inpatient hospitalization). Case management is a voluntary member-facing program that does not include coverage determinations. Medical Case Management does not modify or influence a benefit determination. Case Managers do not make or recommend medical necessity determinations, do not direct treatment, or place treatment limitations based on program participation or lack thereof.	Medical Case Management is a collaborative process between a member, that member's treating providers, and the Plan to improve the member's functional health and well-being and support the member's recovery. Such programs seek to achieve this goal by proactively engaging members before their health declines and helping them avoid escalation to higher levels of care (for example inpatient hospitalization). Case management is a voluntary member-facing program that does not include coverage determinations. Medical Case Management does not modify or influence a benefit determination. Case Managers do not make or recommend medical necessity determinations, do not direct treatment, or place treatment limitations based on program participation or lack thereof.
Network Adequacy & Provider Reimbursement Rates	Step 1 For MH/SUD, the Plan conducts network adequacy reporting (by state/county) on a regular basis (no less than quarterly) to determine if Time, Distance, and Provider Threshold requirements are met. The network adequacy report incorporates both M/S and MH/SUD provider specialties. MH/SUD utilize the network adequacy report and ensure that the Network Variation Tracker (NVT) and Analytics tools are used when inconsistencies are identified. For MH/SUD, the results of the network adequacy report are sent to the National Quality Improvement Committees (NQIC) as well as the respective Health Plan Oversight Committee through the NVT. The Health Plan Oversite Committee assesses and reviews the results and recommends interventions, as needed. If a network gap is identified, a network recruitment plan is developed by the MH/SUD Provider Relations and Contracting teams. Step 2 There are no differences in the factors used Step 3 There are no differences in the standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis.	Step 1 For M/S, the Plan conducts network adequacy reporting (by state/county) on a regular basis (no less than quarterly) to determine if Time, Distance, and Provider Threshold requirements are met. The network adequacy report incorporates both M/S and MH/SUD provider specialties. M/S and MH/SUD utilize the network adequacy report and ensure that the Network Variation Tracker (NVT) and Analytics tools are used when inconsistencies are identified. For M/S, the results of the network adequacy report are sent to the Regional Director of Network Deficiencies through an NVT. If network gaps are identified, a network recruitment plan is developed by the M/S Provider Relations and Contracting teams. Step 2 There are no differences in the factors used Step 3 There are no differences in the standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis. All analysis and material documentation is available upon request. **Provider Reimbursement - Professional**

	All analysis and material documentation is available upon request.
	
	Provider Reimbursement - Professional
	Step 1
	For MH/SUD providers, the Plan uses a comparable process to negotiate and establish reimbursement rate(s) for INN professional services. The Plan delegates negotiation of reimbursement rates for MH/SUD providers to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.
	
	Key steps in the INN professional services reimbursement negotiation process for both M/S and MH/SUD services include:
	• The provider submits a completed application to the Plan to be included in the Plan's provider network
	• Based on the above, the Plan offers a contract and reimbursement rate package to the provider for the services/programs the provider intends to offer
	• If the provider rejects the contract proposal, the Plan may negotiate with the provider using the factors described
	
	Detailed process for the INN professional services reimbursement negotiation:
	
	For MH/SUD professionals, the Plan follows a comparable process. The Plan starts with the CMS national physician fee schedule rate for the service type and practitioner type at issue and then determines the percentage of CMS reimbursement based upon CMS locality fee schedules and the factors, evidentiary standards, and sources described in Steps 2 and 3 below. The Plan maintains five (5) internally developed standard fee schedules based on the CMS national physician fee schedule rates and the CMS geography-specific rates for the provider's area. Individual or group MH/SUD care providers are assigned to one of these standardized fee schedules based on their geographic location.
	
	For MH/SUD professional providers, the Plan uses CMS annual national RVUs and other data to determine whether routine, non-negotiation-based adjustments to the fee schedules may be necessary. If an RVU is not available for a particular code, the Plan uses other sources such as the FairHealth Medicare Gap Fill Database and then market research to determine an appropriate rate.
	
	Providers already in the network may also negotiate for non-routine adjustments upon contract renewal or changing market circumstances. For both M/S and MH/SUD professional providers, the fee schedule rates are negotiable, and the Plan assesses the market dynamic factors listed in Step 2 to reach agreement with providers.
	
	Step 2
	There are no differences in the factors used
	
	Step 3
		Step 1
		For both M/S and MH/SUD providers, the Plan uses a comparable process to negotiate and establish reimbursement rate(s) for INN professional services.
		
		Key steps in the INN professional services reimbursement negotiation process for both M/S and MH/SUD services include:
		• The provider submits a completed application to the Plan to be included in the Plan's provider network
		• Based on the above, the Plan offers a contract and reimbursement rate package to the provider for the services/programs the provider intends to offer
		• If the provider rejects the contract proposal, the Plan may negotiate with the provider using the factors described
		
		Detailed process for the INN professional services reimbursement negotiation:
		
		For M/S professionals, the Plan contracts for services using standardized reimbursement templates. These templates are organized by Medicare carrier locality and reflect 100% of Geographic Practice Cost Indices (GPCI)-adjusted Centers for Medicare & Medicaid Services (CMS) reimbursement for a given rate year. The Plan uses the following fee sources to create these templates:
		• CMS Resource Based Relative Value Scale (RBRVS) is determined by calculating the CMS relative value units (RVU):
		  ○ The CMS RVU for a given service or procedure is derived using the following mathematical formula: (work RVU x work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI) x CF. This is also referred to as the CMS benchmark rate
		  ○ Definitions:
		  ▪ Work = Provider work reflects the provider's work when performing a procedure or service including provider's technical skills, physical effort, mental effort and judgment, stress related to patient risk, and the amount of time required to perform the service or procedure
		  ▪ PE = Provider Expense reflects the costs for medical supplies, office supplies, clinical and administrative staff, and pro rata costs of building space, utilities, medical equipment, and office equipment
		  ▪ MP = Malpractice Insurance expense reflects the cost of professional liability insurance based on an estimate of the relative risk associated with procedure or service
		  ▪ CF = Conversion Factor
		  ▪ GPCI = Geographic Practice Cost Indices
		• Applicable CMS RVU
		• FAIR Health Medicare GapFill PLUS database
		• CMS Clinical Lab Fee Schedule
		• CMS DMEPOS (Durable Medical Equipment, Prosthetics/Orthotics, and Supplies) Fee Schedule
		• CMS ASP (Average Sales Pricing) and RJ Health ASP (for drug pricing)
		• CMS Ambulance Fee Schedule
		• RBRVS (for codes not priced by CMS) M/S providers only
		• CMS Carrier Priced Fees (for codes referred to the local carrier for pricing)
		• Within these templates, Current Procedural Technology® (CPT), Healthcare Common Procedure Coding System (HCPCS) codes are organized into 54 type of service categories:
		  ○ Evaluation & Management – 4 categories
		  ○ Surgery – 15 categories
		  ○ Radiology – 10 categories
		  ○ Laboratory/Pathology – 3 categories

	There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request. **Provider Reimbursement - Facility** Step 1 Negotiation For MH/SUD facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. The Plan delegates negotiation of reimbursement rates for MH/SUD facility providers to, it's delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Key steps in the INN facility reimbursement negotiation process for MH/SUD services include: • The facility submits a completed application to the Plan to be included in the Plan's provider network • The Plan reviews the facility reimbursement proposal • Based on the above, the Plan accepts the reimbursement proposal or negotiates reimbursement rates with the facility using the factors described Detailed process for the INN facility reimbursement negotiation: Facilities newly seeking to join the Plan provider network submit a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility. Existing market rates are used as the baseline for negotiating rates. For MH/SUD providers, the Plan prepares an analysis of market dynamics that the Plan contracting team may access to inform negotiations. MH/SUD facilities that participate in the Plan provider network may negotiate reimbursement adjustments upon contract renewal or changing market circumstances by submitting a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility. For facilities already in the network, the existing facility contract rates are used as the contract negotiation baseline. The Plan may take market dynamics into consideration when negotiating reimbursement rates with facilities. For MH/SUD providers, the Plan prepares an analysis of market dynamics that the Plan contracting team may access to inform negotiations. Inpatient MH/SUD – Inpatient and Residential The Plan contracts for inpatient MH/SUD services using the following methodology: • Per Diem – The facility is paid using negotiated MH/SUD per diem rates. The per diem rate is multiplied by the number of days corresponding to the per diem type	○ Medicine – 10 categories ○ Obstetrics – 1 category ○ Immunizations/Injectables – 5 categories ○ DME & Supplies – 5 categories ○ Ambulance – 1 category This standardized structure enables the Plan to tailor fee schedules around specific CPT/HCPCS codes, generally the highest volume codes, billed by different types of providers. Thus, the fee schedules are not specialty-specific; but instead based on the codes most likely to be billed by a particular provider. Before creating a new fee schedule for a negotiation, the Plan determines if there is an existing fee schedule that will meet the needs of the negotiation; for example, if the negotiation is with a primary care group in Bridgeport, the Plan would look to find other primary care group fee schedules for that geographic locality that included the relevant codes. If no existing fee schedule fits the factual scenario, then the creation of a new fee schedule will be approved. The Plan does not maintain designated "go-out" or "base rate" fee schedules for M/S services. Rather, the Plan begins with the standardized structure described here and then negotiates a percentage of CMS reimbursement with providers for the service categories listed above, applying the factors described in Step 2 and evidentiary sources described in Step 3 below. Any CPT/HCPCS codes not reflected in the fee schedule templates are paid at a negotiated percentage of charges. Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request. **Provider Reimbursement - Facility** Step 1 Negotiation For both M/S facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. Key steps in the INN facility reimbursement negotiation process for M/S services include: • The facility submits a completed application to the Plan to be included in the Plan's provider network • The Plan reviews the facility reimbursement proposal • Based on the above, the Plan accepts the reimbursement proposal or negotiates reimbursement rates with the facility using the factors described

	In addition, MH/SUD agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics. Outpatient MH/SUD – Intensive Outpatient Programs and Partial Hospitalization Programs The Plan contracts for outpatient MH/SUD facility services are negotiated and mutually agreed upon with the facility. The starting point is usually a proposal from the engaged facility. The Plan will use other available information including market dynamics and CMS guidelines (when available) as benchmarks to support its negotiation position. The Plan contracts for MH/SUD services using the following methodology: • Per Diem – The facility is paid using negotiated MH/SUD per diem rates In addition, MH/SUD agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics. Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "as written" and "in operation" analysis All analysis and material documentation is available upon request. **OON Reimbursement - Inpatient/Outpatient** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request.	Detailed process for the INN facility reimbursement negotiation: Facilities newly seeking to join the Plan provider network submit a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility. Existing market rates are used as the baseline for negotiating rates. For M/S services, the Plan may document the market dynamic factors that inform a provider-specific negotiation. The Plan does not apply defined formulae to establish base rates or standard fee schedules. M/S facilities that participate in the Plan provider network may negotiate reimbursement adjustments upon contract renewal or changing market circumstances by submitting a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility. For facilities already in the network, the existing facility contract rates are used as the contract negotiation baseline. The Plan may take market dynamics into consideration when negotiating reimbursement rates with facilities. For M/S services, the Plan may document the market dynamic factors that inform a provider-specific negotiation. The Plan does not apply defined formulae to establish base rates or standard fee schedules. Inpatient M/S -- General Acute Care, Children's, and Long-Term Acute Care Facilities The Plan contracts for inpatient M/S services using one of four key inpatient reimbursement methodologies: MS-Diagnosis Related Group (DRG), Per Case, Per Diem, and Percentage Payment Rate (PPR). While these methodologies provide a starting point, the rate categories, rate category definitions, and rate types can be modified based on negotiations with facilities. In addition, a given contract will often feature a combination of inpatient reimbursement methodologies. For example, within a Per Diem contract, it's not uncommon for cases associated with a defined list of cardiac and/or musculoskeletal MS-DRGs to be reimbursed on a per-case basis, while all other M/S cases are reimbursed on a per diem basis. The following provides an overview of the inpatient reimbursement methodologies used by the Plan: • MS-DRG – The facility is paid using a single, negotiated base rate. The base rate is multiplied by the Centers for Medicare & Medicaid Services (CMS) MS-DRG relative weight for the MS-DRG assigned to the case. Contracts are written to use the current version of the MS-DRGs and relative weights • Per Case – The facility is paid using negotiated M/S case rates. The per case rate is paid for the entire case, regardless of the MS-DRG assigned to the case or the length of stay. There may be separate per case rates for medical cases versus surgical cases. This reimbursement method is rarely used for M/S cases; it's more likely to be used for specific types of cases "carved out" from M/S per diem rates. Examples of services that may be carved out include high-cost drugs, implants, obstetrics, NICU, and outliers • Per Diem – The facility is paid using negotiated M/S per diem rates. The per diem rate is multiplied by the number of days corresponding to the per diem type. There may be separate per diem rates for medical cases versus surgical cases • PPR – The facility is paid a percentage of charges. The PPR rate is multiplied by the eligible charges for the case In addition, M/S agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics. Outpatient M/S -- General Acute Care, Children's, and Long-Term Acute Care Facilities

	OON Reimbursement - Emergency Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request.	The Plan contracts for outpatient M/S facility services using standardized reimbursement templates, each of which is organized around one of five key outpatient reimbursement methodologies: Ambulatory Payment Classifications (APC), Per Case, Per Visit, Per Unit, and PPR. While these templates provide a starting point, the rate categories, rate category definitions, and rate types reflected in the templates can be modified based on negotiations with providers. In addition, a given contract will often feature a combination of outpatient reimbursement methodologies. For example, within a fixed outpatient contract, services may be subject to Per Case, Per Visit, and Per Unit reimbursement. At the same time, contract variations would allow any or all services to be subject to PPR reimbursement. It is also possible for a single outpatient claim (except for claims paid on a Per Case basis) to be paid using more than one of these reimbursement methodologies. For example, some services on a given claim may be subject to Per Visit reimbursement, while other services may be subject to Per Unit reimbursement. The following provides an overview of the outpatient reimbursement methodologies used: • APC – The facility is paid using a single, negotiated APC conversion factor for services subject to such reimbursement under the Medicare outpatient prospective payment system (OPPS). The conversion factor is multiplied by the relative weights for the APCs assigned to the case by the OPPS pricing software. Services not subject to APC payment are paid using facility fee schedules (see Per Unit below). Contracts are written to use the current version of the APCs and relative weights • Per Case – The facility is paid using negotiated per case rates for certain types of outpatient cases, including outpatient surgery, observation, emergency room, and urgent care. All services provided during the encounter are included in the per case payment and are not separately reimbursable • Per Visit – The facility is paid using negotiated per visit rates for certain types of outpatient services. The per visit rate is multiplied by the number of visits billed on a given claim. If a given claim spans multiple dates of service, then the visits on each of the separate days are reimbursable. Examples of services that may be subject to Per Visit reimbursement include, IV therapy, oncology treatment, and dialysis • Per Unit – The facility paid is using a negotiated facility fee schedule for certain types of outpatient services, including laboratory, pathology, and radiology. The per unit rate is multiplied by the number of units billed for a given Current Procedural Technology® (CPT), or Healthcare Common Procedure Coding System (HCPCS) code on a given claim. Facility fee schedules are generally based on a percentage of the CMS rate • PPR – The facility is paid a percentage of charges. The PPR rate is multiplied by the eligible charges for the case M/S agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics. Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "as written" and "in operation" analysis

		All analysis and material documentation is available upon request. **OON Reimbursement - Inpatient/Outpatient** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request. **OON Reimbursement - Emergency** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request.
(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 a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information for the NQTLs. The findings of the comparative analysis 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 both “as written” and "in operation." 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 (3b)

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 (13) 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.	Step 1 The Plan covers MH/SUD services/technologies (e.g., services, interventions, devices, medically administered MH/SUD drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member's disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as , Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII) guidelines as well as internally developed objective, evidence-based, behavioral clinical policies. Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination. The Plan publishes its medical necessity criteria, which are available online and upon request. This document includes the following information: • Process for developing and approving medical necessity criteria for MH/SUD services and technologies • Description of the NQTL and application (Step 1) • Factors used to determine which services and technologies are subject to the NQTL (Step 2) • Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3) • NQTL "as written" and "in operation" comparability and stringency analysis (Step 4) • Findings and conclusions (Step 5) The Plan concludes that the methodologies used to develop and approve medical necessity criteria and behavioral clinical policies for MH/SUD services and technologies are comparable and applied no more stringently for MH/SUD than M/S both "as written" and "in operation."	Step 1 The Plan covers M/S services/technologies (e.g., services, interventions, devices, medically administered M/S drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member's disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as InterQual® and MCG® as well as internally developed objective, evidence-based, medical clinical policies. Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination. The Plan publishes its medical necessity criteria, which are available through the Plan's website and upon request. This document includes the following information: • Process for developing and approving medical necessity criteria for M/S services and technologies • Description of the NQTL and application (Step 1) • Factors used to determine which services and technologies are subject to the NQTL (Step 2) • Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3) • NQTL "as written" and "in operation" comparability and stringency analysis (Step 4) • Findings and conclusions (Step 5) The Plan concludes that the methodologies used to develop and approve medical necessity criteria and medical clinical policies for M/S services and technologies are comparable and applied no more stringently for MH/SUD both "as written" and "in operation." Per the Clinical Services Medical Management Operational Policy: Approved Definitions, Medical Necessity is defined as: "Health care services provided for the purpose of preventing, evaluating, diagnosing or

	Per the Clinical Services Medical Management Operational Policy: Approved Definitions, Medical Necessity is defined as: "Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following. • 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-related and addictive disorders, disease or its symptoms. • Not mainly for your convenience or that of your doctor or other health care provider. • 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." The September 2023, MH/SUD National Network Manual defines Medical Necessity as "Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or state laws (also referred to as Clinical Necessity)." The Plan delegates UM of MH/SUD services to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Both M/S and MH/SUD have UM program descriptions that are the foundation for the objectives and guidelines of the Plan's UM strategy. Medical necessity criteria or medical/behavioral clinical policies are not included in the UM program descriptions. The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, MH/SUD uses externally developed evidence-based medical necessity criteria (e.g., LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. All MH/SUD internally developed medical and behavioral clinical policies are reviewed at least annually. The MH/SUD Clinical Criteria Development/Selection and Application Policy outline the processes to ensure medical necessity criteria are developed consistently. The Plan uses the following standard process to review externally developed medical necessity criteria: The Clinical Quality and Operations Committee (CQOC) assesses and approves the use of externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based, clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its assessment and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. The CQOC is comprised of representatives from sub-committees, representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician. The Plan uses the following standard process to develop and approve internal medical necessity criteria:	treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following. • 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-related and addictive disorders, disease or its symptoms. • Not mainly for your convenience or that of your doctor or other health care provider. • 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. The Plan delegates UM of MH/SUD services to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. M/S have UM program descriptions that are the foundation for the objectives and guidelines of the Plan's UM strategy. Medical necessity criteria or medical/behavioral clinical policies are not included in the UM program descriptions. The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, M/S use externally developed evidence-based medical necessity criteria (e.g., InterQual and MCG) when making clinical coverage determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical clinical policies are used when making medical necessity clinical coverage determinations. All M/S internally developed medical and behavioral clinical policies are reviewed at least annually. The M/S Clinical Review Criteria Operational Policy outlines the processes to ensure medical necessity criteria are developed consistently. The Plan uses the following standard process to review externally developed medical necessity criteria: The Medical Technology Assessment Committee (MTAC) assesses externally developed clinical criteria for M/S services and technologies. MTAC uses scientifically based, clinical evidence and the M/S Hierarchy of Clinical Evidence in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members. MTAC is comprised of, but not limited to, medical directors with diverse medical and surgical specialties and sub-specialties, representatives from business segments, legal services, consumer affairs, medical policy development and operations teams, benefit interpretation team, and other guests, as needed. MTAC voting members include medical directors with the following specialties (note that some doctors have multiple specialties): • Plastic Surgery • Internal Medicine (x7) • Medical Oncology • Thoracic and Cardiothoracic Vascular Surgery (x2) • Preventative Medicine • Pediatrics • Diagnostic Radiology and Vascular/Interventional Radiology

	The Plan uses committees to assess technologies and conduct a thorough review of scientifically based clinical evidence and peer-reviewed literature in accordance with the M/S and Behavioral Health Hierarchies of Clinical Evidence to develop behavioral clinical policies that apply to the technologies. The CQOC develops and approves behavioral clinical policies for MH/SUD services when externally developed criteria are not available. CQOC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. The Clinical Technology Assessment Committee (CTAC) is a sub-committee of CQOC and is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies. CTAC's purpose is to make determinations regarding technologies that may or may not be experimental, investigational, or unproven (EIU). CTAC members include behavioral health medical directors, senior leaders of clinical operations, research and development, clinical review, legal, compliance, and policy. CTAC voting members include six psychiatrists and one licensed independent social worker (LISW), plus two co-chairs, both of whom are psychiatrists. CTAC obtains approval of its determinations from the CQOC. When assessing the safety efficacy, and appropriateness of services/technologies used to treat MH/SUD conditions, CQOC and CTAC first look for scientifically based clinical evidence and peer reviewed literature. In addition, the committees will look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials and cohort studies. In addition, CTAC (for EIU) and CQOC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions. In the absence of any strong and compelling scientific evidence, CQOC (and CTAC for potential EIU technologies) assesses services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs. CQOC (and CTAC for potential EIU technologies) will not deem a service or technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. The CQOC reviews and validates behavioral clinical policies endorsed by CTAC. If CQOC determines that any behavioral clinical policies are not appropriately supported by clinical evidence, then CQOC refers the behavioral clinical policy back to CTAC. Internally developed medical and behavioral clinical policies are publicly available on the Plan's website The Plan uses the following standard process to apply medical necessity criteria: MH/SUD clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available,	• Ophthalmology • Physical Medicine & Rehabilitation Pain Medicine • Family Practice • Emergency Medicine The National Medical Care Management Committee (NMCMC) annually reviews and validates medical necessity criteria endorsed by MTAC. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization, Concurrent Review, and Retrospective Review processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. MTAC reports to the UMPC. The Plan uses the following standard process to develop and approve internal medical necessity criteria: The Plan uses committees to assess technologies and conduct a thorough review of scientifically based clinical evidence and peer-reviewed literature in accordance with the M/S Hierarchies of Clinical Evidence to develop medical clinical policies that apply to the technologies. MTAC develops and approves medical clinical policies for M/S services and technologies when externally developed criteria are not available. MTAC uses scientifically based clinical evidence and the M/S Hierarchy of Clinical Evidence in its development and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members. When assessing the safety, efficacy, and appropriateness of the services/technologies used to treat M/S conditions, MTAC first looks for any strong and compelling scientific evidence such as statistically robust,

	MH/SUD use externally developed evidence-based medical necessity criteria (e.g., LOCUS, CALOCUS-CASII and ECSII) when making medical necessity coverage benefit determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, behavioral clinical policies are used when making medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This means that there are either externally developed medical necessity criteria available or there are internally developed behavioral clinical policies available. MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies. Per the Clinical Services Medical Management Operational Policy: Approved Definitions, Medical Necessity is defined as follows: "Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following. • 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-related and addictive disorders, disease or its symptoms. • Not mainly for your convenience or that of your doctor or other health care provider. • 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. The MH/SUD National Policy Definitions List defers to the definition of Medical Necessity as set forth in member Plan documents: "This term is variable and defined in the member's applicable Plan or Coverage document." The September 2023, MH/SUD National Network Manual defines Medical Necessity as: "Generally, the evaluation of health care services to determine whether the services meet plan criteria for coverage; are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. This definition may vary according to Member Benefit Plans or state laws (also referred to as Clinical Necessity)." Step 2 The Plan relies on the following factor to develop and approve medical necessity criteria: II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM	well-designed, randomized, controlled, trials and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies. In the absence of any strong and compelling scientific evidence, MTAC assesses technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD). MTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. The NMCMC annually reviews and validates medical clinical policies endorsed by MTAC. If NMCMC determines that any medical clinical policies are not appropriately supported by clinical evidence, then NMCMC refers the medical clinical policy back to MTAC. As of April 1, 2023, UMPC began reviewing and validating the medical clinical policies endorsed by MTAC. If UMPC determines that any medical clinical policies are not appropriately supported by clinical evidence, then UMPC refers the medical clinical policy back to MTAC. Internally developed medical and behavioral clinical policies are publicly available on the Plan's website: The Plan uses the following standard process to apply medical necessity criteria: M/S clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available, M/S use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG) when making medical necessity coverage benefit determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical clinical policies are used when making medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This means that there are either externally developed medical necessity criteria available or there are internally developed medical clinical policies available. M/S clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The M/S Peer Clinical Review Operational Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical clinical policies. Step 2 The M/S Factors are the same as MH/SUD Step 3

	• MH/SUD Committee Considerations (Qualitative) including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical/behavioral clinical policies and medical necessity criteria Step 3 Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. These evidentiary standards and sources apply for the following: II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM • Factor – MH/SUD Committee Considerations, including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical/behavioral clinical policies and medical necessity criteria ○ Clinical Effectiveness – Is a characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective ○ Safety of Service or Technology - Is a state in which hazards and conditions leading to physical or psychological harm are minimized to preserve the health and wellbeing of a person receiving health care ○ Appropriateness of the Proposed Service or Technology – The service or technology is suitable for the member's clinical presentation and the expected health benefits from the medical service or technology are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin • The Plan's evidentiary standard and sources that define and/or trigger the MH/SUD Committee Considerations factor: ○ The Plan uses scientifically based clinical evidence and the Behavioral Health Hierarchies of Clinical Evidence to determine which MH/SUD services or technologies are safe and effective and, therefore, eligible for benefit coverage. The Behavioral Health Hierarchies of Clinical Evidence detail the hierarchy of clinical evidence that is preferred when assessing which health services or technologies are safe and effective. To be deemed safe and effective, a health service or technology only has to have evidence in at least one category. ○ MH/SUD assesses evidence from the following when developing or approving behavioral clinical policies/medical necessity criteria: • Scientifically based clinical evidence • Peer-reviewed literature • Behavioral Health Hierarchy of Clinical Evidence • In the absence of strong and compelling scientific evidence, behavioral clinical policies/clinical criteria may be based upon: ○ National consensus statements ○ Publications by recognized authorities such as government sources and/or professional societies ○ LOCUS, CALOCUS-CASII, and ECSII (for review of external medical necessity criteria) Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available.	Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. These evidentiary standards and sources apply for the following: I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM • Factor – M/S Committee Considerations, including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical clinical policies and medical necessity criteria ○ Clinical Effectiveness – Is a characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective ○ Safety of Service or Technology - Is a state in which hazards and conditions leading to physical or psychological harm are minimized to preserve the health and wellbeing of a person receiving health care ○ Appropriateness of the Proposed Service or Technology – The service or technology is suitable for the member's clinical presentation and the expected health benefits from the medical service or technology are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin • The Plan's evidentiary standard and sources that define and/or trigger the M/S Committee Considerations factor: ○ The Plan uses scientifically based clinical evidence and the M/S Clinical Evidence to determine which M/S services or technologies are safe and effective and, therefore, eligible for benefit coverage. The M/S Clinical Evidence detail the hierarchy of clinical evidence that is preferred when assessing which health services or technologies are safe and effective. To be deemed safe and effective, a health service or technology only has to have evidence in at least one category. ○ M/S assesses evidence from the following when developing or approving medical clinical policies/medical necessity criteria: • Scientifically based clinical evidence • Peer-reviewed literature • M/S Hierarchy of Clinical Evidence • In the absence of strong and compelling scientific evidence, medical policies may be based upon: ○ National guidelines and consensus statements ○ CMS NCDs ○ Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence, e.g., American College of Physicians (ACP), The Society for Post-Acute and Long-Term Care Medicine (AMDA), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), etc. • InterQual or MCG (for review of external medical necessity criteria) Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available. Step 4 As Written

	These evidentiary standards and sources MH/SUD services and technologies and are defined in a qualitative manner.
	
	The factor and evidentiary standards used as the basis for developing and approving MH/SUD medical necessity criteria are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for developing and approving M/S medical necessity criteria "as written" and "in operation."
	
	Step 4
	As Written
	The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information MH/SUD uses to
	• develop internal, objective, evidence-based, behavioral clinical policies and
	• approve third-party, externally developed clinical criteria
	• to the strategies, processes, factors, evidentiary standards, and source information M/S uses to:
	• develop internal, objective, evidence-based, medical clinical policies and
	• approve third-party, externally developed clinical criteria
	• for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S "as written."
	
	National internal committees evaluate the applicable factors and standards when developing and approving Medical Necessity criteria.
	
	Review of Factor and Evidentiary Standards
	When developing and approving medical and behavioral clinical policies/medical necessity criteria, MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed services or technologies.
	
	The MH/SUD Behavioral Health Hierarchies of Clinical Evidence are comparable. MH/SUD use the following categories of sources:
	• Well-designed evidence-based studies
	• Observational studies
	• Case studies
	• Consensus statements
	• Clinical and professional opinion papers
	
	Review of Operational Policies and Procedures
	The Plan reviewed the following MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.
	
	MH/SUD
	• Behavioral Health Hierarchy of Clinical Evidence
	  ○ The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which MH/SUD health services or technologies are safe and effective and, therefore,
		The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information MH/SUD uses to
		• develop internal, objective, evidence-based, behavioral clinical policies and
		• approve third-party, externally developed clinical criteria
		• to the strategies, processes, factors, evidentiary standards, and source information M/S uses to:
		• develop internal, objective, evidence-based, medical clinical policies and
		• approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S "as written."
		
		National internal committees evaluate the applicable factors and standards described in Steps 2 and 3 when developing and approving Medical Necessity criteria.
		
		Review of Factor and Evidentiary Standards
		When developing and approving medical clinical policies/medical necessity criteria, M/S committees both consider clinical efficacy, safety, and appropriateness of the proposed services or technologies.
		
		The M/S Hierarchies of Clinical Evidence use the following categories of sources:
		• Well-designed evidence-based studies
		• Observational studies
		• Case studies
		• Consensus statements
		• Clinical and professional opinion papers
		
		Review of Operational Policies and Procedures
		The Plan reviewed the following M/S operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes.
		
		M/S
		• Hierarchy of Clinical Evidence
		  ○ The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which M/S health services or technologies are safe and effective and, therefore, eligible for benefit coverage. In developing the hierarchy, M/S uses scientifically based clinical evidence to identify safe and effective health services or technologies for members.
		• MTAC Charter
		  ○ MTAC's mission is to review the scientifically based clinical evidence used in the development of M/S medical policies and clinical programs in an effort to ensure transparency and consistency and to identify safe and effective health services or technologies for members. MTAC's Charter outlines the structure, objectives, responsibilities, and scope of the activities carried out by the committee
		• NMCMC Charter
		  ○ The NMCMC is responsible for overseeing the development, implementation, and evaluation of the M/S UM program
		• Utilization Management Program Committee Charter

	eligible for benefit coverage. In developing the hierarchy, MH/SUD uses scientifically based clinical evidence to identify safe and effective health services or technologies for members
	• CTAC Charter
	  ○ CTAC is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies
	• CQOC Charter
	  ○ The role and purpose of the CQOC is to review and approve externally developed medical necessity criteria, develop behavioral clinical policies when externally developed criteria is not available, and to review and validate CTAC's assessment of EIU technologies
	• Management of Behavioral Health Benefits
	  ○ The purpose of this policy is to describe the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and ensure that members receive appropriate, high quality behavioral health services or technologies in a timely manner
	• Clinical Criteria Development Selection and Application Policy
	  ○ This document addresses MH/SUD selection, development, and use of clinical criteria in making benefit determinations. MH/SUD uses written clinical criteria consistent with National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) requirements and applicable laws and regulations
	  ○ MH/SUD selects and uses clinical criteria that are consistent with generally accepted standards of care, including objective criteria that are based on sound clinical evidence. MH/SUD uses the criteria to make standardized coverage determinations and to inform discussions about evidence-based practices and discharge planning
	
	Where available, MH/SUD use externally developed evidence-based medical necessity criteria (e.g., LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, behavioral clinical policies are used when making medical necessity clinical coverage determinations.
	
	CQOC (and CTAC for EIU) develop internal clinical policies only. CQOC review and approve externally developed medical necessity criteria. In either case, a comparable process is followed. In some cases, the Plan is obligated by State regulations to use certain externally developed medical necessity criteria. The committees assess the clinical efficacy, safety, and appropriateness of the proposed services or technologies used for the treatment of health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD potential EIU technologies, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S technologies including the Hierarchy of Clinical Evidence. Additionally, CQOC's assessment process for MH/SUD services, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S services including the M/S Hierarchy of Clinical Evidence.
	
	All MH/SUD behavioral clinical policies are reviewed at least annually.
	
	Review of processes to review externally developed medical necessity criteria
	The CQOC assesses externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development,
		○ The UMPC is responsible for oversight of the UM program and the development and maintenance of the scope and processes of prior authorization, concurrent review, and retrospective review, including defining the services that require prior authorization, concurrent review, and post-service review
		• Applying Benefit Plan and Review Criteria Standard Operating Procedure
		  ○ This standard operating procedure outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making clinical coverage determinations
		• UMPD of the Company
		  ○ This document summarizes the philosophy, structure and standards that govern M/S medical management, utilization management and utilization review responsibilities and functions
		• Clinical Review Criteria Operational Policy
		  ○ The purpose of this operational policy is to document that M/S will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently
		
		Where available, M/S use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG) when making clinical coverage determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations.
		
		MTAC and CQOC (and CTAC for EIU) develop internal clinical policies only. MTAC and CQOC review and approve externally developed medical necessity criteria. In either case, a comparable process is followed. In some cases, the Plan is obligated by State regulations to use certain externally developed medical necessity criteria. The committees assess the clinical efficacy, safety, and appropriateness of the proposed services or technologies used for the treatment of health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD potential EIU technologies, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S technologies including the M/S Hierarchy of Clinical Evidence. Additionally, CQOC's assessment process for MH/SUD services, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S services including the M/S Hierarchy of Clinical Evidence.
		
		All M/S medical clinical policies are reviewed at least annually.
		
		Review of processes to review externally developed medical necessity criteria
		A standard and comparable process is followed to review externally developed, third party medical necessity criteria. The MTAC assesses externally developed clinical criteria for M/S services or technologies. MTAC uses scientifically based, clinical evidence and the M/S Hierarchy of Clinical Evidence in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members.
		
		M/S committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services or technologies to approve medical clinical policies.
		
		Further, both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.

	assessment, and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services or technologies to approve medical/behavioral clinical policies. Further, both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors. LOCUS, CALOCUS-CASII, and ECSII are widely recognized as best-in-class externally developed medical necessity criteria sources. The MH/SUD external medical necessity criteria is developed by nationally recognized organizations. The MH/SUD medical necessity criteria sets apply to specific clinical conditions and do not overlap. Review of processes to develop and approve internal medical necessity criteria CQOC (and CTAC for EIU technologies) develops and approves behavioral clinical policies for MH/SUD services and technologies. CQOC/CTAC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CQOC/CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services and technologies for members. When assessing services and technologies used to treat M/S and MH/SUD conditions, both MTAC and CQOC/CTAC first look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. CQOC/CTAC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions. In the absence of any strong and compelling scientific evidence, CQOC/CTAC assess services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs. Neither CQOC nor CTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services and technologies to develop or approve medical/behavioral clinical policies. Review of Medical Necessity Processes MH/SUD clinical reviewers follow a hierarchy of authority when making medical necessity determinations. MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations (see enclosed MH/SUD Clinical Criteria Development Selection and Application Policy). Internally developed clinical policies or externally developed third party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. As there is no duplication	The Plan uses InterQual medical necessity criteria for M/S services or technologies because InterQual monitors more than 3,000 guidelines, guideline issuers and medical societies for newly published medical literature, and an independent clinical review panel drawn from more than 1,000 experts provides authoritative peer review. The M/S medical necessity criteria sets apply to specific clinical conditions and do not overlap. Review of processes to develop and approve internal medical necessity criteria MTAC develops and approves medical clinical policies for M/S services or technologies. MTAC uses scientifically based clinical evidence and the M/S Hierarchy of Clinical Evidence in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members. In the absence of any strong and compelling scientific evidence, MTAC assess services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs. MTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. M/S committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services and technologies to develop or approve medical clinical policies. Review of Medical Necessity Processes M/S clinical reviewers follow a hierarchy of authority when making medical necessity determinations. M/S clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations (see enclosed M/S Applying Benefit Plan and Review Criteria Standard Operating Procedure). Internally developed clinical policies or externally developed third party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. As there is no duplication between internally and externally developed medical necessity criteria, M/S clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. The Plan generally assesses the appropriate application of its medical necessity criteria in operation by comparing the results of its mandatory M/S Inter-Rater Reliability (IRR) assessment outcomes. In Operation The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to • develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria • to the strategies, processes, factors, evidentiary standards, and source information M/S uses to: • develop internal, objective, evidence-based, medical clinical policies and • approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S “in operation.”

	between internally and externally developed medical necessity criteria, MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria.
	
	The Plan generally assesses the appropriate application of its medical necessity criteria in operation by comparing the results of its mandatory MH/SUD Inter-Rater Reliability (IRR) assessment outcomes.
	
	In Operation
	
	The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to
	• develop internal, objective, evidence-based, behavioral clinical policies and
	• approve third-party, externally developed clinical criteria
	• to the strategies, processes, factors, evidentiary standards, and source information M/S uses to:
	• develop internal, objective, evidence-based, medical clinical policies and
	• approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S "in operation."
	
	Review of Factor and Evidentiary Standards
	When reviewing and developing medical/behavioral clinical policies and medical necessity criteria, MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed services and technologies. The Behavioral Health Hierarchies of Clinical Evidence are comparable. The factors and evidentiary standards were applied to MH/SUD services and technologies comparably and not more stringently to MH/SUD services than to M/S services and technologies "in operation."
	
	Review of Operational Policies and Procedures
	The Plan reviewed MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. The MH/SUD Clinical Criteria Development/Selection and Application Policy outline the processes to ensure medical necessity criteria are developed consistently. Second level, or peer review, determinations include clinical judgment; the MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal behavioral clinical policies. Further, review of the committee charters confirms that both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.
	
	Review of process to develop and approve medical necessity criteria
	The strategy for developing and approving medical necessity criteria is comparable and applied no more stringently to MH/SUD than M/S services and technologies. The Plan conducted a review of the MH/SUD processes to confirm comparability. The review focused on the following aspects of the process for MH/SUD:
	• The committees follow standard processes outlined in their respective charters and apply their respective Hierarchies of Clinical Evidence when developing, assessing, and approving medical/behavioral clinical policies and medical necessity criteria.
		Review of Factor and Evidentiary Standards
		When reviewing and developing medical clinical policies and medical necessity criteria, M/S committees both consider clinical efficacy, safety, and appropriateness of the proposed services and technologies. The M/S Hierarchies of Clinical Evidence are comparable. The factors and evidentiary standards were applied to M/S services and technologies comparably and not more stringently to MH/SUD services than to M/S services and technologies "in operation."
		
		Review of Operational Policies and Procedures
		The Plan reviewed M/S operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. The M/S Clinical Review Criteria Operational Policy outline the processes to ensure medical necessity criteria are developed consistently. Second level, or peer review, determinations include clinical judgment; the M/S Peer Clinical Review Operational Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical clinical policies. Further, review of the committee charters confirms that both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.
		
		Review of process to develop and approve medical necessity criteria
		The strategy for developing and approving medical necessity criteria is comparable for both M/S and applied no more stringently to MH/SUD services and technologies. The Plan conducted a review of the M/S processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD:
		• The committees follow standard processes outlined in their respective charters and apply their respective Hierarchies of Clinical Evidence when developing, assessing, and approving medical clinical policies and medical necessity criteria.
		  ○ MTAC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new medical clinical policies when external criteria were not available
		  ○ UMPC reviewed and validated the MTAC assessment and approval of medical necessity criteria.
		• If UMPC determine that any internally developed medical clinical policies are not appropriately supported by clinical evidence, then UMPC refer the medical necessity criteria back to MTAC.
		
		Review of Use of Medical Necessity Criteria
		M/S utilize medical clinical policies and medical necessity criteria when making medical necessity clinical coverage benefit determinations related to M/S services and technologies. All M/S clinical staff and peer reviewers who make clinical coverage benefit determinations utilizing medical clinical policies and medical necessity criteria are required to participate in an IRR assessment to ensure clinical policies and medical necessity criteria are applied in a consistent and appropriate manner "in operation." Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager.

	○ CQOC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new behavioral clinical policies when external criteria were not available. ○ CTAC developed behavioral clinical policies for EIU. • CQOC reviewed and approved EIU behavioral clinical policies developed by CTAC • If CQOC determines that any internally developed behavioral clinical policies are not appropriately supported by clinical evidence, then CQOC refer the medical necessity criteria back to CTAC. Review of Use of Medical Necessity Criteria MH/SUD utilize behavioral clinical policies and medical necessity criteria when making medical necessity clinical coverage benefit determinations related to MH/SUD services and technologies. All MH/SUD clinical staff and peer reviewers who make clinical coverage benefit determinations utilizing behavioral clinical policies and medical necessity criteria are required to participate in an IRR assessment to ensure clinical policies and medical necessity criteria are applied in a consistent and appropriate manner "in operation." Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager. Second level, or peer review, medical necessity benefit coverage determinations include clinical judgment. The MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal behavioral clinical policies.	Second level, or peer review, medical necessity benefit coverage determinations include clinical judgment. The M/S Peer Clinical Review Operational Policy outlines the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria.
In-Patient & In-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
In-Patient & Out-of-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network

	• Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	• Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
Out-Patient & In-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
Out-Patient & Out-of-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.

Emergency Services/Benefits NQTL Practices	Concurrent Review and Retrospective Review are not performed on MH/SUD Emergency services. Emergency services for MH/SUD, as defined by the prudent layperson standard (and as defined by the state), are covered without medical necessity.	Concurrent and Retrospective Review are not performed on M/S Emergency services. Emergency services for M/S, as defined by the prudent layperson standard (and as defined by the state), are covered without medical necessity.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	Prescription Drug List (PDL) Design Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors Step 3 There are no differences in the evidentiary standards and sources Step 4 The Pharmacy & Therapeutics (P&T) Committee assesses a MH/SUD prescription drug's place in therapy, and its relative safety and efficacy, in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. 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 a single P&T Committee. The Plan reviewed the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis The findings of the Prescription Drug Tier Analysis (see data below) indicated the percent of prescription drugs by tiers for MH/SUD prescription drugs were comparable to the percent of prescription drugs by tiers for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. The following are results of each analysis in 2022: • January 2021 – 59.0% of MH/SUD drugs are on Tiers 1 and 2 • May 2022 – 57.9% of MH/SUD drugs are on Tiers 1 and 2 • September 2022 – 56.9% of MH/SUD drugs are on Tiers 1 and 2 These evaluations were based on the Advantage PDL, which is the most commonly used PDL. Prescription Drug Prior Authorization / Step Therapy / Quantity Limits For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop MH/SUD drug policies through a single Pharmacy & Therapeutics (P&T) Committee. The findings of the prescription drug prior authorization or step therapy outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for M/S prescription drugs. Data is for (January, May, and September 2023). The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.	Prescription Drug List (PDL) Design Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors Step 3 There are no differences in the evidentiary standards and sources Step 4 The Pharmacy & Therapeutics (P&T) Committee assesses a M/S prescription drug's place in therapy, and its relative safety and efficacy, in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. 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 a single P&T Committee. The Plan reviewed the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis The findings of the Prescription Drug Tier Analysis (see data below) indicated the percent of prescription drugs by tiers for MH/SUD prescription drugs were comparable to the percent of prescription drugs by tiers for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. The following are results of each analysis in 2022: • January 2022 – 53.3% of M/S drugs are on Tiers 1 and 2 • May 2022 – 52.9% of M/S drugs are on Tiers 1 and 2 • September 2022 – 52.8% of M/S drugs are on Tiers 1 and 2 These evaluations were based on the Advantage PDL, which is the most commonly used PDL. Prescription Drug Prior Authorization / Step Therapy / Quantity Limits For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop M/S drug policies through a single Pharmacy & Therapeutics (P&T) Committee. The findings of the prescription drug prior authorization or step therapy outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for M/S prescription drugs. Data is for (January, May, and September 2023). The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

	The following are results of each analysis in 2023 • January 2023 – 33.7% (165) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • May 2023 – 33.7% (165) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • September 2023 – 34.0% (166) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits All analysis and material documentation is available upon request.	The following are results of each analysis in 2023 • January 2023 – 38.5% (1,575) of M/S drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • May 2023 – 39.3% (1,618) of M/S drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • September 2023 – 40.1% (1,657) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits
Prior-Authorization NQTL Practices	**IP and INN** N/A. The Plan does not perform Prior Authorizations **IP and OON** N/A. The Plan does not perform Prior Authorizations **OP and INN** N/A. The Plan does not perform Prior Authorizations **OP and OON** N/A. The Plan does not perform Prior Authorizations	**IP and INN** N/A. The Plan does not perform Prior Authorizations **IP and OON** N/A. The Plan does not perform Prior Authorizations **OP and INN** N/A. The Plan does not perform Prior Authorizations **OP and OON** N/A. The Plan does not perform Prior Authorizations
Concurrent Review Benefit NQTL	**IP and INN** N/A. The Plan does not perform Concurrent Review on IP services. The Plan only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per Plan language. **IP and OON** N/A. The Plan does not perform Concurrent Review on IP services. The Plan only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per Plan language. **OP and INN** Step 1 The MH/SUD National Policy Definitions List defines a Concurrent (Review) Request as: “a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.” The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan’s operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.	**IP and INN** N/A. The Plan does not perform Concurrent Review on IP services. The Plan only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per Plan language. **IP and OON** N/A. The Plan does not perform Concurrent Review on IP services. The Plan only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per Plan language. **OP and INN** Step 1 Per the Clinical Services Medical Management Operational Policy: Approved Definitions, Concurrent Review is defined as “a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called “continued stay review.”” The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan’s operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted.

	Concurrent Review MH/SUD outpatient services consist of the following: the Plan only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits, per injury or sickness, per Plan language. **OP and OON** Step 1 The MH/SUD National Policy Definitions List defines a Concurrent (Review) Request as "a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care." The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Concurrent Review of MH/SUD outpatient services consist of the following: the Plan only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per Plan language.	The Plan only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per Plan language. **OP and OON** Step 1 Per the Clinical Services Medical Management Operational Policy: Approved Definitions, Concurrent Review is defined as "a clinical review of an extension of previously approved, ongoing course of treatment over a period of time or number of treatments conducted during an inpatient stay or ongoing ambulatory care. It is sometimes called "continued stay review." The Plan structures outpatient Concurrent Review processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per Plan language.
Retrospective Review Benefit NQTL Practices	**IP and INN** Step 1 The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to its delegated MH/SUD MBHO vendor. MH/SUD claims for inpatient services submitted by INN providers may be subject to Retrospective Review to determine that the services meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve requests for payment or refer requests to peer clinical reviewers (Medical Directors).	**IP and INN** Step 1 Retrospective Review may be performed to determine if the services meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan. Additionally, the Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (e.g., Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service

	Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.	was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual

	MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.
	
	List of services subject to NQTL
	• MH/SUD claims/requests that include the following services are subject to Retrospective Review:
	  ○ Inpatient (non-emergent) MH Acute Care
	  ○ Inpatient Detoxification
	  ○ Inpatient Rehabilitation
	  ○ Residential Detoxification
	  ○ Residential Rehabilitation
	  ○ Residential MH Treatment
	
	Step 2 – There are no differences in the factors used
	
	Step 3 – The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
	• Clinical criteria from nationally recognized, third-party sources (e.g., LOCUS, CALOCUS-CASII and ECSII guidelines)
	• Clinical Technology Assessment Committee (CTAC) review
	• Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
	
	Step 4
	• Timeframe to submit. The MH/SUD National Network Manual (for MH/SUD) was reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent.
	  ○ For MH/SUD, facilities have 180 days after the service is rendered to request a Retrospective Review
	• Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
	  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
	• Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as LOCUS, CALOCUS-CASII and ECSII guidelines.
	
	Outcomes data reviewed for comparability
	
	INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
	
	There is no data for MH/SUD INN inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data.
	
	All analysis and material documentation is available upon request.
		• Chief Medical Officer, Medicare & Retirement
		• Chief Medical Officer, Community & State
		• Chief Medical Officer, Individual & Family Plans
		• Vice President, Clinical Transformation & Affordability
		• Senior Director, Mental Health Parity
		• Vice President, Utilization Management Strategy & Implementation
		
		One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.
		
		Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.
		
		M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.
		
		List of services subject to NQTL
		• Services to determine if they meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan.
		• M/S Claims that are denied, if requested by an INN facility
		• Services where the service or procedure codes do not match a diagnosis code
		• EIU services
		• Services that are subject to benefit limits/exclusions
		
		Step 2 – There are no differences in the factors used
		
		Step 3 – The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
		  ○ Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG)
		  ○ Medical Technology and Assessment Committee (MTAC) review
		  ○ Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.)
		
		Step 4
		• Timeframe to submit. The Administrative Guide (for M/S) was reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent.
		  ○ For M/S, facilities must request the Retrospective Review within the requirements outlined in their provider contract
		• Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements.
		  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.

	IP and OON Step 1 The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to its delegated MH/SUD MBHO vendor. MH/SUD claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review to determine if the services meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes, or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. The OON provider may bill non-reimbursable charges to the member. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate.	• Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG. The Plan may perform Retrospective Review to determine if the services meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan. Additionally, M/S claims/requests for inpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Outcomes data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There are no M/S INN Inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data. All analysis and material documentation is available upon request. **IP and OON** Step 1 Retrospective Review of M/S Inpatient Admissions consist of the following: The Plan may conduct Retrospective Review to determine if the services meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan. Additionally, a Retrospective Review may be performed if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, cases are referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth

	The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable. List of services subject to NQTL • MH/SUD claims/requests that include the following services are subject to Retrospective Review: ○ Inpatient (non-emergent) MH Acute Care ○ Inpatient Detoxification ○ Inpatient Rehabilitation ○ Residential Detoxification ○ Residential Rehabilitation ○ Residential MH Treatment Step 2 There are no differences in the factors used Step 3 The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: ○ Clinical criteria from nationally recognized, third-party sources (e.g., LOCUS, CALOCUS-CASII and ECSII guidelines) ○ Clinical Technology Assessment Committee (CTAC) review ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.) Step 4	in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® Guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer, • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans

	• Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
	  ○ For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review
	• Notification of Decisions to Providers and Members. The Plan notifies MH/SUD OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.
	• Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
	  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.
	• Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as LOCUS, CALOCUS-CASII and ECSII guidelines.
	
	Outcomes data reviewed for comparability
	
	OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
	
	There is no MH/SUD OON inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data.
	
	All analysis and material documentation is available upon request.
	
	OP and INN
	Step 1
	The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to its delegated MH/SUD MBHO vendor.
	
	MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review to determine if the services meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.
	
	Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.
	
	First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists).
		• Vice President, Clinical Transformation & Affordability
		• Senior Director, Mental Health Parity
		• Vice President, Utilization Management Strategy & Implementation
		
		One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.
		
		Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.
		
		M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable.
		
		List of services subject to NQTL
		• To determine if the services meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan.
		• Services where the service or procedure codes do not match a diagnosis code
		• EIU services
		• Services that are subject to benefit limits/exclusions
		
		Step 2
		There are no differences in the factors used
		
		Step 3
		The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
		  ○ Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG)
		  ○ Medical Technology and Assessment Committee (MTAC) review
		  ○ Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.)
		
		Step 4
		• Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
		  ○ For M/S, members must notify the Plan within timely filing requirements
		
		• Notification of Decisions to Providers and Members. The Plan notifies M/S OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.
		• Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements.
		  ○ M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.

	Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.	• Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG. Outcomes data used for comparability OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There are no cases of M/S or MH/SUD OON inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes. All analysis and material documentation is available upon request. **OP and INN** Step 1 Retrospective Review of M/S Outpatient Services consists of the following: Retrospective Review for certain outpatient services begins after the Plan receives claims from INN providers. The Plan may perform a Retrospective Review to determine if the services meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan. Additionally, the Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. INN providers may also request Retrospective Review of outpatient claims that are denied. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physician or nurse) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim.

	MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.
	
	List of services subject to NQTL
	• MH/SUD claims/requests that include the following services are subject to Retrospective Review:
	  ○ Partial Hospitalization Program (PHP)/Day Treatment
	  ○ Intensive Outpatient Program (IOP)
	  ○ Transcranial Magnetic Stimulation (TMS)
	  ○ Electroconvulsive Therapy (ECT)
	  ○ Psychological Testing
	  ○ Applied Behavioral Analysis (ABA)
	
	Step 2
	There are no differences in the factors used
	
	Step 3
	The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
	• Clinical criteria from nationally recognized, third-party sources (e.g., LOCUS, CALOCUS-CASII and ECSII guidelines)
	• Clinical Technology Assessment Committee (CTAC) review
	• Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
	
	Step 4
	• Timeframe to submit. The MH/SUD National Network Manual (for MH/SUD) were reviewed for requirements relating to timeliness of notification to the Plan and it was determined MH/SUD was no more stringent.
	  ○ For MH/SUD, providers have 180 days after the service is rendered to request a Retrospective Review
	• Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements.
	  ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists.
	• Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based, behavioral clinical policies or use clinical criteria from third party sources such as LOCUS, CALOCUS-CASII and ECSII guidelines.
	
	Outcomes data reviewed for comparability
	INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
		Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.
		
		Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.
		
		Monitoring/Quality Oversight: The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.
		
		The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.
		
		The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.
		
		The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, and Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician.
		
		As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of:
		• Chief Medical Officer, Medical Management (Co-Chair)
		• Senior Vice President, Clinical Advancement (Co-Chair)
		• Chief Medical Officer
		• Senior Vice President, Clinical Appeals & Grievances
		• Chief Medical Officer, Clinical Policy
		• Chief Medical Officer, Employer & Individual
		• Chief Medical Officer, Medicare & Retirement
		• Chief Medical Officer, Community & State
		• Chief Medical Officer, Individual & Family Plans
		• Vice President, Clinical Transformation & Affordability
		• Senior Director, Mental Health Parity
		• Vice President, Utilization Management Strategy & Implementation

	There are no MH/SUD INN outpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data.
	
	All analysis and material documentation is available upon request.
	
	OP and OON
	Step 1
	The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to its delegated MH/SUD MBHO vendor.
	
	MH/SUD claims may be subject to Retrospective Review to determine if the services meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU.
	
	Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.
	
	First Level Clinical Review/Initial Review. The clinical reviewer (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists).
	
	Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim.
	
	The OON provider may bill non-reimbursable charges to the member.
	
	Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are excluded. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.
	
	Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child
		One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.
		
		Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons.
		
		M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.
		
		List of services subject to NQTL
		• Services, to determine they meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan
		• Claims that are denied, if requested by INN provider
		• Services where the service or procedure codes do not match a diagnosis code
		• EIU services
		• Services that are subject to benefit limits/exclusions
		
		Step 2
		There are no differences in the factors used
		
		Step 3
		The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
		o Clinical criteria from nationally recognized, third-party sources (e.g., LOCUS, CALOCUS-CASII and ECSII guidelines)
		o Clinical Technology Assessment Committee (CTAC) review
		o Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
		
		Step 4
		• Timeframe to submit. The Administrative Guide (for M/S) was reviewed for requirements relating to timeliness of notification to the Plan and it was determined MH/SUD was no more stringent.
		  o For M/S, providers must request the Retrospective Review within the requirements outlined in their provider contract
		• Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements.
		  o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
		• Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based, medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG.
		
		Outcomes data reviewed for comparability

	and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines.
	
	Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate.
	
	The Plan conducts monthly quality audits of individual non-clinical staff clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. A minimum of two audits are completed per staff, per month. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated.
	
	The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.
	
	The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.
	
	Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.
	
	MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable.
	
	List of services subject to NQTL
	• MH/SUD claims that include the following services are subject to Retrospective Review:
	  ○ Partial Hospitalization Program (PHP)/Day Treatment
	  ○ Intensive Outpatient Program (IOP)
	  ○ Transcranial Magnetic Stimulation (TMS)
	  ○ Electroconvulsive Therapy (ECT)
	  ○ Psychological Testing
	  ○ Applied Behavioral Analysis (ABA)
	
	Step 2
	There are no differences in the factors used
	
	Step 3
	• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
		INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
		
		There is an insufficient number M/S INN outpatient cases and no MH/SUD INN outpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data.
		
		All analysis and material documentation is available upon request.
		
		OP and OON
		Step 1 – Retrospective Review for certain outpatient services begins after the Plan receives claims from OON providers. The Plan may perform Retrospective Review to determine if the services meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan. Additionally, the Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion.
		
		Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity.
		
		First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors).
		
		Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. The OON provider may bill non-reimbursable charges to the member.
		
		Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.
		
		Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual® or MCG® guidelines.

	○ Clinical criteria from nationally recognized, third-party sources (e.g., LOCUS, CALOCUS-CASII and ECSII guidelines) ○ Clinical Technology Assessment Committee (CTAC) review ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.) Step 4 • Timeframe to submit. The timeframe for the member to submit a Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent. • For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review • Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state, and federal requirements. ○ MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. • Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as LOCUS, CALOCUS-CASII and ECSII guidelines. Outcomes data for comparability OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There are no MH/SUD OON outpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data. All analysis and material documentation is available upon request.	Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to- end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's National Medical Care Management Committee (NMCMC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The NMCMC is comprised of the Chief Medical Officer, and representatives from clinical policy, clinical advocacy and grievances, business standardization and advancement, regional chief medical officers, inpatient care management, lines of business, medical policy, clinical operations, an Behavioral Health. The Chair of the NMCMC must be an executive leader and licensed physician. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable.

		List of services subject to NQTL
		• Services, to determine if the meet the definition of a Covered Medical Expense, including Medical Necessity, per the Plan
		• Services where the service or procedure codes do not match a diagnosis code
		• EIU services
		• Services that are subject to benefit limits
		
		Step 2
		There are no differences in the factors used
		
		Step 3
		• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
		  ○ Clinical criteria from nationally recognized, third-party sources (e.g., LOCUS, CALOCUS-CASII and ECSII guidelines)
		  ○ Clinical Technology Assessment Committee (CTAC) review
		  ○ Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.)
		
		Step 4
		• Timeframe to submit. The timeframe for the member to submit a Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent.
		  ○ For M/S, members must notify the Plan within timely filing requirements
		• Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state, and federal requirements.
		  ○ M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.
		• Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG.
		
		Outcomes data reviewed for comparability
		OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.
		
		There are no of OON outpatient for M/S cases or MH/SUD OON outpatient cases from 01/01/2023 - 12/31/2023 to support an analysis of clinical outcomes data.
		
		All analysis and material documentation is available upon request.

Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no differences in clinical procedure coding, billing coding and process NQTL practices that limit benefits within the similarly mapped classification when compared between medical/surgical and mental health/substance use disorder.	There are no differences in clinical procedure coding, billing coding and process NQTL practices that limit benefits within the similarly mapped classification when compared between medical/surgical and mental health/substance use disorder.

Case & Medical Management NQTL Practices	Medical Case Management is a collaborative process between a member, that member's treating providers, and the Plan to improve the member's functional health and well-being and support the member's recovery. Such programs seek to achieve this goal by proactively engaging members before their health declines and helping them avoid escalation to higher levels of care (for example inpatient hospitalization). Case management is a voluntary member-facing program that does not include coverage determinations. Medical Case Management does not modify or influence a benefit determination. Case Managers do not make or recommend medical necessity determinations, do not direct treatment, or place treatment limitations based on program participation or lack thereof.	Medical Case Management is a collaborative process between a member, that member's treating providers, and the Plan to improve the member's functional health and well-being and support the member's recovery. Such programs seek to achieve this goal by proactively engaging members before their health declines and helping them avoid escalation to higher levels of care (for example inpatient hospitalization). Case management is a voluntary member-facing program that does not include coverage determinations. Medical Case Management does not modify or influence a benefit determination. Case Managers do not make or recommend medical necessity determinations, do not direct treatment, or place treatment limitations based on program participation or lack thereof.
Network Adequacy & Provider Reimbursement Rates	Step 1 For MH/SUD, the Plan conducts network adequacy reporting (by state/county) on a regular basis (no less than quarterly) to determine if Time, Distance, and Provider Threshold requirements are met. The network adequacy report incorporates both M/S and MH/SUD provider specialties. MH/SUD utilize the network adequacy report and ensure that the Network Variation Tracker (NVT) and Analytics tools are used when inconsistencies are identified. For MH/SUD, the results of the network adequacy report are sent to the National Quality Improvement Committees (NQIC) as well as the respective Health Plan Oversight Committee through the NVT. The Health Plan Oversite Committee assesses and reviews the results and recommends interventions, as needed. If a network gap is identified, a network recruitment plan is developed by the MH/SUD Provider Relations and Contracting teams. Step 2 There are no differences in the factors used Step 3 There are no differences in the standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis. All analysis and material documentation is available upon request. **Provider Reimbursement - Professional** Step 1 For MH/SUD providers, the Plan uses a comparable process to negotiate and establish reimbursement rate(s) for INN professional services. The Plan delegates negotiation of reimbursement rates for MH/SUD providers to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Key steps in the INN professional services reimbursement negotiation process for both M/S and MH/SUD services include: • The provider submits a completed application to the Plan to be included in the Plan's provider network • Based on the above, the Plan offers a contract and reimbursement rate package to the provider for the services/programs the provider intends to offer • If the provider rejects the contract proposal, the Plan may negotiate with the provider using the factors described	Step 1 For M/S, the Plan conducts network adequacy reporting (by state/county) on a regular basis (no less than quarterly) to determine if Time, Distance, and Provider Threshold requirements are met. The network adequacy report incorporates both M/S and MH/SUD provider specialties. M/S and MH/SUD utilize the network adequacy report and ensure that the Network Variation Tracker (NVT) and Analytics tools are used when inconsistencies are identified. For M/S, the results of the network adequacy report are sent to the Regional Director of Network Deficiencies through an NVT. If network gaps are identified, a network recruitment plan is developed by the M/S Provider Relations and Contracting teams. Step 2 There are no differences in the factors used Step 3 There are no differences in the standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis. All analysis and material documentation is available upon request. **Provider Reimbursement - Professional** Step 1 For both M/S and MH/SUD providers, the Plan uses a comparable process to negotiate and establish reimbursement rate(s) for INN professional services. Key steps in the INN professional services reimbursement negotiation process for both M/S and MH/SUD services include: • The provider submits a completed application to the Plan to be included in the Plan's provider network • Based on the above, the Plan offers a contract and reimbursement rate package to the provider for the services/programs the provider intends to offer • If the provider rejects the contract proposal, the Plan may negotiate with the provider using the factors described Detailed process for the INN professional services reimbursement negotiation:

	Detailed process for the INN professional services reimbursement negotiation:
	
	For MH/SUD professionals, the Plan follows a comparable process. The Plan starts with the CMS national physician fee schedule rate for the service type and practitioner type at issue and then determines the percentage of CMS reimbursement based upon CMS locality fee schedules and the factors, evidentiary standards, and sources described in Steps 2 and 3 below. The Plan maintains five (5) internally developed standard fee schedules based on the CMS national physician fee schedule rates and the CMS geography-specific rates for the provider's area. Individual or group MH/SUD care providers are assigned to one of these standardized fee schedules based on their geographic location.
	
	For MH/SUD professional providers, the Plan uses CMS annual national RVUs and other data to determine whether routine, non-negotiation-based adjustments to the fee schedules may be necessary. If an RVU is not available for a particular code, the Plan uses other sources such as the FairHealth Medicare Gap Fill Database and then market research to determine an appropriate rate.
	
	Providers already in the network may also negotiate for non-routine adjustments upon contract renewal or changing market circumstances. For both M/S and MH/SUD professional providers, the fee schedule rates are negotiable, and the Plan assesses the market dynamic factors listed in Step 2 to reach agreement with providers.
	
	Step 2
	There are no differences in the factors used
	
	Step 3
	There are no differences in the evidentiary standards and sources used
	
	Step 4
	There are no differences in the "As Written" and "In Operation" analysis
	
	All analysis and material documentation is available upon request.
	
	Provider Reimbursement - Facility
	Step 1
	Negotiation
	
	For MH/SUD facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. The Plan delegates negotiation of reimbursement rates for MH/SUD facility providers to it's delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.
	
	Key steps in the INN facility reimbursement negotiation process for MH/SUD services include:
	• The facility submits a completed application to the Plan to be included in the Plan's provider network
	• The Plan reviews the facility reimbursement proposal
	• Based on the above, the Plan accepts the reimbursement proposal or negotiates reimbursement rates with the facility using the factors described
	
	Detailed process for the INN facility reimbursement negotiation:
		For M/S professionals, the Plan contracts for services using standardized reimbursement templates. These templates are organized by Medicare carrier locality and reflect 100% of Geographic Practice Cost Indices (GPCI)-adjusted Centers for Medicare & Medicaid Services (CMS) reimbursement for a given rate year. The Plan uses the following fee sources to create these templates:
		• CMS Resource Based Relative Value Scale (RBRVS) is determined by calculating the CMS relative value units (RVU):
		  ○ The CMS RVU for a given service or procedure is derived using the following mathematical formula: (work RVU x work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI) x CF. This is also referred to as the CMS benchmark rate
		  ○ Definitions:
		  ▪ Work = Provider work reflects the provider's work when performing a procedure or service including provider's technical skills, physical effort, mental effort and judgment, stress related to patient risk, and the amount of time required to perform the service or procedure
		  ▪ PE = Provider Expense reflects the costs for medical supplies, office supplies, clinical and administrative staff, and pro rata costs of building space, utilities, medical equipment, and office equipment
		  ▪ MP = Malpractice Insurance expense reflects the cost of professional liability insurance based on an estimate of the relative risk associated with procedure or service
		  ▪ CF = Conversion Factor
		  ▪ GPCI = Geographic Practice Cost Indices
		• Applicable CMS RVU
		• FAIR Health Medicare GapFill PLUS database
		• CMS Clinical Lab Fee Schedule
		• CMS DMEPOS (Durable Medical Equipment, Prosthetics/Orthotics, and Supplies) Fee Schedule
		• CMS ASP (Average Sales Pricing) and RJ Health ASP (for drug pricing)
		• CMS Ambulance Fee Schedule
		• RBRVS (for codes not priced by CMS) M/S providers only
		• CMS Carrier Priced Fees (for codes referred to the local carrier for pricing)
		• Within these templates, Current Procedural Technology® (CPT), Healthcare Common Procedure Coding System (HCPCS) codes are organized into 54 type of service categories:
		  ○ Evaluation & Management – 4 categories
		  ○ Surgery – 15 categories
		  ○ Radiology – 10 categories
		  ○ Laboratory/Pathology – 3 categories
		  ○ Medicine – 10 categories
		  ○ Obstetrics – 1 category
		  ○ Immunizations/Injectables – 5 categories
		  ○ DME & Supplies – 5 categories
		  ○ Ambulance – 1 category
		
		This standardized structure enables the Plan to tailor fee schedules around specific CPT/HCPCS codes, generally the highest volume codes, billed by different types of providers. Thus, the fee schedules are not specialty-specific; but instead based on the codes most likely to be billed by a particular provider.
		
		Before creating a new fee schedule for a negotiation, the Plan determines if there is an existing fee schedule that will meet the needs of the negotiation; for example, if the negotiation is with a primary care group in Bridgeport, the Plan would look to find other primary care group fee schedules for that geographic locality

	Facilities newly seeking to join the Plan provider network submit a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility. Existing market rates are used as the baseline for negotiating rates. For MH/SUD providers, the Plan prepares an analysis of market dynamics that the Plan contracting team may access to inform negotiations. MH/SUD facilities that participate in the Plan provider network may negotiate reimbursement adjustments upon contract renewal or changing market circumstances by submitting a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility. For facilities already in the network, the existing facility contract rates are used as the contract negotiation baseline. The Plan may take market dynamics into consideration when negotiating reimbursement rates with facilities. For MH/SUD providers, the Plan prepares an analysis of market dynamics that the Plan contracting team may access to inform negotiations. Inpatient MH/SUD – Inpatient and Residential The Plan contracts for inpatient MH/SUD services using the following methodology: • Per Diem – The facility is paid using negotiated MH/SUD per diem rates. The per diem rate is multiplied by the number of days corresponding to the per diem type In addition, MH/SUD agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics. Outpatient MH/SUD – Intensive Outpatient Programs and Partial Hospitalization Programs The Plan contracts for outpatient MH/SUD facility services are negotiated and mutually agreed upon with the facility. The starting point is usually a proposal from the engaged facility. The Plan will use other available information including market dynamics and CMS guidelines (when available) as benchmarks to support its negotiation position. The Plan contracts for MH/SUD services using the following methodology: • Per Diem – The facility is paid using negotiated MH/SUD per diem rates In addition, MH/SUD agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics. Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "as written" and "in operation" analysis	that included the relevant codes. If no existing fee schedule fits the factual scenario, then the creation of a new fee schedule will be approved. The Plan does not maintain designated "go-out" or "base rate" fee schedules for M/S services. Rather, the Plan begins with the standardized structure described here and then negotiates a percentage of CMS reimbursement with providers for the service categories listed above, applying the factors described in Step 2 and evidentiary sources described in Step 3 below. Any CPT/HCPCS codes not reflected in the fee schedule templates are paid at a negotiated percentage of charges. Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request. **Provider Reimbursement - Facility** Step 1 Negotiation For both M/S facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. Key steps in the INN facility reimbursement negotiation process for M/S services include: • The facility submits a completed application to the Plan to be included in the Plan's provider network • The Plan reviews the facility reimbursement proposal • Based on the above, the Plan accepts the reimbursement proposal or negotiates reimbursement rates with the facility using the factors described Detailed process for the INN facility reimbursement negotiation: Facilities newly seeking to join the Plan provider network submit a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility. Existing market rates are used as the baseline for negotiating rates. For M/S services, the Plan may document the market dynamic factors that inform a provider-specific negotiation. The Plan does not apply defined formulae to establish base rates or standard fee schedules. M/S facilities that participate in the Plan provider network may negotiate reimbursement adjustments upon contract renewal or changing market circumstances by submitting a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility. For facilities already in the network, the existing facility contract rates are used as the contract negotiation baseline. The Plan may take market dynamics into consideration when negotiating reimbursement rates with facilities. For M/S services, the Plan may document the market dynamic factors that inform a provider-

	All analysis and material documentation is available upon request. **OON Reimbursement - Emergency** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request.	specific negotiation. The Plan does not apply defined formulae to establish base rates or standard fee schedules. Inpatient M/S -- General Acute Care, Children's, and Long-Term Acute Care Facilities The Plan contracts for inpatient M/S services using one of four key inpatient reimbursement methodologies: MS-Diagnosis Related Group (DRG), Per Case, Per Diem, and Percentage Payment Rate (PPR). While these methodologies provide a starting point, the rate categories, rate category definitions, and rate types can be modified based on negotiations with facilities. In addition, a given contract will often feature a combination of inpatient reimbursement methodologies. For example, within a Per Diem contract, it's not uncommon for cases associated with a defined list of cardiac and/or musculoskeletal MS-DRGs to be reimbursed on a per-case basis, while all other M/S cases are reimbursed on a per diem basis. The following provides an overview of the inpatient reimbursement methodologies used by the Plan: • MS-DRG – The facility is paid using a single, negotiated base rate. The base rate is multiplied by the Centers for Medicare & Medicaid Services (CMS) MS-DRG relative weight for the MS-DRG assigned to the case. Contracts are written to use the current version of the MS-DRGs and relative weights • Per Case – The facility is paid using negotiated M/S case rates. The per case rate is paid for the entire case, regardless of the MS-DRG assigned to the case or the length of stay. There may be separate per case rates for medical cases versus surgical cases. This reimbursement method is rarely used for M/S cases; it's more likely to be used for specific types of cases "carved out" from M/S per diem rates. Examples of services that may be carved out include high-cost drugs, implants, obstetrics, NICU, and outliers • Per Diem – The facility is paid using negotiated M/S per diem rates. The per diem rate is multiplied by the number of days corresponding to the per diem type. There may be separate per diem rates for medical cases versus surgical cases • PPR – The facility is paid a percentage of charges. The PPR rate is multiplied by the eligible charges for the case In addition, M/S agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics. Outpatient M/S -- General Acute Care, Children's, and Long-Term Acute Care Facilities The Plan contracts for outpatient M/S facility services using standardized reimbursement templates, each of which is organized around one of five key outpatient reimbursement methodologies: Ambulatory Payment Classifications (APC), Per Case, Per Visit, Per Unit, and PPR. While these templates provide a starting point, the rate categories, rate category definitions, and rate types reflected in the templates can be modified based on negotiations with providers. In addition, a given contract will often feature a combination of outpatient reimbursement methodologies. For example, within a fixed outpatient contract, services may be subject to Per Case, Per Visit, and Per Unit reimbursement. At the same time, contract variations would allow any or all services to be subject to PPR reimbursement. It is also possible for a single outpatient claim (except for claims paid on a Per Case basis) to be paid using more than one of these reimbursement methodologies. For example, some services on a

		given claim may be subject to Per Visit reimbursement, while other services may be subject to Per Unit reimbursement. The following provides an overview of the outpatient reimbursement methodologies used: • APC – The facility is paid using a single, negotiated APC conversion factor for services subject to such reimbursement under the Medicare outpatient prospective payment system (OPPS). The conversion factor is multiplied by the relative weights for the APCs assigned to the case by the OPPS pricing software. Services not subject to APC payment are paid using facility fee schedules (see Per Unit below). Contracts are written to use the current version of the APCs and relative weights • Per Case – The facility is paid using negotiated per case rates for certain types of outpatient cases, including outpatient surgery, observation, emergency room, and urgent care. All services provided during the encounter are included in the per case payment and are not separately reimbursable • Per Visit – The facility is paid using negotiated per visit rates for certain types of outpatient services. The per visit rate is multiplied by the number of visits billed on a given claim. If a given claim spans multiple dates of service, then the visits on each of the separate days are reimbursable. Examples of services that may be subject to Per Visit reimbursement include, IV therapy, oncology treatment, and dialysis • Per Unit – The facility paid is using a negotiated facility fee schedule for certain types of outpatient services, including laboratory, pathology, and radiology. The per unit rate is multiplied by the number of units billed for a given Current Procedural Technology® (CPT), or Healthcare Common Procedure Coding System (HCPCS) code on a given claim. Facility fee schedules are generally based on a percentage of the CMS rate • PPR – The facility is paid a percentage of charges. The PPR rate is multiplied by the eligible charges for the case M/S agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics. Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "as written" and "in operation" analysis All analysis and material documentation is available upon request. **OON Reimbursement - Inpatient/Outpatient** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used

		Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request. OON Reimbursement - Emergency Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request.
(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 a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information for the NQTLs. The findings of the comparative analysis 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 both “as written” and "in operation." 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 (4)

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 (13) 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.	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). **Plan Terms and/or Description of NQTL:** According to the standard language of XXXXX's benefit plans, "medically necessary" or "medical necessity" means: "Health care services or supplies that prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our discretion: • 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 illness, injury or disease • Not primarily for your convenience, the convenience of your [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 your illness, injury or disease • "'Generally accepted standards of medical practice' mean: • Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and • Following the standards set forth in our clinical policies and applying clinical judgment" These elements are incorporated into the following guidelines utilized by XXXXX's clinicians in making medical necessity determinations: • XXXXX Clinical Policy Bulletins (www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html) • MCG Health care guidelines® (www.mcg.com/care-guidelines/care-guidelines/) • National Comprehensive Cancer Network treatment guidelines (www.nccn.org/guidelines/category_1) • American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) • XXXXX's Applied Behavioral Analysis (ABA) Medical Necessity Guide (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) • Level of Care Utilization System for Psychiatric and Addictive Services (LOCUS) (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) • Child Adolescent Level of Care Utilization System for Psychiatric and Addictive Services/ Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) Fully insured plans in a state that mandates a different definition of medical necessity are administered in accordance with the state's requirements.	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).

	M/S services NQTL applies to: All inpatient, outpatient, and emergency care services **MH/SUD services NQTL applies to:** All inpatient, outpatient, and emergency care services Factors: Factors used in designing the NQTL: XXXXX's Clinical Policy Council (CPC) follows a standard process to develop and/or approve medical necessity criteria for MH/SUD and M/S services. As detailed in the XXXXX Clinical Policy Council Charter, the factors the CPC considers are: • The technology must have final approval from the appropriate governmental regulatory bodies. • The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. • The technology must improve the net health outcome. • The technology must be as beneficial as any established alternatives. • The improvement must be attainable outside the investigational settings. No formula is used for weighting these factors. CPC members apply their clinical training and expertise in evaluating them. Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL Strategy: Medical necessity determinations rely upon the clinical reviewers' exercise of their clinical judgment based on their training and experience, guided by clinical criteria adopted by the Clinical Policy Council, and informed by the member's clinical presentation, to determine whether to authorize coverage. Sources and Evidentiary Standards: • 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 • Clinical training, experience and judgment of XXXXX's clinical reviewers Process: XXXXX's Chief Medical Officer (CMO) and by delegation, the Vice President for Clinical Policy, is charged with whether medical services, drugs and devices are considered experimental, cosmetic, or medically necessary. The XXXXX Clinical Policy Council provides guidance and advice to the CMO or designee on specific clinical topics under review for coverage (see XXXXX Clinical Policy Council Charter). The voting members of the CPC are 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 CPC applies the factors, sources and evidentiary standards identified above to develop (in the case of XXXXX Clinical Policy Bulletins) or approve (in the case of clinical guidelines published by third parties) evidence-based guidelines that are used by XXXXX's clinicians to evaluate the medical necessity of a service, drug or device. The CPC has approved the following sets of guidelines to be used by XXXXX's clinicians in making medical necessity determinations: LOCUS and CALOCUS/CASII (MH/SUD) XXXXX uses the most current versions of LOCUS and CALOCUS/CASII, which are recognized nationally as a generally accepted standard of care tool, to guide clinicians in making medically necessary level of care determinations for mental health services. The Level of Care Utilization System (LOCUS) assessment was developed by the American Association of Community Psychiatrists (AACP) in 1996 to help determine the mental health care resource intensity needs of adults. CALOCUS was developed by the American Association of Community Psychiatrists in collaboration with the American Association of Child and Adolescent Psychiatry to help determine the mental health care resource intensity needs of children and adolescents.	

	The decision to adopt LOCUS and CALOCUS was made in 2021 by XXXXX's Chief Psychiatric Officer, in consultation with Behavioral Health (BH) Senior Medical Director (MD) and other members of the BH Clinical Operations leadership team, after consideration of other tools. XXXXX's National Quality Advisory Committee (NQAC - a committee that includes external members and participating providers) and National Quality Oversight Committee (NQOC) approved the decision. ASAM (MH/SUD) XXXXX uses the most current criteria published by the American Society of Addiction Medicine Criteria to guide clinicians in evaluating the medical necessity of levels and types of care for substance use disorders. ASAM criteria are generally accepted, national standards for SUD treatment decisions and are recognized as such by many courts and regulators. Some states, notably New York, New Jersey and Texas, require state-specific SUD level of care criteria. In those states, XXXXX uses the criteria required by law. The decision to adopt LOCUS and CALOCUS was made in 2021 by XXXXX's Chief Psychiatric Officer, in consultation with BH Senior MD and other members of the BH Clinical Operations leadership team, after consideration of other tools. XXXXX's National Quality Advisory Committee (NQAC - a committee that includes external members and participating providers) and National Quality Oversight Committee (NQOC) approved the decision. MCG Health Care Guidelines® (M/S) XXXXX uses the most current evidence-based care guidelines published by MCG Health to guide clinicians in making medically necessary level of care determinations for M/S services. The decision to use MCG was made in 2002. XXXXX Clinical Policy Bulletins (CPBs) (MH/SUD and M/S) XXXXX CPBs are developed and approved by the CPC based on the factors, sources and evidentiary standards listed above. Both new and revised CPBs undergo a comprehensive review process entailing review by the CPC and external practicing clinicians, and approval by XXXXX's Chief Medical Officer or designee. In developing a CPB, for each technology selected for evaluation the CPC 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. The opinions of relevant experts are obtained where that would be informative. Once approved, new or revised CPBs are published on XXXXX's public websites within 60 days. CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of the technology. If the CPC 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 CPC for review and approval. Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation As Written: XXXXX applies the same strategy, Certificate of Coverage definition of "medical necessity", and factors/sources/process to determine medical necessity for both MH/SUD and M/S services. The XXXXX Clinical Policy Bulletins and third-party clinical guidelines used by clinicians to make MH/SUD and M/S medical necessity determinations are developed and adopted by the same Clinical Policy Council pursuant to its written charter. This satisfies the as-written comparability and stringency tests. In Operation: Reviewing denial rates and appeal overturn rates for precertification, concurrent review and retrospective review decisions provides a way to compare into how XXXXX determines medical necessity for MH/SUD and M/S services in operation. Denial Rates for MH/SUD and M/S medical necessity reviews: We examined the medical necessity denials for in-network and out-of-network services subject to precertification, concurrent review or retrospective review for XXXXX's national, fully insured book of business in 2022. This analysis concluded that determinations made on the basis of medical necessity are performed comparably, and not more stringently, on MH/SUD services compared to M/S services. Data is available upon request. Summary of Conclusions: The factors and sources used to determine medical necessity are comparable, and not more stringent, for MH/SUD benefits both in writing and in operation.	

	Referenced Policies and Documents: • XXXXX Clinical Policy Council Composition • XXXXX Clinical Policy Council Charter • XXXXX Clinical Policy Bulletins (www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html) • MCG Health care guidelines® (www.mcg.com/care-guidelines/care-guidelines/) • National Comprehensive Cancer Network treatment guidelines (www.nccn.org/guidelines/category_1) • American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) • XXXXX's Applied Behavioral Analysis (ABA) Medical Necessity Guide (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) • Level of Care Utilization System for Psychiatric and Addictive Services (LOCUS) (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) • Child Adolescent Level of Care Utilization System for Psychiatric and Addictive Services/ Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) Form 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. Medically necessary, medical necessity Health care services that are state or federally mandated to prevent, evaluate, diagnose, or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our discretion: • 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 illness, injury or disease • Not primarily for your convenience, the convenience of your 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 your illness, injury or disease • Generally accepted standards of medical practice mean: • Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and • Following the standards set forth in our clinical policies and applying clinical judgment Important note: We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is experimental or investigational. They are subject to change. You can find these bulletins and other information at [https://www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html]. You can also contact us. See the Contact us section for how. 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, Participating Provider Reimbursement, Participating Facility Reimbursement, Network Adequacy, and Provider Admission Standards - Credentialing.	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.
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, Non-Participating Provider Reimbursement. 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 & In-Network NQTL Practices	The description in column A reflects a benefit classification which the Plan subclassifies as Outpatient-Office Visit and Outpatient-All Other. NQTLs that apply to the Outpatient-Office Visit benefit classification are: Medical Necessity Criteria, Participating Provider Reimbursement, Participating Facility Reimbursement, Network Adequacy, and Provider Admission Standards - Credentialing. 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, Participating Provider Reimbursement, Participating Facility Reimbursement, Network Adequacy, and Provider Admission Standards - Credentialing. 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 the Plan subclassifies as Outpatient-Office Visit and Outpatient-All Other. NQTLs that apply to the Outpatient-Office Visit benefit classification are: Medical Necessity Criteria and Non-Participating Provider Reimbursement. 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 and Non-Participating Provider Reimbursement. 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, Participating Provider Reimbursement, Participating Facility Reimbursement, Non-Participating Provider Reimbursement, Network Adequacy, and Provider Admission Standards – Credentialing. 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 practices to apply limits to Rx Formulary Design, Management and Pharmacy Services they are not different for Mental Health & Substance Use Disorder Benefits when compared to Medical/Surgical Benefits. A comprehensive report of XXXXX's Non-Quantitative Treatment Limits for Rx Formulary Design, Management and Pharmacy Services is available upon request.	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 medical/surgical conditions.

Prior-Authorization – In NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of prior authorization - in-network NQTL practices between medical/surgical and MH/SUD. **Plan Terms and/or Description of NQTL:** Precertification is a utilization review service performed by licensed healthcare professionals before inpatient admissions and select ambulatory procedures and outpatient services under the Outpatient-All Other classification, to determine medical necessity and appropriateness of treatment. The member's certificate of coverage identifies whether precertification is required and what the consequences are of failing to obtain precertification. For in-network benefits, precertification applies to: • Services on the XXXXX Participating Provider Precertification List, • Services on the XXXXX Behavioral Health Precertification List, and • Services that require precertification under the terms of the member's plan (typically applicable to self-insured plans). It is the participating provider's responsibility to seek precertification. The XXXXX Participating Provider Precertification List and XXXXX Behavioral Health Precertification List are referred to collectively as the National Precertification List (NPL). The most current version is publicly available at www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html. For out-of-network benefits, precertification applies to the services listed in the member's certificate of coverage, referred to in this document as the Member Precertification List (MPL). It is the member's responsibility to seek precertification. **In-network services subject to Precertification** **Medical Surgical (M/S) services NQTL applies to:** **INN Inpatient:** All inpatient admissions including hospital at home, skilled nursing facilities and rehabilitation facilities (except hospice and maternity/newborn stays within the standard length of stay) **INN Outpatient-All Other:** Too numerous to list -- see the Participating Provider Precertification List **Emergency:** Fixed-wing Aircraft Transport **Mental Health and Substance Use Disorder (MH/SUD) services NQTL applies to:** **INN Inpatient:** All inpatient admissions including residential treatment facilities **INN Outpatient-All Other:** • Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder • Transcranial Magnetic Stimulation • Partial Hospitalization (PHP) • Gender Affirmation Surgery **Emergency:** • Fixed-wing Aircraft Transport **Factors:** **Factors used in designing the NQTL**	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 - in-network NQTL practices between medical/surgical and MH/SUD.

Factors for Adding a Service to the NPL:
All services must meet one or more of the following three criteria to be added to the NPL:

a. Cost – Cost of treatment is satisfied when the average paid Medicare rate is at least $150 for the service being considered (based on XXXXX's national paid Medicare claims experience)
b. High-cost growth (projected or actual) – 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 2020 per member per month (PMPM)=$1.00, the 2021 PMPM=$2.00, and the 2022 PMPM=$3.00, then that would be a 200% trend increase over the two-year period - calculate by subtracting the 2020 PEPM from the 2022 PMPM and then dividing by the 2020 PMPM.)
c. Variability in cost and practice – 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

In addition, a forecasted ROI of at least 3:1 is expected. ROI refers to health care cost expense savings related to denials of non-medically necessary care divided by administrative costs. There are two variables in the ROI calculation: (i) gross dollar amount of claims costs saved through appropriate denials of coverage for that service, and (ii) gross dollar amount of costs to administer precertification for that service. ROI is calculated by dividing (i) by (ii).
The 3:1 ROI threshold has been utilized by XXXXX for many years to assess whether potential cost-containment initiatives warrant implementing and is deemed appropriate for purposes of adding, retaining or removing services, drugs and devices on the NPL. A service may be added to the NPL if it does not have a forecasted ROI of at least 3:1 but one or more of the three criteria above are met.

Extenuating Factors: The NPL Committee may add a service that does not meet the above criteria, based on the following Extenuating Factors:

- Patient safety - considers whether precertification can minimize potential harm to a member, particularly for life changing procedures that are irreversible post-surgery
- Clinical quality control - refers to ensuring a provider and proposed treatment are qualified and appropriate so that the possibility of adverse outcomes is reduced.
- Marked variation in provider utilization patterns - refers to there being a significant range providers' utilization of the service, drug or device, suggesting that some of the utilization may be unnecessary.
- Incorrect utilization - refers to the potential that a given service, drug or device is not appropriate for the member's condition.
- Application of Clinical Policy Bulletin (CPB) requirements - refers to the opportunity to make determinations required under XXXXX's CPBs and other clinical policies pertaining to the experimental/investigational nature of a service, appropriate use of new/changing technology, step therapy, or site of service.
- Standards of industry practice - refers to what other health insurers and administrators have decided to be appropriate in terms of precertification.

There are no fixed quantitative standards for the above factors; rather, they are evaluated in comparison to other services in the same benefit classification.

Factors for Retaining a Service on the NPL:

- ROI 3:1 or greater – retain
- ROI 2 to 2.9:1 – consider Extenuating Factors
- 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) – consider Extenuating Factors

While ROI is the primary factor in deciding whether to retain a service on the NPL, it is not an absolute determinant. The NPL Committee may also consider the factors for adding a service to the NPL and/or any Extenuating Factors. There are no fixed quantitative standards for the factors; rather, they are evaluated in comparison to other services in the same benefit classification.

Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL
Process for Developing the National Precertification List (NPL):
The NPL is used by participating providers to identify which MH/SUD and M/S services require precertification for INN coverage. The NPL Committee is responsible for determining which services to add, retain or remove from the NPL. It comprises clinicians and other subject matter experts representing both MH/SUD and M/S expertise. Proposed additions or changes to the NPL are submitted to the NPL Committee. The Committee considers the factors listed above and decides whether to

add or remove the service. Also, the Committee annually reviews services on the NPL to decide whether to retain or remove them. Any factors and Extenuating Factors relied upon in making the decision must be documented; this allows for validation that they are being applied comparably, and not more stringently, to MH/SUD services. The process is comprehensively described in the NPL Committee Policy & Procedure.

Evidentiary Standards for Developing the NPL:

- Medicare rates
- Internal claims database analysis
- Internal analysis of administrative costs
- Clinical guidelines and standards of practice. (These depend on the service under consideration and would include, by way of example, the most currently available versions of CMS Coverage Determinations and Medicare Benefit Policy Manual, MCG Health guidelines, National Comprehensive Cancer Network (NCCN) guidelines, American Society of Addiction Medicine (ASAM) Criteria, CALOCUS/LOCUS guidelines, and XXXXX Clinical Policy Bulletins.)

Process and Standards for Performing Precertification:

XXXXX's processes for precertifying services that are on the NPL are designed in accordance with National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation, and applicable state and federal law. In brief, precertification requests and supporting documentation are reviewed by clinical support staff who are not licensed health care providers. They can make coverage approvals that do not require clinical review, and administrative denials (due to member's lack of eligibility or benefit plan exclusions, for example). Coverage decisions that require clinical review are performed by licensed clinicians who are Registered Nurses (RNs), licensed clinical social workers (LSCWs) or physicians. If a licensed clinician is unable to approve coverage, the clinician refers the request to a Medical Director who is a physician or to a consulting psychiatrist/ psychologist/ board certified behavior analyst-doctoral (BCBA-D) for further review and action. Consulting psychiatrists/psychologists/BCBA-D use the available clinical information to approve a coverage request or, when unable to approve, make a level of care or service recommendation and forward the recommendation to the Medical Director or the designated psychologist/BCBA-D for issuance of the coverage determination. The licensed clinician or Medical Director draws upon his or her training and expertise in applying the applicable clinical review criteria to the request. (See XXXXX's Medical Necessity NQTL Comparative Analysis for more information about clinical review criteria.) The precertification determination is made and communicated to the provider/member according to the established timeframes for urgent or non-urgent requests. In some circumstances the treating provider may have a peer-to-peer consultation with a physician. These processes are described in detail in these XXXXX National Clinical Services policies and procedures:

- NCS 100 Precertification Policy & Procedure
- NCS 503 Medical Review Policy & Procedure
- NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy
- NCS 505 Denial of Coverage Policy and Notification
- NCS 506 Peer-to-Peer Review Policy
- NCS 510 Internal Quality Review Policy

Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation

As Written: The same factors and sources, and the same National Precertification List Policy and Procedure, apply to MH/SUD and M/S benefits in deciding which services to add to, retain or remove from the National Precertification list. The same factors and sources, and the same National Clinical Services Policies and Procedures, apply to handling precertification requests for MH/SUD and M/S benefits. Thus, as written this NQTL is applied comparably, and not more stringently, to MH/SUD benefits.

In Operation: The following measures are used to assess comparability and stringency:

Evaluation of determinations adding to or removing MH/SUD and M/S services from the NPL: Precertification is required for all inpatient admissions for both MH/SUD and M/S services. (The exceptions for hospice and short maternity/newborn stays are not significant enough to suggest a parity concern.) Precertification is not required for any MH/SUD or M/S Outpatient-Office Visits. As for Outpatient-All Other benefits, there are only 5 MH/SUD services in that classification subject to precertification compared to approximately 34 categories of M/S services, and no new MH/SUD services have been added to the NPL in the past 5 years (since the framework for inclusion on the NPL was formalized). In the NPL Committee's 2022 annual retention review, no MH/SUD or M/S services that met the ROI were

	removed from the NPL. For services that did not meet the ROI, two M/S services were retained on the NPL due to clinical quality control concerns (kyphectomy) and marked variation in utilization patterns (motorized scooters), and one MH/SUD service was retained on the list due to clinical quality control concerns (partial hospitalization). From this information it is clear that the factors and sources used to add to, retain or remove a service from the NPL are comparable, and not more stringent, for MH/SUD services. Denial Rates and turnaround times for INN MH/SUD and M/S precertifications: We compared data from INN precertification decisions for services on the NPL for Aetna's fully insured book of business in 2022. This analysis concluded that precertification is applied comparably, and not more stringently, to MH/SUD services compared to M/S services. Data is available upon request. Internal Quality Reviews and Inter-Rater Reliability assessments: The IQR/IRR process described in NCS 510 Internal Quality Review Policy & Procedure provides a way to evaluate whether utilization review of MH/SUD and M/S services is performed comparably, and not more stringently for MH/SUD, in operation. In that process, Medical Directors and Utilization Management Clinicians are audited for accuracy and consistency in their application of utilization management criteria. Corrective actions are taken if the results do not meet the goal of 90%. The IQR and IRR results for both Behavioral Health and Medical clinicians and Medical Directors show that the audits were performed as required and the overall goals met. Some Behavioral Health and Medical individual clinicians fell below the goal and were identified for corrective actions should they continue to score below the goal. These IQR/IRR reports show that utilization review is performed comparably, and not more stringently, for MH/SUD services. (The detailed results of the IQR and IRR reviews are available upon request.) Summary of Conclusions: The factors and sources used in determining what INN services are subject to precertification, and in handling precertification requests, are comparable, and not more stringent, for MH/SUD benefits both in writing and in operation. Referenced Policies and Documents: • National Precertification List (NPL), publicly available at www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html • NPL Committee Composition • National Precertification List Policy & Procedure • NCS 100 Precertification Policy & Procedure • NCS 503 Medical Review Policy & Procedure • NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy • NCS 505 Denial of Coverage Policy and Notification • NCS 506 Peer-to-Peer Review Policy • NCS 510 Internal Quality Review Policy 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. 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. Sometimes you or your provider may want us to review a service that doesn't require precertification before you get care. This is called a predetermination, and it is different from precertification. Predetermination means that you or your provider requests the pre-service clinical review of a service that does not require precertification 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: No reference	
Prior-Authorization – Out-of-network NQTL Practices	There are no non-comparable iACnconsistencies or differences in the application, as written and in operation, of prior authorization - out-of-network NQTL practices between medical/surgical and MH/SUD. **Plan Terms and/or Description of NQTL:** Precertification is a utilization review service performed by licensed healthcare professionals before inpatient admissions and select ambulatory procedures and outpatient services under the Outpatient-All Other classification, to determine medical necessity and appropriateness of treatment. The member's certificate of coverage identifies whether precertification is required and what the consequences are of failing to obtain precertification.	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 - out-of-network NQTL practices between medical/surgical and MH/SUD.

For out-of-network benefits, precertification applies to the services listed in the member's certificate of coverage, referred to in this document as the Member Precertification List (MPL). It is the member's responsibility to seek precertification.

Out of Network Services Subject to Precertification
Description of NQTL: The Member Precertification List (MPL) is part of the certificate of coverage which is filed with each State department of insurance. It describes which services (if any) are subject to precertification and what the consequences are (if any) of failing to obtain it. Members are responsible for seeking precertification of services on the MPL. The analysis below is for XXXXX's standard certificate of coverage.

M/S services NQTL applies to:
Inpatient:
- Stays in a hospital
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Stays in a skilled nursing facility

Outpatient-All Other:
- Advanced reproductive technology (ART) services
- Complex imaging
- Comprehensive infertility services
- Cosmetic and reconstructive surgery
- Gene-based, cellular and other innovative therapies (GCIT)
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Gender affirming treatment
- Kidney dialysis
- Knee surgery
- Non-emergency transportation by airplane
- Outpatient back surgery not performed in a physician's office
- Private duty nursing services
- Sleep studies
- Wrist surgery

Emergency:
- Non-emergency transportation by airplane

MH/SUD services NQTL applies to:
Inpatient:
- Stays in a hospital
- Stays in a residential treatment facility

Outpatient-All Other:
- Applied behavior analysis
- Gender affirming treatment
- Partial hospitalization treatment
- Transcranial magnetic stimulation (TMS)

Emergency:
- Non-emergency transportation by airplane

Factors:
Factors used in designing the NQTL:

	The factors used in designing the original Member Precertification List cannot be listed because the MPL has existed long before the MHPAEA regulations were issued and there was not an explicit list of factors or processes. Effective September 2023, the factors and process for adding or removing a service from the MPL have been formalized in the Member Precertification List Policy and Procedure. The factors are: Adding a Service, Drug or Device to the MPL: A service, drug or device must meet one or more of the following criteria to be added to the MPL: • Cost – Cost of treatment is satisfied when the average paid Medicare rate is at least $150 for the service being considered (based on XXXXX's national paid Medicare claims experience) • 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, raising quality of care concerns • Patient safety - considers whether precertification can minimize potential harm to a member, particularly for life changing procedures that are irreversible post-surgery. • Clinical quality control - refers to ensuring a provider and proposed treatment are qualified and appropriate so that the possibility of adverse outcomes is reduced. • Marked variation in provider utilization patterns - refers to there being a significant range providers' utilization of the service, drug or device, suggesting that some of the utilization may be unnecessary. • Incorrect utilization - refers to the potential that a given service, drug or device is not appropriate for the member's condition. • Application of Clinical Policy Bulletin (CPB) requirements - refers to the opportunity to make determinations required under XXXXX's CPBs and other clinical policies pertaining to the experimental/investigational nature of a service, appropriate use of new/changing technology, step therapy, or site of service. • Standards of industry practice - refer to what other health insurers and administrators have decided to be appropriate in terms of precertification. There are no fixed quantitative standards for the above factors; rather, they are evaluated in comparison to other services in the same benefit classification. In addition, a forecasted ROI of at least 3:1, based on anticipated out-of-network utilization costs, is expected. A service, drug or supply may be added to the MPL if it does not have a forecasted ROI of at least 3:1 but one or more of the criteria above are met. Definition of ROI: Return on investment (ROI) is the calculation of the monetary value of an investment versus its cost. In the context of the NPL, ROI means "health care cost expense savings related to denials of non-medically necessary care divided by administrative costs." There are two variables in the ROI calculation: (i) gross dollar amount of claims costs saved through appropriate denials of coverage for that service, and (ii) gross dollar amount of costs to administer precertification for that service. ROI is calculated by dividing (i) by (ii). The 3:1 ROI threshold has been utilized by Aetna for many years to assess whether potential cost-containment initiatives warrant implementing, and is deemed appropriate for purposes of adding, retaining or removing services, drugs and devices on the MPL. There are groupings of services to arrive at ROI code level aggregation. Refer to the categorization on the MPL list for groupings of services. Forecasted ROI is produced by the review of expected claim experience and the estimated resources needed for medical review. Actual ROI is produced by the review of actual claim experience and the actual resources needed for medical review. Removing a Service, Drug or Device from the MPL: A service, drug or device may be removed from the MPL if the actual ROI (based on actual out-of-network utilization) is less than 3:1 and/or if the other factor(s) that warranted including the service on the MPL are no longer present. Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL Process for Developing the MPL: The Policy and Plan Design Committee (PPDC), a group of clinicians, product managers, legal counsel, compliance leads, and other subject matter experts representing both MH/SUD and M/S expertise, is responsible for deciding whether to add or remove services from the MPL. PPDC members and business partners may propose changes to the MPL. The PPDC considers the factors listed above and votes on whether to approve a change. Any factors relied upon in making the decision must be documented; this allows for validation that they are being applied comparably, and not more stringently, to MH/SUD services. The process is comprehensively described in the XXXXX Member Precertification List (MPL) Policy & Procedure.	

Evidentiary Standards for Developing the MPL:

- Medicare rates
- Internal analysis of administrative costs
- Clinical guidelines and standards of practice

Process and Standards for Performing Precertification:
XXXXX's processes for precertifying services that are on the MPL are designed in accordance with National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation, and applicable state and federal law. In brief, precertification requests and supporting documentation are reviewed by clinical support staff who are not licensed health care providers. They can make coverage approvals that do not require clinical review, and administrative denials (due to member's lack of eligibility or benefit plan exclusions, for example). Coverage decisions that require clinical review are performed by licensed clinicians who are RNs, licensed clinical social workers or physicians. If a licensed clinician is unable to approve coverage, the clinician refers the request to a Medical Director who is a physician or to a consulting psychiatrist/ psychologist/ board certified behavior analyst-doctoral (BCBA-D) for further review and action. Consulting psychiatrists/psychologists/BCBA-D use the available clinical information to approve a coverage request or, when unable to approve, make a level of care or service recommendation and forward the recommendation to the Medical Director or the designated psychologist/BCBA-D for issuance of the coverage determination. The licensed clinician or Medical Director draws upon his or her training and expertise in applying the applicable clinical review criteria to the request. (See XXXXX's Medical Necessity NQTL Comparative Analysis for more information about clinical review criteria.) The precertification determination is made and communicated to the provider/member according to the established timeframes for urgent or non-urgent requests. In some circumstances the treating provider may have a peer-to-peer consultation with a physician. These processes are described in detail in these XXXXX National Clinical Services policies and procedures:

- NCS 100 Precertification Policy & Procedure
- NCS 503 Medical Review Policy & Procedure
- NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy
- NCS 505 Denial of Coverage Policy and Notification
- NCS 506 Peer-to-Peer Review Policy
- NCS 510 Internal Quality Review Policy

Comparability and Stringency Analysis:
Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation
As Written: The same factors and sources, and the same Member Precertification List Policy and Procedure, apply to MH/SUD and M/S benefits in deciding which services to add to or remove from the Member Precertification list. The same factors and sources, and the same National Clinical Services Policies and Procedures, apply to handling precertification requests for MH/SUD and M/S benefits. Thus, as written this NQTL is applied comparably, and not more stringently, to MH/SUD benefits.

In Operation: The following measures are used to assess comparability and stringency:

Evaluation of determinations adding to or removing MH/SUD and M/S services from the MPL: Precertification is required for all inpatient admissions for both MH/SUD and M/S services. Precertification is not required for any MH/SUD or M/S Outpatient-Office Visits. As for Outpatient-All Other benefits, there are only 5 MH/SUD services in that classification subject to precertification compared to approximately 13 categories of M/S services. From this information it can be inferred that the factors and sources used to add or remove a service from the MPL are not being applied more stringently to MH/SUD services.

Denial Rates and turnaround times for OON MH/SUD and M/S precertifications: We compared data from OON precertification decisions on the MPL for XXXXX's fully insured book of business in 2022. This analysis concluded that precertification is applied comparably, and not more stringently, to MH/SUD services compared to M/S services. Data is available upon request.

	Internal Quality Reviews and Inter-Rater Reliability assessments: The IQR/IRR process described in NCS 510 Internal Quality Review Policy & Procedure provides a way to evaluate whether utilization review of MH/SUD and M/S services is performed comparably, and not more stringently for MH/SUD, in operation. In that process, Medical Directors and Utilization Management Clinicians are audited for accuracy and consistency in their application of utilization management criteria. Corrective actions are taken if the results do not meet the goal of 90%. The IQR and IRR results for both Behavioral Health and Medical clinicians and Medical Directors show that the audits were performed as required and the overall goals met. Some Behavioral Health and Medical individual clinicians fell below the goal and were identified for corrective actions should they continue to score below the goal. These IQR/IRR reports show that utilization review is performed comparably, and not more stringently, for MH/SUD services. (The detailed results of the IQR and IRR reviews are available upon request.) **Summary of Conclusions:** The factors and sources used in determining what OON services are subject to precertification, and in handling precertification requests, are comparable, and not more stringent, for MH/SUD benefits both in writing and in operation. Referenced Policies and Documents: • XXXXX Member Precertification List (MPL) Policy & Procedure • Policy & Plan Design Committee Composition • NCS 100 Precertification Policy & Procedure • NCS 503 Medical Review Policy & Procedure • NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy • NCS 505 Denial of Coverage Policy and Notification • NCS 506 Peer-to-Peer Review Policy • NCS 510 Internal Quality Review Policy Plan Language: COC: Precertification You need pre-approval from us for some covered services. Pre-approval is also called precertification. 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 –

- Gender affirming treatment
- [Gene-based, cellular and other innovative therapies (GCIT)]
- Obesity (bariatric) surgery
- Stays in a hospice facility
- Stays in a hospital
- Stays in a rehabilitation facility
- Stays in a residential treatment facility for treatment of mental health disorders and substance related disorders
- Stays in a skilled nursing facility]

[Outpatient –

- [Applied behavior analysis]
- ART services
- Complex imaging
- Comprehensive infertility services
- Cosmetic and reconstructive surgery
- Gender affirming treatment
- [Gene-based, cellular and other innovative therapies (GCIT)]
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Kidney dialysis
- Knee surgery
- Non-emergency transportation by airplane
- Outpatient back surgery not performed in a [physician’s] office
- Partial hospitalization treatment – mental health disorders and substance related disorders treatment
- [Private duty nursing services]
- Sleep studies
- Transcranial magnetic stimulation (TMS)
- Wrist surgery]

Contact us to get a complete list of the services that require precertification. The list may change from time to time.

Sometimes you or your provider may want us to review a service that doesn't require precertification before you get care. This is called a predetermination, and it is different from precertification. Predetermination means that you or your provider requests the pre-service clinical review of a service that does not require precertification
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 • 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 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	
Concurrent Review Benefit NQTL Practices	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. **Plan Terms and/or Description of NQTL:** Concurrent review is performed by licensed healthcare professionals to review the medical necessity of a patient's care while in the hospital or while undergoing outpatient treatment, for dates of service beyond the initial precertification authorization. The purpose 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 is performed on all inpatient admissions and outpatient services that are subject to precertification. (See the Prior Authorization NQTL Comparative Analysis for information about precertification.) **M/S services NQTL applies to:** All inpatient admissions and outpatient services subject to precertification that entail an ongoing course of treatment (refer to Prior Authorization NQTL Comparative Analysis) **MH/SUD services NQTL applies to:** All inpatient admissions and outpatient services subject to precertification that entail an ongoing course of treatment (refer to Prior Authorization NQTL Comparative Analysis)	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 concurrent review benefit NQTL benefit practices between medical/surgical and MH/SUD.

	Factors: Factors used in designing the NQTL: The factors used in determining what services are subject to precertification and, by extension, to concurrent review, are described in XXXXX's Prior Authorization NQTL Comparative Analysis. The factors used in determining how concurrent review is performed are: • National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation • Applicable state and federal law **Sources:** Processes, strategies and/or evidentiary standards used to design and apply the NQTL: The processes and evidentiary standards used in determining what services are subject to precertification and, therefore, to concurrent review, are described in XXXXX's Prior Authorization NQTL Comparative Analysis. <u>Evidentiary Standards for Performing Concurrent Review:</u> XXXXX's concurrent review processes are designed in accordance with National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation, and applicable state and federal law. <u>Strategy for Performing Concurrent Review:</u> For both MH/SUD and M/S services, the guiding strategy behind concurrent review relies upon the clinical reviewers' exercise of their clinical judgment, guided by clinical criteria, to determine whether to authorize coverage for additional units of care. They rely upon their training and experience, informed by the member's medical history, clinician progress notes and discharge plans, to assess "severity" and "complexity" (as those terms are used within XXXXX's National Clinical Services policies and procedures and clinical guidelines). <u>Process for Performing Concurrent Review:</u> Concurrent review is initiated before the authorized coverage period under the initial precertification or previous concurrent review expires. Updated information about the patient's condition, progress and treatment/discharge plan is obtained from the provider. Concurrent reviews are performed by licensed clinicians who are RNs, licensed clinical social workers or physicians. The licensed clinician may approve coverage for additional units of care or, if unable to approve coverage, will refer the case to a Medical Director who is a physician or to a consultant psychiatrist/ psychologist/ board certified behavior analyst-doctoral (BCBA-D) for further review and action. Consultant psychiatrists/ psychologists/ BCBA-Ds use the available clinical information to approve a coverage request or, when unable to approve, make a level of care or service recommendation and forward the recommendation to the Medical Director or the designated psychologist/BCBA-D for issuance of the coverage determination. The licensed clinician or Medical Director draws upon his or her training and expertise in applying the applicable clinical review criteria to the request. (See XXXXX's Medical Necessity NQTL Comparative Analysis for more information about clinical review criteria.) The concurrent review determination is made and communicated to the provider/member according to the established timeframes for urgent or non-urgent requests. In some circumstances the treating provider may have a peer-to-peer consultation with a physician. These processes are described in detail in these XXXXX National Clinical Services policies and procedures: • NCS 200 Concurrent Review and Discharge Planning Policy & Procedure • NCS 503 Medical Review Policy & Procedure • NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy • NCS 505 Denial of Coverage Policy and Notification • NCS 506 Peer-to-Peer Review Policy • NCS 510 Internal Quality Review Policy Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards, and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation	

	As Written: The same factors and sources apply to MH/SUD and M/S benefits in deciding which services are subject to precertification and, by extension, to concurrent review. The same factors and sources, and the same National Clinical Services Policies and Procedures, apply to handling concurrent review requests for MH/SUD and M/S benefits. Thus, as written this NQTL is applied comparably, and not more stringently, to MH/SUD benefits. In Operation: The following measures are used to assess comparability and stringency: Denial Rates and turnaround times for INN and OON MH/SUD and M/S concurrent reviews: We examined INN and OON concurrent review data for services on the NPL and/or MPL for XXXXX's fully insured book of business in 2022. This analysis concluded that concurrent review is performed comparably, and not more stringently, on INN and OON MH/SUD services compared to M/S services. Data is available upon request. Internal Quality Reviews and Inter-Rater Reliability assessments: The IQR/IRR process described in NCS 510 Internal Quality Review Policy & Procedure provides a way to evaluate whether utilization review of MH/SUD and M/S services is performed comparably, and not more stringently for MH/SUD, in operation. In that process, Medical Directors and Utilization Management Clinicians are audited for accuracy and consistency in their application of utilization management criteria. Corrective actions are taken if the results do not meet the goal of 90%. The IQR and IRR results for both Behavioral Health and Medical clinicians and Medical Directors show that the audits were performed as required and the overall goals met. Some Behavioral Health and Medical individual clinicians fell below the goal and were identified for corrective actions should they continue to score below the goal. These IQR/IRR reports show that utilization review is performed comparably, and not more stringently, for MH/SUD services. (The detailed results of the IQR and IRR reviews are available upon request.) **Summary of Conclusions:** The factors and sources used in determining what services are subject to precertification (and by extension, to concurrent review), and in performing concurrent reviews, are comparable, and not more stringent, for MH/SUD benefits both in writing and in operation. Referenced Policies and Documents: • National Precertification List (NPL), publicly available at www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html. • NPL Committee Composition • National Precertification List Policy & Procedure • NCS 200 Concurrent Review and Discharge Planning Policy & Procedure • NCS 503 Medical Review Policy & Procedure • NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy • NCS 505 Denial of Coverage Policy and Notification • NCS 506 Peer-to-Peer Review Policy • NCS 510 Internal Quality Review Policy Plan language: COC: Concurrent care claim extension A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a hospital stay or adding a number of visits to a provider. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days. Concurrent care claim reduction or termination A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us [or an external review organization if the situation is eligible for external review.	

	During this continuation period, you are still responsible for your share of the costs, such as copayments, coinsurance and deductibles that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period. SOB: No reference	
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. **Plan Terms and/or Description of NQTL:** 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. For OON services, XXXXX performs retrospective review on 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. For INN services, XXXXX performs retrospective review in the following limited circumstances: when an INN psychiatric hospital or other MH/SUD or M/S facility that is not a Hospital or Children's Hospital failed to precertify or give timely notice of inpatient admission; when required by state law or XXXXX's contract with a facility; when provider precertification requirements are waived due to a state or federal disaster declaration; or when there is a valid reason for failure to precertify or give timely notice (e.g., member was unable to provide insurance information at the time). For Emergency services, XXXXX performs retrospective review on M/S and MH/SUD services where the diagnosis code signifies a condition that potentially was not an "emergency" under the federal "prudent layperson" standard. **M/S services NQTL applies to:** All OON M/S inpatient services, and all outpatient-all other services on the Member Precertification List, that were not precertified. INN inpatient services when provided by a facility (other than a hospital or children's hospital) that failed to precertify or give timely notice of admission "Emergency" M/S services on the Non-Emergent ER Diagnosis List **MH/SUD services NQTL applies to:** All OON MH/SUD inpatient services, and outpatient-all other services on the Member Precertification List, that were not precertified. INN inpatient services when provided by a psychiatric hospital or facility (other than a hospital or children's hospital) that failed to precertify or give timely notice of admission "Emergency" MH/SUD services on the Non-Emergent ER Diagnosis List **Factors:** Factors used in designing the NQTL: The factors used in determining what services are subject to retrospective review are: • National Participating Provider Precertification List (NPL) for INN services; Member Precertification List (MPL) for OON services (see XXXXX's Prior Authorization NQTL Comparative Analysis for more information) • Terms of XXXXX's contracts with INN providers • State and federal laws pertaining to waiver of INN provider precertification requirements • Federal law defining "prudent layperson" standard for emergency services • ICD10 and DSM-V coding descriptions The factors used in determining how retrospective review is performed are:	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 retrospective review benefit NQTL benefit practices between medical/surgical and MH/SUD.

	• National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation • Applicable state and federal law **Sources:** Processes, strategies and/or evidentiary standards used to design and apply the NQTL: Some of the processes and evidentiary standards used in determining what services are subject to retrospective review are described in XXXXX's Prior Authorization NQTL Comparative Analysis. Additionally, XXXXX reviews its contracts with participating facility providers and monitors state and federal laws and disaster declarations to determine when the standard obligation for the provider to give timely notice of an admission must be waived; when the obligation to give timely notice of an admission is waived, then XXXXX will perform retrospective review instead of imposing a payment penalty on the participating provider. Regarding the list of non-emergent diagnosis codes that trigger a retrospective review of "emergency" services, that list is maintained by XXXXX's Payment Policy and Coding Committee. The Medical Directors on the PPDC review ICD10 and DSM-V coding descriptions and apply their clinical training, experience and judgment to assess whether the symptoms would typically cause a "prudent layperson" (as that term is defined in federal law) to believe emergency care was needed. Evidentiary Standards for Performing Retrospective Review: The evidentiary standards/sources for XXXXX's retrospective review processes are National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation, applicable state and federal law. Strategy for Performing Retrospective Review: For both MH/SUD and M/S services, the guiding strategy behind retrospective review relies upon the clinical reviewers' exercise of their clinical judgment based on their training and experience, guided by clinical criteria and informed by the member's medical history, to determine whether to approve coverage for care already provided. Process for Performing Retrospective Review: Retrospective review is performed after services have already been provided. It is done by licensed clinicians who are RNs, licensed clinical social workers or physicians. The licensed clinician may approve coverage or, if unable to approve coverage, will refer the case to a Medical Director who is a physician or to a consultant psychiatrist/ psychologist/ board certified behavior analyst-doctoral (BCBA-D) for further review and action. Consultant psychiatrists/ psychologists/ BCBA-Ds use the available clinical information to approve a coverage request or, when unable to approve, make a level of care or service recommendation and forward the recommendation to the Medical Director or the designated psychologist/BCBA-D for issuance of the coverage determination. The licensed clinician or Medical Director draws upon his or her training and expertise in applying the applicable clinical review criteria to the request. (See XXXXX's Medical Necessity NQTL Comparative Analysis for more information about clinical review criteria.) For retrospective reviews of non-emergent diagnosis codes, a Medical Director reviews the available clinical information and applies his or her clinical training, experience and judgment to evaluate whether a "prudent layperson" (as that term is used under applicable law) would have believed emergency care was required. The retrospective review determination is made and communicated to the provider/member according to the established timeframes. In some circumstances the treating provider may have a peer-to-peer consultation with a physician. These processes are described in detail in these XXXXX National Clinical Services policies and procedures: • NCS 300 Retrospective Review Policy & Procedure • NCS 503 Medical Review Policy & Procedure • NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy • NCS 505-01 Denial of Coverage Policy and Notification • NCS 506 Peer-to-Peer Review Policy • NCS 510 Internal Quality Review Policy Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation	

	As Written: The same factors and sources, and the same National Clinical Services Policies and Procedures, apply to handling retrospective review requests for MH/SUD and M/S benefits. Regarding "emergency" services that are subject to retrospective review, of the 1495 diagnosis codes that trigger retrospective review, only 80 (5%) are for MH/SUD conditions. Thus, as written this NQTL is applied comparably, and not more stringently, to MH/SUD benefits. In Operation: The following measures are used to assess comparability and stringency: Denial Rates for INN and OON MH/SUD and M/S retrospective reviews: We examined the retrospective review denials of INN and OON benefits for XXXXX's national, fully insured book of business in 2022. This analysis concluded that retrospective review is performed comparably, and not more stringently, on MH/SUD services compared to M/S services. Data is available upon request. Internal Quality Reviews and Inter-Rater Reliability assessments: The IQR/IRR process described in NCS 510 Internal Quality Review Policy & Procedure provides a way to evaluate whether utilization review of MH/SUD and M/S services is performed comparably, and not more stringently for MH/SUD, in operation. In that process, Medical Directors and Utilization Management Clinicians are audited for accuracy and consistency in their application of utilization management criteria. Corrective actions are taken if the results do not meet the goal of 90%. The IQR and IRR results for both Behavioral Health and Medical clinicians and Medical Directors show that the audits were performed as required and the overall goals met. Some Behavioral Health and Medical individual clinicians fell below the goal and were identified for corrective actions should they continue to score below the goal. These IQR/IRR reports show that utilization review is performed comparably, and not more stringently, for MH/SUD services. (The detailed results of the IQR and IRR reviews are available upon request.) **Summary of Conclusions:** The factors and sources used in determining what services are subject to retrospective review, and in performing retrospective reviews, are comparable, and not more stringent, for MH/SUD benefits both in writing and in operation. Referenced Policies and Documents: • Non-Emergent ER Diagnosis List effective 10012022.pdf • Payment Policy and Coding Committee Composition • NCS 300 Retrospective Review Policy • NCS 503 Medical Review Policy & Procedure • NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy • NCS 505-01 Denial of Coverage Policy and Notification • NCS 506 Peer-to-Peer Review Policy • NCS 510 Internal Quality Review Policy Plan Language: COC & SOB: No reference	
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no clinical 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 clinical procedure coding, billing coding and process practices between medical/surgical and MH/SUD.	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 clinical procedure coding, billing coding and process practices between medical/surgical and MH/SUD.
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. These are provided to help high risk members and those who support them to improve management of health conditions as well as improve impact on functioning and overall health. We outline in our Behavioral Health Case Management Program Policy NCS 415 (available	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

	upon request), “Eligible members have the right to participate or decline participation.” If a member decided not to participate in the case management program, or does not complete the care plan, benefits are not excluded or denied.	members. There are no adverse consequences to the member if a member decides not to enroll or use information provided during case management. These are provided to help high risk members and those who support them to improve management of health conditions as well as improve impact on functioning and overall health. We outline in our Behavioral Health Case Management Program Policy NCS 415 (available upon request), “Eligible members have the right to participate or decline participation.” If a member decided not to participate in the case management program, or does not complete the care plan, benefits are not excluded or denied.
Participating Provider Reimbursement - Professionals NQTL	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of participating provider reimbursement - professionals NQTL practices between medical/surgical and MH/SUD. **Plan Terms and/or Description of NQTL:** This NQTL is implemented by the plan’s definition of Negotiated Charge, which is the amount a network provider has agreed to accept or that we have agreed to pay them or a third-party vendor (including any administrative fee in the amount paid). **M/S services NQTL applies to:** Applies to all M/S benefits delivered in-network **MH/SUD services NQTL applies to:** Applies to all MH/SUD benefits delivered in-network Factors: Factors used in designing the NQTL The following factors are used to establish the Aetna Market Fee Schedule (“AMFS”), which is the preferred fee schedule for MH/SUD and M/S network providers. AMFS rates are established at the market level by the Medical and Behavioral Health (BH) network teams in collaboration with Aetna’s Medical Economics Unit (MEU). When a provider does not accept the AMFS, the AMFS is used as a starting point for contract negotiations. <u>Provider type:</u> Provider type refers to the provider’s licensure type (e.g., MD, DO, LCSW, RN). <u>Service type:</u> Service type is a factor that bases reimbursement on the billing codes submitted by a provider (e.g., initial assessments are generally reimbursed at a higher rate than follow-up appointments). Service types are identified by CPT and HCPC codes. <u>Index rates:</u> The Resource Based Relative Value System (RBRVS) payment methodology developed by the Centers for Medicare and Medicaid Services (CMS) is used as a benchmark in developing the AMFS and contracting with providers for the Negotiated Charges. CMS, in consultation with the American Medical Association, assigns Relative Value Units (RVUs) to service codes to reflect the physician or other provider work involved, practice expense and liability insurance each service code entails. CMS applies a conversion factor to the RVU and an adjustment for the geographic area to calculate the resulting RBRVS rate. Where there is no RBRVS rate, the rate from Optum (a third party) is used; where there is no Optum rate, the Developed XXXXX Rate Table (“DART”) rate is used, which is 80% of the average allowed amount.	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 participating provider reimbursement - professionals NQTL practices between medical/surgical and MH/SUD.

Market dynamics: The local networks establish their own AMFS rates to take into consideration the unique characteristics of that market including supply and demand, the carrier's market penetration compared to other carriers and networks, and any other relevant characteristics specific to that market.

When contracting with a given provider, additional factors may enter into consideration:

Unit Cost Trend Target: This refers to the percentage of unit cost by which the network determines it can adjust overall M/S and MH/SUD rates when refreshing them. Plans establish unit cost trend targets for provider contract rates so they can estimate future health care costs in order to set appropriate premiums. The trend target is a baseline in which to begin the negotiations with providers. The network teams still negotiate with providers as needed to maintain an adequate network even if that means their overall trend target is exceeded. To establish the trend target, XXXXX's Medical Economics Unit (MEU) performs analyses of utilization, current network rates, estimated competitor unit cost trends, and the provider contracts up for renewal that year to create unit cost increase targets for the network teams to aim for when contracting with network providers. MEU uses an XXXXX tool called pModel to do these analyses. Unit cost trend targets are set at an overall market level, not at the level of individual providers (except that the trend target for the Behavioral Health network is set at the national level). Each network team is charged with contracting with providers in a way that allows them to achieve the overall trend target for their market. If they agree on a rate with one provider that's below the unit cost trend target, they then have leeway to agree on a rate that's higher with another provider, and vice versa.

Separate trend targets are established for M/S and standalone MH/SUD providers because the network teams responsible for contracting with MH/SUD providers are different. The network teams are responsible for tracking to their given trend target as they contract with providers. As provider contracts are finalized in the course of the year, the pModel is updated with the newly-agreed rates to monitor whether the market is on track to meet the target or whether there will be a variance from it.

Provider leverage: AKA bargaining power. This is generally a function of the relative scarcity of the provider's specialty or area of focus, member needs for that specialty/focus, whether the provider group is a large system or practice group that includes numerous specialties, plan sponsor demand, the provider's participation with other payors, and any other factors that dictate a provider's ability to negotiate a rate higher than AMFS, as well as the number of members the carrier is able to drive to the provider.

Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL
Strategy: Achieve total health care cost rates that are competitive with the total health care cost rates for similar products issued by third parties in the market so as to achieve premium pricing required to compete effectively and drive membership growth.

Process:

1. Develop the AMFS rates.
    a. XXXXX's Medical Economics Unit (MEU) identifies the CMS RBRVS rates for the service codes and proposes the AMFS rates as a percentage of the CMS rates. (Variations: Where there is no CMS rate for a code, the Optum rate is used; where there is no Optum rate, the DART rate is used. Also, a network may choose to use a flat rate instead of a percentage of CMS rates for some services. MEU communicates the preliminary rates to network management.
    b. XXXXX's Behavioral Health (BH) and local market network management in collaboration with MEU adjusts those preliminary rates up or down (or makes no adjustment) based on the network's analysis of market dynamics. Codes are classified as Medical class (most commonly billed by Medical professionals but may also be billed by BH professionals) or BH class (most commonly billed by BH professionals though could also be billed by Medical professionals). For new CPT/HCPC codes released by the American Medical Association, BH network will classify them as BH class or Medical class and decide if specialty tiering is to be applied. AMFS for BH class codes will be set at a percentage of then–available Medicare/GAP rates (percentage to be based on BH network's direction). AMFS for BH providers billing Medical class codes will be at least the then-current Medical class. For BH class codes, AMFS is determined utilizing the following hierarchy of sources: CMS RBRVS, GAP supplied by Optum 360, DART rates, historical pricing if no other source is available, or rates recommended by national workgroups and medical directors (may be used even if Medicare-based pricing sources are available). For Medical class codes, the BH AMFS rate is set at or above the Medical AMFS rates. This results in the final AMFS rates.
    c. For service types that are billed both by MH/SUD and M/S providers, after the rate for M/S providers is determined the rate for the same service for MH/SUD providers is set at or above that rate.
    d. For both MH/SUD and M/S providers, rates are tiered based on provider type/level of training:

- Doctors (MD's) (MH/SUD and M/S) & Clinical Psychologists receive 100% of the rate.
- Nurse Practitioners, Physician Assistants and Certified Nurse Specialist (MH/SUD and M/S) receives 85% of the new rate.
- Drug and Alcohol Counselor, Licensed Professional Counselor, Marriage and Family Therapist, Pastoral Counselor, Social Worker receive 75% of the new rate.
- Audiologist, Registered Dietician, Genetic Counselor, Massage Therapist, Nutritionist, Respiratory Therapist receive 75% of the new rate.

e. This is consistent with CMS methodology -- see Medicare Claims Processing Manual Chapter 12, available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf. For example, see section 110, which indicates Medicare pays physician assistants 80% of the lesser of the actual charge or 85% of what a physician would be paid for the same service, and section 150, which indicates Medicare pays 75% of the physician fee schedule for clinical social worker services.)

2. Update the AMFS rates periodically. The frequency varies by market.
   a. To refresh the AMFS rates for M/S services, and MH/SUD services that are not also billable by M/S providers, MEU indexes the rates against CMS rates and adjusts the rates for various service code ranges to maintain cost neutrality. BH and local market network management collaborate with MEU to make adjustments based on their understanding of market dynamics.
   b. To refresh the AMFS rates for MH/SUD providers for the service codes that can also be billed by M/S providers, those rates are compared to the M/S AMFS rates to develop the AMFS rates for MH/SUD providers. That process works as follows:
   The Medical and BH network and MEU personnel agree on when the AMFS rates will be refreshed for a given market. After the Medical network finalizes the refreshed rates for the codes shared with MH/SUD providers, those rates are communicated to BH network personnel. BH network personnel, supported by MEU, compare the refreshed rates to the existing rates for MH/SUD providers. BH class codes are set at % of Medicare to achieve overall market budget neutral. If the refreshed M/S rate is higher, the BH network will adopt the M/S rate or a rate that is higher (but not lower) than the M/S rate. The refreshed MH/SUD rates are effective at the same time as the refreshed M/S rates. MH/SUD rates can also be refreshed apart from Medical's rate refresh, which occurs when the American Medical Association releases new CPT4® codes for MH/SUD services or when the BH network team observes that the volume of nonstandard rates in provider contracts has increased due to provider demand for higher reimbursement.

For more detail about steps 1 and 2, refer to the AMFS Rate Development P&P for Non-Facility Providers.

3. Use the AMFS rates as the basis for contracting with providers.
   a. When seeking to contract with a new provider, the contract negotiator proposes the AMFS rates as the Negotiated Charges. If the provider agrees, then the AMFS rates become the Negotiated Charges. If the provider does not agree to AMFS, the contract negotiator offers adjustments to the rates in light of the Unit Cost Trend Target, until the parties agree on the final Negotiated Charges. Provider Leverage is the key factor in determining whether and by how much the final Negotiated Charges differ from the proposed rates. (Variation: Whereas AMFS is the preferred basis for contract with providers, it is possible that a different percentage of AMFS or an alternate methodology may be agreed upon, either for some or all service codes. The parties may agree to lower rates for some services but higher rates for others).
   b. When the AMFS is refreshed, the refreshed rates are communicated to network providers at least 90 days before they take effect, and according to whether the provider's contract permits rate changes. Providers may seek to negotiate the changes, and the unit cost trend target and provider leverage determine whether the parties will agree to the refreshed AMFS rates as the new Negotiated Charges or negotiate something different.

Evidentiary Standards: The evidentiary standard for index rates used in setting the AMFS rates is the CMS Resource Based Relative Value Scale (RBRVS) payment system. Those CMS rates are used as an index when developing rates for new service codes, as well as when refreshing M/S rates and rates for services that can be billed for both MH/SUD and M/S providers. When there is no RBRVS rate for a service code, the Optum rate is the standard used. When there is no Optum rate, the DART rate is the standard used.

Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation
There are two main steps for setting network provider reimbursement, which are the same for MH/SUD and M/S services: (1) developing and refreshing the AMFS rates which are the baseline for contracting with providers; and (2) contracting with providers. Below is the comparability and stringency analysis for each step.

(1) In developing and refreshing the AMFS rates, the Plan uses comparable factors, strategies, processes and evidentiary standards for MH/SUD and M/S services, both as written and in operation. There is a difference in the process for setting the rates for MH/SUD services that can also be billed by M/S providers, but this is more favorable for MH/SUD services. For example, the rates for office-based MH/SUD physicians are higher than for office-based M/S physicians for the four most frequently billed shared codes, as shown by the chart below. The Medicare rate is included for comparison purposes.

AMFS (Office-Based Providers):

Service Code	M/S Physician	Psychiatrist	Medicare 2Q22
99203	$91.06	$115.79	$113.82
99204	$135.78	$176.28	$169.72
99213	$74.12	$80.50	$92.65
99214	$104.76	$116.83	$130.95

(2) In contracting with providers, the Plan also uses comparable factors, strategies, processes and evidentiary standards for MH/SUD providers and M/S providers, both as written and in operation. The key factors are the Unit Cost Trend Target and Provider Leverage. The fact that the Trend Target for standalone MH/SUD providers is set at the national level whereas the trend target for M/S providers is at the local market level does not render the process incomparable; it is because the MH/SUD network is managed by a national team whereas the M/S networks are managed at the market level. As for Provider Leverage, it is specific to the circumstances of the particular contract negotiation; a MH/SUD provider may have more leverage in a given negotiation than a M/S provider, and vice versa.

Even though the Plan's factors, processes and evidentiary standards for developing and maintaining the AMFS for MH/SUD rates are not more stringent than for M/S rates, the final Negotiated Charges resulting from contract negotiations may not reflect identical or more favorable MH/SUD rates in every instance. Provider groups and individual providers are free to negotiate rates different from the fee schedules, and the bargaining power they bring to such negotiations may result in Negotiated Charges that are different from the AMFS rates. According to DOL, HHS and Treasury, "[u]nder this analysis, the focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity" (see FAQs part 45, April 2, 2021, at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf).

Summary of Conclusions:
In summary, the factors, processes, strategies and evidentiary standards used to reimburse MH/SUD network providers are comparable to, and are applied no more stringently than, for M/S providers, both as written and in operation.
Referenced Policies and Documents:

- AMFS Rate Development P&P for Non-Facility Providers

Plan language:
COC:
Negotiated charge
For health coverage:
This is the amount a network [provider] has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).
For surprise billing, calculations will be made based on the median contracted rate.
Some providers are part of XXXXX's network for some XXXXX plans but are not considered [network] providers for your plan. For those providers, the negotiated charge is the amount that provider has agreed to accept for rendering services or providing prescription drugs to members of your plan.
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: When you get a prescription drug, we have agreed to this amount for the prescription or paid this amount to the network pharmacy or third-party vendor that provided it. The negotiated charge may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties underprice guarantees. SOB: No reference	
Participating Provider Reimbursement - Facilities NQTL	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of participating provider reimbursement - facilities NQTL practices between medical/surgical and MH/SUD. **Plan Terms and/or Description of NQTL:** This NQTL is implemented by the plan's definition of Negotiated Charge, which is the amount a network provider has agreed to accept or that we have agreed to pay them or a third-party vendor (including any administrative fee in the amount paid). **M/S services NQTL applies to:** Applies to all M/S benefits delivered in-network **MH/SUD services NQTL applies to:** Applies to all MH/SUD benefits delivered in-network **Factors:** Factors used in designing the NQTL The factors on which Negotiated Charges are based are: Provider type: Type of facility (inpatient hospital, ambulatory surgery center, etc.) Scope and complexity of services: range of practice specialties, levels of care and settings offered by the facility Service type: Service type is a factor that bases reimbursement on the billing codes submitted by a provider (e.g., initial assessments are generally reimbursed at a higher rate than follow-up appointments). Service types are identified by CPT and HCPC codes. For facility-based providers, type of service also refers to inpatient or outpatient. Index rates: Medicare DRGs and Medicare RVRBS rates Competitive data: Refers to what competitors pay the facility for the same services, to the extent that can be determined from information publicly available through state and federal All Payor Claims Databases. Also includes consultants' analyses of XXXXX's discount position in the market compared to other carriers, and what XXXXX pays other facilities. Market dynamics: The local networks establish their own reimbursement strategies to take into consideration the unique characteristics of that market including supply and demand, the carrier's market penetration compared to other carriers and networks, and any other relevant characteristics specific to that market. When contracting with a given provider, additional factors may enter into consideration: Unit Cost Trend Target: This refers to the percentage of unit cost by which the network determines it can adjust overall M/S and MH/SUD rates when refreshing them. Plans establish unit cost trend targets for provider contract rates so they can estimate future health care costs in order to set appropriate premiums. The trend target is a baseline in which to begin the negotiations with providers. the network teams still negotiate with providers as needed to maintain an adequate network even if that means their overall trend target is exceeded. To establish the trend target, XXXXX's Medical Economics Unit (MEU) performs analyses of utilization, current network rates, estimated competitor unit cost trends, and the provider contracts up for renewal that year to create unit cost increase targets for the network teams	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 participating facility reimbursement NQTL practices between medical/surgical and MH/SUD.

	to aim for when contracting with network providers. MEU uses an XXXXX tool called pModel to do these analyses. Unit cost trend targets are set at an overall market level, not at the level of individual providers (except that the trend target for the Behavioral Health network is set at the national level). Each network team is charged with contracting with providers in a way that allows them to achieve the overall trend target for their market. If they agree on a rate with one provider that's below the unit cost trend target, they then have leeway to agree on a rate that's higher with another provider, and vice versa. Separate trend targets are established for M/S and standalone MH/SUD providers because the network teams responsible for contracting with MH/SUD providers are different. The network teams are responsible for tracking to their given trend target as they contract with providers. As provider contracts are finalized in the course of the year, the pModel is updated with the newly-agreed rates to monitor whether the market is on track to meet the target or whether there will be a variance from it. Provider leverage: AKA bargaining power. This is generally a function of the relative scarcity of the facility's licensure type and services provided, member needs for that type of facility, whether the facility is part of a large system and/or includes numerous practice specialties, plan sponsor demand, the facility's participation with other payors, and any other factors that dictate a facility's ability to negotiate higher reimbursement, as well as the number of members the carrier is able to drive to the facility. Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL Strategy: Achieve total health care cost rates that are competitive with the total health care cost rates for similar products issued by third parties in the market so as to achieve premium pricing required to compete effectively and drive membership growth. Process: Behavioral Health (BH) and local market network management and the Medical Economics Unit (MEU) examine what XXXXX pays other facilities in the area and what competitive data reveals regarding what competitors are paying (though BH network does not currently use competitive data). The provider type, scope and complexity of the services, and service types are considered, along with market dynamics. Based on this, a proposed reimbursement methodology and set of rates are offered to the facility. For M/S facilities there is no standard or preferred proposed reimbursement methodology (e.g., per diem, fee for service, DRG, % of charges) or set of rates when contracting with a new facility. For MH/SUD facilities the standard proposed reimbursement methodology is per diem. Rates for MH/SUD service codes that can also be billed by M/S facility-based professionals are set at or above the rate established for M/S providers. After the contract negotiator proposes contract terms and reimbursement rates, the provider may accept them or seek to negotiate. The contract negotiator may offer adjustments to the rates in light of the Unit Cost Trend Target, until the parties agree on the final Negotiated Charges. Provider Leverage is the key factor in determining whether and by how much the final Negotiated Charges differ from the proposed rates. Evidentiary Standards Index rates are referred to when developing rates for services that are paid according to a Medicare DRG or fee for service (AMFS) methodology. Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation The factors, strategy, processes and evidentiary standards for determining reimbursement for MH/SUD facility-based providers are comparable to M/S facility-based providers, inasmuch as the Negotiated Charges are ultimately subject to individualized negotiations between XXXXX and the facility. Notwithstanding the comparable processes, most MH/SUD facilities are paid on a per diem basis, whereas M/S facilities are paid by a wide variety of reimbursement methodologies including DRGs, per diem, percent of Medicare and percent of billed charges. This difference is due to the fact that Medicare DRGs are not available for MH/SUD services. Also, the structures and scope of services of MH/SUD facilities are simpler than those of M/S facilities which often have multiple specialties and locations and provide a wide range of service types; multiple reimbursement methodologies are therefore more common within a single M/S facility contract. A comparison of Negotiated Charge amounts between facilities that are paid using different reimbursement methodology(ies) such as DRG versus per diem, and for different services, is not possible because they are too disparate to allow comparison. Nevertheless, there are some professional services that can be billed by both MH/SUD and M/S facility-based providers, and under some facility contracts those may be reimbursed on a fee for service bases using AMFS. For those shared codes, the AMFS rates are higher for MH/SUD providers than M/S providers. For example, the rates for facility-based MH/SUD physicians are higher than for facility-based M/S physicians for the four most frequently billed shared codes, as shown by the chart below. The Medicare rate is included for comparison purposes. AMFS (Facility-Based Providers):	

	Service Code / M/S Physician / Psychiatrist / Medicare 2Q22 99203 / $66.92 / $115.79 / $113.82 99204 / $108.79 / $176.28 / $169.72 99213 / $53.95 / $80.50 / $92.65 99214 / $79.48 / $116.83 / $130.95 Even though XXXXX's factors, processes and evidentiary standards for developing and maintaining the AMFS for MH/SUD rates are comparable and not more stringent than for M/S rates, the final Negotiated Charges will not reflect identical or more favorable MH/SUD rates in every instance. Providers are free to negotiate rates different from the proposed fee schedule, and their bargaining power may result in Negotiated Charges that are different from the AMFS rates. According to DOL, HHS and Treasury, "[u]nder this analysis, the focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity" (see FAQs part 45, April 2, 2021, at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf). **Summary of Conclusions:** In summary, the factors, processes, strategies and evidentiary standards used to reimburse MH/SUD network facilities are comparable to, and are applied no more stringently than, for M/S providers, both as written and in operation. **Plan language:** COC: Negotiated charge For health coverage: This is the amount a network [provider] has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid). For surprise billing, calculations will be made based on the median contracted rate. Some providers are part of XXXXX's network for some XXXXX plans but are not considered [network] providers for your plan. For those providers, the negotiated charge is the amount that provider has agreed to accept for rendering services or providing prescription drugs to members of your plan. 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: When you get a prescription drug, we have agreed to this amount for the prescription or paid this amount to the network pharmacy or third party vendor that provided it. The negotiated charge may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees. SOB: No reference	
Non-Participating Provider Reimbursement NQTL	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of non-participating provider reimbursement NQTL practices between medical/surgical and MH/SUD. **Plan Terms and/or Description of NQTL:** This NQTL is implemented by the Allowable Amount, which is the amount of an out-of-network provider's charge that is eligible for coverage according to the method defined in the Certificate (typically a specified percentile of prevailing charges or a percentage of Medicare rates). The method for determining the Allowable Amount for a given plan is always the same for MH/SUD and M/S providers. The Allowable Amount depends on the geographic area where members get the service or supply.	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 non-participating provider reimbursement NQTL practices between medical/surgical and MH/SUD.

	M/S services NQTL applies to: Applies to all M/S benefits delivered out of network **MH/SUD services NQTL applies to:** Applies to all MH/SUD benefits delivered out of network **Factors:** Factors used in designing the NQTL Single-case contract: XXXXX negotiates with the provider at the time of precertification to agree on a rate before services are provided; if a rate is agreed upon, the member cannot be balance billed. National Advantage Program (NAP) rate: XXXXX contracts with providers directly or through vendors to provide services to members at a reduced rate, while not being in-network providers. NAP providers are not permitted to balance bill members. NAP is not available when the member pays the provider up front. Plan's standard OON rate: The Plan's standard OON rate is specified in the plan documents. It is generally a percentage of the CMS rates or a specified percentile of the prevailing charges. Facility Charge Review: XXXXX determines the recognized charged based on cost-to-charge ratios the facilities report to the government. Includes a patient advocacy process in which negotiates with the provider to accept the charges and not balance bill the patient. If the provider agrees, the member is not balance billed. Ad hoc post-service negotiations: Negotiations are done with the provider after services are provided. If this results in an agreed-upon rate, the provider cannot balance bill the member. Non-par reasonable rate: 125% of Medicare rate for professional services and 200% of Medicare rate for facility services. Default rate: 50% of billed charges. State and federal law: State and federal laws prescribe how plans must reimburse OON providers for emergency services or when the member did not voluntarily use OON benefits Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL Strategy XXXXX compensates OON providers based on the terms of the member's plan, at the lesser of the billed charges or the allowable amount. The allowable amount is determined by a standard rate hierarchy that is the same for both MH/SUD and M/S. Process The Plan applies the following rate hierarchy to determine the allowable amount for OON claims. If one step is unsuccessful in producing a rate, the claim continues to the next step in the hierarchy until it is successfully priced. First tier: single-case contracting (pre-service negotiation) Second tier: National Advantage Program (NAP) rate Third tier: the Plan's standard OON rate* Fourth tier: Facility Charge Review (for facility claims only) Fifth tier: Ad hoc post-service negotiations Sixth tier: Non-par reasonable rate Seventh tier: Default rate	

*Where reimbursement is based on the Plan's standard OON rate then payment is tiered according to provider licensure:

	M/S	MH/SUD
100%	Doctors (MDs)	Doctors (MDs) Clinical psychologists
85%	Nurse Practitioners Physician Assistants Certified Nurse Midwives Clinical Nurse Specialists (e.g., Nurse Practitioner or Registered Nurse)	Nurse Practitioner (NPB) Physician Assistant (PAB) Psychiatric Nurses Drug and Alcohol counselor Licensed Professional counselor Marriage and Family counselor Pastoral counselor Psychological Examiner Social Worker

NOTE: This tier is used for MH/SUD providers when the OON rate is based on prevailing charges. When the OON rate is based on Medicare, all MH/SUD providers are paid at 100%

75%	Audiologists Registered Dieticians Genetic Counselors Massage Therapists Nutritionists Respiratory Therapists	n/a

For emergency and other involuntary OON services, applicable state and/or federal law is applied to determine the allowed amount and protect the member from balance billing.

Evidentiary Standards
CMS Medicare rates or the FAIR Health prevailing charges database are the benchmarks used to determine the Plan's standard OON rate. Medicare rates are also the standard for the Non-par reasonable rate. CMS' National Correct Coding Initiative (NCCI) and similar external materials about billing and coding practices, as well as generally accepted standards of medical practice, are also standards used to determine whether an OON bill is appropriately coded.

Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation

As written: The factors, strategy, process and evidentiary standards are comparable as written, and not more stringent for MH/SUD services, inasmuch as the plan's method for determining the Allowable Amount for OON services is the same for M/S and MH/SUD providers, and the same OON rate hierarchy tiers apply to MH/SUD and M/S claims. As for the payment tiers according to provider licensure type, the fact that there is a 75% tier for M/S providers whereas no MH/SUD providers are paid at 75% (even where their licensure requirements are comparable) shows that the Allowable Amount is more favorable to members, not less, for OON MH/SUD services.

In operation: Comparing out-of-network utilization of MH/SUD and M/S services can indicate whether reimbursement for out-of-network providers is disparately affecting members who use MH/SUD benefits. The below chart compares INN and OON utilization for MH/SUD and M/S services for XXXXX's commercial fully insured business in 2022:

OON Utilization	2022 Fully Insured Commercial BoB
M/S Voluntary OON Claims as % of all M/S Claims	4%
MH/SUD Voluntary OON Claims as % of all MH/SUD Claims	12%
Rate of Voluntary OON MH/SUD to M/S:	3:1

XXXXX's rate of voluntary OON MH/SUD claims is 3 times that of voluntary OON M/S claims in 2022. This is close to the relative OON MH/SUD utilization found in a 2013 peer-reviewed study from the HHS Public Access Database entitled, "Out-of-Network Provider Use More Likely in Mental Health than General Health Care Among Privately Insured" by Kyanko, et al. (available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4707657/#:~:text=Approximately%2018%25%20(n%20%3D%20163,population%20(P%20%3C%200.01. According to the study, the people surveyed sought OON MH/SUD care 2.66 times more than they sought OON M/S care. The 3 most common reasons reported related to mental health care were, the physician was recommended (26.1%), continuity with previous known provider (23.7%), and skill of physician (19.3%). Fewer respondents noted reasons related to network size and composition, such as appointment wait time, convenient location, service or specialty not covered by insurance, needed care right away, or no in-network availability. In aggregate, network size and composition reasons were much less commonly cited as reasons for going out-of-network for mental health care (7.5%) than for general health care (19.6%). XXXXX's level of voluntary MH/SUD OON utilization relative to M/S OON utilization is close to that in the study. It suggests that OON provider reimbursement is not adversely affecting XXXXX members' choice to use their OON benefits for MH/SUD services. It's also important to note that the higher level of voluntary OON MH/SUD utilization is most likely not due to lack of network adequacy, because the MH/SUD network availability standards are met in the great majority of geographic areas. (See Network Adequacy NQTL analysis for details; the states where MH/SUD network availability did not meet standards are generally sparsely populated, and the availability of in-network outpatient MH/SUD services through XXXXX's contracted telemedicine providers mitigates those network gaps.)

Summary of Conclusions:
In summary, the factors, processes, strategies and evidentiary standards used to reimburse OON MH/SUD providers are comparable to, and are applied no more stringently than, for OON M/S providers, both as written and in operation.

Plan Language:
COC:
Allowable amount
This is the amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all charges above this amount. The allowable amount depends on the geographic area where you get the service or supply . Allowable amount doesn't apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an out-of-network provider
- Not available from a network provider
- An emergency service

The table below shows the method for calculating the allowable amount for specific services or supplies:

Service or supply:	Allowable amount is based on:
• Professional services and other services or supplies not mentioned below	Reasonable amount rate 50%-400% of Medicare allowed rate
• Services of hospitals and other facilities	Reasonable amount rate 50%-400% of Medicare allowed rate

	• Prescription drugs — 50%-200% of average wholesale price (AWP) • Prescription drugs for gene-based, cellular and other innovative therapies (GCIT) — 50%-200% of average wholesale price (AWP) Important note: See Special terms used, below, for a description of what the allowable amount is based on. If the provider bills less than the amount calculated using a method above, the allowable amount is what the provider bills. If your ID card displays the National Advantage Program (NAP) logo, your cost share may be lower when you get care from a NAP provider. These are out-of-network providers and third party vendors who have contracts with us but are not network providers. When you get care from a NAP provider, your out-of-network cost share applies. Special terms used: • Our out-of-network rates (AONR) are our standard rates used to begin contract talks with providers in a specific geographic area. For areas where we don't maintain AONR, we use 50%-400% of the Medicare allowed rates. • Average wholesale price (AWP) is the current average wholesale price of a prescription drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use. • Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider's estimated costs for the service and leave the provider with a reasonable profit. This means for: o Hospitals and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS o Facilities that don't report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities We may adjust the formula as needed to maintain the reasonableness of the allowable amount. For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS. • Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state. • Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific provider performance. We update our system with these when revised within 30-180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply: o The method CMS uses to set Medicare rates o How much other providers charge or accept as payment o How much work it takes to perform a service o Other things as needed to decide what rate is reasonable We may make the following exceptions: o For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs o Our rate may exclude other payments that CMS may make directly to hospitals or other providers and backdated adjustments o For anesthesia, our rate may be at least 100%-350% of the rate CMS establishes o For lab, our rate may be 5%-75% of the rate CMS establishes o For DME, our rate may be 25%-75% of the rate CMS establishes For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 50%-100% of the rates CMS establishes. When the allowable amount is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to providers under Medicare programs.	

	• Prevailing charge rate is the 50th-95th percentile value reported in a database prepared by FAIR Health®, a non-profit company. FAIR Health may change these periodically. We update our systems within 30-180 days of receiving them from FAIR Health. If the database becomes unavailable, we may substitute a different, comparable database. If the alternate data source doesn't contain a value for a service or supply, we will base the allowable amount on the Medicare allowed rate. • Reasonable amount rate means your plan has established a rate amount as follows: Service or supply: — Reasonable amount is: • Professional services — 50th-95th percentile value reported in a database prepared by FAIRHEALTH • Inpatient and outpatient hospital charges — 50%-500% of Medicare allowed rate The FCR rate What the provider bills • Inpatient and outpatient charges that are not from a hospital — 50%-500% of Medicare allowed rate The FCR rate What the provider bills Our reimbursement policies We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the allowable amount. When we do this, we consider: • The length and difficulty of a service • Whether additional expenses are needed, when multiple procedures are billed at the same time • Whether an assistant surgeon is needed • If follow up care is included • Whether other conditions change or make a service unique • Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line • The educational level, licensure, or length of training of the provider We base our reimbursement policies on our review of: • CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate • Generally accepted standards of medical and dental practice • The views of physicians and dentists practicing in relevant clinical areas We use commercial software to administer some of these policies. Policies may differ for professional services and facility services. SOB: No Reference	
Network Adequacy NQTL	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of network adequacy NQTL practices between medical/surgical and MH/SUD. **Plan Terms and/or Description of NQTL:** XXXXX maintains sufficient numbers and types of MH/SUD and M/S providers in its network and monitors how effectively this network meets the needs and preferences of its membership. XXXXX establishes mechanisms to ensure access to appointments for MH/SUD and M/S services. **M/S services NQTL applies to:** Applies to all M/S benefits delivered in-network **MH/SUD services NQTL applies to:** Applies to all MH/SUD benefits delivered in-network	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 network adequacy NQTL practices between medical/surgical and MH/SUD.

	Factors: Factors used in designing the NQTL • State network availability and accessibility standards (where applicable) • Default network availability and accessibility standards (aka "XXXXX's NCQA standards") **Definitions:** Network availability refers to the extent to which practitioners of the appropriate type and number are geographically distributed to meet the needs of members. Network accessibility refers to members' ability to receive timely care from network providers (that is, to schedule an appointment). Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL XXXXX's strategy in having network adequacy standards is to ensure a sufficient number of network providers are available within a reasonable distance to provide covered services to members within a reasonable time, and to comply with state law and NCQA accreditation requirements. The evidentiary standards and processes for developing and maintaining the network adequacy standards for MH/SUD and M/S providers are found in state law (where applicable) and NCQA accreditation requirements. XXXXX's default network availability and accessibility standards are developed and monitored in accordance with NCQA's requirements (specifically, NCQA's HPA standards NET 1—AVAILABILITY OF PRACTITIONERS and NET 2—ACCESSIBILITY OF SERVICES and MBHO standards QI 3-AVAILABILITY OF PRACTITIONERS and QI 4-ACCESSIBILITY OF SERVICES). XXXXX, which has NCQA accreditation as a Health Plan and a Managed Behavioral Healthcare Organization, has submitted these standards to NCQA which has accepted them as part of XXXXX's accreditation. In the application of the Network availability and accessibility standards, XXXXX applies the most stringent of the applicable Federal, State, or XXXXX standard. Network availability and accessibility standards for MH/SUD and M/S providers are established and monitored pursuant to written policies applicable to both provider types. (See XXXXX policies QM 07, QM 10 and QM 87.) Network adequacy for both provider types is overseen by the National Quality Oversight Committee (NQOC). • A qualitative and quantitative analysis by product line is performed by the NCQA HPA Accreditation team using network adequacy data which includes member complaints/grievances and appeals, accessibility, availability, out of network requests, and member experience data (CAHPS or member experience survey). • Separate qualitative and quantitative analyses by product line are performed by the NCQA MBHO Accreditation team for Availability, Accessibility, and Member Experience* • Network adequacy complaints/ grievances and appeals at or in excess of .01 per thousand member months and volume greater than five. Complaint Threshold: Complaint rate per 1000 member months > 0.01 & volume of > 5** trigger an additional review. • Requests to cover OON providers at the INN level of benefits are reported at the product line-level per thousand members. The above data is reviewed to identify barriers and opportunities for improvement which the local market network management (for M/S) and BH (Behavioral Health) network management for (MH/SUD) is responsible for addressing. Network availability standards express the minimum goal for number and geographic location of providers. XXXXX continues to contract with new MH/SUD providers even when the standard is met in a given state or market; this is not the case in every market with respect to M/S providers. * BH Member Experience Analysis includes member complaints/grievances and appeals, out of network requests, and member experience survey data ** Effective 01/01/2024 Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation The factors, strategy, processes and evidentiary standards for maintaining and monitoring network adequacy are comparable for MH/SUD and M/S providers. This does not, however, mean the actual metrics are identical for various kinds of MH/SUD and M/S providers. State laws vary in the type of standard they apply (numerical or time-and-distance or both) and what the actual standards are.	

	As Written: XXXXX maintains uniform network adequacy policies and practices that are equally applicable to MH/SUD and M/S (see XXXXX policies QM 07, QM 10 and QM 87). In operation: Availability: The 2022 annual network availability reports to NQOC for MH/SUD and M/S providers show a range of results in meeting the various network availability standards. For example, in 2022 XXXXX's commercial PPO (non-Medicare) M/S network met or exceeded the numeric standards in all states except AK and WY. The M/S network met or exceeded the geographic standards in all states except ND and SD. As for the commercial PPO MH/SUD network, in 2022 it met or exceeded the numeric standards in all states except DC, HI, MT, NJ and ND. It met or exceeded the geographic standards in all states except AK, AR, HI, MN, MS, MT, ND, NE, NM, NV, OR, SD, UT, WI, WV and WY. (The MH/SUD report notes potential data integrity concerns, so these findings are subject to correction.) For both the MH/SUD and M/S networks, the reports also propose corrective actions to fill network gaps. These corrective actions are at least as strong for MH/SUD providers as M/S providers. The states where MH/SUD network availability did not meet standards are generally sparsely populated, and the availability of outpatient MH/SUD services on an in-network basis through XXXXX's contracted telemedicine providers mitigates those network gaps. Accessibility: The 2022 annual network accessibility reports to NQOC for MH/SUD and M/S providers show mixed results in meeting the various network accessibility standards (after-hours availability, wait times for routine and follow-up appointments, etc.), with both MH/SUD and M/S providers meeting standards in some areas and not meeting them in others. For both the MH/SUD and M/S networks, the reports also propose corrective actions where standards were not met. These corrective actions are at least as strong for MH/SUD providers as M/S providers. According to DOL, HHS and Treasury, "[u]nder this analysis, the focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity" (see FAQs part 45, April 2, 2021, at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf). Summary of Conclusions: In summary, the factors, processes, strategies and evidentiary standards used to determine network adequacy for MH/SUD providers are comparable to, and are applied no more stringently than, for M/S providers, both as written and in operation. Referenced Policies and Documents: • QM 07 – Member Access to Practitioners and Member Services • QM 10 – Provider Availability Standards • QM 87 – Assessment of Network Adequacy Policy and Procedure Plan Language: COC & SOB: No Reference	
(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 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.	

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

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 (13) 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 (MH/SUD)	***Medical/Surgical Benefits (M/S)***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S medical necessity clinical determinations are made using externally developed, evidence based clinical criteria. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S. MH/SUD medical necessity clinical determinations are made using the following criteria when applicable: American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) as well as internally developed objective, evidence-based, MH/SUD clinical policies. The MH/SUD Clinical Technology Assessment Committee (CTAC) assesses externally developed clinical criteria and develops and approves internal clinical policies for MH/SUD services. CTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective services for MH/SUD members. CTAC is comprised of, but is not limited to, medical directors, senior leaders of clinical operations and representatives from the clinical quality improvement department, utilization management, clinical operations, appeals, legal, compliance, network strategy, and provider experience teams. The Clinical Quality and Operations Committee (CQOC) reviews and validates behavioral clinical policies/clinical criteria endorsed by CTAC.	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S medical necessity clinical determinations are made using externally developed, evidence based clinical criteria. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S. M/S medical necessity clinical determinations are made using Milliman Care Guidelines (MCG) criteria when applicable as well as internally developed objective, evidence-based M/S clinical policies. The M/S Medical Policy Committee assesses externally developed clinical criteria and develops and approves internal clinical policies for M/S services. The Medical Policy Committee uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. The Medical Policy Committee conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective services for M/S members. The Medical Policy Committee is comprised of, but is not limited to, M/S medical directors, senior leaders of clinical operations and representatives from the clinical quality improvement department, utilization management, clinical operations, appeals, legal, compliance, network strategy, and provider experience teams. The Medical Policy Committee reports quarterly to the Medical Management Committee.
In-Patient & In-Network NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for in-network (INN) inpatient admissions. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for in-network (INN) inpatient admissions. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
In-Patient & Out-of-Network NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for for out-of-network (OON) inpatient admissions when the plan has OON benefits. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for for out-of-network (OON) inpatient admissions when the plan has OON benefits. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S
Out-Patient & In-Network NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for certain in-network (INN) outpatient services. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for certain in-network (INN) outpatient services. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S
Out-Patient & Out-of-Network NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for certain out-of-network (OON) outpatient services. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for certain out-of-network (OON) outpatient services. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S
Emergency Services/Benefits NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
Prior-Authorization NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have INN and OON inpatient and outpatient services subject to prior authorization. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have INN and OON inpatient and outpatient services subject to prior authorization. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.

Concurrent Review Benefit NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have INN and OON inpatient and outpatient services subject to concurrent review. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have inpatient and outpatient services subject to concurrent review. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
Retrospective Review Benefit NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have OON and INN inpatient and outpatient services subject to retrospective review. Any service that requires prior authorization is also eligible for retrospective review. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have inpatient and outpatient services subject to retrospective review. Any service that requires prior authorization is also eligible for retrospective review. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
Case & Medical Management NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD and M/S do not require participation in any of its supportive case management programs and non-participation does not limit benefits or services in any way. Therefore, case management services are not a treatment limitation (NQTL). MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD and M/S do not require participation in any of its supportive case management programs and non-participation does not limit benefits or services in any way. Therefore, case management services are not a treatment limitation (NQTL). MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
Network Adequacy & Provider Reimbursement Rates	No distinction in any NQTL practice between MH/SUD and M/S for both Network Adequacy & Provider Reimburesemt Rates. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S. Both MH/SUD and M/S assess network adequacy based on access standards that are in accordance with Centers for Medicare & Medicaid Services (CMS) and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), both MH/SUD and M/S consider network adequacy and access reports. Network adequacy and access reports are prepared on a regular basis and shared with network teams for recruitment purposes to ensure regulatory network access requirements are met. If MH/SUD or M/S determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by state or federal requirements, the network team will actively seek to add providers to the network in that specialty or provider type. If there is a supply gap, Plan language allows members to seek an exception and receive services from an out-of-network (OON) provider at the in-network (INN) benefit level.	No distinction in any NQTL practice between MH/SUD and M/S for both Network Adequacy & Provider Reimburesemt Rates. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S. Both MH/SUD and M/S assess network adequacy based on access standards that are in accordance with Centers for Medicare & Medicaid Services (CMS) and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), both MH/SUD and M/S consider network adequacy and access reports. Network adequacy and access reports are prepared on a regular basis and shared with network teams for recruitment purposes to ensure regulatory network access requirements are met. If MH/SUD or M/S determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by state or federal requirements, the network team will actively seek to add providers to the network in that specialty or provider type. If there is a supply gap, Plan language allows members to seek an exception and receive services from an out-of-network (OON) provider at the in-network (INN) benefit level.
(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.**	

EXHIBIT A (6)

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 (13) 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, the Company uses ASAM criteria for review of Mental Health/Substance Use Disorder (MH/SUD) services.	For Medical/Surgical services, the Company utilizes internally created medical polices and clinical guidelines and MCG.
In-Patient & In-Network NQTL Practices	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company 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 prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company 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 prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company 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 prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company 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 MH/SUD 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. The Company maintains a single committee that reviews drugs for the formulary regardless of whether the drug is used to cover medical/surgical and MH/SUD conditions. 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.
Concurrent Review Benefit NQTL Practices	There are no comparable inconsistencies or differences in the application, as written and in operation. The company does not initiate any concurrent reviews. Instead, the company conducts a continued stay/concurrent review when the treating provider/facility requests that the member's inpatient stay or outpatient treatment be approved for an ongoing stay in a facility or course of treatment due to the member's current medical condition. The same processes, strategies, evidentiary standards and other factors for continued stay/concurrent reviews for both MH/SUD and medical surgical benefits. Further, the company does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits.	Same as for 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 NQTL practices between medical/surgical and MH/SUD benefits. The company 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, the company will conduct a retrospective review for services for which it maintains a medical policy or clinical UM guideline and the service does not require a prior authorization. Because the company 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 the company'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. Anthem 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. The company 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. The company 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. As noted in previous discussions, the company's case management program for M/S and MH/SUD services should not be considered a non-quantitative treatment limitation. The voluntary case management program does not limit the scope and duration of benefits. Further, the voluntary case management program is separate and distinct from the UM process.	Same as for MH/SUD.
Network Adequacy & Provider Reimbursement Rates	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document.	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.*	The company did not identify any areas of concern with respect to its NQTL analysis. As noted above, we do have one area of disparity within the source of the medical policies used to review cases for medical necessity. The company is required by law to use ASAM for medical necessity reviews, so that disparity is compliant with MHPAEA. Therefore, the company is compliant with respect to the above NQTLs.	