

**Regulation 1410 – Appendix A**

**Guidance concerning providing the information required on the NQTL portion of the Data Collection Tool for Mental Health Parity Analysis**

Below is an in-depth description of each step that is delineated in the NQTL spreadsheet that is codified in Regulation 1410 – Appendix A (18 DE Admin. Code § 1410). Each managed care organization and its vendors (if applicable) should refer to this document for full context regarding completing each step in the NQTL spreadsheet.

**Step 1: Provide the specific plan language regarding the NQTL and describe all services to which it applies in each respective classification of benefits.**

Identify and provide the specific language of the NQTL as provided in the plan documents. This shall include each step, associated triggers, timelines, forms and requirements.

**Step 2: Identify the factors that trigger the application of the NQTL.**

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. The following table provides examples of factors and sources, but these examples are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.

<b>STEP 2 EXAMPLES</b>					
<i>Factors for medical management and utilization review include (these examples are merely illustrative and not exhaustive):</i>	<i>Sources for medical management and utilization review factors include:</i>	<i>Factors for provider network adequacy include:</i>	<i>Sources for provider network adequacy factors include:</i>	<i>Factors for provider reimbursement include:</i>	<i>Sources for provider reimbursement factors include:</i>
<ul style="list-style-type: none"> <li>• Excessive utilization</li> <li>• Recent medical cost escalation</li> <li>• Lack of adherence to quality standards</li> <li>• High levels of variation in length of stay</li> <li>• High variability in cost per episode of care</li> <li>• Clinical efficacy of the proposed treatment or service</li> <li>• Provider discretion in</li> </ul>	<ul style="list-style-type: none"> <li>• Internal claims analyses</li> <li>• Internal quality standard studies</li> <li>• Expert medical review</li> </ul>	<ul style="list-style-type: none"> <li>▪ Service type</li> <li>▪ Geographic market</li> <li>▪ Current demand for services</li> <li>▪ Projected demand for services</li> <li>▪ Practitioner supply and provider-to-enrollee ratios</li> <li>▪ Wait times</li> <li>▪ Geographic access standards</li> <li>▪ Out-of-</li> </ul>	<ul style="list-style-type: none"> <li>• State and federal regulatory requirements</li> <li>• National accreditation standards</li> <li>• Internal plan market analyses</li> <li>• CAHPS data</li> </ul>	<ul style="list-style-type: none"> <li>• Geographic market (i.e., market rate and payment type for provider type and/or specialty)</li> <li>• Provider type (i.e., hospital, clinic, and practitioner) and/or specialty</li> <li>• Supply of provider type and/or specialty</li> <li>• Network need and/or demand for provider type and/or specialty</li> <li>• Medicare reimbursement</li> </ul>	<ul style="list-style-type: none"> <li>• External healthcare claims database (e.g., Fair Health)</li> <li>• Medicare Physician Fee Schedule</li> <li>• Internal market and competitive analysis</li> <li>• Medicare RVUs for CPT codes</li> </ul>

determining diagnoses <ul style="list-style-type: none"> <li>• Claims associated with a high percentage of fraud</li> <li>• Severity or chronicity of the MH/SUD or medical/surgical condition</li> </ul>		network utilization rates		rates <ul style="list-style-type: none"> <li>• Training, experience, and licensure of provider</li> </ul>	
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**Step 3: Identify and describe the evidentiary standard for each of the factors identified in Step 2 and any other evidence relied upon to design and apply the NQTL.**

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term “evidentiary standards” is not limited to a means for defining “factors.” Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

*Examples of evidentiary standards to define the factors identified in Step 2, their sources, and other evidence considered include:*

- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.

- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

As noted above, these are illustrations of evidentiary standards and are not an exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.

**Step 4: Provide the comparative analyses used to determine as written comparability and equivalent stringency.**

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/ surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Additional as written processes may include, but are not limited to, utilization management manuals, utilization review criteria, specific criteria hierarchy for performing utilization review, factors considered when applying utilization review criteria, initial screening scripts and algorithms, case management referral criteria, stipulations about submitting written treatment plans, utilization management committee and/or quality management committee notes, description of processes for identifying and evaluating clinical issues and utilizing performance goals, delegation agreements, network contracting information, factors that determine reimbursement rates, among others.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:

- Results from analyses of the health plan’s paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan’s MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had “high cost variability” (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.

- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

As noted above, these are illustrations of comparative analyses and are not an exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.

**Step 5: Provide the comparative analyses used to determine in operation comparability and equivalent stringency.**

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL.

- In operation processes include, but are not limited to, peer clinical review, telephonic consultations with attending providers, consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, adherence to utilization review criteria and criteria hierarchy, professional judgment used in lieu of utilization review criteria, actions taken when incomplete information is received from attending providers, utilization review decision timeliness, requests of patient medical records, process for sharing all clinical and demographic information on individual patients among various clinical and administrative departments, among others.

Illustrative analyses includes:

- Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrate utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type

- or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

#### *Network Adequacy*

- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

As noted above, these are illustrations of comparative analyses and are not an exhaustive list of comparative analyses. While not illustrated, additional analyses would apply to different types of NQTLs.

**Step 6: Summary statement justifying how performing the comparative analyses required by the subsequent steps has led the plan to conclude that it is in compliance.**

Based on the responses provided in Steps 1 - 5, clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on medical/surgical benefits in each classification of benefits in which the NQTL is imposed.

**NON-QUANTITATIVE TREATMENT LIMITATIONS**

Benefit Plan Design(s) Identifier(s): (Submit a separate form for each benefit plan design.) \_\_\_\_\_

Plan Name: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Line of Business (check one): \_\_\_ HMO \_\_\_ EPO \_\_\_ POS ---- PPO

Contract Type (check one): \_\_\_ large group \_\_\_ small group \_\_\_ individual

Benefit Plan Effective Date: \_\_\_\_\_

Area	Medical/Surgical Benefits <i>Summarize the plan's applicable NQTLs, including any variations, by benefit.</i>	Mental Health/Substance Use Disorder Benefits <i>Summarize the plan's applicable NQTLs, including any variations, by benefit.</i>	Explanation <i>Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below. <b>Please refer to the NQTL Spreadsheet Guidance that describes each of Steps 1-6 as well as the descriptions of the information required in each cell of this tool.</b></i>					
			Step 1: Describe the NQTL's requirements and associated procedures	Step 2: Describe the reason for applying the NQTL	Step 3: Identify and describe evidentiary standards and other evidence relied upon	Step 4: Processes and strategies used to design NQTL as written	Step 5: Processes in implementation of NQTL in operation	Step 6: Summary conclusion of how plan or issuer has determined overall compliance
<p><b>A. Definition of Medical Necessity</b> <i>What is the definition of medical necessity?</i></p>	<p>Benefit/Service(s) to which the medical necessity applies. Medical necessity will also apply as a component of the application of prior authorization, concurrent review, retrospective review, outlier review, and appeals. However, it must be analyzed as a separate NQTL.</p>	<p>Benefit/Service(s) to which the medical necessity applies. Medical necessity will also apply as a component of the application of prior authorization, concurrent review, retrospective review, outlier review, and appeals. However, it must be analyzed as a separate NQTL.</p>	<p><b>STEP 1</b> NA (proceed to steps 3-6)</p>	<p><b>STEP 2</b> NA (proceed to steps 3-6)</p>	<p><b>STEP 3</b> Provide the comparative analysis demonstrating that the evidentiary standard(s) and other evidence relied upon in the creation the medical necessity criteria for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) and other evidence relied upon in the creation the medical necessity criteria for medical/surgical benefits. Describe evidentiary standards and evidence</p>	<p><b>STEP 4</b> Provide the comparative analysis demonstrating that the processes and strategies used to design the medical necessity criteria, as written for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the medical necessity criteria, <b>as written</b>, for medical/surgical benefits. <sup>ii</sup></p>	<p><b>STEP 5</b> Provide the comparative analysis demonstrating that the processes and strategies used in applying the medical necessity criteria, in operation, to MH/SUD benefits are comparable and no more stringently applied than the processes and strategies used in applying the medical necessity criteria, <b>in operation</b>, to medical surgical benefits. <sup>iii</sup></p>	<p><b>STEP 6</b> Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to design and apply the medical necessity criteria for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and</p>

					considered, but rejected. <sup>i</sup>			factors used to design and apply the medical necessity criteria for medical/surgical benefits in each classification of benefits in which utilization review is performed involving the use of the medical necessity criteria.
1. Inpatient, In-Network:	[List the services which the medical necessity criteria is relied upon during utilization review]	[List the services which the medical necessity criteria is relied upon during utilization review]			[Provide the <b>STEP 3</b> documentation]	[Provide the <b>STEP 4</b> documentation]	[Provide the <b>STEP 5</b> documentation]	[Provide the <b>STEP 6</b> documentation]
2. Inpatient, Out-of-Network:	[List the services which the medical necessity criteria is relied upon during utilization review]	[List the services which the medical necessity criteria is relied upon during utilization review]			[Provide the <b>STEP 3</b> documentation]	[Provide the <b>STEP 4</b> documentation]	[Provide the <b>STEP 5</b> documentation]	[Provide the <b>STEP 6</b> documentation]
3. Outpatient, In-Network:	[List the services which the medical necessity criteria is relied upon during utilization review]	[List the services which the medical necessity criteria is relied upon during utilization review]			[Provide the <b>STEP 3</b> documentation]	[Provide the <b>STEP 4</b> documentation]	[Provide the <b>STEP 5</b> documentation]	[Provide the <b>STEP 6</b> documentation]
4. Outpatient, out-of-network	[List the services which the medical necessity criteria is relied upon during utilization review]	[List the services which the medical necessity criteria is relied upon during utilization review]			[Provide the <b>STEP 3</b> documentation]	[Provide the <b>STEP 4</b> documentation]	[Provide the <b>STEP 5</b> documentation]	[Provide the <b>STEP 6</b> documentation]

<b>B. Prior-authorization Review Process</b> <i>Include all services for which prior authorization is required. Describe any step therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans.</i>	Benefit/Service(s) to which prior authorization applies.	Benefit/Service(s) to which prior authorization applies.	<b>STEP 1</b> • Describe the prior authorization procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms and requirements. <sup>iv</sup>	<b>STEP 2</b> Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of prior authorization for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. <sup>v</sup>	<b>STEP 3</b> Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the prior authorization protocols for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the prior authorization protocols for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected. <sup>vi</sup>	<b>STEP 4</b> Provide the comparative analysis demonstrating that the processes and strategies used to design the prior authorization protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the prior authorization protocols, as written, for medical/surgical benefits. <sup>ii</sup>	<b>STEP 5</b> Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing prior authorization for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing prior authorization for medical surgical benefits.	<b>STEP 6</b> Based on the responses provided in <b>Steps 1-5</b> , please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose prior authorization on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose prior authorization on medical/surgical benefits in each classification of benefits in which prior authorization is imposed.
1. Inpatient, In-Network:	[List the services to which prior authorization applies]	[List the services to which prior authorization applies]	[Provide the <b>Step 1</b> documentation and answer the question]	[Provide the <b>STEP 2</b> documentation]	[Provide the <b>STEP 3</b> documentation]	[Provide the <b>STEP 4</b> documentation]	[Provide the <b>STEP 5</b> documentation]	[Provide the <b>STEP 6</b> documentation]
2. Outpatient, In-Network: Office Visits:	[List the services to which prior authorization applies]	[List the services to which prior authorization applies]	[Provide the <b>Step 1</b> documentation and answer the question]	[Provide the <b>STEP 2</b> documentation]	[Provide the <b>STEP 3</b> documentation]	[Provide the <b>STEP 4</b> documentation]	[Provide the <b>STEP 5</b> documentation]	[Provide the <b>STEP 6</b> documentation]
3. Outpatient, In-Network: Other Outpatient Items and Services:	[List the services to which prior authorization applies]	[List the services to which prior authorization applies]	[Provide the <b>Step 1</b> documentation and answer the question]	[Provide the <b>STEP 2</b> documentation]	[Provide the <b>STEP 3</b> documentation]	[Provide the <b>STEP 4</b> documentation]	[Provide the <b>STEP 5</b> documentation]	[Provide the <b>STEP 6</b> documentation]
4. Inpatient, Out-of-Network:	[List the services to which prior authorization applies]	[List the services to which prior authorization applies]	[Provide the <b>Step 1</b> documentation and answer the question]	[Provide the <b>STEP 2</b> documentation]	[Provide the <b>STEP 3</b> documentation]	[Provide the <b>STEP 4</b> documentation]	[Provide the <b>STEP 5</b> documentation]	[Provide the <b>STEP 6</b> documentation]
5. Outpatient, Out-of-Network: Office Visits:	[List the services to which prior authorization applies]	[List the services to which prior authorization applies]	[Provide the <b>Step 1</b> documentation and answer the question]	[Provide the <b>STEP 2</b> documentation]	[Provide the <b>STEP 3</b> documentation]	[Provide the <b>STEP 4</b> documentation]	[Provide the <b>STEP 5</b> documentation]	[Provide the <b>STEP 6</b> documentation]



6. Outpatient, Out-of-Network: Other Items and Services:	[List the services to which prior authorization applies]	[List the services to which prior authorization applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>STEP 2</i> documentation]	[Provide the <i>STEP 3</i> documentation]	[Provide the <i>STEP 4</i> documentation]	[Provide the <i>STEP 5</i> documentation]	[Provide the <i>STEP 6</i> documentation]
<b>C. Concurrent Review Process, including frequency and penalties for all services.</b> Describe any step therapy or “fail first” requirements and requirements for submission of treatment required forms or treatment plans.	Benefit/Service(s) to which concurrent review applies.	Benefit/Service(s) to which concurrent review applies.	<b>Step 1</b> • Describe the concurrent review procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms and requirements. <sup>iii</sup>	<b>STEP 2</b> Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of concurrent review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. <sup>v</sup>	<b>STEP 3</b> Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the concurrent review protocols for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the concurrent review protocols for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected. <sup>vi</sup>	<b>STEP 4</b> Provide the comparative analysis demonstrating that the processes and strategies used to design the concurrent review protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the concurrent review protocols, as written, for medical/surgical benefits. <sup>ii</sup>	<b>STEP 5</b> Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing concurrent review for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing concurrent review for medical surgical benefits. <sup>vii</sup>	<b>STEP 6</b> Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose concurrent review on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose concurrent review on medical/surgical benefits in each classification of benefits in which prior authorization is imposed.
1. Inpatient, In-Network:	[List the services to which concurrent review applies]	[List the services to which concurrent review applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
2. Outpatient, In-Network: Office Visits:	[List the services to which concurrent review applies]	[List the services to which concurrent review applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
3. Outpatient, In-Network: Other Outpatient Items and Services:	[List the services to which concurrent review applies]	[List the services to which concurrent review applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
4. Inpatient, Out-of-Network:	[List the services to which concurrent review applies]	[List the services to which concurrent review applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
5. Outpatient, Out-of-	[List the services to	[List the services to	[Provide the <i>Step 1</i>	[Provide the <i>Step 2</i>	[Provide the <i>Step 3</i>	[Provide the <i>Step 4</i>	[Provide the <i>Step 5</i>	[Provide the <i>Step 6</i>

Network: Office Visits:	which concurrent review applies]	which concurrent review applies]	documentation and answer the question]	documentation]	documentation]	documentation]	documentation]	documentation]
6. Outpatient, Out-of-Network: Other Items and Services:	[List the services to which concurrent review applies]	[List the services to which concurrent review applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
<b>D. Retrospective Review Process, including timeline and penalties.</b>	Benefit/Service(s) to which retrospective review applies.	Benefit/Service(s) to which retrospective review applies.	<i>Step 1</i> • Describe the retrospective review procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms and requirements. <sup>iii</sup>	<i>Step 2</i> Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of retrospective review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. <sup>v</sup>	<i>Step 3</i> Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the retrospective review protocols for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the retrospective review protocols for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected. <sup>vii</sup>	<i>Step 4</i> Provide the comparative analysis demonstrating that the processes and strategies used to design the retrospective review protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the retrospective review protocols, as written, for medical/surgical benefits. <sup>ii</sup>	<i>Step 5</i> Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing retrospective review for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing retrospective review for medical surgical benefits. <sup>vii</sup>	<i>Step 6</i> Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose retrospective review on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose retrospective review on medical/surgical benefits in each classification of benefits in which prior authorization is imposed.
1. Inpatient, In-Network:	[List the services to which retrospective review applies]	[List the services to which retrospective review applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
2. Outpatient, In-Network: Office Visits:	[List the services to which retrospective review applies]	[List the services to which retrospective review applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
3. Outpatient, In-Network: Other Outpatient Items and Services:	[List the services to which retrospective review applies]	[List the services to which retrospective review applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
4. Inpatient, Out-of-Network:	[List the services to which retrospective	[List the services to which retrospective	[Provide the <i>Step 1</i> documentation and	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]

	review applies]	review applies]	answer the question]					
5. Outpatient, Out-of-Network: Office Visits:	[List the services to which retrospective review applies]	[List the services to which retrospective review applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
6. Outpatient, Out-of-Network: Other Items and Services:	[List the services to which retrospective review applies]	[List the services to which retrospective review applies]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
<b>E. Emergency Services</b>	[List the services to which prior authorization applies] [List the services to which concurrent review applies] [List the services to which retrospective review applies] [List the services to which outlier review applies] [List the services to which coding edits apply] [List the services which the medical necessity criteria is relied upon during utilization review] [List the services or items that have been reviewed to determine if they are experimental or investigational] [List the services or items that are excluded because they are court ordered or the result of an involuntary hold] [Identify the services and/or provider types for which there are approval requirements in place unlicensed/uncertified practitioners or staff.] [List the type of providers for which coverage is excluded.]	[List the services to which prior authorization applies] [List the services to which concurrent review applies] [List the services to which retrospective review applies] [List the services to which outlier review applies] [List the services to which coding edits apply] [List the services which the medical necessity criteria is relied upon during utilization review] [List the services or items that have been reviewed to determine if they are experimental or investigational] [List the services or items that are excluded because they are court ordered or the result of an involuntary hold] [Identify the services and/or provider types for which there are approval requirements in place unlicensed/uncertified practitioners or staff.] [List the type of providers for which coverage is excluded.]	[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]

<b>F. Pharmacy Services</b> Include all services for which prior authorization is required, any step therapy or "fail first" requirements, any other NQTLs. Tier 1:								
Tier 2:								
Tier 3:								
Tier 4:								
<b>G. Prescription Drug Formulary Design</b> Describe how formulary decisions are made for the diagnosis and medically necessary treatment of medical, mental health and substance use disorder conditions.								
Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.			<b>Step 1</b> <ul style="list-style-type: none"> <li>Describe the fail first procedures. Include each step, associated triggers, timelines, forms and requirements.</li> <li>What are the required qualifications/training for persons determining which benefits shall be subject to a fail-first requirement?</li> </ul>	<b>Step 2</b> Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of fail-first protocols for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. <sup>v</sup>	<b>Step 3</b> Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the fail-first protocols for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the fail-first protocols for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected. <sup>vi</sup>	<b>Step 4</b> Provide the comparative analysis demonstrating that the processes and strategies used to design the fail-first protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the fail-first protocols, as written, for medical/surgical benefits. <sup>ii</sup>	<b>Step 5</b> Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing fail-first protocols for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing fail-first protocols for medical surgical benefits. <sup>vii</sup>	<b>Step 6</b> Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose fail-first protocols on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose fail-first protocols on medical/surgical benefits in each classification of benefits in which fail-

								first protocols are imposed.
1. Inpatient, In-Network:			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
2. Outpatient, In-Network:			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
3. Inpatient, Out-of-Network:			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
4. Outpatient, Out-of-Network:			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
5. Prescription Drugs			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in development of the formulary for medications to treat medical, mental health and substance use disorder conditions?			<p><i>Step 1</i></p> <ul style="list-style-type: none"> <li>Describe the Formulary Design procedures and requirement. Include each step, associated triggers, timelines, forms and requirements.</li> <li>What are the required qualifications/training for persons developing and applying the formulary?</li> </ul>	<p><i>Step 2</i></p> <p>Provide the comparative analysis demonstrating that comparable factors were used to determine how and whether to include drugs on the formulary for MH/SUD medications as were used for medical/surgical medications, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. <sup>v</sup></p>	<p><i>Step 3</i></p> <p>Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in <i>Step 2</i> and any other evidence relied upon to develop the formulary for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to develop the formulary for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected.</p>	<p><i>Step 4</i></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used to develop the formulary, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to develop the formulary, as written, for medical/surgical benefits.<sup>ii</sup></p>	<p><i>Step 5</i></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used in providing coverage for MH/SUD medications that are not on the formulary in certain instances are comparable to and no more stringently applied than the processes and strategies used in providing coverage for medical surgical medications in certain instances.<sup>vii</sup></p>	<p><i>Step 6</i></p> <p>Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose prior authorization on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose prior authorization on medical/surgical benefits in each classification of benefits in which prior authorization is imposed.</p>



<b>H. Case Management</b> What case management services are available?	[List Benefits/Services here]	[List Benefits/Services here]						
What case management services are required?	[List Benefits/Services here]	[List Benefits/Services here]	<p><b>STEP 1</b></p> <ul style="list-style-type: none"> <li>Describe the referral to required case management procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms and requirements.</li> </ul>	<p><b>STEP 2</b></p> <p>Provide the comparative analysis demonstrating that comparable factors were used to determine whether case management services will be required for a beneficiary receiving MH/SUD benefits as were used for a beneficiary receiving medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.</p>	<p><b>STEP 3</b></p> <p>Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the protocol for required case management services for beneficiaries receiving MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the protocol for required case management services for beneficiaries receiving medical/surgical benefits. Describe evidentiary standards that were considered, but rejected.</p>	<p><b>STEP 4</b></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used to design the required case management services protocol, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the required case management services protocol, as written, for medical/surgical benefits</p>	<p><b>STEP 5</b></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing referral to required case management services for beneficiaries receiving MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the referral to required case management services for beneficiaries receiving medical surgical benefits.</p>	<p><b>STEP 6</b></p> <p>Based on the responses provided in Steps 1-5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish required case management services for beneficiaries receiving MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish required case management services for beneficiaries receiving medical/surgical benefits in each classification of benefits in which prior authorization is imposed.</p>
Inpatient, In-Network:			[Provide the <b>Step 1</b> documentation and answer the question]	[Provide the <b>Step 2</b> documentation]	[Provide the <b>Step 3</b> documentation]	[Provide the <b>Step 4</b> documentation]	[Provide the <b>Step 5</b> documentation]	[Provide the <b>Step 6</b> documentation]
Inpatient, Out-of-Network:			[Provide the <b>Step 1</b> documentation and answer the question]	[Provide the <b>Step 2</b> documentation]	[Provide the <b>Step 3</b> documentation]	[Provide the <b>Step 4</b> documentation]	[Provide the <b>Step 5</b> documentation]	[Provide the <b>Step 6</b> documentation]
Outpatient, In-Network:			[Provide the <b>Step 1</b> documentation and	[Provide the <b>Step 2</b> documentation]	[Provide the <b>Step 3</b> documentation]	[Provide the <b>Step 4</b> documentation]	[Provide the <b>Step 5</b> documentation]	[Provide the <b>Step 6</b> documentation]

			answer the question]					
Outpatient, Out-Of-Network:			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
What are the eligibility criteria for case management services?	[List Benefits/Services here]	[List Benefits/Services here]						
<b>I. Process for Assessment of New Technologies</b> Definition of experimental/investigational	[insert definition here]							
Benefit/Service(s) which have been subject to review to determine if they are experimental or investigational.	[List Benefits/Services here]	[List Benefits/Services here]	<p><b>Step 1</b> Qualifications of individuals evaluating new technologies:</p> <p>For each new technology, answer the question, what are the required qualifications/training for persons that review services, items, and medications to determine if they are experimental or investigational?</p>	<p><b>Step 2</b> Describe the reason for applying the NQTL</p> <p>Provide the comparative analysis demonstrating that comparable factors were used to identify services, items, or medications for review to determine if they are experimental or investigational, for MH/SUD benefits and for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.</p>	<p><b>Step 3</b> Evidence consulted in evaluating new technologies:</p> <p>Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define a factor identified in Step 2 and any other evidence relied upon to determine if a service, item, or medication is experimental are comparable and applied no more stringently for MH/SUD benefits and medical/surgical benefits. Describe evidentiary standards that were considered, but rejected.</p>	<p><b>Step 4</b> Processes and strategies used to design NQTL as written</p> <p>Provide the comparative analysis demonstrating that the processes and strategies used to determine whether services, items, or medications are deemed experimental or investigational, as written, for MH/SUD benefits are comparable to and no more stringent than the processes and strategies used to determine whether services, items, or medications are deemed experimental or investigational, as written, for medical/surgical benefits.<sup>ii</sup></p>	<p><b>Step 5</b> Processes in implementation of NQTL in operation</p> <p>Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing any experimental or investigational restrictions or limitations for MH/SUD benefits are comparable and no more stringent than the processes and strategies used in operationalizing any experimental or investigational restrictions or limitations for medical surgical benefits.<sup>vii</sup></p>	<p><b>Step 6</b> Summary conclusion of how plan or issuer has determined overall compliance</p> <p>Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to determine if services, items, or medications are experimental or investigational for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to determine if services, items, or medications are experimental or investigational for medical/surgical benefits in each</p>

								classification of benefits.
<b>J. Standards for Provider Credentialing and Contracting</b> Is the provider network open or closed?	[Provide the response to the question]							
What are the credentialing standards for physicians?	<i>Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers.</i>	<i>Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers.</i>	<p><b>Step 1</b></p> <ul style="list-style-type: none"> <li>Describe the provider credentialing procedures. Include each step, associated triggers, timelines, forms and requirements.</li> <li>What are the required qualifications/training for persons implementing the provider credentialing process?</li> </ul>	<p><b>Step 2</b></p> <p>n/a</p>	<p><b>Step 3</b></p> <p>Provide the comparative analysis demonstrating that the evidentiary standard(s) used to create the credentialing procedures for MH/SUD providers is comparable to and applied no more stringently than the evidentiary standard(s) used to create the credentialing procedures for medical/surgical providers. Describe evidentiary standards that were considered, but rejected.</p>	<p><b>Step 4</b></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used to design the credentialing procedures, as written, for MH/SUD providers are comparable to and applied no more stringently than the processes and strategies used to design the credentialing procedures, as written, for medical/surgical providers.</p> <p>Processes include, but are not limited to the composition and deliberations of decision-making staff, the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided</p>	<p><b>Step 5</b></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used to implement the credentialing procedures, in operation, for MH/SUD providers are comparable to and applied no more stringently than the processes and strategies used to implement the credentialing procedures, in operation, for medical/surgical providers.</p> <p>This includes the duration of the process, the documentation requests, the exceptions, stringency of analysis of submitted materials, fidelity of the credentialing system to the drafted process, as well as interrater reliability in the application of the credentialing process.</p>	<p><b>Step 6</b></p> <p>Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to design and implement the provider credentialing procedures for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to design and implement the provider credentialing procedures for medical/surgical benefits in each applicable classification of benefits.</p>



						by third-party organizations.		
1. Inpatient, In-Network			[Provide the <i>Step 1</i> documentation and answer the question]	n/a	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
2. Outpatient, In-Network			[Provide the <i>Step 1</i> documentation and answer the question]	n/a	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
What are the credentialing standards for licensed non-physician providers?	<i>Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers?</i>	<i>Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers?</i>	<p><b>Step 1</b></p> <ul style="list-style-type: none"> <li>Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.</li> <li>What are the required qualifications/training for persons determining whether to allow for licensure in the absence of a license?</li> </ul>	<p><b>Step 2</b></p> <p>Provide the comparative analysis demonstrating that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for MH/SUD providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical providers. List factors considered but rejected.</p>	<p><b>Step 3</b></p> <p>Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements for medical/surgical providers. List evidentiary standards considered but rejected.</p> <ul style="list-style-type: none"> <li>What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, and statistics)?</li> </ul>	<p><b>Step 4</b></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, for medical/surgical providers.<sup>ii</sup></p>	<p><b>Step 5</b></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for medical surgical providers.</p>	<p><b>Step 2</b></p> <p>Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for medical/surgical providers in each classification of benefits.</p>

1. Inpatient, In Network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
2. Inpatient, out-of-network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
3. Outpatient, In Network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
4. Outpatient, out-of-network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?			<p><i>Step 1</i></p> <ul style="list-style-type: none"> <li>Describe the procedures governing service provision by unlicensed/uncertified practitioners/staff. Include each step, associated triggers, timelines, forms and requirements.</li> <li>What are the required qualifications/training for persons implementing the plan or issuer's role in approving/managing unlicensed/uncertified practitioners/staff?</li> </ul>	<p><i>Step 2</i></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used to design the unlicensed/uncertified practitioners/staff approval requirements for MH/SUD benefits, as written, are comparable to and applied no more stringently than processes and strategies used to design the unlicensed/uncertified practitioners/staff approval requirements, as written, for medical/surgical benefits.</p>	<p><i>Step 3</i></p> <p>Provide the comparative analysis demonstrating that the standards or evidence that supports the rationale for applying the unlicensed/uncertified practitioners/staff requirements to MH/SUD benefit(s) are comparable and no more stringently applied than the standards or evidence that supports the rationale for applying the unlicensed/uncertified practitioners/staff requirements to medical/surgical benefits (e.g., practice guidelines, published research, data analysis, statistics)</p>	<p><i>Step 4</i></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used to design the unlicensed/uncertified practitioners/staff approval requirements for MH/SUD benefits, as written, are comparable to and applied no more stringently than processes and strategies used to design the unlicensed/uncertified practitioners/staff approval requirements, as written, for medical/surgical benefits.</p>	<p><i>Step 5</i></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the unlicensed/uncertified practitioners/staff approval requirements for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the unlicensed/uncertified practitioners/staff approval requirements for medical surgical providers. This must include discussion of the timelines and approval rates for MH/SUD unlicensed/uncertified practitioners/staff in comparison to those for M/S unlicensed/uncertified practitioners/staff. It should also include information on exceptions to the</p>	<p><i>Step 6</i></p> <p>Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish unlicensed/uncertified practitioners/staff approval requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish unlicensed/uncertified practitioners/staff approval requirements for medical/surgical providers in each classification of benefits.</p>

							policy (if any) as well as information on the fidelity and consistency of the application of the process.	
1. Inpatient, In Network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
2. Inpatient, out-of-network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
3. Outpatient, In Network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
4. Outpatient, out-of-network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
<b>K. Exclusions for Failure to Complete a Course of Treatment</b>	Does the plan exclude benefits for failure to complete treatment?	Does the plan exclude benefits for failure to complete treatment?	<p><i>Step 1</i></p> <ul style="list-style-type: none"> <li>Describe the complete/initiate first procedures. Include each step, associated triggers, timelines, forms and requirements.</li> <li>What are the required qualifications/training for persons determining which benefits shall be subject to a complete/initiate-first requirement?</li> </ul>	<p><i>Step 2</i></p> <p>Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of complete/initiate first protocols for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. <sup>v</sup></p>	<p><i>Step 3</i></p> <p>Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the complete/initiate first protocols for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the complete/initiate first protocols for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected. <sup>vi</sup></p>	<p><i>Step 4</i></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing complete/initiate first protocols for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing complete/initiate first protocols for medical surgical benefits. <sup>vii</sup></p>	<p><i>Step 5</i></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing complete/initiate first protocols for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing complete/initiate first protocols for medical surgical benefits. <sup>vii</sup></p>	<p><i>Step 6</i></p> <p>Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose complete/initiate first protocols on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose complete/initiate first protocols on medical/surgical benefits in each classification of</p>

								benefits in which complete/initiate first protocols are imposed.
1. Inpatient, In Network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
2. Inpatient, out-of-network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
3. Outpatient, In Network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
4. Outpatient, out-of-network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
<b>L. Restrictions that Limit Duration or Scope of Benefits for Services</b> Does the plan restrict the geographic location in which services can be received; e.g., service area, within the state, within the United States?			<i>Step 1</i> • Describe the procedures that must be followed for the coverage of out-of-area services. Include each step, associated triggers, timelines, forms and requirements.  • What are the required qualifications/training for persons implementing the out-of-area coverage determination protocols?	<i>Step 2</i> n/a	<i>Step 3</i> Provide the comparative analysis demonstrating that the evidentiary standard(s) used to develop the out-of-area approval protocols for MH/SUD benefits are comparable to the evidentiary standards used to develop the out-of-area approval protocols for medical/surgical benefits.	<i>Step 4</i> Provide the comparative analysis demonstrating that the processes and strategies used to design the out-of-area approval protocols, as written, for MH/SUD benefits are comparable to and no more stringent than the processes and strategies used to design the out-of-area approval protocols, as written, for medical/surgical benefits. <sup>ii</sup>	<i>Step 5</i> Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing out-of-area approval protocols for MH/SUD benefits are comparable and no more stringent than the processes and strategies used in operationalizing the out-of-area approval protocols for medical/surgical benefits.	<i>Step 6</i> Based on the responses provided in <i>Steps 1-5</i> , please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to design and apply the out-of-area approval protocols for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to design and apply the out-of-area approval protocols for medical/surgical benefits in each applicable classification of benefits.

1. In-Patient, Out-of-network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
2. Out-Patient, Out-of-network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
Does the plan restrict the type(s) of facilities in which enrollees can receive services								
<b>M. Restrictions for Provider Specialty</b> Does the plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?			<p><i>Step 1</i></p> <ul style="list-style-type: none"> <li>Describe the procedures governing categorical exclusions of provider types. Include each step, associated triggers, timelines, forms and requirements.</li> <li>What are the required qualifications/training for persons determining that certain provider types will be excluded?</li> </ul>	<p><i>Step 2</i></p> <p>Provide the comparative analysis demonstrating that the factors used to determine the applicability of a categorical exclusion of certain MH/SUD provider types are comparable to the factors used to determine the applicability of a categorical exclusion of certain medical/surgical provider types. List factors considered but rejected.<sup>v</sup></p>	<p><i>Step 3</i></p> <p>Provide the comparative analysis demonstrating that the standards or evidence that supports the rationale for applying a categorical exclusion of certain MH/SUD provider types are comparable to and no more stringently applied than the standards or evidence that supports the rationale for applying a categorical exclusion of certain medical/surgical provider types. (e.g., practice guidelines, published research, data analysis, statistics)</p>	<p><i>Step 4</i></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used to design any categorical exclusions of certain MH/SUD provider types, as written, are comparable to and applied no more stringently than processes and strategies used to design any categorical exclusions of certain medical/surgical provider types, as written.</p>	<p><i>Step 5</i></p> <p>Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing any categorical exclusions of certain MH/SUD provider types are comparable to and no more stringently applied than the processes and strategies used in operationalizing any categorical exclusions of certain medical surgical provider types.</p>	<p><i>Step 6</i></p> <p>Based on the responses provided in Steps 1 - 5, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose categorical exclusions of certain MH/SUD provider types are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose categorical exclusions of certain medical/surgical provider types in each classification of benefits.</p>
1. Inpatient, In Network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
2. Inpatient, out-of-network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
3. Outpatient, In Network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]



4. Outpatient, out-of-network			[Provide the <i>Step 1</i> documentation and answer the question]	[Provide the <i>Step 2</i> Documentation]	[Provide the <i>Step 3</i> documentation]	[Provide the <i>Step 4</i> documentation]	[Provide the <i>Step 5</i> documentation]	[Provide the <i>Step 6</i> documentation]
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**List of Documents Referenced Above**  
List each document referenced above, including reference to exhibit number, file name, or other identifying information for examiners.

<sup>i</sup> Evidentiary standards include all evidence or guidelines the plan or issuer considers in designing and applying its medical necessity criteria, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

<sup>ii</sup> These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

<sup>iii</sup> Processes and strategies used in applying the medical necessity criteria may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in applying the criteria, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination. A key indicator for determining if the medical necessity criteria has been applied comparably and no more stringently may be an examination and comparison of interrater reliability audits for MH/SUD and medical/surgical utilization reviewers.

<sup>iv</sup> State whether the required qualifications/training for persons performing the review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.).

<sup>v</sup> Examples of factors for determining that the NQTL is appropriate include (these examples are merely illustrative and not exhaustive):

- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD condition.

Examples of sources for data to identify factors:

- Internal claims analyses
- Internal quality standard studies
- Expert medical review

<sup>vi</sup> Please note, the term “evidentiary standards” is not limited to a means for defining “factors”. Evidentiary standards also include all evidence considered in designing and applying its NQTL protocols such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations. Examples of evidentiary standards and their sources are provided in the toolkit.

<sup>vii</sup> Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy and the selection of information deemed reasonably necessary to make a medical necessity determination.