Attachment A

This Attachment A provides examples of factors, evidentiary standards, sources, and comparative analyses referenced in the five steps of the Instructions for NQTL Comparative Analysis Compliance Filing.[1] The examples are merely illustrative and not exhaustive.

Step 1: The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorders (MH/SUD) and medical or surgical benefits to which each such term applies in each respective benefits classification.

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

Examples of factors for medical management and utilization review (i.e., prior authorization, concurrent review and retrospective review) include:

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

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

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

a. *Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.*
b. *Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.*
c. *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.*

[1] Attachment A includes similar examples of factors, evidentiary standards, sources, and comparative analysis provided by other states.

d. *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.*
e. *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.*
f. *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).*
g. *Two published RCTs required to establish a treatment or service is not experimental or investigational.*
h. *Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria or American Psychiatric Association (APA) treatment guidelines.*
i. *State regulatory standards for health plan network adequacy.*
j. *Health plan accreditation standards for quality assurance.*

Examples of sources for medical management and utilization review factors include:

a. *Internal claims analyses*
b. *Internal quality standard studies*
c. *Expert medical review*

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

Examples of comparative analyses include:

a. *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% per year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.*
b. *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.

c. *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.*
d. *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.*
e. *Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.*
f. *Internal review to determine that the 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.*
g. *Internal review to determine 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.*

Step 5: The specific findings and conclusions reached by the health plan, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.[2]

[2] 42 U.S.C. § 300gg-26(a)(8)(A)(i)-(v).