NQTL: Blanket Exclusions of Benefits

Classification(s): separate analyses should be submitted for each classification of benefits for which Blanket Exclusions of Benefits are applied.

Step 1 - Identify the specific plan or coverage terms or other relevant terms regarding Blanket Exclusions of Benefits and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

1(a): Define Blanket Exclusions of Benefits

"Blanket Exclusions of Benefits" means exclusions of benefits that apply uniformly to all claims or service requests for identified benefits for all Plan beneficiaries, with no consideration of Medical Necessity or other factors.

"Blanket Exclusions of Benefits" excludes Experimental/Investigational Determinations, Exclusions for Court-Ordered Treatment or Involuntary Holds, Provider-Type Exclusions, Out-of-Network Coverage Standards, and Geographic Restrictions.

1(b): Identify the benefits/services that are subject to a Blanket Exclusion of Benefits

List all benefits in this classification that are subject to a Blanket Exclusion of Benefits.

In general, no analysis of comparability and stringency is required for this Step.

NOTE: If no Blanket Exclusion of Benefits are applied to any MH/SUD benefit or service (notwithstanding any coverage exclusions that are analyzed under other NQTLs), this NQTL analysis may be marked "N/A".

NOTE: This NQTL type does not apply to blanket exclusions of benefits for a given condition or diagnosis.

Step 2 – Identify the factors used to determine that Blanket Exclusions of Benefits will apply to mental health or substance use disorder benefits and medical or surgical benefits

Identify the factors used to determine which benefits are subject to a Blanket Exclusion of Benefits.

Plans have broad discretion to select and define factors for determining whether to apply a Blanket Exclusion of Benefits to a given benefit. Examples of selection factors include:

- Treatments and services for non-covered diagnoses or conditions
- Treatments and services that do not meet the Plan's definition for "medical treatments and services," including dental, cosmetic, lifestyle, and social services

- Treatments and services determined to be high cost and to deliver poor clinical efficacy relative to alternative treatments or placebo
- Treatments and services delivered outside of the United States
- Treatments and services that are rarely covered in the market and for which coverage is determined to create a risk of adverse selection

Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply Blanket Exclusions of Benefits to mental health or substance use disorder benefits and medical or surgical benefits.

Each factor must be defined with an evidentiary standard that may or may not include a quantitative threshold, but that is set forth with sufficient precision to determine whether a given benefit or service does or does not meet the standard. The data source(s) that are used to evaluate or measure the factor and determine whether or not the factor is met must also be identified for each factor. Plans have broad discretion to select these data sources and evidentiary standards. Examples of data sources include:

- Plan coverage documents
- Preponderance of the medical literature
- Plan economic projections
- Market analysis of coverage trends

Note that this step does NOT require Plans to analyze the evidence base for any specific service that is subject to a Blanket Exclusion of Benefits. Instead, this step focuses on the factors, data sources, and evidentiary standards that were used to decide to apply a Blanket Exclusion of Benefits.

Step 4 – Provide comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply Blanket Exclusions of Benefits to mental health or substance use disorder 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 Blanket Exclusions of Benefits to medical or surgical benefits in the benefits classification

Step 4(a) - In Writing: For each benefit subject to a Blanket Exclusion of Benefits, identify which of the factor(s) in Step 3 were met

Include a brief summary description of the data or evidence relied upon to determine that the benefit met each factor that it was determined to meet, in addition to a breakdown of which factors apply to each benefit that is subject to Blanket Exclusion of Benefits on a benefit-by-benefit basis. **A sample grid is provided below, but any format can be used.** One or more factors may be indicated for a given benefit. No factors should be applied that are only met by MH/SUD benefits. For the prescription drugs classification, the Plan may indicate that this

factor-level analysis for a given drug, formulation, or dosage level is available to regulators upon request in the event of a complaint or suspicion of noncompliance.

It is not necessary to provide the actual data or evidence relied upon to determine that the benefit met the indicated factors. It is sufficient to provide a brief summary of the data types and/or sources of evidence that are used to apply or implement the factors listed in Step 3. The underlying data or evidence should be collected and documented internally and may be required by the state, including in the case of an audit or investigation.

	Non-covered diagnoses	**Non-medical Benefits**	**High cost/low efficacy**
MH/SUD benefits			
Supported employment		X	
Equine therapy			X
Psych testing, except for specified diagnoses	X		
Etc.			
M/S benefits			
Private duty nursing			X
Orthodontic treatment		X	
Massage therapy		X	
Routine foot care, except to treat specified diagnoses	X		
Etc.			

Step 4(b): Briefly describe the processes by which Blanket Exclusions of Benefits are applied.

Provide a brief description of each step of the processes by which the Plan decides to apply a Blanket Exclusion to a service. This should include descriptions of any documented policies and procedures for the processes used to make a determination ("as written"), as well as any additional details, including common exceptions or deviations from the documented policies and procedures, regarding the processes that are used in practice to make a determination ("in operation"). As noted in the general instructions, the underlying policies and procedures and related Plan documents should be identified but do not have to be attached to this report. Instead, key details from these documents should be summarized and analyzed here.

Information provided for these items should be ordered and formatted to facilitate direct comparisons between M/S and MH/SUD benefits, and in particular should note any differences between the process for determining to apply a Blanket Exclusion of Benefits to a MH/SUD treatment or service vs. a M/S treatment or service.

Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Blanket Exclusions of Benefits

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to its Blanket Exclusions of Benefits.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as annual reviews of Blanket Exclusion of Benefits exclusions or internal audits of the application of its Blanket Exclusions of Benefits.

A brief comparability and stringency analysis should be provided for each factor, process, and/or operations measure that is identified.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section.

Provide a brief comparability and stringency analysis for any substantive differences in the information provided in each of the preceding steps.

NQTL: Exclusions for Court-Ordered Treatment or Involuntary Holds

Classification(s): separate analyses should be submitted for each classification of benefits for which Exclusions for Court-Ordered Treatment or Involuntary Holds are applied.

Step 1 - Identify the specific plan or coverage terms or other relevant terms regarding Exclusions for Court-Ordered Treatment or Involuntary Holds and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Step 1(a): Define Court-Ordered Treatment or Involuntary Holds Exclusions

Exclusions for Court-Ordered Treatment or Involuntary Holds (COT Exclusions) is defined to mean an exclusion of coverage for all court-ordered treatment or involuntary holds for all Plan beneficiaries, with no consideration of Medical Necessity or other factors.

COT Exclusions do not include Blanket Exclusions of Benefits, Experimental/ Investigational Determinations, Provider-type Exclusions, Out-of-Network Coverage Standards, or Geographic Restrictions.

NOTE: If no Court-Ordered Treatment or Involuntary Holds Exclusions are applied to any MH/SUD benefit or service (notwithstanding any coverage exclusions that are analyzed under other NQTLs), this NQTL analysis may be marked "N/A".

Step 1(b): Identify the benefits/services that are subject to a Court-Ordered Treatment or Involuntary Holds Exclusion

List all benefits in this classification that are subject to a Court-Ordered Treatment or Involuntary Holds Exclusion.

In general, no analysis of comparability and stringency is required for this Step.

Step 2 – Identify the factors used to determine that Exclusions for Court-Ordered Treatment or Involuntary Holds will apply to mental health or substance use disorder benefits and medical or surgical benefits

Identify the factors used to determine which benefits are subject to a Court-Ordered Treatment or Involuntary Holds Exclusion. Plans have broad discretion to select and define factors for determining whether to apply a Court-Ordered Treatment or Involuntary Holds Exclusion to a given benefit.

Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence

relied upon to design and apply Exclusions for Court-Ordered Treatment or Involuntary Holds to mental health or substance use disorder benefits and medical or surgical benefits.

Each factor must be defined with an evidentiary standard that may or may not include a quantitative threshold, but that is set forth with sufficient precision to determine whether a given benefit or service does or does not meet the standard. The data source(s) that are used to evaluate or measure the factor and determine whether or not the factor is met must also be identified for each factor. Plans have broad discretion to select these data sources and evidentiary standards. Examples of data sources include:

- Plan coverage documents
- Preponderance of the medical literature
- Adherence to identified national standards

Note that this step does NOT require Plans to analyze the evidence base for any specific service that is subject to a Court-Ordered Treatment or Involuntary Holds Exclusion. Instead, this step focuses on the factors, data sources, and evidentiary standards that were used to decide to apply a Court-Ordered Treatment or Involuntary Holds Exclusion to the service.

Step 4 – Provide comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply Exclusions for Court-Ordered Treatment or Involuntary Holds to mental health or substance use disorder 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 Exclusions for Court-Ordered Treatment or Involuntary Holds to medical or surgical benefits in the benefits classification

Step 4(a): For each benefit subject to a Court-Ordered Treatment or Involuntary Holds Exclusion, identify which of the factor(s) in Step 3 were met

Include a brief summary description of the data or evidence relied upon to determine that the benefit met each factor that it was determined to meet, in addition to a breakdown of which factors apply to each benefit that is subject to a Court-Ordered Treatment or Involuntary Holds Exclusion on a benefit-by-benefit basis. A grid or list may be provided as an attachment if necessary. One or more factors may be indicated for a given benefit. No factors should be applied that are only met by MH/SUD benefits. For the prescription drugs classification, the Plan may indicate that this factor-level analysis for a given drug, formulation, or dosage level is available to regulators upon request in the event of a complaint or suspicion of noncompliance.

It is not necessary to provide the actual data or evidence relied upon to determine that the benefit met the indicated factors. It is sufficient to provide a brief summary of the data types and/or sources of evidence that are used to apply or implement the factors listed in Step 3. The underlying data or evidence should be collected and documented internally and may be required by the state, including in the case of an audit or investigation.

Step 4(b): Briefly describe the processes by which Court-Ordered Treatment or Involuntary Holds Exclusions are applied.

Provide a brief description of each step of the processes by which the Plan decides to apply a Court-Ordered Treatment or Involuntary Holds Exclusion to a claim or authorization request. This should include descriptions of any documented policies and procedures for the processes used to make a determination ("as written"), as well as any additional details, including common exceptions or deviations from the documented policies and procedures, regarding the processes that are used in practice to make a determination ("in operation"). As noted in the general instructions, the underlying policies and procedures and related Plan documents should be identified but do not have to be attached to this report. Instead, key details from these documents should be summarized and analyzed here.

Information provided for these items should be ordered and formatted to facilitate direct comparisons between M/S and MH/SUD benefits, and in particular should note any differences between the process for determining to apply a Court-Ordered Treatment or Involuntary Holds Exclusion to a claim or authorization request for an MH/SUD treatment or service vs. a M/S treatment or service.

Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Court-Ordered Treatment or Involuntary Holds Exclusions

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to the implementation of its Court-Ordered Treatment or Involuntary Holds Exclusions policy.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as annual reviews of Court-Ordered Treatment or Involuntary Holds Exclusions or internal audits of Court-Ordered Treatment or Involuntary Holds Exclusion determinations.

A brief comparability and stringency analysis should be provided for each factor, process, and/or operations measure that is identified.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section.

Provide a brief comparability and stringency analysis for any substantive differences in the information provided in each of the preceding steps.

NQTL: Provider-Type Exclusions

Classification(s): separate analyses should be submitted for inpatient and outpatient benefit classifications for which Provider-Type Exclusions (Provider Type Exclusion) are applied. No analysis is required for prescription drugs or emergency classifications.

Step 1 - Identify the specific plan or coverage terms or other relevant terms regarding Provider Type Exclusions and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Step 1(a): Define Provider-Type Exclusions

"Provider-Type Exclusions" (PT Exclusions) means exclusions of coverage for all covered benefits by any provider of a licensed healthcare provider type, as the provider type is defined by the Plan, without regard to Member-specific considerations such as the Medical Necessity of the service.

Provider-Type Exclusions do not include Experimental/Investigational Determinations, Blanket Exclusions of, Exclusions for Court-Ordered Treatment or Involuntary Holds, Out-of-Network Coverage Standards, and Geographic Restrictions.

NOTE: If no Provider Type Exclusions are applied to any MH/SUD benefit or service (notwithstanding any coverage exclusions that are analyzed under other NQTLs), this NQTL analysis may be marked "N/A".

Step 1(b): Identify the Provider Types that are subject to a Provider Type Exclusion

List all Provider Types in this classification that are subject to a Provider Type Exclusion.

In general, no analysis of comparability and stringency is required for this Step.

Step 2 – Identify the factors used to determine that Provider Type Exclusions will apply to mental health or substance use disorder benefits and medical or surgical benefits

Each factor must be defined with sufficient precision to determine whether a given benefit or service does or does not meet the definition.

Plans have broad discretion to select and define factors for determining whether to apply a Provider Type Exclusion to a given benefit. Examples of factors include Provider Types for which:

- State licensing is not available in the Plan state
- The majority of the services delivered by the Provider Type are not covered benefits under the Plan

- Specifically identified concerns regarding service quality and efficacy, patient safety, provider fraud waste and abuse, and/or comparable concerns are documented to be widespread among the Provider Type

Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply Provider Type Exclusions to mental health or substance use disorder benefits and medical or surgical benefits.

Each factor must be defined with an evidentiary standard that may or may not include a quantitative threshold, but that is set forth with sufficient precision to determine whether a given benefit or service does or does not meet the standard. The data source(s) that are used to evaluate or measure the factor and determine whether or not the factor is met must also be identified for each factor. Plans have broad discretion to select these data sources and evidentiary standards. Examples of data sources include:

- State licensing programs
- Provider websites and marketing materials
- Plan coverage documents
- Federal or State government reports
- Preponderance of the medical literature

Note that this step does NOT require Plans to analyze the evidence base for any specific Provider Type that is subject to a Provider Type Exclusion. Instead, this step focuses on the factors, data sources, and evidentiary standards that were used to decide to apply a Provider Type Exclusion to the Provider Type.

Step 4 – Provide comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply Provider Type Exclusions to mental health or substance use disorder 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 Provider Type Exclusions to medical or surgical benefits in the benefits classification

Step 4(a): For each Provider Type subject to a Provider Type Exclusion, identify which of the factor(s) in Step 3 were met

Include a brief summary description of the data or evidence relied upon to determine that the Provider Type met each factor that it was determined to meet, in addition to a breakdown of which factors apply to each Provider Type that is subject to a Provider Type Exclusion on a Provider Type-by-Provider Type basis. A grid or list may be provided as an attachment if necessary. One or more factors may be indicated for a given benefit. No factors should be applied that are only met by Provider Types that primarily deliver MH/SUD treatments and services.

It is not necessary to provide the actual data or evidence relied upon to determine that the Provider Type met the indicated factors. It is sufficient to provide a brief summary of the data types and/or sources of evidence that are used to apply or implement the factors listed in Step 3. The underlying data or evidence should be collected and documented internally and may be required by the state, including in the case of an audit or investigation.

Step 4(b): Briefly describe the processes by which Provider Type Exclusions are applied.

Provide a brief description of each step of the processes by which the Plan decides to apply a Provider Type Exclusion to a Provider Type. This should include descriptions of any documented policies and procedures for the processes used to make a determination ("as written"), as well as any additional details, including common exceptions or deviations from the documented policies and procedures, regarding the processes that are used in practice to make a determination ("in operation"). As noted in the general instructions, the underlying policies and procedures and related Plan documents should be identified but do not have to be attached to this report. Instead, key details from these documents should be summarized and analyzed here.

Information provided for these items should be ordered and formatted to facilitate direct comparisons between M/S and MH/SUD Provider Types, and in particular should note any differences between the process for determining to apply a Provider Type Exclusion to a Provider Type that primarily delivers MH/SUD treatments and services vs. M/S treatments and services.

Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Provider Type Exclusions

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to the implementation of its Provider Type Exclusions policy.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as annual reviews of Provider Type Exclusions or internal audits of Provider Type Exclusion determinations.

A brief comparability and stringency analysis should be provided for each factor, process, and/or operations measure that is identified.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section.

Provide a brief comparability and stringency analysis for any substantive differences in the information provided in each of the preceding steps.

NQTL: Out-of-Network Coverage Standards

Classification(s): separate analyses should be submitted for each classification of benefits for which limits based on Out-of-Network Coverage Standards are applied.

Step 1 - Identify the specific plan or coverage terms or other relevant terms regarding Out-Of-Network Coverage Standards and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Step 1(a): Define "Out-of-Network Coverage Standards"

"Out-of-Network Coverage Standards" means the standards and processes used by the Plan to authorize coverage for treatments and services delivered by out-of-network providers.

NOTE: This NQTL type is primarily relevant for Medicaid Managed Care Organizations, given the absence of out-of-network benefit classifications for Medicaid parity analyses.

Commercial Plans should generally analyze limits on coverage for out-of-network benefits under the out-of-network benefit classifications for other NQTL types. Commercial health plans that do not apply any specific Out-of-Network Coverage Standards that are not addressed under other reported NQTL analyses may mark this NQTL "N/A."

Commercial health plans that offer Out-of-Network coverage only for covered MH/SUD benefits that are medically necessary and not available in-network and that do not offer Out-of-Network coverage for M/S benefits may indicate "N/A" for this NQTL.

Step 1(b): Identify all limits on coverage that are based on Out-of-Network Coverage Standards.

For example, the Plan may apply:

- Pre-service notice or administrative approval of all non-emergent out-of-network services
- Exclusions of coverage for all non-authorized out-of-network services

Step 2 – Identify the factors used to determine that Out-Of-Network Coverage Standards will apply to mental health or substance use disorder benefits and medical or surgical benefits

Plans have broad discretion to select and define factors for determining how to design and apply Out-of-Network Coverage Standards, though limits on OON coverage must comply with federal and state laws and guidance, particularly for Medicaid programs. Examples of factors include:

- The treatment or service is Medically Necessary

    - *NOTE: strategies and processes for making the Medical Necessity determination itself may be analyzed under a separate NQTL, e.g. Prior Authorization or Concurrent Review*
- No contracted providers are available to deliver the service, including any definitions the used to determine "availability" (e.g. with regard to cultural competence)
- A member who is presently located outside the service area requires services
- Treatment by an OON provider with whom the member has an existing treatment provider relationship is necessary to ensure continuity of care in transitioning to an in-network provider
- Urgent or emergency treatments and services

Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply Out-Of-Network Coverage Standards to mental health or substance use disorder benefits and medical or surgical benefits.

Each factor must be defined with an evidentiary standard that may or may not include a quantitative threshold, but that is set forth with sufficient precision to determine whether a given authorization request or claim for OON coverage will be approved. The data source(s) that are used to evaluate or measure the factor and determine whether or not the factor is met must also be identified for each factor. Plans have broad discretion to select these data sources and evidentiary standards. Examples of data sources include:

- Plan data regarding network adequacy and/or in-network provider availability
- Medical management system data regarding the member's treatment needs and/or existing provider relationships

Step 4 – Provide comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply Out-Of-Network Coverage Standards to mental health or substance use disorder 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 Out-Of-Network Coverage Standards to medical or surgical benefits in the benefits classification

Step 4(a): Briefly describe the processes by which Out-of-Network Coverage Standards are applied.

Provide a brief description of each step of the processes by which Out-of-Network Coverage Standards are applied. This should include descriptions of any documented policies and procedures for the processes used to make the OON coverage determination ("as written"), as well as any additional details, including common exceptions or deviations from the documented policies and procedures, regarding the processes that are used in practice to apply Out-of-Network Coverage Standards ("in operation"). As noted in the general instructions, the underlying policies and procedures and related Plan documents should be identified but do not

have to be attached to this report. Instead, key details from these documents should be summarized and analyzed here.

This analysis may include discussion of relevant:

- Timelines and deadlines for making an OON coverage determination
- Processes to determine the Medical Necessity of the service
- Processes to verify the lack of availability of in-network treatment providers

Authorization processes based on Medical Necessity (prior, concurrent, and/or retrospective) that are described and analyzed under another NQTL and are applied in the same manner to OON coverage determinations may be incorporated here by reference. However, administrative approval processes not based on Medical Necessity that occur before, during, or after the service delivery (such as processes to verify the lack of availability of in-network treatment providers) should be described.

Information provided for these items should be ordered and formatted to facilitate direct comparisons between M/S and MH/SUD benefits. Discussion of these items should be brief, not comprehensive, but sufficient to enable a high-level comparison between any differences between the process of applying Out-of-Network Coverage Standards to MH/SUD benefits relative to M/S benefits.

Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Out-of-Network Coverage Standards

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to its Out-of-Network Coverage Standards.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as the following examples:

- Denial rates for OON coverage requests
- Internal audits of OON coverage determinations

A brief comparability and stringency analysis should be provided for each factor, process, and/or operations measure that is identified.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section.

Provide a brief comparability and stringency analysis for any substantive differences in the information provided in each of the preceding steps.

NQTL: Geographic Restrictions

Classification(s): separate analyses should be submitted for each classification of benefits for which coverage limits are applied based on Geographic Restrictions.

Step 1 - Identify the specific plan or coverage terms or other relevant terms regarding Geographic Restrictions and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Step 1(a): Define "Geographic Restrictions"

"Geographic Restrictions" means coverage limits based only on the geographic location of the provider, such as limits on coverage for treatments and services delivered by out-of-area or out-of-state providers on an in-person (non-telehealth) basis, where such limit is applied differently to MH/SUD providers from the application to M/S providers.

Geographic Restrictions does not include limits on coverage for out-of-network services that are analyzed under the out-of-network benefit classifications for other reported NQTLs.

NOTE: if all Geographic Restrictions apply to all MH/SUD and M/S benefits, without regard to the condition being treated, the Plan may indicate "N/A" for this NQTL.

NOTE: if no limits or exclusions based on the geographic location of the provider are applied that are not analyzed under another NQTL analysis, the Plan may indicate "N/A" for this NQTL.

NOTE: Medicaid Managed Care Organizations that do not apply any Geographic Restrictions that are not addressed their Out-of-Network Coverage Standards NQTL analysis may indicate "N/A" for this NQTL.

Step 1(b): Identify the Geographic Restrictions that are applied to the Plan's coverage

Identify all limits on coverage that are based on Geographic Restrictions. For example, the Plan may apply:

- Pre-service notice or administrative approval of all non-emergent out-of-area services for identified MH/SUD benefits

Step 2 – Identify the factors used to determine that Geographic Restrictions will apply to mental health or substance use disorder benefits and medical or surgical benefits

If only specific benefits are subject to Geographic Restrictions, the factors used to determine which benefits are subject to Geographic Restrictions should be listed here. Each factor must be

defined with sufficient precision to determine whether a given benefit or service does or does not meet the definition.

Plans have broad discretion to select and define factors for determining whether to apply exclusions based on Geographic Restrictions to a given benefit. Examples of selection factors and definitions include:

- The treatment or service is determined to be Medically Necessary
    - *NOTE: strategies and processes for making the Medical Necessity determination itself may be analyzed under a separate NQTL, e.g. Prior Authorization or Concurrent Review*
- No contracted providers are available within the service area to deliver the service, including any definitions for:
    - the geographic area within which in-network provider availability is assessed
    - the capacity of in-area providers to accept new patients
    - acceptable appointment wait times for in-area providers
- A member who is presently located outside the service area requires services
- Treatment by an out-of-area provider with whom the member has an existing treatment provider relationship is necessary to ensure continuity of care in transitioning to an in-area provider
- Urgent or emergency treatments and services

Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply Geographic Restrictions to mental health or substance use disorder benefits and medical or surgical benefits.

Each factor must be defined with an evidentiary standard that may or may not include a quantitative threshold, but that is set forth with sufficient precision to determine whether a given benefit or service does or does not meet the standard. The data source(s) that are used to evaluate or measure the factor and determine whether or not the factor is met must also be identified for each factor. Plans have broad discretion to select these data sources and evidentiary standards. Examples of data sources include:

- Plan data regarding in-area network adequacy and/or provider availability
- Medical management system data regarding the member's treatment needs and/or existing provider relationships

Step 4 – Provide comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply Geographic Restrictions to mental health or substance use disorder 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 Geographic Restrictions to medical or surgical benefits in the benefits classification

Step 4(a): Briefly describe the processes by which Geographic Restrictions are applied.

Provide a brief description of each step of the processes by which Geographic Restrictions are applied. This should include descriptions of any documented policies and procedures for the processes used to make the OON coverage determination ("as written"), as well as any additional details, including common exceptions or deviations from the documented policies and procedures, regarding the processes that are used in practice to apply Geographic Restrictions ("in operation"). As noted in the general instructions, the underlying policies and procedures and related Plan documents should be identified but do not have to be attached to this report. Instead, key details from these documents should be summarized and analyzed here.

This analysis may include discussion of relevant:

- Timelines and deadlines for making coverage determinations for benefits subject to Geographic Restrictions
- Processes to determine the Medical Necessity of the service
- Processes to verify the lack of availability of in-area treatment providers

Authorization processes based on Medical Necessity (prior, concurrent, and/or retrospective) that are described and analyzed under another NQTL and are applied in the same manner to OON coverage determinations may be incorporated here by reference. However, administrative approval processes not based on Medical Necessity that occur before, during, or after the service delivery (such as processes to verify the lack of availability of in-area treatment providers) should be described.

Information provided for these items should be ordered and formatted to facilitate direct comparisons between M/S and MH/SUD benefits. Discussion of these items should be brief, not comprehensive, but sufficient to enable a high-level comparison between any differences between the process of applying Geographic Restrictions to MH/SUD benefits relative to M/S benefits.

Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Geographic Restrictions

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to its Geographic Restrictions.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as the following examples:

- Denial rates based on Geographic Restrictions
- Internal audits of coverage determinations based on Geographic Restrictions

A brief comparability and stringency analysis should be provided for each factor, process, and/or operations measure that is identified.

Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section.

Provide a brief comparability and stringency analysis for any substantive differences in the information provided in each of the preceding steps.