TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE
CHAPTER 6. DEPARTMENT OF INSURANCE
ARTICLE 15. MENTAL HEALTH PARITY

Section

ARTICLE 15. MENTAL HEALTH PARITY

R20-6-1501. Definitions

The definitions in A.R.S. § 20-3501 and the following definitions apply to this Article:

"Arizona Mental Health Parity Act" means the statutes found at A.R.S. §§ 20-3501 through 20-3505.

"Coverage unit" means the way in which a health plan (or health insurance coverage) groups individuals for purposes of determining benefits, or premiums, or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.

"Department" means the Arizona Department of Insurance and Financial Institutions.

"Division" means the Division of Insurance of the Department.

"Financial requirement (FR)" means deductibles, copayments, coinsurance, or out-of-pocket maximums. FRs do not include aggregate lifetime or annual dollar limits.

"Health care insurer" has the meaning prescribed in A.R.S. § 20-3501(2).

"Health plan" has the meaning prescribed in A.R.S. § 20-3501(3).

"HEDIS" means the Healthcare Effectiveness Data and Information Set published by the National Committee for Quality Assurance (NCQA).

"HHS MHPAEA tool" means the Mental Health Parity tool offered by the U.S. Department of Health and Human Services.

"Inpatient, in-network benefits" are benefits furnished on an inpatient basis and within a network of contracted providers under a health plan.

"Inpatient, out-of-network benefits" are benefits furnished on an inpatient basis by providers without a contract under a health plan or for a health plan that has no network of providers.

"Medical/surgical (Med/Surg) benefits" means benefits with respect to items or services for medical conditions or surgical procedures as defined under the terms of the health plan or health insurance coverage and in accordance with federal and state law and consistent with generally recognized independent standards of current medical practice. Med/Surg benefits does not include mental health (MH) or substance use disorder (SUD) benefits.

"Mental (MH) health benefits" means benefits with respect to items or services for mental health conditions as defined under the terms of the health plan or health insurance coverage and in accordance with applicable federal and state law and consistent with generally recognized independent standards of current medical practice. MH benefits include intermediate benefits (such as residential treatment, partial hospitalization and intensive outpatient treatment), medication assisted treatment (MAT) and treatment for eating disorders.

"MHPAEA" means the Mental Health Parity and Addiction Equity Act prescribed in A.R.S. § 20-3501(4).

"Nonquantitative treatment limitation (NQTL)" is a limitation that restricts the scope or duration of benefits for treatment under a health plan or coverage. Illustrations of NQTLs include: medical management standards limiting or excluding benefits based on medical necessity or appropriateness or based on whether the treatment is experimental or investigative as identified under 45 C.F.R. 146.136(c)(4)(ii)(A); formulary design for prescription drugs as identified under 45 C.F.R. 146.136(c)(4)(ii)(B); network tier design (for health plans with multiple network tiers such as preferred providers and participating providers) as identified under 45 C.F.R. 146.136(c)(4)(ii)(C); standards for provider admission to participate in a network, including reimbursement rates as identified under 45 C.F.R. 146.136(c)(4)(ii)(D); methods for determining usual, customary, and reasonable charges as identified under 45 C.F.R. 146.136(c)(4)(ii)(E); refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first policies" or "step therapy protocols") as identified under 45 C.F.R. 146.136(c)(4)(ii)(F); exclusions based on failure to complete a course of treatment; and restrictions based on geographic location as identified under 45 C.F.R. 146.136(c)(4)(ii)(G), facility type, provider specialty, and other criteria than limit the scope or duration of benefits for services provided under the health plan or coverage as identified under 45 C.F.R. 146.136(c)(4)(ii)(H).

"Outpatient, in-network benefits" are benefits furnished on an outpatient basis and within a network of providers established or recognized under a health plan.

"Outpatient, out-of-network benefits" are benefits furnished on an outpatient basis and outside any network of providers established or recognized under a health plan or under a health plan that has no network of providers.

"Predominant test" means that if a type of FR or QTL applies to substantially all of the Med/Surg benefits in a classification, the predominant level of the FR or QTL is the level that applies to more than 1/2 of the Med/Surg benefits in that classification subject to the FR or QTL. If no single level can be determined, the health plan (or health insurance issuer) may combine levels until the combination of levels applies to more than 1/2 of Med/Surg benefits subject to the FR or QTL in the classification. The least restrictive level within the combination is considered the predominant level of that type of classification. For this purpose, a health plan may combine the most restrictive levels first with each less restrictive level added to the combination until the combination applies to more than 1/2 of the benefits subject to the FR or QTL.

"Quantitative treatment limitation (QTL)" is a limitation on the scope or duration of a benefit that can be expressed numerically that includes day or visit limits such as "50 outpatient visits per year." QTLs include annual, episode, and lifetime day and visit limits such as number of treatments, number of visits, or days of coverage.

"Substance use disorder (SUD) benefits" means benefits with respect to items or services for substance use disorders as defined under the terms of the health plan or health insurance coverage and in accordance with applicable federal and state law and consistent with generally recognized independent standards of current medical practice. Substance use disorder benefits include intermediate benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment), medication assisted treatment (MAT), and treatment for eating disorders.

"Substantially all test" means that a FR or QTL applies to at least 2/3 of all Med/Surg benefits in a classification of benefits for a coverage unit. (For this purpose, benefits expressed as subject to a zero level of a type of FR are treated as not subject to that type of FR. In addition, benefits expressed as subject to an unlimited QTL are treated as not subject to that type of QTL.) If a type of FR or QTL does not apply to at least 2/3 of all Med/Surg benefits in a classification, then that type of FR or QTL cannot be applied to MH or SUD benefits in that classification.

R20-6-1502. Additional Guidance

Additional guidance regarding MHPAEA include, but are not limited to the following:

A. 42 U.S.C. 300gg-26;

B. 45 CFR 146.136;

C. U.S. Department of Labor at www.dol.gov/agencies/ebsa and by using the Department of Labor Self-Compliance Tool;

D. The Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at www.cms.gov/CCIIO and the HHS MHPAEA tool; and

E. The National Association of Insurance Commissioners (NAIC) at www.naic.org.

R20-6-1503. Medical Necessity Criteria and NQTL Reporting

A. Health care insurers subject to the reporting requirement. A health care insurer that issues health plans in Arizona is required to file the reports required by this Section with the Division.

B. Health plans subject to reporting. A health care insurer shall submit a separate report for all health plans it offers in this state (including grandfathered and non-grandfathered health plans) that meet all of the criteria listed in subsections (B)(1) through (B)(4) of this Section. If a health care insurer determines that the information to be reported varies by network plan, or varies in the individual, small group, or large group market, the health care insurer must submit a report for each variation.

1. The health plan offers either MH or SUD benefits in addition to Med/Surg benefits.
2. The health plan offers either MH or SUD benefits in any one of the following classifications:
   a. Inpatient, in-network;
   b. Inpatient, out-of-network;
   c. Outpatient, in-network;
   d. Outpatient, out-of-network;
   e. Emergency care; or
   f. Prescription drugs.
3. The health plan is offered on a group (large or small) or individual basis.
4. The health plan has not received and notified the Division of an increased cost exemption pursuant to 45 C.F.R. 146.136(g).

C. Health plans exempt from reporting. A health plan that meets the criteria of Subsection (B) above is exempt from reporting under this Article if it is one of the following types of health plans:

1. A small group grandfathered health plan; or
2. A health plan that meets the definition of excepted benefit provided in 45 C.F.R. 146.145(b) or 45 C.F.R. 148.220.

D. Required reports. A health care insurer shall file a separate report for each fully insured product network type the insurer issues in Arizona. If the information to be reported varies by network or health plan, or varies in the individual, small group or large group market, the insurer must file a separate report for each variation.

E. Triennial Reports.

1. Existing health care insurers. Beginning on March 15, 2022 and every third year thereafter, a health care insurer issuing health plans and collecting premium in Arizona as of January 1, 2022 shall file a triennial report with the Division for each health plan subject to reporting.
2. Entering or re-entering health care insurers. On or before March 15 of the second year an entering or re-entering health care insurer issues health plans and collects premiums in Arizona, a health care insurer shall file an original triennial report with the Division for each health plan subject to reporting. Following the filing of the original triennial report, the health care insurer shall submit subsequent triennial reports on the schedule described in subsection (E)(1) of this Section.

3. Due date for triennial reports. Triennial reports are due on or before March 15 of each reporting year.
4. Content of the original triennial report. Health care insurers shall file an original triennial report with the Division under A.R.S. § 20-3502(B) that provides the required information in Exhibits A and B, and Section R20-6-1506.
5. Subsequent triennial reports.
    a. A health care insurer must file an updated triennial report, including the information required in Exhibits A and B, and Section R20-6-1506, unless the insurer can attest that it has made no changes since the previously filed triennial report.
    b. As required by A.R.S. § 20-3502(E), a health care insurer shall file the following with the Division for each health plan subject to reporting:
        i. An updated triennial report, including the information required in Exhibits A and B, and Section R20-6-1506; or
        ii. The last triennial report filed with the Division and a written attestation that the health care insurer has made no changes since it filed the previous triennial report.

F. Annual Reports. Pursuant to A.R.S. § 20-3502(E), on or before March 15 of each intervening year between the filing of a triennial report, a health care insurer shall file:
1. A report that summarizes any changes made to its medical necessity criteria and NQTLs;
2. A written attestation that the insurer is in compliance with MHPAEA; and
3. If requested by the Division, the additional data required in Sections R20-6-1505 and R20-6-1506.

G. Additional information. At any time after an insurer files a report under this Section, the Division may request additional information, including an updated triennial or annual report, by contacting the insurer and making the request in writing. The insurer shall provide contact information to the Division when it files any of the reports required by this Section. The Division may set a deadline for an insurer to respond to its request.

R20-6-1504. FR and QTL Reporting

A. Method of reporting. A health care insurer that issues health plans in Arizona and is not exempt from the form filing requirement shall demonstrate its compliance with the FR and QTL parity requirements of MHPAEA through its form and rate filings with the Division.

B. Division's authority to require additional data. In addition to the forms filed by a health insurer, the Division may require a health insurer to submit additional data relating to its methods for meeting the MHPAEA FR and QTL standards. The Division may utilize the HHS MHPAEA tool and may request samples of a health insurer's internal testing to demonstrate compliance with the substantially all and predominant tests within each classification of benefits for a health plan.

C. Separate consolidated report for large group health plans. The Division may require a health insurer that issues large group health plans to file a report that demonstrates compliance with the substantially all and predominant tests within each classification of benefits for health plans with similar benefit structures.

D. Special rule for FRs - Prescription Drug Classification. The multi-tiered prescription drug benefits exception of A.R.S. § 20-3502(D)(1) applies to the FRs for the prescription drug classification. For example, a health plan applies 4 tiers as follows: Tier 1: Generic Drugs for which the health plan pays 90%; Tier 2: Preferred Brand-name Drugs for which the health plan pays 80%; Tier 3: Non-preferred Brand-name drugs for which the health plan pays 60%; and Tier 4: Specialty Drugs for which the health plan pays 50%. These FRs are applied without regard to whether a drug is prescribed for Med/Surg or MH/SUD benefits. In addition, the process for certifying a particular drug within a tier complies with the rules for NQTLs. Therefore, the FRs applied to prescription drug benefits meet the parity requirements under MHPAEA.

E. Special rules for FRs and QTLs.
1. In-network Classifications. The multiple network tiers exception of A.R.S. § 20-3502(D)(2) applies to the FRs and QTLs for the in-network classifications. For example, a health plan has 2 tiers of in-network providers: Tier 1: Preferred provider; and Tier 2: Participating provider. Placement of a provider into a tier complies with the rules for NQTLs and is determined without regard to whether the provider specializes in the treatment of Med/Surg conditions or MH/SUD disorders. The in-network classifications are divided into 2 subclassifications: 1. In-network preferred; and 2. In-network participating. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to all Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the in-network subclassifications that reflect the provider tiers meet the parity requirements under MHPAEA.

2. Outpatient Classifications. The sub-classification permitted for the office visits exception of A.R.S. § 20-3502(D)(3) applies to the FRs and QTLs for the outpatient classifications. For example, a health plan divides the outpatient, in-network classification into 2 subclassifications: 1. In-network office visits; and 2. All other outpatient, in-network items and services. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the outpatient subclassifications for office visits and all other outpatient items and services meet the parity requirements under MHPAEA.
   The health plan cannot use a subclassification for generalists and specialists. The only subclassifications permitted for the in-network classifications are: 1. Office visits (such as physician visits); and 2. All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

R20-6-1505. HEDIS Reporting

Health insurers subject to reporting under Section R20-6-1503 will submit the requested HEDIS measures identified in Exhibit B to the Division unless collection of any measure has been discontinued by the NCQA.

R20-6-1506. NQTL Compliance Indicators Reporting

A. Authority. Pursuant to A.R.S. § 20-3502(B)(3) and 45 C.F.R. 146.136(c)(4)(i), a health plan may not impose a NQTL with respect to MH and SUD benefits in any classification unless, under the terms of the health plan as written and in operation, any process, strategy, evidentiary standard or other factor used in applying the NQTL to MH and SUD benefits in the classification are comparable to, and are applied no more stringently than, any process, strategy, evidentiary standard or other factor used in applying the limit with respect to Med/Surg benefits in the classification. Further, if a health plan or issuer provides MH or SUD benefits in any classification described in the MHPAEA final regulation, MH or SUD benefits must be provided in every classification in which Med/Surg benefits are provided. *See*, 45 CFR 146.136(c)(2)(ii)(A). To demonstrate compliance with MHPAEA NQTL parity requirements, an insurer subject to reporting under Section R20-6-1503 shall submit additional reports to the Division pursuant to A.R.S. §§ 20-3502(A), (B)(3), (F), and 45 C.F.R. 146.136(c)(4)(ii).

B. Compliance indicators. Compliance indicators, as set forth in this Section, are used by the Division to evaluate MHPAEA compliance comprehensively. Any report submitted pursuant to this Section that triggers submitting additional analysis and data to the Division does not establish a per se MHPAEA violation.

C. Required reports. A health care insurer shall file a separate report for each fully insured product network type the insurer issues in Arizona. If the information to be reported varies by network or health plan, or varies in the individual, small group or large group market, the insurer must file a separate report for each variation.

D. Health plans exempt from reporting. A health care insurer that offers health plans that meet the criteria of Section R20-6-1503(B) is exempt from reporting under this Section if it insures 25 lives or less across all health plans which are otherwise subject to reporting.

E. Reporting schedule. The reports required by this Section shall be submitted to the Division with the insurer's triennial report required under subsection R20-6-1503(E) and, if requested by the Division, with its annual report required under subsection R20-6-1503(F).

F. Compliance indicators for medical management standards.

1. To demonstrate parity compliance with medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative as identified under 45 C.F.R. 146.136(c)(4)(ii)(A), a health plan shall submit Exhibits I, J, K and N to the Division.
2. Prior authorization denial rate for which no claim was subsequently submitted. As reported in Exhibit I, if the prior authorization denial rate for which no claim was subsequently submitted for any type of MH/SUD services (reported separately for prior authorization requests for inpatient facility stays, outpatient facility visits, and office visits and reported separately for prior authorization denials due to medical necessity, out-of-network benefit, non-covered benefit, and administrative reasons) exceeds the same denial rate measure for Med/Surg services by more than a factor of three to one, the insurer shall report additional data regarding the development and application of NQTLs to the Division that includes:

a. A description of how medical management standards for MH/SUD benefits result in higher denial rates than for requests for Med/Surg benefits within the same category;
b. An analysis of the information and support provided to both MH/SUD providers and Med/Surg providers to assist providers in their submission of complete requests for medically necessary services; and
c. An analysis of any other factors that may result in a disproportionate percentage of denials of prior authorization requests for MH/SUD benefits compared to Med/Surg benefits within each category.

3. Claim denial rate for medically necessary services. As reported in Exhibit J, if the claim denial rate for MH/SUD claims (reported separately for inpatient facility stays, outpatient facility visits, and office visits and reported separately for claim denials due to medical necessity, out-of-network benefit, non-covered benefit, and administrative reasons) exceeds the same denial rate measure for Med/Surg claims by more than a factor of three to one, the insurer shall report additional data regarding the development and application of NQTLs to the Division that includes:
   a. A description of how medical management standards for MH/SUD benefits result in higher claim denial rates than for requests for Med/Surg benefits within the same category;
   b. An analysis of the information and support provided to both MH/SUD providers and Med/Surg providers to assist in the submission of complete claims for medically necessary services; and
   c. A listing of any other factors which may result in a disproportionate percentage of denials of claims for MH/SUD benefits compared to Med/Surg benefits within each category.
4. Approval of only lower level of care services. As reported in Exhibit K, if the rate at which an insurer approves services only for a lower level of care for MH/SUD benefits (reported separately for inpatient facility stays, outpatient facility visits, and office visits and reported separately for benefit reductions due to medical necessity, out-of-network benefit, non-covered benefit, and administrative reasons) exceeds the same lower level of care approval rate for Med/Surg services by more than a factor of three to one, the insurer shall report additional data regarding the development and application of NQTLs to the Division that includes:
   a. A description of how medical management standards for MH/SUD benefits result in higher rates of approval only for lower level of care than for requests for Med/Surg benefits within the same category;
   b. An analysis of the information and support provided to both MH/SUD providers and Med/Surg providers to assist in the submission of complete requests for medically necessary services at an appropriate level of care; and
   c. A listing of any other factors which may result in a disproportionate percentage of approval only for lower level of care for MH/SUD benefits compared to Med/Surg benefits within each category.

G. Compliance indicators for formulary design. To demonstrate parity compliance with formulary design for prescription drugs under 45 C.F.R. 146.136(c)(4)(ii)(B), a health plan shall submit Exhibit H to the Division.

H. Compliance indicators for network tier design.
1. To demonstrate parity compliance with network tier design under 45 C.F.R. 146.136(c)(4)(ii)(C), a health plan with multiple network tiers (such as preferred providers and participating providers) shall submit Exhibit G to the Division.
2. If the percentage of Med/Surg specialty care providers placed in the lowest network tier exceeds the percentage of MH/SUD providers placed in the lowest network tier by more than a factor of two to one, the insurer shall submit additional information to the Division that includes:
   a. An analysis of the relative cost to the insurer for Med/Surg providers compared to MH/SUD providers for services provided in the lowest network tier and in any other network tier; and
   b. Any other factors the insurer uses in determining how providers are placed into tiers.

I. Compliance indicators for provider admission standards.
1. To demonstrate parity compliance with provider admission standards to participate in a network (including reimbursement rates) under 45 C.F.R. 146.136(c)(4)(ii)(D), a health plan shall submit Exhibits C, D, E, F and L to the Division.
2. Ratio of allowed claims. As reported in Exhibit D, if the ratio of allowed claims for MH/SUD out-of-network benefits to allowed claims for Med/Surg benefits received from a specialist exceeds a factor of three to one, the insurer must provide documentation of the corrective actions it will implement to improve the ratio.
3. Percentage of providers accepting new patients. As reported in Exhibit E, if the total percentage of providers accepting new patients for any type of MH/SUD provider type listed in Exhibit E is less than half

of the percentage of Med/Surg specialist providers accepting new patients, the insurer shall report corrective data to the Division that includes:

a. The results of a root cause analysis identifying the reason(s) for the limited number of such providers accepting new patients, which may include documenting that there is a provider shortage for providers of that type; and
b. The strategies and steps the insurer will employ to increase the number of contracted MH/SUD providers of that type(s) accepting new patients.

4. No in-network claims for outpatient services. As reported in Exhibit F, if the percentage of psychiatrists, child psychiatrists, psychologists, licensed independent clinical social workers, or other MD/SUD licensed professionals who file no in-network claims for outpatient services exceeds the percentage of Med/Surg specialist providers who file no in-network claims for outpatient services, the insurer shall report corrective data to the Division that includes:
   a. The results of a root cause analysis identifying the reason(s) for the limited number of such providers filing outpatient claims; and
   b. The strategies and steps the insurer will employ to ensure that such MH/SUD providers of that type(s) are actively utilized in the network.

J. Compliance indicators for determining charges.

1. To demonstrate parity compliance of health plan methods for determining usual, customary and reasonable charges under 45 C.F.R. 146.136(c)(4)(ii)(E), a health plan shall submit Exhibits C, D, E, F, L and M to the Division and any additional reports generated under Exhibits D, E, and F.
2. Credentialing timeframes. As reported in Exhibit M, if the average time an insurer takes to conclude the process of credentialing and loading an applicant's information into its billing system for any type of MH/SUD provider exceeds the average time an insurer takes to complete the same activities for Med/Surg providers, the insurer shall submit an analysis of the reasons for delay, including provider education, credentialing resources, internal insurer timelines for a response, or any other factor that may result in a disparity between MH/SUD provider credentialing and Med/Surg provider credentialing.

K. Compliance indicators for restrictions on scope or duration of benefits. To demonstrate parity compliance of health plan restrictions that limit the scope or duration of benefits for services provided under the health plan or coverage based on geographic location, facility type, provider specialty, or other criteria under 45 C.F.R. 146.136(c)(4)(ii)(H), a health plan shall submit Exhibits C, D, E and F and any additional reports generated under Exhibits D, E, and F.

L. Duplication of submissions not required. If a health plan is required to submit an exhibit or additional reports under more than one compliance indicator listed at subsections F through K above, a health plan complies with the reporting requirement if it submits one copy of the requested exhibit or additional report to the Division. For example, a health plan that submits Exhibit C to the Division, complies with the portion of subsections I, J, and K requiring the submission of Exhibit C. The health plan is still required to submit all the exhibits or additional reports listed in each subsection.

Exhibit A
Medical Necessity Criteria and NQTL Reports

Instructions
Report information related to the process used to develop or select, and the application of, medical necessity criteria and NQTLs for Med/Surg benefits and MH and SUD benefits. Submit a response for each fully insured, major medical health plan subject to reporting under Section R20-6-1503(B). Please submit the information in a word-searchable PDF file which is organized and identified by the numbered sections that appear below.
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit A.

Reporting Year:		
Insurer Name:		
Insurer NAIC Company Code:		
Network Name(s):		
Service Area: (List all counties in the service area for these networks)		
Covered Lives: (List the number of covered lives enrolled in plans in these networks in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Section A: Med/Surg Benefits

A.1. Processes and Strategies Utilized For Developing Medical Necessity Criteria
[Describe and itemize the processes and strategies which are utilized for identifying and developing medical necessity criteria for Med/Surg benefits.]

A.2. Evidentiary Standards Utilized For Developing Medical Necessity Criteria
[Describe and itemize the evidentiary standards which are utilized for developing medical necessity criteria for Med/Surg benefits.]

A.3. Other Factors Utilized For Developing Medical Necessity Criteria
[Describe and itemize any other factors which are utilized for developing medical necessity criteria for Med/Surg benefits.]

A.4. Identify all NQTLs
[Identify all nonquantitative treatment limits that are applied to Med/Surg benefits within each classification of benefits.]

A.5. Retrospective Review Standards
[Describe any retrospective review standards for medical necessity standards for Med/Surg benefits.]

A.6. Use of Treatment Plans
[Describe the circumstances and method by which treatment plans must be submitted to obtain or continue coverage for Med/Surg benefits.]

A.7. Use of Fail-First or Step Therapy Protocols
[Describe how fail-first or step therapy protocols are established and how the determination is made to apply them to covered Med/Surg benefits.]

A.8. Concurrent Review Requirements
[Describe how factors for concurrent review requirements for Med/Surg benefits are determined.]

A.9. Requirements for Improvement
[Furnish a list of all Med/Surg benefits which make approval contingent upon improvement within a specific number of days.]

A.10. Other Limitations on Obtaining Covered Benefits
[Furnish a list of any other limitations imposed on obtaining Med/Surg benefits covered by the health benefit plan.]

Section B. MH Benefits

B.1. Processes and Strategies Utilized For Developing Medical Necessity Criteria
[Describe and itemize the processes and strategies which are utilized for identifying and developing medical necessity criteria for MH benefits.]

B.2. Evidentiary Standards Utilized for Developing Medical Necessity Criteria
[Describe and itemize the evidentiary standards which are utilized for developing medical necessity criteria for MH benefits.]

B.3. Other Factors Utilized for Developing Medical Necessity Criteria
[Describe and itemize any other factors which are utilized for developing medical necessity criteria for MH benefits.]

B.4. Identify all NQTLs
[Identify all nonquantitative treatment limits that are applied to MH benefits within each classification of benefits.]

B.5. Retrospective Review Standards
[Describe any retrospective review standards for medical necessity standards for MH benefits.]

B.6. Use of Treatment Plans
[Describe the circumstances and method by which treatment plans must be submitted to obtain or continue coverage for MH benefits.]

B.7. Use of Fail-First or Step Therapy Protocols
[Describe how fail-first or step therapy protocols are established and how the determination is made to apply them to covered MH benefits.]

B.8. Concurrent Review Requirements
[Describe how factors for concurrent review requirements for MH are determined.]

B.9. Requirements for Improvement
[Furnish a list of all MH benefits which make approval contingent upon improvement within a specific number of days.]

B.10. Other Limitations on Obtaining Covered Benefits
[Furnish a list of any other limitations imposed on obtaining MH benefits covered by the health benefit plan.]

B.11. Comparison of NQTLs Applied to MH and Med/Surg Benefits
[Furnish a comparison to demonstrate that any process, strategy, evidentiary standard or other factor used in applying nonquantitative treatment limits to MH benefits is applied not more stringently than any process, strategy, evidentiary standard or other factor used in applying the treatment limit for Med/Surg benefits in the same classification.]

B.12. Program of Auditing and Monitoring For Compliance
[Furnish a description of the program for auditing and monitoring the application of medical necessity criteria and other medical management standards and nonquantitative treatment limits to MH benefits to ensure that they are not applied more stringently than those criteria or standards applied to Med/Surg benefits in the same classification.]

Section C. SUD Benefits

C.1. Processes and Strategies Utilized for Developing Medical Necessity Criteria
[Describe and itemize the processes and strategies which are utilized for identifying and developing medical necessity criteria for SUD benefits.]

C.2. Evidentiary Standards Utilized for Developing Medical Necessity Criteria
[Describe and itemize the evidentiary standards which are utilized for developing medical necessity criteria for SUD benefits.]

C.3. Other Factors Utilized for Developing Medical Necessity Criteria
[Describe and itemize any other factors which are utilized for developing medical necessity criteria for SUD benefits.]

C.4. Identify all NQTLs
[Identify all nonquantitative treatment limits that are applied to SUD benefits within each classification of benefits.]

C.5. Retrospective Review Standards
[Describe any retrospective review standards for medical necessity standards for SUD benefits.]

C.6. Use of Treatment Plans
[Describe the circumstances and method by which treatment plans must be submitted to obtain or continue coverage for SUD benefits.]

C.7. Use of Fail-First or Step Therapy Protocols
[Describe how fail-first or step therapy protocols are established and how the determination is made to apply them to covered SUD benefits.]

C.8. Concurrent Review Requirements
[Describe how factors for concurrent review requirements for SUD are determined.]

C.9. Requirements for Improvement
[Furnish a list of all SUD benefits which make approval contingent upon improvement within a specific number of days.]

C.10. Other Limitations on Obtaining Covered Benefits
[Furnish a list of any other limitations imposed on obtaining SUD benefits covered by the health benefit plan.]

C.11. Comparison of NQTLs Applied to SUD and Med/Surg Benefits
[Furnish a comparison to demonstrate that any process, strategy, evidentiary standard or other factor used in applying nonquantitative treatment limits to SUD benefits is applied not more stringently than any process, strategy, evidentiary standard or other factor used in applying the treatment limit for Med/Surg benefits in the same classification.]

C.12. Program of Auditing and Monitoring for Compliance
[Furnish a description of the program for auditing and monitoring the application of medical necessity criteria and other medical management standards and nonquantitative treatment limits to SUD benefits to ensure that they are not applied more stringently than those criteria or standards applied to Med/Surg benefits in the same classification.]

Section D. Pharmacy Benefits

D.1. Factors for Med/Surg Pharmacy Benefits
[Furnish a list of the factors considered, including any factors considered and discarded, when establishing prior authorization for pharmacy benefits for Med/Surg conditions.]

D.2. Factors for MH Pharmacy Benefits
[Furnish a list of the factors considered, including any factors considered and discarded, when establishing prior authorization for pharmacy benefits for MH conditions.]

D.3. Factors for SUD Pharmacy Benefits
[Furnish a list of the factors considered, including any factors considered and discarded, when establishing prior authorization for pharmacy benefits for SUD conditions.]

D.4. Fail-First or Step Therapy for Med/Surg Pharmacy Benefits
[Describe the decision-making process for determining if fail-first or step-therapy is required for pharmacy benefits for Med/Surg conditions.]

D.5. Fail-First or Step Therapy for MH Pharmacy Benefits
[Describe the decision-making process for determining if fail-first or step-therapy is required for pharmacy benefits for MH conditions.]

D.6. Fail-First or Step Therapy for SUD Pharmacy Benefits
[Describe the decision-making process for determining if fail-first or step-therapy is required for pharmacy benefits for SUD conditions.]

D.7. Tiering Pharmacy Drugs for Med/Surg Pharmacy Benefits
[Furnish a list of the factors considered when tiering pharmacy drugs for Med/Surg conditions.]

D.8. Tiering Pharmacy Drugs for MH Pharmacy Benefits
[Furnish a list of the factors considered when tiering pharmacy drugs for MH conditions.]

D.9. Tiering Pharmacy Drugs for SUD Pharmacy Benefits
[Furnish a list of the factors considered when tiering pharmacy drugs for SUD conditions.]

D.10. Other Limitations on Pharmacy Benefits
[Furnish a list of any other limitations imposed on obtaining pharmacy benefits covered by the health benefit plan.]

D.11. Comparison of NQTLs Applied to Pharmacy Benefits
[Provide a comparison to demonstrate that any process, strategy, evidentiary standard or other factor used in applying nonquantitative treatment limits to MH and SUD pharmacy benefits is applied not more stringently than any process, strategy, evidentiary standard or other factor used in applying the treatment limit for Med/Surg benefits in the same classification.]

D.12. Program of Auditing and Monitoring For Compliance
[Describe the program for auditing and monitoring the application of prior authorization, fail-first or step therapy, or formulary tiering to ensure that standards applied to MH and SUD benefits are not applied more stringently than those criteria or standards applied to Med/Surg benefits.]

Exhibit B
Selected HEDIS Measures

Instructions
For each fully insured major medical plan subject to reporting under R20-6-1503(B) submit the HEDIS measures listed below. Please submit the information in a word-searchable PDF file which is organized and identified by the measures listed below. The reporting year is the year, from January 1 through December 31, preceding the submission of this table for which final HEDIS data has been collected.

Reporting Year:		
Insurer Name:		
Insurer NAIC Company Code:		
Network Name(s):		
Service Area: (List all counties in the service area for these networks)		
Covered Lives: (List the number of covered lives enrolled in plans in these networks in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

1. Follow-Up After Hospitalization for Mental Illness (FUH)
2. Follow-Up After Emergency Department Visit for Mental Illness (FUM)
3. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
4. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
5. Identification of Alcohol and Other Drug Services (IAD)
6. Mental Health Utilization (MPT)
7. Depression Screening and Follow-Up for Adolescents and Adults (DSF)
8. Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)
9. Depression Remission or Response for Adolescents and Adults (DRR)
10. Unhealthy Alcohol Use Screening and Follow-Up
11. Prenatal Depression Screening and Follow-up (PND)
12. Postpartum Depression Screening and Follow-up (PDS)

Exhibit C
Complaints Related to Network Access

Instructions
Provide data on complaints received from members related to the ability to access care through network providers. Complete one table for each network utilized by fully insured, major medical plans.
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit C.

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity
	MH/SUD Care	**Med/Surg Care**
Member complaints regarding inability to access a provider or provider type		

Exhibit D
Percentage of Allowed Claims for Out of Network (OON) Services

Instructions
Provide data related to complaints received from members related to the ability to access care through network providers.
Complete one table for each network utilized by fully insured, major medical plans.
"Inpatient facility stays" include hospitalization for scheduled procedures, admission at the direction of a physician, as well as hospitalization following the receipt of emergency services as defined at A.R.S. § 20-2801.
"Outpatient facility visits" include care which does not require hospital admission, but which is not rendered in a physician's office.
"Services obtained through network exception" are services authorized when the enrollee or enrollee's referring provider cannot find a contracted provider who is timely accessible or available pursuant to Section R20-6-1910.
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit D.

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Provide the percentage of all allowed claims that were for OON, for Med/Surg and for MH/SUD services.

Setting	Column A Percentage of all allowed Med/Surg specialist provider claims that were for OON services (including, for HCSOs, services obtained through network exception)	Column B Percentage of all allowed MH/SUD provider claims that were for OON services (including, for HCSOs, services obtained through network exception)	Column C The absolute difference in percentage points between Column A and Column B	Column D The ratio of Column B to Column A
Inpatient Facility Stays				
Outpatient Facility Visits				
Office Visits				

Exhibit E
Percentage of In-Network Providers Accepting New Patients

Instructions
Provide data related to providers who are accepting new patients. Complete one table for each network utilized by fully insured, major medical plans.
"Provider accepting new patients" is a provider who a member can contact directly to receive an appointment as a new patient.
"Child psychiatrist" is a psychiatrist who has received specialized training to provide treatment for children or adolescents up to the age of 18 years old.
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit E.

Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Provide the total number of providers, total number of providers with open panels, and the total percentage of providers with open panels for each provider type.

	Provider Type	Column A: Total Number of Providers	Column B: Total Number Accepting New Patients	Column C: Total Percentage Accepting New Patients (Column A / Column B)
1	Med/Surg primary care providers			
2	Med/Surg specialist providers			
3	All MH/SUD providers			
4	Psychiatrists, including child psychiatrists			
5	Child psychiatrists			
6	Psychologists			
7	Licensed independent clinical social workers			
8	Licensed independent professional counselors			
9	Licensed independent marriage and family therapists			
10	Licensed independent substance abuse counselors			
11	Board certified behavioral analysts			
12	Nurse practitioners certified as mental health and psychiatric nurses			
13	Physician assistants certified as mental health and psychiatric physician assistants			

Exhibit F
Active Providers Listed in Network Directory by Provider Type

Instructions
Report data related to providers who are actively providing care to members in the network as evidenced through submission of claims during the reporting year. Complete one Exhibit F for each network utilized by fully insured, major medical plans.
"Child psychiatrist" is a psychiatrist who has received specialized training to provide treatment for children or adolescents up to the age of 18 years old.
"Claims" include claims for outpatient services, with dates of service during the applicable reporting period, including claims received through a date beyond the end of the applicable reporting period.
"Other MH/SUD Licensed Professionals" include licensed independent marriage and family therapists, licensed independent professional counselors, licensed independent substance abuse counselors, board certified behavioral analysts, nurse practitioners certified as mental health and psychiatric nurses, and physician assistants certified as mental health and psychiatric physician assistants.
The applicable reporting period is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit F.

Reporting Period (mm/dd/yy – mm/dd/yy)		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

	Psychiatrist Data	
1	Total number of psychiatrists (including child psychiatrists) who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
2	Number of psychiatrists (including child psychiatrists) who submitted zero in-network, claims during the Applicable Reporting Period:	
3	Number of psychiatrists (including child psychiatrists) who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
4	Number of psychiatrists (including child psychiatrists) who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
5	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
6	Total number of members served by this network (insured lives, unique individuals):	
7	Ratio of psychiatrists (including child psychiatrists) to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
8	Ratio of psychiatrists (including child psychiatrists) who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
9	Percentage of psychiatrists who submitted zero in-network claims (Row 2 divided by Row 1):	
	Child Psychiatrist Data	
10	Total number of child psychiatrists who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	

11	Number of child psychiatrists who submitted zero in-network claims during the Applicable Reporting Period:	
12	Number of child psychiatrists who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
13	Number of child psychiatrists who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
14	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
15	Total number of members under age 19 served by this network (insured lives, unique individuals):	
16	Ratio of child psychiatrists to total child covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
17	Ratio of child psychiatrists who submitted in-network claims for 1 or more unique individuals to total child covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
18	Percentage of child psychiatrists who submitted zero in-network claims (Row 2 divided by Row 1):	
	Psychologist Data	
19	Total number of psychologists who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
20	Number of psychologists who submitted zero in-network claims during the Applicable Reporting Period:	
21	Number of psychologists who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
22	Number of psychologists who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
23	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
24	Total number of members served by this network (insured lives, unique individuals):	
25	Ratio of psychologists to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
26	Ratio of psychologists who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
27	Percentage of psychologists who submitted zero in-network claims (Row 2 divided by Row 1):	
	Licensed Independent Clinical Social Worker (LICSW) Data	
28	Total number of LICSWs who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
29	Number of LICSWs who submitted zero in-network claims during the Applicable Reporting Period:	
30	Number of LICSWs who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
31	Number of LICSWs who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
32	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
33	Total number of members served by this network (insured lives, unique individuals):	
34	Ratio of LICSWs to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
35	Ratio of LICSWs who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
36	Percentage of LICSWs who submitted zero in-network claims (Row 2 divided by Row 1):	
	Other MH/SUD Licensed Professional Data	

37	Total number of Other MH/SUD Licensed Professionals who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
38	Number of Other MH/SUD Licensed Professionals who submitted zero in-network claims during the Applicable Reporting Period:	
39	Number of Other MH/SUD Licensed Professionals who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
40	Number of Other MH/SUD Licensed Professionals who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
41	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
42	Total number of members served by this network (insured lives, unique individuals):	
43	Ratio of Other MH/SUD Licensed Professionals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
44	Ratio of Other MH/SUD Licensed Professionals who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
45	Percentage of Other MH/SUD Licensed Professionals who submitted zero in-network claims (Row 2 divided by Row 1):	
Primary Care Provider (PCP) Data		
46	Total number of PCPs who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
47	Number of PCPs who submitted zero in-network claims during the Applicable Reporting Period:	
48	Number of PCPs who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
49	Number of PCPs who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
50	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
51	Total number of members served by this network (insured lives, unique individuals):	
52	Ratio of PCPs to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
53	Ratio of PCPs who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
54	Percentage of PCPs who submitted zero in-network claims (Row 2 divided by Row 1):	
Med/Surg Specialist Provider Data		
55	Total number of Med/Surg Specialists who were listed as participating in this network during any time in the most recent 12 months for which reasonably complete claims data is available ("Applicable Reporting Period"):	
56	Number of Med/Surg Specialists who submitted zero in-network claims during the Applicable Reporting Period:	
57	Number of Med/Surg Specialists who submitted in-network claims for 1 to 4 unique individuals during the Applicable Reporting Period:	
58	Number of Med/Surg Specialists who submitted in-network claims for 5 or more unique individuals during the Applicable Reporting Period:	
59	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
60	Total number of members served by this network (insured lives, unique individuals):	
61	Ratio of Med/Surg Specialists to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by Row 1):	
62	Ratio of Med/Surg Specialists who submitted in-network claims for 1 or more unique individuals to total covered lives under the network, indicated as 1:xxx (calculating xxx by dividing Row 6 by (Row 3 + Row 4)):	
63	Percentage of Med/Surg Specialists who submitted zero in-network claims (Row 2 divided by Row 1):	

Exhibit G
Provider Network Tiers

Instructions
Provide data on the percentage of providers of certain types who are placed in the lowest tier of a tiered network. Complete one Exhibit G for each network that utilizes network tiers utilized by fully insured, major medical plans.
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit G.

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Provide the percentage of providers who are placed in the lowest network tier for each provider type.

1	Med/Surg primary care providers	
2	Med/Surg specialist providers	
3	All MH/SUD providers	
4	Psychiatrists, including child psychiatrists	
5	Child psychiatrists	
6	Psychologists	
7	Licensed independent clinical social workers	
8	Licensed independent professional counselors	
9	Licensed independent marriage and family therapists	
10	Licensed independent substance abuse counselors	
11	Board certified behavioral analysts	
12	Nurse practitioners certified as a mental health and psychiatric nurse	
13	Physician assistants certified as a mental health and psychiatric physician assistant	

Exhibit H
Formulary Tiers

Instructions
Provide a count of the total number of Chemically Distinct Drugs in each selected United States Pharmacopeia category and class, the total number of Chemically Distinct Drugs in each selected class on the formulary, and the total number of Chemically Distinct Drugs in each selected class placed in the lowest cost drug tier. Complete one Exhibit H for each formulary utilized by fully insured, major medical plans during the reporting year.
"Chemically Distinct Drug" is a drug which has its own RxNorm Concept Unique Identifier (RXCUI).
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit H.

Reporting Year:		
Formulary Name/Identifier:		
Service Area: (List all counties in the service area where this formulary is in use)		
Covered Lives: (List the number of covered lives enrolled in plans that utilized this formulary in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

	United States Pharmacopeia Category and Class	**Total Number of Drugs in Class**	**Total Number of Drugs on Formulary**	**Total Number of Drugs Placed in Lowest Cost Tier**
1	Anti-Addiction/Substance Abuse Treatment Agents: Alcohol Deterrents/Anti-craving			
2	Anti-Addiction/Substance Abuse Treatment Agents: Opioid Dependence Treatments			
3	Anti-Addiction/Substance Abuse Treatment Agents: Opioid Reversal Agents			
4	Anti-Addiction/Substance Abuse Treatment Agents:			
5	Antidepressants: Monoamine Oxidase Inhibitors			
6	Antidepressants: SSRIs/SNRIs			
7	Antidepressants: Tricyclics			
8	Antidepressants: Antidepressants, Other			
9	Antipsychotics: 1st Generation/Typical			
10	Antipsychotics: 2nd Generation/Atypical			
11	Antipsychotics: Treatment-Resistant			
12	Anxiolytics: Benzodiazepines			
13	Anxiolytics: SSRIs/SNRIs			
14	Anxiolytics: Anxiolytics, Other			
15	Bipolar Agents: Mood Stabilizers			
16	Bipolar Agents: Bipolar Agents, Other			
17	Blood Glucose Regulators: Antidiabetic Agents			
18	Blood Glucose Regulators: Glycemic Agents			
19	Blood Glucose Regulators: Insulins			
20	Central Nervous System Agents: Attention Deficit Hyperactivity Disorder Agents, Amphetamines			
21	Central Nervous System Agents: Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines			

22	Gastrointestinal Agents: Antispasmodics, Gastrointestinal			
23	Gastrointestinal Agents: Histamine2 (H2) Receptor Antagonists			
24	Gastrointestinal Agents: Irritable Bowel Syndrome Agents			
25	Gastrointestinal Agents: Laxatives			
26	Gastrointestinal Agents: Protectants			
27	Gastrointestinal Agents: Proton Pump Inhibitors			
28	Gastrointestinal Agents: Gastrointestinal Agents, Other			

Exhibit I
Prior Authorization Denial Rates for Which No Claim Subsequently Submitted (Med/Surg v. MH/SUD)

Instructions
Provide data on the prior authorization denial rates for which no claim was subsequently submitted. Complete one Exhibit I for each network utilized by fully insured, major medical plans.
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit I

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)

Prior Authorization Denial Rates for which No Claim Subsequently Submitted

	Benefit Category & Denial Reason	**Setting**		
		Inpatient Facility Stays	**Outpatient Facility Visits**	**Office Visits**
1	Med/Surg – Medical Necessity			
2	MHSUD – Medical Necessity			
3	Med/Surg – Out of Network Benefit			
4	MHSUD – Out of Network Benefit			
5	Med/Surg – Non-Covered Benefit			
6	MHSUD – Non-Covered Benefit			
7	Med/Surg – Administrative			
8	MHSUD - Administrative			

Exhibit J
Claim Denial Rates for Med/Surg v. MH/SUD

Instructions
Provide data on the claim denial rates for Med/Surg versus MH/SUD benefits. Complete one Exhibit J for each network utilized by fully insured, major medical plans.
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit J.

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Claim Denials

	Benefit Category & Denial Reason	**Setting**		
		Inpatient Facility Stays	**Outpatient Facility Visits**	**Office Visits**
1	Med/Surg – Medical Necessity			
2	MHSUD – Medical Necessity			
3	Med/Surg – Out of Network Benefit			
4	MHSUD – Out of Network Benefit			
5	Med/Surg – Non-Covered Benefit			
6	MHSUD – Non-Covered Benefit			
7	Med/Surg – Administrative			
8	MHSUD – Administrative			

Exhibit K
Rates of Approval only for Lower Level of Care for Med/Surg v. MH/SUD Care

Instructions
Provide data on denial of the requested care and approval of a lower level of care. Complete one Exhibit K for each network utilized by fully insured, major medical plans.
A "prior authorization is authorized for a lower level of care" when a request is received for inpatient care, but only outpatient facility care or office visits is approved; or when a request is received for outpatient facility care but only office visits are approved.
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit K.

Reporting Year:		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)

Rates at which the Insurer Approved a Lower Level of Care

	Benefit Category & Denial Reason	**Setting**		
		Inpatient Facility Stays	**Outpatient Facility Visits**	**Office Visits**
1	Med/Surg – Medical Necessity			
2	MHSUD – Medical Necessity			
3	Med/Surg – Out of Network Benefit			
4	MHSUD – Out of Network Benefit			
5	Med/Surg – Non-Covered Benefit			
6	MHSUD – Non-Covered Benefit			
7	Med/Surg – Administrative			
8	MHSUD – Administrative			

Exhibit L
Allowed Amounts, Med/Surg v. MH/SUD, using Medicare Benchmark

Instructions
Provide data on the Weighted Average Allowed Amounts for certain physician types compared to the Medicare allowed amount. Complete one Exhibit L for each network utilized by fully insured, major medical plans.
"Weighted Average Allowed Amount" is the sum of the allowed amounts for every claim for the indicated CPT code that was allowed for these providers, divided by the total number of claims for the indicated CPT code allowed for such providers.
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit L.

Reporting Year		
Network Name:		
Network's Service Area: (List all counties in the service area for this network)		
Covered Lives: (List the number of covered lives enrolled in plans in this network in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Primary Care Physicians ("PCPs") and Non-Psychiatrist Medical/Surgical Specialist Physicians (Combined)					
Weighted Average Allowed Amount for the Reporting Year		National Medicare Fee Schedule Allowed Amount for the Reporting Year		Weighted Average Allowed Amount as a Percentage of National Medicare Fee Schedule Allowed Amount	
CPT 99213	CPT 99214	CPT 99213	CPT 99214	CPT 99213	CPT 99214
$	$	$	$	%	%
Psychiatrists, Including Child Psychiatrists					
Weighted Average Allowed Amount for the Reporting Year		National Medicare Fee Schedule Allowed Amount for the Reporting Year		Weighted Average Allowed Amount as a Percentage of National Medicare Fee Schedule Allowed Amount	
CPT 90834	CPT 90837	CPT 90834	CPT 90837	CPT 90834	CPT 90837
$	$	$	$	%	%
Physical Therapists					
Weighted Average Allowed Amount for the Reporting Year		National Medicare Fee Schedule Allowed Amount for the Reporting Year		Weighted Average Allowed Amount as a Percentage of National Medicare Fee Schedule Allowed Amount	
CPT 97162	CPT 97110	CPT 97162	CPT 97110	CPT 97162	CPT 97110
$		$		%	
Psychologists					
Weighted Average Allowed Amount for the Reporting Year		National Medicare Fee Schedule Allowed Amount for the Reporting Year		Weighted Average Allowed Amount as a Percentage of National Medicare Fee Schedule Allowed Amount	
CPT 90834	CPT 90837	CPT 90834	CPT 90837	CPT 90834	CPT 90837
$	$	$	$	%	%
Licensed Independent Clinical Social Workers					
Weighted Average Allowed Amount for the Reporting Year		National Medicare Fee Schedule Allowed Amount for the Reporting Year		Weighted Average Allowed Amount as a Percentage of National Medicare Fee Schedule Allowed Amount	
CPT 90834	CPT 90837	CPT 90834	CPT 90837	CPT 90834	CPT 90837
$	$	$	$	%	%

Exhibit M
Credentialing Timeframes, Med/Surg v. MH/SUD

Instructions
Provide data on the average time to credential and load providers of certain types. Complete one Exhibit M providing these averages across all fully insured, major medical plans subject to reporting under R20-6-1503(B).
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit M.

Reporting Year:		
Covered Lives: (List the number of covered lives enrolled in plans subject to reporting in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

	Provider Type	**Average time to conclude the process of credentialing and load the applicant's information into the health insurer's billing system**	**Average time to load the provider's information into the health insurer's network directory**
1	Med/Surg Providers		
2	All MH/SUD Providers		
3	Psychiatrists, including child psychiatrists		
4	Child psychiatrists		
5	Psychologists		
6	Licensed independent clinical social workers		
7	Licensed independent professional counselors		
8	Licensed independent marriage and family therapists		
9	Licensed independent substance abuse counselors		
10	Board certified behavioral analysts		
11	Nurse practitioners certified as a mental health and psychiatric nurse		
12	Physician assistants certified as a mental health and psychiatric physician assistant		

Exhibit N
Medical Management Techniques by Benefit

Instructions
Indicate which of the identified medical management categories apply to the identified list of benefits. Complete one Exhibit N for each fully insured, major medical plan. If the application of medical management standards varies across plans, submit one Exhibit N for each variation.
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit N.

Reporting Year:		
Covered Lives: (List the number of covered lives enrolled in plans subject to reporting in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

	Benefit Name	**Medical Management**			
		Prior authorization/ Precertification Required	**Fail-First or Step Therapy Requirements Apply**	**Concurrent Authorization Requirements Apply**	**Retrospective Review Applies**
1	Allergy Testing				
2	Autism Spectrum Disorders				
2a	Applied Behavior Analysis (ABA) Based Therapies				
2b	Evaluation and Assessment Services				
2c	Habilitative Care				
2d	Rehabilitative Care				
2e	Pharmacy Care and Medication				
2f	Psychiatric Care				
2g	Psychological Care, Including Family Counseling				
3	Drugs – Generic				
4	Drugs - Preferred Brand				
5	Drugs - Non-Preferred Brand				
6	Drugs – Specialty				
7	Durable Medical Equipment				
8	Emergency Room Services				
8a	Med/Surg				
8b	Behavioral Health/MH				
8c	SUD				
9	Emergency Transportation/Ambulance				
9a	Med/Surg				
9b	Behavioral Health/MH				
9c	SUD				
10	Habilitative Occupational Therapy – Adult				
11	Habilitative Occupational Therapy – Child				
12	Habilitative Physical Therapy - Adult				
13	Habilitative Physical Therapy - Child				
14	Habilitative Speech Therapy - Adult				

15	Habilitative Speech Therapy - Child					
16	Home Health Care Services					
17	Hospice Services					
18	Imaging (CT/PET Scans, MRIs)					
19	Inpatient Hospital Services (e.g., Hospital Stay)					
19a	Med/Surg					
19b	Behavioral Health/MH					
19c	SUD					
20	Inpatient Physician and Surgical Services					
20a	Med/Surg					
20b	Behavioral Health/MH					
20c	SUD					
21	Intensive Outpatient Therapy for MH					
22	Intensive Outpatient Therapy for SUD					
23	Laboratory Outpatient and Professional Services					
24	Long-Term/Custodial Nursing Home Care					
25	Other Practitioner Office Visit (Nurse, Physician Assistant)					
25a	Med/Surg					
25b	Behavioral Health/MH					
25c	SUD					
26	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					
27	Outpatient Surgery Physician/Surgical Services					
28	Partial Hospitalization for Behavioral Health/MH					
29	Partial Hospitalization for SUD					
30	Postpartum MH/SUD					
30a	Med/Surg					
30b	Behavioral Health/MH					
30c	SUD					
31	Preventive Care/Screening/Genetic Testing/Immunization – Adult					
31a	Med/Surg					
31b	Behavioral Health/MH					
31c	SUD					
32	Preventive Care/Screening/Genetic Testing/Immunization – Child					
32a	Med/Surg					
32b	Behavioral Health/MH					
32c	SUD					
33	Primary Care Visit to Treat an Injury or Illness					
33a	Med/Surg					
33b	Behavioral Health/MH					
33c	SUD					
34	Rehabilitative Occupational Therapy – Adult					
35	Rehabilitative Occupational Therapy – Child					
36	Rehabilitative Physical Therapy - Adult					
37	Rehabilitative Physical Therapy - Child					
38	Rehabilitative Speech Therapy - Adult					
39	Rehabilitative Speech Therapy - Child					
40	Residential Day Treatment for MH					

41	Residential Day Treatment for SUD					
42	Skilled Nursing Facility					
43	Specialist Visit					
43a		Med/Surg				
43b		Behavioral Health/MH				
43c		SUD				
44	Telehealth PCP					
44a		Med/Surg				
44b		Behavioral Health/MH				
44c		SUD				
45	Telehealth Specialist					
45a		Med/Surg				
45b		Behavioral Health/MH				
45c		SUD				
46	Transplant					
47	Urgent Care Centers or Facilities					
48	X-rays and Diagnostic Imaging					