NQTL: Blanket Exclusions of Services

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

Step 1 - In Writing: Define Blanket Exclusions of Services

Define "Blanket Exclusions of Services" as applied by the Plan to benefits in this classification.

This definition should focus on coverage exclusions that apply uniformly to all Plan beneficiaries, even if it is recommended or prescribed by a physician or it is the only available treatment for a condition or diagnosis, with no consideration of Medical Necessity or other factors.

The definition may include or exclude Experimental/Investigational Determinations, Provider-type Exclusions, Exclusions for Court-Ordered Treatment or Involuntary Holds, Out-of-Network Coverage Standards (e.g. for an exclusive provider organization), and Geographic Restrictions, and related concepts. To the extent that these other NQTLs are not included and analyzed under Blanket Exclusion of Services, they should each be analyzed as a separate NQTL.

NOTE: If no Blanket Exclusion of Services 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 2 - In Writing: Identify the benefits/services that are subject to a Blanket Exclusion of Services

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

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

Step 3 - In Writing: Identify and define the factors used to determine which benefits are subject to a Blanket Exclusion of Services

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 Blanket Exclusion of Services to a given benefit. Examples of selection factors and definitions 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

Definitions may or may not include a quantitative threshold, but each definition should include a clearly-identified evidentiary standard and/or data source that is used to evaluate or measure the factor and determine whether or not the factor is met. 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

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 Services. Instead, this step focuses on the factors, data sources, and evidentiary standards that were used to decide to apply a Blanket Exclusion of Services.

Step 4 - In Writing: For each benefit subject to a Blanket Exclusion of Services, 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 Services 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 5 - In Operation: Briefly describe the processes by which Blanket Exclusions of Services 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 Services to a MH/SUD treatment or service vs. a M/S treatment or service.

Step 6 - In Operation: Identify and define the factors and processes that are used to monitor and evaluate the application of Blanket Exclusions of Services

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

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

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

Appendix A – Factors Grid

	Non-covered diagnoses	**Non-medical services**	**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.			

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 - In Writing: Define Court-Ordered Treatment or Involuntary Holds Exclusions

Define "Exclusions for Court-Ordered Treatment or Involuntary Holds" as applied by the Plan to benefits in this classification. This definition should focus on coverage exclusions that apply uniformly to all Plan beneficiaries, with no consideration of Medical Necessity or other factors.

The definition may include or exclude Experimental/Investigational Determinations, Blanket Exclusions, Provider-type Exclusions, Out-of-Network Coverage Standards (e.g. for an exclusive provider organization), and Geographic Restrictions, and related concepts. To the extent that these other NQTLs are not included and analyzed under Exclusions for Court-Ordered Treatment or Involuntary Holds, they should each be analyzed as a separate NQTL.

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 2 - In Writing: 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 3 - In Writing: Identify and define the factors used to determine which benefits are subject to a Court-Ordered Treatment or Involuntary Holds Exclusion

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 Court-Ordered Treatment or Involuntary Holds Exclusion to a given benefit.

Definitions may or may not include a quantitative threshold, but each definition should include a clearly-identified evidentiary standard and/or data source that is used to evaluate or measure the factor and determine whether or not the factor is met. 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 - In Writing: 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 5 - In Operation: 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 6 - In Operation: 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.

NQTL: Provider-Type Exclusions

Classification(s): separate analyses should be submitted for each classification of benefits for which Provider-Type Exclusions (Provider Type Exclusion) are applied

Step 1 - In Writing: Define Provider-Type Exclusions

Define "Provider-Type Exclusions" as applied by the Plan to benefits in this classification. The Plan's definition should focus on exclusions of coverage for otherwise-covered services when such services are delivered by a defined Provider Type. This may include policies that exclude coverage for designated services when delivered by the identified Provider Type, and/or policies that exclude coverage for all services when delivered by the identified Provider Type. This definition should focus on coverage exclusions that apply uniformly to all Plan beneficiaries, with no consideration of Medical Necessity or other factors.

The definition may include or exclude Experimental/Investigational Determinations, Blanket Exclusions, Exclusions for Court-Ordered Treatment or Involuntary Holds, Out-of-Network Coverage Standards (e.g. for an exclusive provider organization), and Geographic Restrictions, and related concepts. To the extent that these other NQTLs are not included and analyzed under Provider-type Exclusions, they should each be analyzed as a separate NQTL.

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 2 - In Writing: 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 3 - In Writing: Identify and define the factors used to determine which Provider Types are subject to a Provider Type Exclusion

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 services 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

Definitions may or may not include a quantitative threshold, but each definition should include a clearly-identified evidentiary standard and/or data source that is used to evaluate or measure the factor and determine whether or not the factor is met. 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 - In Writing: 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 5 - In Operation: 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 6 - In Operation: 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.

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 - In Writing: Define "Out-of-Network Coverage Standards"

Define "Out-of-Network Coverage Standards" as applied by the Plan to benefits in this classification. The Plan's definition should focus on standards and processes for authorizing coverage for treatments and services delivered by out-of-network providers.

The Plan's definition may exclude NQTLs related to the development and retention of the provider network itself, including Provider Reimbursement and Provider Network Admission Standards, which may be analyzed as separate NQTLs.

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."

Step 2 - In Writing: Identify the Plan's limits that are based on Out-of-Network Coverage Standards

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
- Concurrent or Retrospective Review for all urgent or emergency out-of-network services
- Exclusions of coverage for all non-authorized out-of-network services

Step 3 - In Writing: Identify and define the factors used to apply Out-of-Network Coverage Standards

Each factor must be defined with sufficient precision to determine whether a given authorization request or claim for OON coverage will be approved.

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 selection factors and definitions 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

Definitions may or may not include a quantitative threshold, but each definition should include a clearly-identified evidentiary standard and/or data source that is used to evaluate or measure the factor and determine whether or not the factor is met. 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 - In Writing: For each benefit subject to Out-of-Network Coverage Standards, identify which of the factor(s) in Step 3 were met

N/A

Step 5 - In Operation: 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 6 - In Operation: 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.

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 - In Writing: Define "Geographic Restrictions"

Define "Geographic Restrictions" as applied by the Plan to benefits in this classification. The Plan's definition should focus on 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, and may focus on limits on coverage for in-person (non-telehealth) treatments and services.

The definition may exclude limits on coverage that include geographic components but are analyzed under other NQTL analyses. For example, limits on coverage for out-of-network

(OON) services that are analyzed under the OON benefit classifications for other reported NQTLs. Similarly, Prior Authorization requirements for services delivered by OON providers outside of the service area may be analyzed under the OON benefit classifications of the Prior Authorization analysis. Limits on provider networks outside of the state or service area may be analyzed under the in-network and OON benefit classifications of the Provider Network Admissions analysis. Exclusions of coverage for treatments and services delivered outside of the United States may be analyzed under the Blanket Exclusions of Services analysis.

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 2 - In Writing: 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
- Concurrent or retrospective Review for all urgent or emergency out-of-area services
- Exclusions of coverage for all non-authorized out-of-area services

Step 3 - In Writing: Identify and define the factors used to apply Geographic Restrictions

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

Definitions may or may not include a quantitative threshold, but each definition should include a clearly-identified evidentiary standard and/or data source that is used to evaluate or measure the factor and determine whether or not the factor is met. 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 - In Writing: For each benefit subject to Geographic Restrictions, identify which of the factor(s) in Step 3 were met

N/A

Step 5 - In Operation: 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 6 - In Operation: 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.